AMERICAN-AMICABLE LIFE INSURANCE COMPANY OF TEXAS

P.O. BOX 2549, WACO, TX 76702-2549 • (254) 297-2777

INDIVIDUAL LIFE INSURANCE APPLICATION (Please print in black ink)

Telephone Case No:_____

Proposed Insured _____ (First) (Middle) (Last)

Address (No. & Street)_____

City State Zip Code

Telephone interview completed ☐ Yes ☐ No ☐ am ☐ pm

_____ Phone _____ Best time to call

E-mail Address:

Sex	Date of Birth	Age	State of Birth	SS#	Height	Weight	Occupation
☐ Male ☐ Female	Mo. Day Yr / /			DL#	ft in	lbs	Date of Hire / Annual Salary

Owner: Name _____ SS#_____ Address:_____

Payor: Name SS# Address:

Primary Beneficiary_____ SS#_____ Relationship _____

Contingent Beneficiary SS# Relationship

Plan: ☐ Financial Lifeline ☐ Financial Lifeline II ☐ Financial Lifeline III **Face Amount $**_____

☐ Check here if you are willing to accept any plan for which you qualify based on this application. I understand the death benefit purchased based upon my selected premium will be affected by the Lifeline plan for which I ultimately qualify.

During the past 12 months have you used tobacco in any form (excluding occasional pipe and cigar use)? ☐ Yes ☐ No

Rider: ☐ Total Disability Benefit $_____ ☐ FIA _____Unit(s) ☐ Grandchild Rider _____ Units ☐ BonusMaster $_____

☐ ADB* Amount $_____ ☐ CIA* _____Unit(s) ☐ Other_____ ☐ Flex Annuity Plus $_____

☐ WP* (*ADB, CIA & WP not available on Financial Lifeline III) ☐ Annuity Rider Amt. $_____

Within the past 12 months have you been medically diagnosed or treated for bone, muscle, or joint disorder or any injury? ☐ Yes ☐ No

Mode: ☐ Bank Draft ☐ Draft 1st Prem Modal Prem $_____ ☐ Other ☐ Payroll Deduction $

☐ E-Check Immediate 1st Prem Collected $

Mail Policy To: ☐ Agent ☐ Insured ☐ Owner

Requested Policy Date: / /

Do you have existing life or disability insurance or an annuity contract? ☐ Yes ☐ No

Will you replace existing life or disability insurance or an annuity? ☐ Yes ☐ No

Company

Policy # Amt of Coverage $

Personal Physician: Name Address

Current Medications:

HEALTH INFORMATION

1. Within the past 12 months have you had any diagnostic testing (excluding AIDS/HIV tests), surgery, or hospitalization recommended by a medical professional which has not been completed or for which the results have not been received? ..... ☐ Yes ☐ No
2. Within the past 12 months have you been medically diagnosed or treated, or taken medication for internal cancer, melanoma, Hodgkin's disease, leukemia, lymphoma, or systemic lupus (SLE)? ..... ☐ Yes ☐ No
3. Within the past 12 months have you been on probation or parole or convicted of any felony, or had your driver's license revoked, or been convicted of driving under the influence of alcohol or drugs, or used illegal drugs, or received medical treatment or counseling for, or been advised by a physician to discontinue the use of alcohol or prescribed or non-prescribed drugs? ..... ☐ Yes ☐ No
4. Have you ever been treated by a medical professional for insulin shock, diabetic coma, had an amputation caused by disease or been advised to have an organ transplant? ..... ☐ Yes ☐ No
5. Have you ever been medically diagnosed, treated, or taken medication for congestive heart failure, cardiomyopathy, Huntington's disease, cystic fibrosis, motor neuron disease, liver or kidney failure (including dialysis), or renal insufficiency? ... ☐ Yes ☐ No
6. Have you been medically treated or diagnosed by a medical professional as having Acquired Immune Deficiency Syndrome (AIDS), AIDS related complex (ARC), or any immune deficiency related disorder or tested positive for the Human Immunodeficiency Virus (HIV)? ..... ☐ Yes ☐ No

If any answer to questions 1 through 6 is "Yes" the Proposed Insured is not eligible for any coverage.

