

American Income Life Insurance Company
P.O. Box 2608 Waco, Texas 76797 (254)761-6400 www.aillife.com

POLICY SERVICE REQUEST

PLEASE PRINT CLEARLY

POLICIES TO BE CHANGED

Policy Number	Insured	Owner
Policy Number	Insured	Owner
Policy Number	Insured	Owner

ADDRESS CHANGE

☐ Old Address

☐ New Address

☐ Telephone

☐ E-mail Address ☐ Date Change Effective

NAME CHANGE

☐ Change name of ☐ Insured ☐ Owner ☐ Premium Payor ☐ Beneficiary

☐ Former Name

☐ New Name

Reason for change: ☐ Marriage ☐ Divorce ☐ Court Order ☐ Correction ☐ Adoption

BENEFICIARY CHANGE

PRIMARY BENEFICIARY:

Unless otherwise specified, proceeds to be paid in equal shares to the survivor(s).	ADDRESS	RELATIONSHIP	BIRTHDATE

CONTINGENT BENEFICIARY - To be paid if no surviving Primary Beneficiary at the time of death.

Unless otherwise specified, proceeds to be paid in equal shares to the survivor(s).	ADDRESS	RELATIONSHIP	BIRTHDATE

MISCELLANEOUS

☐

Date

Signature of Owner

Printed Agent Name

Agent Signature

Agent Number

L-7 (R208)

IT IS NOT NECESSARY TO SEND US YOUR POLICY.

L7



Dear Policyholder,

Everyone likes to save time and money and we want to help you do just that. By authorizing us to automatically withdraw your premium from your checking or savings account, you may be able to enjoy a slight reduction in your premium and at the same time save on postage. It is convenient and saves you time, and could possibly save checking fees at your bank.

If you are currently paying your premium through a bill paying service, why not take advantage of this savings and convenience as well?

If you do wish to have your premium deducted automatically, please complete the form below and enclose it along with your current payment indicated on your account. If you have a preference of which day of the month you want us to withdraw your premium, please indicate that day on the form. If no date is noted on the form, we will withdraw your premium on the due date each month.

Note: If you receive other billing notices from us, you will have a similar opportunity to save money by converting to automatic premium payments.

BANK DRAFT AUTHORIZATION

American Income Life Insurance Company is authorized to initiate debit entries to the account indicated below, and the bank named below is authorized to debit the same to such account. This authority can be terminated by the undersigned at any time by written notification to the Company, provided only that the Company and the bank will have a reasonable opportunity to act on such notification.

Bank Name _____

Address _____

Transit/ABA No. _____ Account No. _____

Type of Account: ☐ Checking ☐ Savings

PLEASE ATTACH A VOIDED PERSONAL CHECK

X _____
Signature of Payor _____ Date _____ Year _____

Name of Insured _____

Policy Number(s) of Existing Policies _____, _____, _____

Requested Draw Date, If Any _____ AG-2032 (R1105)



American Income Life Insurance Company

P.O. Box 2500 • Waco, Texas 76702

CLAIMANT'S STATEMENT

Please carefully read all of the following information before completing this statement.

Any person who knowingly presents a false or fraudulent claim for payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

Arkansas, Louisiana, Rhode Island, Texas and West Virginia: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Alaska: A person who knowingly and with intent to injure, defraud, or deceive an insurance company files a claim containing false, incomplete or misleading information may be prosecuted under state law.

Arizona: For your protection Arizona law requires the following statement to appear on this form. Any person who knowingly presents a false or fraudulent claim for payment of a loss is subject to criminal and civil penalties.

California: For your protection California law requires that you be made aware of the following: Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in a state prison.

Colorado: It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the department of regulatory agencies.

District of Columbia: WARNING: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.

Florida: Any person who knowingly or with intent to injure, defraud or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

Hawaii: For your protection, Hawaii law requires you to be informed that any person who presents a fraudulent claim for payment of a loss or benefit is guilty of a crime punishable by fines or imprisonment, or both.

Idaho: Any person who knowingly, and with intent to defraud or deceive any insurance company, files a statement of claim containing any false, incomplete or misleading information is guilty of a felony.

