**ARKANSAS BANKERS LIFE INSURANCE COMPANY**
3616 JEFFERSON TEXARKANA, ARKANSAS 71854
(A Stock Company Herein Called the Company)

# HEALTH APPLICATION

(Check One)

☐ Regular Credit Life/Disability
(Form #ARK-P1101)

☐ Age-rated Level Credit Life
(Form #ARK-P1102)

☐ Other _____

Creditor Name _____ Location _____

| | Amount | Term (Months) | Premium |
|---|---|---|---|
| Decreasing Coverage | $ | | $ |
| Level Coverage | $ | | $ |
| Disability | $ Benefit /Per Month | | $ |

Policy # _____ Issue Date _____

Insured's Name _____ Birthdate _____
Month Day Year

Residence _____
Street City State Zip

Social Security Number _____ Place of Birth _____
State

Occupation _____ Height _____ Weight _____

Physician's Name _____

Physician's Address _____
Street City State Zip

1. To the best of your knowledge and belief, are you now in good health? _____
2. Have you ever been postponed, rated or refused life insurance? _____
3. Has a doctor seen you or treated you within the last five years for: (a) cancer or malignant tumor, or (b) heart disease or trouble, or coronary artery disease, (c) diseases of lungs or respiratory systems, or (d) disorder of the brain or nervous system, or (e) diabetes, or (f) paralysis or (g) liver or kidney disease or (h) Acquired Immune Deficiency Syndrome (AIDS or AIDS Related Complex (ARC)? _____

If yes, specify _____

4. Do you smoke? _____

## MIB AUTHORIZATION AND ACKNOWLEDGMENT

"I hereby authorize any licensed physician, medical practitioner, pharmacy benefits manager, hospital, clinic or other medical or medically related facility, insurance company, MIB, Inc. ("MIB") or other organization, institution or person, that has any records or knowledge of me or my health, to give to Arkansas Bankers Life Insurance Company, or its reinsurers, any such information. I authorize Arkansas Bankers Life Insurance Company, or its reinsurers, to make a brief report of my personal health information to MIB. A Photographic copy of this authorization shall be as valid as the original. Duration and Revocation: This authorization will be valid for [24 or 30] months, but I understand that I may revoke it at any time by giving written notice to the Company at the above address. I understand that there are limitations on my right to revoke this authorization. Any action taken in reliance on this authorization will be valid if such action has been taken prior to receipt of notice of revocation. If this authorization is used to collect information in connection with a claim for benefits, it will be valid for the duration of the claim. If the law of my state so provides, my authorization may not be revoked during a contestable investigation. I also understand that my revocation of this authorization will not result in the deletion of codes in the MIB database if such codes are reported by the Company (or the Company becomes obligated to report such codes to MIB) while this authorization is in force".

## FRAUD WARNING

"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.

Date _____

Witness _____ Signature of Applicant _____