7. Within the past 12 months have you been medically diagnosed or treated, or taken medication for any heart or circulatory procedure or surgery? ..... ☐ Yes ☐ No
8. Have you been medically diagnosed or treated for diabetes prior to the age of 39 or been medically diagnosed with diabetes combined with a medical history of any of the following: stroke, arrythmia, heart disease, or circulatory disease? ..... ☐ Yes ☐ No
9. Have you ever been medically diagnosed or treated for chronic obstructive pulmonary disease (COPD), cirrhosis, liver disease, chronic hepatitis, hepatitis C, chronic pancreatitis, sickle cell anemia, hemophilia, or thalassemia? ..... ☐ Yes ☐ No
10. Have you had more than two occurrences of cancer (excluding basal or squamous cell skin cancer) in your lifetime? ..... ☐ Yes ☐ No

If any answer to questions 7 through 10 is "Yes" the Proposed Insured should apply for Financial Lifeline III (Rated Premium Class 3).

11. Within the past 5 years have you been medically diagnosed or treated, or taken medication for:
    a. stroke, angina (chest pain), heart attack, peripheral vascular disease, irregular heartbeat, heart disease or disorder, blood clot, aneurysm, heart or circulatory surgery or any procedure to improve circulation to the heart, brain, or legs? ..... ☐ Yes ☐ No
    b. internal cancer, melanoma, Hodgkin's disease, leukemia, lymphoma? ..... ☐ Yes ☐ No
    c. schizophrenia, bipolar, paralysis of two or more extremeties or any neuro-muscular disease (including cerebral palsy, multiple sclerosis, seizures, or Parkinson's disease)? ..... ☐ Yes ☐ No
    d. Crohn's disease, ulcerative colitis, or surgical treatment for obesity? ..... ☐ Yes ☐ No
12. Have you been treated for high blood pressure prior to the age of 30 or are you currently taking 3 or more medications to control high blood pressure or have you taken insulin shots prior to the age of 50? ..... ☐ Yes ☐ No

If any answer to questions 11 through 12 is "Yes" the Proposed Insured should apply for Financial Lifeline II (Rated Premium Class 2).

If all questions 1 through 12 are "No" the Proposed Insured should apply for Financial Lifeline (Premium Class 1).

FOR DEPENDENT COVERAGE ONLY Other Persons Proposed for Insurance (Complete for FIA, CIA, and Grandchild Riders):

Proposed Insured Name	Rider	Sex	Birthdate	Height	Weight	Relationship

1. To the best of your knowledge and belief, has any proposed insured been treated for or told by a physician that they had:
   a. Hypertension, heart or circulatory disorder?..... Yes ☐ No ☐
   b. Internal cancer, leukemia or melanoma?..... Yes ☐ No ☐
   c. Diabetes, kidney, liver, gastrointestinal disorder? ... Yes ☐ No ☐
   d. Mental or nervous disorder, seizures, ADHD? ..... Yes ☐ No ☐
   e. Asthma or respiratory disorder?..... Yes ☐ No ☐
   f. Any other disease, injury, operation or deformity?.. Yes ☐ No ☐

Give details of any "Yes" answers to Question 1a through 1f and list all current medications:

Name	Medical Condition	Medications	Month/Year	Name and Address of Physician and/or Hospital

AGREEMENT—I agree with American-Amicable Life Insurance Company of Texas (the Company) as follows: (1) To the best of my knowledge and belief, all answers contained in this application are true, complete and correctly recorded; and (2) This application and any policy issued on the basis of such application shall form the entire contract; and (3) No change in this contract shall be effected without my written consent with regard to: (a) the amount of insurance; (b) age at issue; (c) classification of risk; (d) plan of insurance; or (e) benefits. If this application is declined by the Company, I will accept the return of any premium paid. Any person who knowingly presents a false statement in an application for insurance may be guilty of a criminal offense and subject to penalties under state law.