Indiana: Any person who knowingly and with intent to defraud an insurer files a statement of claim containing any false, incomplete, or misleading information commits a felony.

Kentucky: Any person who knowingly or with intent to defraud any insurance company or other person files a statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime.

Maine: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance benefits.

Minnesota: Any person who files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime.

New Hampshire: Any person who, with a purpose to injure, defraud or deceive any insurance company, files a statement of claim containing any false incomplete or misleading information is subject to prosecution and punishment for insurance fraud, as provided in RSA 638.20.

New Jersey: Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.

New Mexico: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to civil fines and criminal penalties.

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

Oklahoma: WARNING: Any person who knowingly and with intent to injure, defraud, or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

Oregon: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents materially false information in an application for insurance may be guilty of a crime and may be subject to fines and confinement in prison.

Pennsylvania: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

Tennessee, Virginia and Washington: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.



AMERICAN INCOME LIFE INSURANCE COMPANY

PO BOX 2500 • Waco, TX 76702
 Phone (254) 761-6400 • Fax (254) 741-5705
 Web www.aillife.com • Email CL@aillife.com

INSTRUCTIONS FOR SUBMITTING AN ACCIDENT, HEALTH OR DISABILITY/WAIVER OF PREMIUM CLAIM

Accident & Illness Claims - Complete Part A for all Claims, and Part B if policy is less than 2 years old

☐ For US Only - Include a copy of all itemized Hospital/Doctor bills and Proof of Treatment which include procedure and diagnosis codes.

☐ For Canada Only - Have the doctor complete Part D - 'Attending Physician's Statement', and attach verification of treatment for services received.

Cancer Claims - Complete Part A for all Claims, and Complete Part B if policy is less than 2 years old

☐ A Pathology Report must be included in the initial claim for the diagnosis of Cancer.

☐ For US Only - Submit any Hospital/Doctor bills related to the treatment of Cancer which include procedure and diagnosis codes.

☐ For Canada Only - Have the doctor complete Part D - 'Attending Physician's Statement', and attach verification of treatment for services received in relation to the claim.

Disability or Waiver of Premium Claims - Complete Part A for all Claims, and Complete Part B if policy is less than 2 years old

☐ Have your Employer Complete Part C - 'Employers Statement'.

☐ Have the doctor complete Part D - 'Attending Physician's Statement'.

Part A - To be Completed by the Insured for all Claims

Policy Numbers					
Policyowner's Name			Policyowner's Mailing Address		
Policyowner's Employer					
Policyowner's Union and Local# (If Union member)			Policyowner's Occupation		
Policyowner's Email Address			Policyowner's Phone #		
Patient's Name		Patient's Date of Birth	Patient's Gender <input type="checkbox"/> Male <input type="checkbox"/> Female		
Patient's Relationship to Policyowner <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other _____		Does patient have any other insurance coverage which provided benefits for this claim? <input type="checkbox"/> No <input type="checkbox"/> Yes If yes, Name: _____			
1. This Claim is in Connection with: (please check) <input type="checkbox"/> Accident <input type="checkbox"/> Illness <input type="checkbox"/> Cancer <input type="checkbox"/> Disability/Waiver of Premium		Was patient confined to hospital due to Accident/Illness claim? <input type="checkbox"/> No <input type="checkbox"/> Yes			
2. Date of Accident/Illness	3. Date First Treated	4. Nature of Injury/Illness sustained & how it happened			
5. Name & Address of Provider treating this condition					

Release of Medical Information Authorization

I hereby authorize any licensed physician, medical practitioner, hospital, clinic or other medical or medically related facility, insurance company, the Medical Information Bureau or other organization, that has any records of me or my health, to give to the American Income Life Insurance Company or its reinsurers any such information with respect to illness, injury, medical history, consultation, or treatments which include alcohol, drug or chemical dependency treatment. Information received is for the purpose of evaluating this claim and determining our liability under your existing coverage with American Income Life Insurance Company. This authorization shall remain valid for one year. You have the right to receive a copy of this authorization upon request. A photographic copy of this authorization shall be as valid as the original.

