Children's Term Insurance Rider Application
from The American Home Life Insurance Company

- Print clearly and use blue or black ink.
- Mail application and check in the provided business reply envelope to P.O. Box 14399, Lexington, KY 40512-9700.
- Coverage amount selected will be the same for all covered children.
- You can apply for coverage on a maximum of 9 children as defined below. Attach a second application to list more than 5 proposed insured children.

Primary Insured's name • **Policy number** *(if known)* •

1. Benefit amount

Coverage amount may not exceed the face amount of the base policy

☐ $2,500 ☐ $5,000 ☐ $7,500 ☐ $10,000

2. Children proposed insurance

Name natural born children, stepchildren, legally adopted children, grandchildren, legally adopted grandchildren, great grandchildren, proposed for insurance. Insurance will not be provided for newborns less than 30 days of age, children greater than 18 years of age, or children that are not US citizens.

Proposed Insured's name	Relationship to Primary Insured	Birth date	Social Security Number	U.S. citizen
•	•	•	•	☐ Yes ☐ No
•	•	•	•	☐ Yes ☐ No
•	•	•	•	☐ Yes ☐ No
•	•	•	•	☐ Yes ☐ No
•	•	•	•	☐ Yes ☐ No

3. Beneficiary

If a trust, give Trustee name, Trust name and Trust date. If no beneficiary is named for any child, the beneficiary designation defaults to the Insured of the base policy. Attach a separate sheet if necessary.

Primary beneficiary's name *(first, M. I. , last)* **Phone** **Share**

• • • %

Address **Social Security Number**

•

Primary beneficiary's name *(first, M. I. , last)* **Phone** **Share**

• • • %

Address **Social Security Number**

•

Percent share must total 100%

Contingent beneficiary's name *(first, M. I. , last)* **Phone** **Share**

• • • %

Address

•

Contingent beneficiary's name *(first, M. I. , last)* **Phone** **Share**

• • • %

Address

•

4. Health history

If any of these questions are answered "yes" that child will be excluded from coverage.

1.	**Is any Proposed Insured child currently institutionalized or in a care facility?**	☐ Yes	☐ No
2.	**Has any Proposed Insured child ever been diagnosed or been treated by a member of the medical profession for: cancer, diabetes, heart or circulatory disorder, mental or nervous disorder, intellectual disability to be supported by the applicant's medical records and/or diagnosis, cerebral palsy, muscular dystrophy, spina bifida, cystic fibrosis, un-operated heart defects, epilepsy, asthma, disorders of the muscles or bones, anemia or other disorders of the blood, bladder, kidneys, liver or lungs, or been recommended for an organ transplant?**	☐ Yes	☐ No
3.	**Has any Proposed Insured child ever tested positive for exposure to the Human Immunodeficiency Virus (HIV) infection or been diagnosed as having AIDS Related Complex (ARC) or Acquired Immune Deficiency Syndrome (AIDS) caused by the HIV infection or other sickness or condition derived from such infection?**	☐ Yes	☐ No
4.	**Has any Proposed Insured child ever used or received treatment, advice or counseling from a physician or other practitioner relating to the usage of alcohol, heroin, cocaine, narcotics, hallucinogens, tranquilizers, barbiturates, amphetamines, or other similar drugs except as prescribed by a physician?**	☐ Yes	☐ No

List the children for which "yes" answers were given.

5. Acknowledgement

I declare and represent that the foregoing statements and answers have been correctly recorded and that they are full, complete and true to the best of my knowledge and belief and shall constitute a part of the application.

Primary Insured/Owner's signature	**City and state where signed**	**Date**
×	•	•

Agent's signature	**Writing number**	**Date**
×	•	•

Any person who knowingly and 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.