AUTHORIZATION—In order to properly classify my application for life insurance, I authorize any and all licensed physicians, medical practitioners, hospitals, clinics, medical or medically-related facilities, health plans, pharmacy benefit managers, pharmacies or pharmacy-related facilities; insurance companies and their business associates and those persons or entities providing services to the insurer's business associates which are related in any way to their insurance plans; the MIB, Inc. or other organization that has knowledge or records of me and my health to give such information to: (a) American-Amicable Life Insurance Company of Texas; and (b) its reinsurers. I understand that any information that is disclosed pursuant to this authorization may be redisclosed and no longer covered by federal rules governing privacy and confidentiality of health information. I understand that I may revoke this authorization in writing at any time, except to the extent that action has been taken in reliance on this authorization or the insurance company exercises a legal right to contest a claim or the policy itself. I may revoke the authorization by sending a written revocation to the Company address of 425 Austin Ave., Waco TX 76701. I understand that if I refuse to sign this authorization to release my complete medical records, my application for insurance with the Company will be rejected.

All said sources, except the MIB, Inc., are authorized to give records or knowledge such as statements regarding hobbies, employment, criminal records or medical history that might be required to determine eligibility for insurance to any agency employed by the Company to collect and transmit data. I authorize American-Amicable Life Insurance Company of Texas to disclose any personal data gathered while processing this application. This data may be released to the following: (a) reinsuring companies; (b) the MIB, Inc.; (c) other persons or groups performing services in connection with this application; or (d) any others to whom it may be lawfully required or authorized. This authorization shall remain valid for two years from this date. A copy of this authorization shall be as valid as the original.

I acknowledge receiving the Fair Credit Reporting Act Notice, MIB, Inc. Pre-Notice, the Terminal Illness and Confined Care Accelerated Benefit Rider Disclosure Forms, if applicable.

CERTIFICATION—I hereby certify, under penalties of perjury, that (1) the social security number indicated above is my correct taxpayer identification number and (2) that I am not subject to backup withholding under Section 3406 (a) (1) (c) of the Internal Revenue Code. The Internal Revenue Service does not require your consent to any provision of this document other than the certification required to avoid backup withholding.

Signed at _____ Proposed Insured Signature:_____
CITY STATE

Date Signed: _____/_____/_____ _____ _____
SIGNATURE OF OWNER (IF OTHER THAN PROPOSED INSURED) SIGNATURE OF SPOUSE (IF APPLYING FOR COVERAGE)

AGENT'S REPORT

Does the proposed insured have any existing life or disability insurance or annuity contract ? ☐ Yes ☐ No

Is the proposed insurance intended to replace or change any existing insurance or annuities? ☐ Yes ☐ No

Agent's remarks:_____

I certify that I have personally asked each question on this application to the proposed insured(s), I have truly and completely recorded on the application the information supplied by him/her, and I witnessed their signature. I certify that the Terminal Illness and Confined Care Accelerated Benefit Rider Disclosure Forms have been presented to the applicant, if applicable.

Agent (SIGNATURE) _____ No: _____%_____ Agent (SIGNATURE)_____ No: _____%_____

PREAUTHORIZATION CHECK PLAN - AUTHORIZATION TO HONOR CHARGE DRAWN

Insured_____ Account Holder_____

Financial Institution (name/address)_____

Transit / ABA Number_____ Account Number_____ ☐ Checking ☐ Savings Requested Draft Day (1st-28th)_____

ATTACH VOIDED CHECK OR DEPOSIT SLIP

As a convenience to me, I hereby request and authorize you to pay and charge to my account amounts drawn on my account, whether by electronic or paper means, by and payable to the order of American-Amicable Life Insurance Company of Texas, for the purpose of paying premiums on life insurance policy, provided there are sufficient funds in said account to pay the same upon presentation. I agree that your rights with respect to each such charge shall be the same as if it were signed personally by me. This authorization is to remain in effect until revoked by me in writing and until you actually receive such notice. I agree that you shall be fully protected in honoring any such check. I further agree that if any such check be dishonored, whether with or without cause, and whether intentionally or inadvertently, you shall be under no liability whatsoever even though such dishonor results in the forfeiture of insurance.