Patient's Signature _____ Date _____

Part B - Health Information**ONLY COMPLETE IF POLICY IS LESS THAN 2 YEARS OLD****List all sickness or injuries and physicians for which treatment was required in the past 5 years**

Physician & Address	Condition	Date Symptoms Appeared	Date of Initial Treatment	Date Diagnosed

Part C - To be Completed by the Employer**DISABILITY OR WAIVER OF PREMIUM ONLY**

Employee's Name		Occupation	
When did sickness or accident occur?		When did he/she cease work?	
If injured, how did it happen?			
When did employee resume any part of employee's work, supervisory or other?			
Company Name		Phone Number	
Street Address	City	State	Zip

Signature of Employer _____ Date _____

Title _____

Part D - To be Completed by the Attending Physician

Patient's Name	Patient's Address
Patient's Date of Birth	
Diagnosis and current conditions: (If diagnosis code other than international classification of diseases, give name)	Does condition arise out of patient's employment? <input type="checkbox"/> Yes <input type="checkbox"/> No
	If Condition due to pregnancy, date pregnancy commenced

REPORT OF SERVICES (or attach itemized bill)

Date of Services	Place of Services	Description of Surgical or Medical Services	Procedural Code (Give name if not current terminology)	Charges
TOTAL CHARGES				

IF HOSPITALIZED, NAME AND ADDRESS OF HOSPITAL AND DATES OF CONFINEMENT

Hospital	Address	Dates

Result of an Accident? <input type="checkbox"/> Yes <input type="checkbox"/> No	Date of Accident?
Date patient first consulted you for this condition	Patient still under your care for this condition? <input type="checkbox"/> Yes <input type="checkbox"/> No
Patient ever had similar condition? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, when:	Was patient referred to you? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, name and address of referring physician
Patient was continuously TOTALLY DISABLED (unable to work) From _____ To _____	Patient was PARTIALLY DISABLED From _____ To _____
If still disabled, date patient should be able to return to work	Does patient have any other health coverage? <input type="checkbox"/> No <input type="checkbox"/> Yes If yes, Name:

Please give name and address of any physicians or other practitioners you referred the patient to see

Name	Address	Phone

Physician's Name (Please print) _____

Physician's Address _____ Phone _____

Signature of Physician _____ Date _____

American Income Life Insurance Company

P.O. Box 2500 • Waco, Texas 76702

PROOFS OF DEATH — CLAIMANT'S STATEMENT

Please carefully read all of the following information before completing this statement.

Any person who knowingly presents a false or fraudulent claim for payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

Arkansas, Louisiana, Rhode Island, Texas and West Virginia: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Alaska: A person who knowingly and with intent to injure, defraud, or deceive an insurance company files a claim containing false, incomplete or misleading information may be prosecuted under state law.

Arizona: For your protection Arizona law requires the following statement to appear on this form. Any person who knowingly presents a false or fraudulent claim for payment of a loss is subject to criminal and civil penalties.

California: For your protection California law requires that you be made aware of the following: Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in a state prison.

Colorado: It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the department of regulatory agencies.

District of Columbia: WARNING: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.

Florida: Any person who knowingly or with intent to injure, defraud or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

Hawaii: For your protection, Hawaii law requires you to be informed that any person who presents a fraudulent claim for payment of a loss or benefit is guilty of a crime punishable by fines or imprisonment, or both.

Idaho: Any person who knowingly, and with intent to defraud or deceive any insurance company, files a statement of claim containing any false, incomplete or misleading information is guilty of a felony.

Indiana: Any person who knowingly and with intent to defraud an insurer files a statement of claim containing any false, incomplete, or misleading information commits a felony.

Kentucky: Any person who knowingly or with intent to defraud any insurance company or other person files a statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime.

Maine: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance benefits.

Minnesota: Any person who files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime.

New Hampshire: Any person who, with a purpose to injure, defraud or deceive any insurance company, files a statement of claim containing any false incomplete or misleading information is subject to prosecution and punishment for insurance fraud, as provided in RSA 638.20.

New Jersey: Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.

New Mexico: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to civil fines and criminal penalties.

