ARKANSAS BANKERS LIFE INSURANCE COMPANY
3616 Jefferson Texarkana, Arkansas 71854
(A Stock Company Herein Called the Company)

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 _____

AUTHORIZATION AND ACKNOWLEDGEMENT

I hereby authorize any physician, hospital, clinic or other medical or medically related facility, insurance company, the Medical Information Bureau, or other organization, institution or person who has any records or knowledge of me or my health to give Arkansas Bankers Life Insurance Company or its Reinsurers any such information. I certify that I have read the information provided above and that it is true. I understand that I may not be eligible for this coverage if my answers above are not: I (1) yes; (2) no: (3) no. I also understand that any false statement, inaccuracy or misrepresentation relative to the risk, may be used by Arkansas Bankers Life insurance Company to deny a claim or void this policy. I acknowledge receipt of the "Pre-Notice" section of this application.

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 _____

Form #ARK-A103 (Rev. Feb. 1998)

DETACH AND HAND TO APPLICANT PRIOR TO COMPLETION OF THIS APPLICATION.

PRE-NOTICE

Information regarding your insurability will be treated as confidential. Arkansas Bankers Life Insurance Company may, however, make a brief report thereon to the Medical Information Bureau, a non-profit membership organization of life insurance companies, which operates an information exchange on behalf of its members. If you apply to another Bureau member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, the Bureau, upon request, will supply such company with the information in its file.

Upon receipt of a request from you, the Bureau will arrange disclosure of any information it may have in your file. (medical Information will be disclosed only to your attending physician.) If you question the accuracy of information in the Bureau's file, you may contact the Bureau and seek a correction in accordance with the procedure set forth in the federal Fair Credit Reporting Act. The address of the Bureau's information office is P.O. Box 105, Essex Station, Boston, Massachusetts 02112, telephone number (617) 426-3660.

Arkansas Bankers Life Insurance Company or its Reinsurers may also release information in its file to other life insurance companies to whom you may apply for life or health insurance, or to whom a claim for benefits may be submitted.