( )Preferred
( ) Standard

Home Office Use Only
Policy #_____
Issue Date_____

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

_____
First MI Last

2. Home Address_____

_____
City ST Zip

3. Phone No._____

Social Security No._____/_____/_____

4. Date of Birth_____/_____/_____
Age_____

5. Height_____ Weight_____

---

6. Primary Beneficiary
_____Age_____
Relationship_____

7. Secondary Beneficiary
_____Age_____
Relationship_____

---

8. Plan_____

9. Amount Insurance_____

10. Monthly Premium_____

11. Amt. Paid with App._____

12. 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? 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 #_____

Give details to "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 name of company and policy number here:
Name_____Address_____Policy#_____

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.

_____Date_____
Signature of Proposed Insured (Parent or Guardian if under 18)

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 ( )is ( )is 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

If a policy cannot be issued as applied for, will a modified whole life policy be acceptable? ( )Yes ( )No

Agent's Signature_____
Funeral Home _____
Agent Number _____
Date _____