RETURN THIS COMPLETED APPLICATION BY EMAIL: Daniel@LifeGuy.com or FAX# 321-218-2557

UNITED AMERICAN INSURANCE COMPANY A LEGAL RESERVE STOCK COMPANY * Administrative Office: McKinney, Texas 75070

Application for Accidental Death Policy

Benefit Amount \$3,000 (\$3,000 spouse, \$2,000 each child)

Annual Mode of Premium

Mode of Premium Payment Send Premium Notices O Automatic Payment Plan Day (01-28) of the Month

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Proposed Insured/Applicant																															
First Name																							Ν	1.1.							
Last Name																															
Address																															
City																		State				Zip Code									
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Child 3 First Name																						<u> </u>	M.I.								
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(Application Continued)

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Child 4 First Name																M.	ı.							
Last Name																								
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Child 5 First Name																M.I.								
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Child 6 First Name																M.	ı.[\neg						
Last Name																	L							
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I hereby declare that the statements recorded above are true and complete to the best of my knowledge and belief with respect to any proposed insured. I agree that: (1) no policy will be binding upon the Company unless upon its date of issue and delivery each proposed insured is alive; (2) no agent has authority to accept risks or make or change contracts or waive the Company's rights or requirements. I understand and agree that the Company reserves the right during the first year the policy is in force, to restrict beneficiaries to designations acceptable to the Company. Except with respect to a minor child of mine, this application is made with the knowledge and consent of the proposed insured. I, HEREBY AUTHORIZE the MIB, Inc., any insurance company, hospital, physician or other practitioner having any information available as to my diagnosis, treatment and prognosis with respect to any physical or mental condition and/or treatment, to disclose such information to United American Insurance Company for the purpose of determining my eligibility for insurance and eligibility for benefits under this policy. I understand that I or an authorized representative may request a copy of this authorization. Information for consumers MIB, Inc. may be obtained on its website at www.mib.com .																								
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. Florida Residents have the right to designate a secondary addressee. Instruction will accompany all Florida policies at issue.																								
Amount Coll	Amount Collected with this Application: \$ 0.00								_	Date Application Signed (mm-dd-yyyy) State City Signed														
Last Name Print First 5	ast Name DRAGAN Agent No. 0 1 1 3 2 Print First 5 Letters of Agent's Last Name										Signed Proposed Insured													
Agent's Florida ID No. P 2 0 5 6 5 2											Signed Applicant (If other than the Proposed Insured)													
SE	END POLICY	TO:	O Age	ent (≫ Ins	ured	The F	Policy	will b	e sen	nt to in	sured		• •	therwise					٠-٧			·-,	

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