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

Oklahoma: WARNING: Any person who knowingly and with intent to injure, defraud, or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

Oregon: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents materially false information in an application for insurance may be guilty of a crime and may be subject to fines and confinement in prison.

Pennsylvania: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

Tennessee, Virginia and Washington: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.



Proofs of Death Submitted to:

AMERICAN INCOME LIFE INSURANCE COMPANY

PO BOX 2500 • Waco, TX 76702
 Phone (254) 761-6400 • Fax (254) 741-5705
 Web www.aillife.com • Email CL@aillife.com

INSTRUCTIONS FOR SUBMITTING A LIFE CLAIM

- 1) Complete as Follows:
 - Part A and C by the Beneficiary, Guardian or Personal Representative for all claims.
 - Part B by the Beneficiary - To be completed only if policy is less than 2 years old.
 - Part D by the Physician - To be completed only if policy is less than 2 years old.
 - Part E by the Beneficiary - Complete only fields with an asterisk* and sign and date at the bottom.
- 2) To expedite Payment, all questions must be answered fully and accurately.
- 3) Send this completed form, along with a Death Certificate (Certified Death Certificate required if face amount exceeds \$15,000), and Obituary (if available) to one of the above.

Part A - To be Completed by Beneficiary

Policy Numbers			
Deceased's Name		Deceased's Date of Birth	Deceased's Gender <input type="checkbox"/> Male <input type="checkbox"/> Female
Deceased's Address		Deceased Union and Local # (if Union member)	
		Did Death Result From: <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Accident If yes, please include all Accident/Police Reports and Newspaper Articles	
Date of Death	Place of Death (if Hospital, Give Name)		Cause of Death
Beneficiary's Name		Beneficiary's Relationship to Insured	
Beneficiary's Mailing Address		Beneficiary's Telephone Number	
		Beneficiary's Social Security Number	
Beneficiary's Email Address		Beneficiary's Date of Birth	

Part B - To be Completed by Beneficiary COMPLETE ONLY IF POLICY IS LESS THAN 2 YEARS OLD

Give the names and addresses of all physicians who treated the deceased during the 5 years prior to death:

Name	Address	Disease or Condition	Dates

When did deceased first complain, or give other indication of illness?	When did deceased first consult a physician for last illness?

Part C - AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION PURSUANT TO HIPAA

Insured's Name	Date Of Birth	Social Security Number	Policy Number
Insured's Address			

I authorize any health plan, physician, health care professional, hospital, clinic, laboratory, pharmacy, pharmacy benefit manager, medical facility, other insurance company, consumer reporting agency, Medical Information Bureau (MIB), or other health care provider that has provided payment, treatment or services to me or on my behalf ("My Providers") to disclose my entire medical record and any other protected health information concerning me to the American Income Life Insurance Company (AIL) and its agents, employees, and representatives. This includes information on the diagnosis or treatment of Human Immunodeficiency Virus (HIV) infection and sexually transmitted diseases. This also includes information on the diagnosis and treatment of mental illness and the use of alcohol, drugs, and tobacco; but excludes psychotherapy notes.

By my signature below, I acknowledge that any agreements I have made to restrict my protected health information do not apply to this authorization and I instruct any physician, health care professional, hospital, clinic, medical facility, or other health care provider to release and disclose my entire medical record without restriction.

This protected health information is to be disclosed under this authorization so that AIL may: 1) administer claims and determine or fulfill responsibility for coverage and provision of benefits; 2) administer coverage; and 3) conduct other legally permissible activities that relate to any coverage I have or have applied for with AIL.

This authorization shall remain in force for 24 months following the date of my signature below, and a copy of this authorization is as valid as the original. I understand that I have the right to revoke this authorization in writing, at any time, by sending a written request for revocation to AIL, Attention: Claims Department, at the above address. I understand that a revocation is not effective to the extent that any of My Providers has relied on this authorization or to the extent that AIL has a legal right to contest a claim under an insurance policy or to contest the policy itself. I understand that any information that is disclosed pursuant to this authorization may be re-disclosed and no longer covered by federal rules governing privacy and confidentiality of health information.