_____ _____
SIGNATURE (AS ON FINANCIAL INSTITUTION RECORDS) DATE

AUTHORIZATION FOR THE RELEASE OF MEDICAL RECORDS
American-Amicable Life Insurance of Texas (here after referred to as the Company)

This Authorization complies with the HIPAA Privacy Rules

The Authorization must be fully completed as a condition of obtaining coverage. A refusal to sign this authorization will result in a rejection of your application for the insurance. A copy of this authorization will be considered as valid as the original.

1. I hereby authorize the following person(s) or group of persons to disclose information to the company: Any and all physicians, medical practitioners, hospitals, clinics, medical or medically-related facilities, health plans, pharmacy benefit managers, pharmacies or pharmacy-related facilities; insurance companies and their business associates and those persons or entities providing services to the insurers' business associates which are related in any way to their insurance plans.

2. This authorization specifically includes the release of **all medical records** including without limitation those containing information relating to diagnoses, treatments, consultation, care, advice, laboratory or diagnostic tests, physical examinations, recommendations for future care, prescription drug information, alcohol or drug abuse, mental illness or information regarding communicable or infectious conditions, such as HIV and/or AIDS.

3. Person(s) or group of persons authorized to receive and use the information: The Company and its business associates and those persons or entities providing services to the Company plans.

4. The information will be used to make enrollment/eligibility for benefit determinations, specifically including, but not limited to, underwriting and risk rating determinations. If coverage is issued, such determinations may include determinations as to whether coverage should be rescinded or reformed if I have made any material omission(s) or misrepresentation(s) in my application.

5. I understand that any information that is disclosed pursuant to this authorization may be redisclosed and no longer covered by federal rules governing privacy and confidentiality of health information.

6. I understand that I may revoke this authorization in writing at any time, except to the extent that action has been taken in reliance on this authorization or the insurance company exercises a legal right to contest a claim or the policy itself. I may revoke the authorization by sending a written revocation to the Company address of 425 Austin Ave, Waco TX 76701.

7. I understand that if I refuse to sign this authorization to release my complete medical records, my application for insurance with the Company will be rejected.

8. This authorization will expire 24 months after the date signed.

Signature of Proposed Insured who is Age 18 and over, Parent (on behalf of a minor) or Legal Representative:

Proposed Insured:_____ Date:_____

Spouse (if applicable):_____ Date:_____

Signature of minor's parent or legal guardian:_____ Date:_____

☐ American-Amicable Life Insurance Company of Texas
☐ IA American Life Insurance Company
☐ Occidental Life Insurance Company of North Carolina
☐ Pioneer Security Life Insurance Company
☐ Pioneer American Insurance Company

IMPORTANT! Your Annuity cannot be issued without your signature on either the Waiver below, or the attached Suitability Questionnaire.

BOTH pages 9671-1 and 9671-2 must be returned along with your application regardless of which sections are completed in order to consider your annuity application.

Statement of Annuity Suitability

We appreciate your interest in an annuity contract from the company. We are required by various states to ask for information that will help determine whether an annuity contract is suitable for your investment goals and financial situation. The questions pertain to your personal situation at the time of this application, and to your understanding of the features of the product for which you are applying. This information will not be used for any other purpose and will remain confidential.

You have the legal right to decline to provide this information. If this is your wish, please read the following statement, sign, date and return this form with your Application for Annuity. The company reserves the right to reject any application that has not had the suitability information completed.

WAIVER of Annuity Suitability Questionnaire

No, I will not answer the questions on the attached sheet, and I take full responsibility for determining whether the proposed annuity is suitable for me.

(The Proposed Annuitant must sign in the "Signature" space below. Your policy cannot be issued without your signature on either this WAIVER or the attached Annuity Suitability Questionnaire.)

Proposed Annuitant's Signature	Print Proposed Annuitant's Name	Date

☐ American-Amicable Life Insurance Company of Texas
☐ IA American Life Insurance Company
☐ Occidental Life Insurance Company of North Carolina
☐ Pioneer Security Life Insurance Company
☐ Pioneer American Insurance Company

Annuity Suitability Questionnaire

Yes, I agree to answer the questions below and I understand that my responses will be used to evaluate the suitability of an annuity contract. I understand that the company may elect not to issue the annuity contract being applied for based on a reasonable determination that the product may not be suitable for me.

