( ) Preferred
( ) Standard

Home Office Use Only
Policy#_____
Issue Date_____

FAMILY PLAN APPLICATION

Allied Funeral Associates Insurance Company

P. O. Box 4080
100 North Parkgate Ext.
Tupelo, MS 38803-4080
662 840-9911 * Fax 662 840-0911

1. **Insured No.1**

_____
First MI Last

2. **Home Address**

_____

_____
City ST Zip

3. **Phone No.**_____

4. **Social Security No.**_____/_____/_____

5. **Date of Birth**_____/_____/_____**Age**_____

6. **Height**_____**Weight**_____

7. **Beneficiary**_____
Relationship_____**Age**_____

8. **Plan**_____
9. **Amount Insurance**_____
10. **Monthly Premium**_____
11. **Amt. Paid with App.**_____

1. **Insured No.2**

_____
First MI Last

2. **Social Security No.**_____/_____/_____

3. **Date of Birth**_____/_____/_____**Age**_____

4. **Height**_____**Weight**_____

5. **Beneficiary**_____
Relationship_____**Age**_____

6. **Plan**_____
7. **Amount Insurance**_____
8. **Monthly Premium**_____
9. **Amt. Paid with App.**_____

Have you ever been diagnosed as having or been treated for:

a.) **Alzheimer's disease or other mental disorder?** Yes( ) No( )
b.) **Alcoholism, drug addiction?** Yes( ) No( )
c.) **Acquired Immune Deficiency Syndrome (AIDS) or AIDS related complex (ARC) or have you tested positive for the HIV antibody?** Yes( ) No( )
d.) **Stroke, Heart or Blood vessel disease?** Yes( ) No( )
e.) **Cancer, Diabetes, Kidney, Liver, Lungs or Nervous system disease (within past 2 years)?** Yes( ) No( )
f.) **Are you currently bedridden or residing in a nursing or long-term health care facility?** Yes( ) No( )
g.) **Have you been hospitalized or disabled during the past 12 months?** Yes( ) No( )
h.) **Are you currently taking medications?** Yes( ) No( )

Physician's Name_____
Address_____
Phone #_____

Identify by Insured's number and give details to any "Yes" answers in "REMARKS" section including date(s) of treatment.

REMARKS:

Will the proposed insurance replace or change any existing life insurance? Yes( ) No( ) If Yes, give Company name and policy number:
Name_____**Policy#**_____
Address_____

I Declare, that all answers to the questions above are complete, true and accurately recorded. I understand and agree that no one has authority to permit me to withhold information or to answer any questions falsely, and that any policy which may be issued by the Company on this application shall be accepted subject to its terms. I expressly authorize any physician or hospital to disclose any information acquired by examination or treatment of me, and I expressly waive all statutory rights governing such disclosure. A photographic copy of this authorization shall be as valid as the original. I understand that insurance applied for shall not take effect until the application is approved by and the first premium received by the Company.

FPApp-97

_____**Date**_____
Signature of Proposed Insured

Listed below are the dependent children, under 18 years of age:

1. Name_____ Relationship to Applicant_____

Date of Birth____/____/____ Age____ Sex____ Height____ Weight____

2. Name_____ Relationship to Applicant_____

Date of Birth____/____/____ Age____ Sex____ Height____ Weight____

3. Name_____ Relationship to Applicant_____

Date of Birth____/____/____ Age____ Sex____ Height____ Weight____

4. Name_____ Relationship to Applicant_____

Date of Birth____/____/____ Age____ Sex____ Height____ Weight____

5. Name_____ Relationship to Applicant_____

Date of Birth____/____/____ Age____ Sex____ Height____ Weight____

Has the proposed child listed above ever been diagnosed as having or been treated for:

a.) Alcoholism, drug addiction? Yes( ) No( )

b.) Acquired Immune Deficiency Syndrome (AIDS) or AIDS related complex (ARC) or have you tested positive for the HIV antibody? Yes( ) No( )

c.) Stroke, Heart or Blood vessel disease? Yes( ) No( )

d.) Cancer, Diabetes, Kidney, Liver, Lungs or Nervous system disease (within past 2 years)? Yes( ) No( )

e.) Are you currently bedridden or residing in a nursing or long-term health care facility? Yes( ) No( )

f.) Have you been hospitalized or disabled during the past 12 months? Yes( ) No( )

g.) Are you currently taking medications? Yes( ) No( )

Physician's Name_____
Address_____
Phone #_____

Identify by name and number and give details to any "Yes" answers, including date(s) of treatment in "REMARKS" section.

REMARKS:

Agent's Statement:

1. I saw the Proposed Insured at the time of application. Yes( ) No( )
2. I asked the health questions and recorded the answers. Yes( ) No( )
3. The Proposed Insured's ( )are ( )are not now in a hospital, nursing home, convalescent home or an extended health care facility.

To the best of your knowledge as Agent, will this insurance replace any other insurance? Yes( ) No( )

Agent's Signature_____
Funeral Home_____
Agent Number_____
Date_____