I understand that My Providers may not refuse to provide treatment or payment for health care services if I refuse to sign this authorization. I further understand that if I refuse to sign this authorization to release my complete medical record, AIL may not be able to process my claim or make any benefit payments. I have received a copy of this authorization.

Name and address of person(s) or category of person to whom this information will be sent	Name of person signing form:
American Income Life PO Box 2500 Waco, TX 76702	
Authority to sign on behalf of deceased. <input type="checkbox"/> Parent <input type="checkbox"/> Legal Guardian <input type="checkbox"/> Child <input type="checkbox"/> Spouse <input type="checkbox"/> Next of Kin <input type="checkbox"/> Executor of Estate <input type="checkbox"/> Other (please specify relationship to Insured) - _____	

All items on this form have been completed and my questions about this form have been answered. American Income Life Insurance Company and I agree that this Claimant's Statement may be electronically signed. By typing my name below, I hereby agree that my electronic signature shall have the same effect as if it were handwritten. Further, I hereby attest that the information given herein is true and accurate to the best of my knowledge.

Signature of Patient/Beneficiary/Guardian or Personal Representative

Date

Please make a copy of this authorization and retain for your record.



Part D - To be Completed by Physician COMPLETE ONLY IF POLICY IS LESS THAN 2 YEARS OLD			
Any person who knowingly presents a false or fraudulent claim for payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.			
Deceased's name	Manner of Death	Date of Death	
How long have you treated this patient?			
Were you the patient's medical attendant or adviser before last illness or infirmity? If so, when and for what disease?			
When was the patient diagnosed with the disease or impairment that resulted in death?			
Was the patient ever treated for drug or alcohol abuse? If so, please list dates and locations of treatment.			
Was the patient ever disabled? If so, when and for what reason?			
From what other disease or impairment has the patient suffered, and when?	Disease or Impairment	Duration	
Was the patient confined to a hospital during the past 3 years? If so, provide the name and address of the hospital.			
Give names & addresses of the referring physicians or other practitioners who, to your knowledge, attended the patient during the past 5 years			
Name	Address	Disease or Impairment	Dates

 Physician's Name (PRINT)

 Street Address

 Physician's Signature

 City

 State

 Zip

 Fax Number

 Phone Number

AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

Part E - To be completed by Beneficiary - COMPLETE ONLY IF POLICY IS LESS THAN 2 YEARS OLD.

Case # _____ App# _____ Operator # _____

*Patient's Name: _____

*Patient's Street Address: _____

*City: _____ *State: _____ *Zip: _____

*Patient's Date of Birth: _____ *SSN: _____

I hereby authorize disclosure of protected health information about me as follows:

(Name of facility or provider) _____

is hereby authorized to disclose medical information about me to:

AI Records
PO box 2608
Waco, TX 76702

Phone: (866) 922-6453
Fax: (866) 622-6458

The purpose of the requested disclosure is for INSURANCE.

Information to be disclosed:

- | | | |
|---|---|---|
| <input type="checkbox"/> Discharge Summary | <input type="checkbox"/> ER Records | <input type="checkbox"/> Progress Notes |
| <input type="checkbox"/> Discharge Instructions | <input type="checkbox"/> X-Rays/Reports | <input type="checkbox"/> Medication Records |
| <input type="checkbox"/> History & Physical | <input type="checkbox"/> Lab Reports | <input type="checkbox"/> Doctor's Notes |
| <input type="checkbox"/> Consultations | <input type="checkbox"/> EKG/ECG Test | <input type="checkbox"/> Nurse's Notes |
| <input type="checkbox"/> Operative Report | <input type="checkbox"/> Therapy Notes | <input type="checkbox"/> HIV Testing |

(Other) _____

Dates of service _____

I understand that the information disclosed pursuant to this authorization may include information relating to treatment of drug or alcohol abuse, psychological or psychiatric impairments, sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), AIDS related complex (ARC) and/or human immunodeficiency virus (HIV).

Right to Revoke. I understand that I may revoke this authorization in writing to _____ at any time except to the extent that action has been taken in reliance on it, or unless this authorization is given as a condition of obtaining health insurance coverage and the insurer has a legal right to contest the policy or claim under the policy.