Proposed Annuitant

Marital Status: _____ Married _____ Single _____ Widowed _____ Divorced

Occupation: _____

_____

Investment Knowledge: _____ Limited _____ Average _____ Extensive

Primary Financial Objectives (Check all that apply)

____ Immediate Income ____ Tax Deferral
____ Wealth Accumulation ____ Charitable Giving
____ Future Income ____ Education Planning
____ Preservation of Capital ____ Inheritance

Time Frame For This Investment

When will you need the money you are investing in this annuity?

____ 1 year or less ____ 7-10 years
____ 1-3 years ____ 10 years or more
____ 3-7 years ____ Never (money is for charity/inheritance)

Financial Information

Annual Household Income $_____
Liquid Net Worth $_____
(Excluding residence and furnishings)

What is the source of funds for the purchase of the proposed annuity? _____

Source of Income: (Check all that apply)

____ Employment ____ Retirement Plans
____ Investments ____ Other
____ Social Security

Tax Bracket: (Check one)
___ 10% ___ 15% ___ 25% ___ 28% ___ 33% ___ 35%

Proposed Annuity represents _____% of my Net Worth

Risk Tolerance: ____ High ____ Moderate ____ Low

Do you have any funds available to you in case of emergency?_____

Other relevant information (financial constraints, health concerns, long-term care considerations, etc.)

_____

Existing Accounts

Are you considering using funds from existing life insurance policies, annuity contracts, or certificates of deposit to purchase this annuity?
____ Yes ____ No

How long has that policy(ies), contract(s), or certificate of deposit(s) been in force?
____ # of Years

Are there any surrender charges associated with the above-mentioned existing policy(ies), contract(s), or certificates of deposit?
____ Yes ____ No ____ Not Applicable

If yes, what is/are the current surrender charge(s)?

_____
_____
_____
_____

I have adequate income or available liquid assets to meet my financial obligations and emergency expenses without using the money I am investing in this annuity. By signing this form, I have agreed that the information on this form was obtained prior to purchase of the annuity and that the information is correct. I also understand the company encourages me to discuss this proposed investment with my personal financial advisor(s).

_____ Proposed Annuitant's Signature
_____ Print Proposed Annuitant's Name
_____ Date

Agent's Statement

I recommend the purchase of this annuity policy, which I believe is suitable based on the information provided by the proposed annuitant regarding his or her insurance needs and financial objectives.

_____ Agent's Signature
_____ Agent's Name
_____ Date

COMPLETE AND RETURN WITH ANNUITY APPLICATION

American-Amicable Life Insurance Company of Texas
P.O. Box 2549, Waco, TX 76702-2549 • (800) 736-7311 • E-mail: contactus@americanamicable.com

ENCORE
STATEMENT OF UNDERSTANDING

I UNDERSTAND THAT: Initial Each Line

I am applying to purchase a Encore modified premium whole life insurance policy. The base death benefit reduces by 50% at age 65 or after 5 years, whichever is later. The base policy premiums are payable to age 100. _____

In the first policy year 100% of my premium is for life insurance and any optional benefits I choose to purchase. After the first policy year, the base premium reduces by approximately 50% and the balance of the premium is paid to the cash accumulation option I chose. _____

The Encore includes (at no additional premium) a Terminal Illness Accelerated Benefit Rider. I acknowledge the receipt of the Terminal Illness Accelerated Benefit Rider Disclosure (Form No. 9474). _____

The Encore includes (at no additional premium) an Accelerated Benefits Rider-Confined Care (not available in CT, DC, IN, MA, NJ, VA and WA). I acknowledge the receipt of the Disclosure for the Accelerated Benefits Rider-Confined Care (Form No. 9675). _____

The Encore includes (at no additional premium) a Beneficiary Guaranteed Insurability Rider. _____

I SELECT THE FOLLOWING CASH ACCUMULATION OPTION (Select One):

☐ **Flexible Premium Annuity Rider** — a tax deferred interest bearing annuity rider. This rider cannot be issued on a tax qualified basis. The guaranteed interest rate is 2%.

☐ **AssetShield** — a tax-deferred annuity that provides a guarantee period allowing the initial interest rate to be locked in for your choice of either one, three or five years. The guaranteed interest rate is 2%. Immediate minimum contribution of $15.00 per month is required. This contract can be issued as a non-qualified annuity, a traditional IRA or a Roth IRA. Please select your choice below:

☐ Non-Qualified Annuity ☐ Traditional IRA ☐ Roth IRA

☐ **Flex Annuity Plus** — a tax deferred interest bearing annuity. The guaranteed interest rate is 2%. Immediate minimum contribution of $15.00 per month is required. This contract can be issued as a non-qualified annuity, a traditional IRA or a Roth IRA. Please select your choice below:

☐ Non-Qualified Annuity ☐ Traditional IRA ☐ Roth IRA

I have the right to examine the policy(ies) during the free look period provided in the policy(ies). If I am not satisfied, I may cancel the policy(ies) and request a refund before the end of the free look period. If I make such a request, all premiums I have paid for the policy(ies) will be refunded to me. I understand that no life insurance premiums will be refunded if a policy is cancelled after its free look provision. _____

My life insurance agent has provided a copy of this Statement of Understanding and I request that my policy be sent to: ____me ____beneficiary ____agent. _____

Applicant_____ Date_____ Witness_____

APPLICATION FOR AN ANNUITY TO AMERICAN-AMICABLE LIFE INSURANCE COMPANY OF TEXAS WACO, TEXAS

(Please Print) **The Proposed Annuitant**

1. Full Name (First) (Middle) (Last)	2. Social Security Number Annuitant:_____ Owner:	3. Birth Date (Mo-Day-Yr)

4. Age	5. Place of Birth	6. Sex	7. Permanent Home Address

8. I request that payment of death benefits, if any, be made in accordance with the contract provisions and the beneficiary designation indicated below:

Primary Beneficiary_____
Relationship Date of Birth

Contingent Beneficiary_____
Relationship Date of Birth

9. The Proposed Annuitant will be the Owner of the contract unless another is designated as follows:

_____
Name

_____
Number and Street

_____
City State Zip Code

10. Is this Annuity, if issued, intended to replace any existing insurance or annuities with this or any other company?

☐ Yes ☐ No

If "Yes", give details: _____

11. Issue Age_____ Age at Maturity_____
(Nearest Birthday)

12. Monthly Income $

13. Guaranteed Period

14. Premium Payment: Single Premium $_____
Mode Premium:
☐ Bank Draft $_____
☐ Quarterly $_____
☐ Semi-Annual $_____
☐ Annual $_____
☐ Other: (Mode/Premium)

15. Tax Qualification Status:
☐ Non-Qualified
☐ IRA
☐ Roth IRA
☐ Other_____

16. Send policy to: ☐ Insured ☐ Beneficiary ☐ Agent

17. Policy Date:

It is hereby agreed that only the President, a Vice-President or the Secretary of the Company has power to make or modify any contract on behalf of the Company or to waive any of the Company's rights or requirements. No waiver shall be valid unless in writing and signed by one of the foregoing officers. No agent has the authority to change or waive any provision of this contract. All of the foregoing statements are offered to the Company as an inducement to issue the Annuity for which application is hereby made.

Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application containing a false or deceptive statement may be guilty of insurance fraud.

CERTIFICATION—I hereby certify, under penalties of perjury, that (1) the social security number indicated above is my correct taxpayer identification number and (2) that I am not subject to backup withholding under Section 3406 (a) (1) (c) of the Internal Revenue Code. The Internal Revenue Service does not require your consent to any provision of this document other than the certification required to avoid backup withholding.

Signed at _____ _____ _____
City State Date of Application

Agent_____ Proposed Annuitant _____
No.

Agent_____ Owner as Designated In Block 9 _____
Every Agent who has an interest in this must sign above. No.

AGENT'S STATEMENT

To the best of my knowledge, replacement of other Life Insurance or Annuities is/is not (circle one) involved in connection with the application.

I certify that the Individual Retirement Annuity Disclosure Statement has been delivered to the Proposed Annuitant and/or Owner.