Right to Refuse to sign this Authorization. I understand that I do not have to sign this authorization in order to obtain health care benefits (treatment, payment, or enrollment).

Redisclosure of Information. I understand that the information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer protected by Federal law.

Right to Inspect. I understand that I have the right to inspect the health information I have authorized to be disclosed by this authorization form.

Right to Receive a Copy of Authorization. I understand that I have the right to receive a signed copy of this form, if I so request.

This authorization expires on _____ or upon the following event: _____
If no date or event is specified, this authorization will expire six months from the date of signature.

Signature of Patient or Patient's Personal Representative _____

*Relationship to Patient (if not signed by Patient) _____

*Date of signature _____

C-30 (R17)

Page 5 of 5



Q27370

AMERICAN INCOME LIFE INSURANCE COMPANY
P.O.BOX 2608 • WACO, TEXAS 76797 • www.aillife.com
LAY-OFF WAIVER OF PREMIUM CLAIM FORM

If you have been regularly employed within the same industry for 12 consecutive months and are laid-off, you may qualify for lay-off waiver of premium. **Lay-off Waiver of Premium** provides for a waiver of premiums while the insured is on a qualified lay-off and is actively seeking work. A qualified lay-off is the termination of employment in an announced reduction of force due to economic reasons affecting at least 10 persons. If this application is returned within 60 days after date of lay-off, one month's premium will be waived for each full month thereafter the insured is unemployed as a result of such lay-off. The maximum benefit period is three months.

The waiver will only apply to policies which were in force 60 days prior to the start date of the lay-off. If the premium is being waived on a policy on which the laid-off employee is the insured, the waiver will also apply to otherwise qualifying policies on which the laid-off employee's spouse is the insured. Send this application to American Income Life Insurance Company. This must be signed by the employer or union officer.

Insured (laid-off person) _____ Policy No. _____
 Insured Spouse _____ Policy No. _____
 Address _____ Phone _____
 Occupation _____
 Employer Name _____
 Union & Local No. _____ Phone _____
 Date you quit work due to lay-off? _____
 Are you now employed? Yes ☐ No ☐
 Date you returned to work? _____
X _____ Date _____
 Signature of Insured

CERTIFICATION BY EMPLOYER OR UNION REPRESENTATIVE

The above person was laid-off on _____ and is unemployed at this time.

X _____ Date _____
Signature of Representative of the Employer or Union Local Officer Title

AG-2147 (R08/06)



From _____

Address _____

**First
Class
Postage
Required**

American Income Life Insurance Company
P.O. Box 2608
Waco, Texas 76797

AMERICAN INCOME LIFE INSURANCE COMPANY**P.O. Box 2608 • Waco, TX 76702 • www.aillife.com****STRIKE WAIVER OF PREMIUM CLAIM FORM**

Strike Waiver provides for waiver of premium while the insured is on authorized strike and thereby prevented from engaging in his usual occupation. One month of premium is waived for each month of the strike. If the strike lasts less than a month, one month of premium will be waived. The maximum waiver is 12 months.

Waiver will only apply to policies which were in force for 90 days prior to the strike. If the premium is being waived on a policy on which the striking union member is the insured, waiver will also apply to otherwise qualifying policies on which the union member's spouse is the insured.

Complete the form below and send it to the Company at the above address. The form must be signed by an authorized union official.

Insured (Striking Union Member) _____ Policy Number(s) _____
 Insured Family Members _____ Policy Number(s) _____
 Address _____ Phone _____
 Occupation _____ Employer _____
 Union & Local No. _____ Phone _____
 On what date did you quit work due to a strike? Month _____ Day _____ Year _____
 Are you currently working? Yes ☐ No ☐
 If so, on what date did you return to work? Month _____ Day _____ Year _____
 Dated _____

 Signature of Insured (Striking Union Member)

CERTIFICATION BY UNION OFFICIAL

This is to certify that the above Union member was prevented from working from _____
 to _____ because of a duly authorized, official strike.

Dated _____

 Signature of Union Local Officer Title

AG-79 (R219)



American Income Life Insurance Company
P.O. Box 2608
Waco, TX 76702

First
Class
Postage
Required

From
Address