_____ _____
Date Agent

FLEX ANNUITY PLUS

AMERICAN-AMICABLE LIFE INSURANCE COMPANY OF TEXAS
425 Austin Avenue, Waco, Texas 76701
P.O. Box 2549, Waco, Texas 76702
(254) 297-2777 • www.americanamicable.com

BENEFIT SUMMARY & DISCLOSURE
FLEXIBLE PREMIUM DEFERRED ANNUITY CONTRACT (Form No. ICC13-AA3056)

The following information is a summary of American-Amicable Life Insurance Company of Texas' Flexible Premium Deferred Annuity contract referenced above. Please refer to your annuity Contract for details.

Accumulation Value: The Accumulation Value is equal to the sum of all premiums paid, less any withdrawals, with interest compounded annually.

Annuitization: You can receive periodic income payments from your annuity. When you annuitize, you can choose from several Settlement Options, which may provide periodic income payments.

Cash Surrender Value: The Cash Surrender Value is equal to the Accumulation Value, and is the amount available to you at the time in which you choose to surrender your Contract.

Death Proceeds: The amount payable to the Beneficiary if the Owner dies before the Income Date. The Death Benefit is equal to the Accumulation Value less applicable Premium Taxes.

Free Look Period: You may cancel your annuity Contract within 30 days after it is delivered to you and receive a complete refund of premiums, less any Partial Surrenders. Please refer to your annuity Contract for details.

Interest: Interest will be earned from the first day after the date each premium is received at our Home Office to the date of payment or other application by us. Interest will be credited on a daily basis, at a daily rate, which is the daily equivalent to the effective annual rate of interest then in effect, but in no event less than the Minimum Guaranteed Interest Rate. Interest that we will credit to this annuity will be established by resolution of our Board of Directors.

Minimum Guaranteed Interest Rate: The Minimum Guaranteed Interest Rate is shown in your annuity Contract and is the minimum effective annual rate of interest we will credit to the Contract.

Partial Surrenders: Upon written request after the end of the first Contract year and before the Income Date, withdrawals may be made from your Contract subject to the following conditions:

a. A withdrawal may not be less than $250.

b. The Accumulation Value remaining after a partial surrender must be at least $2,000.

Premium Payment Limits: The sum of all premiums paid during any taxable year may not exceed $4,000.

Premium Taxes: If the state in which you reside charges a premium tax, we may deduct this tax from premium payments or from the proceeds of your annuity Contract, depending on the laws of the state.

Settlement Options: When you choose to annuitize your annuity Contract you may elect one of these Settlement Options: Option 1 — Interest Income; Option 2 — Installments of Specified Amount; Option 3 — Installments for Specified Period; Option 4 — Life Annuity with Guaranteed Period; and Option 5 — Life Annuity without Guaranteed Period.

ACKNOWLEDGMENT

This annuity is intended to be a long-term retirement instrument. If you keep this annuity only a few years, contract values may be less than the total contributions due to income tax and IRS penalties. Under current federal tax law, amounts withdrawn or distributed may be subject to federal and state income taxes. In addition, a 10% federal tax penalty may apply if distributions are made prior to the Owner reaching age 59 1/2. If you are considering the purchase of an annuity contract for use in an IRA or other qualified plan, you should consider other features of the annuity besides tax deferral. Under current tax law, annuities grow tax deferred and an annuity is not required for tax deferral in qualified plans. Neither American-Amicable Life Insurance Company of Texas nor its agents provide tax or legal advice. Please consult a qualified tax or legal advisor for more details.

To be read and signed by Owner: *I have read and have been given a copy of this Benefit Summary & Disclosure. I acknowledge I have received this Benefit Summary & Disclosure, and features of this product have been explained to me. I understand any values shown to me, with the exception of guaranteed minimum values, are not guarantees, promises, or warranties.*

Owner's Signature: _____ Date: _____

Joint Owner's Signature (if applicable) _____ Date: _____

Agent's Certification: *I hereby certify that I have given the Owner a signed copy of this Benefit Summary & Disclosure. I have made no statements to the Owner that differ in any significant manner from this Benefit Summary & Disclosure, nor have I made any promises or guarantees about the future value of any non-guaranteed elements of this annuity contract.*

Agent's Signature: _____ Date: _____

Agent's Name: _____ Agent's No.: _____