

SCHEDULE OF PREMIUM AND BENEFITS

EFFECTIVE DATE	GROUP POLICYHOLDER	GROUP POLICY NO.	APPLICATION NO. INPAP
CREDITOR BENEFICIARY	ADDRESS	CITY	STATE ZIP
INSURED DEBTOR NAME	AGE	JOINT DEBTOR NAME	AGE
DATE OF BIRTH	SOCIAL SECURITY NUMBER	DATE OF BIRTH	SOCIAL SECURITY NUMBER
ADDRESS		ADDRESS	

COVERAGES	SINGLE	JOINT	INS. TERM (In months)	INS. EXP. DATE (MM/DD/YY)	LOAN TERM (In months)	INITIAL AMOUNT OF INSURANCE	PREMIUM
DECREASING TERM LIFE	_____	_____	_____	_____	_____	_____	\$ _____
LEVEL TERM LIFE	_____	_____	_____	_____	MONTHLY BENEFIT	_____	\$ _____
DISABILITY	_____	_____	_____	_____	\$ _____	_____	\$ _____
<input type="checkbox"/> Check Box for Truncated Coverage		APR% _____	<input type="checkbox"/> Net <input type="checkbox"/> Gross		TOTAL PREMIUM \$ _____		
DAYS TO FIRST PAYMENT	_____ DAYS						
REQUIRED DISABILITY PERIOD	_____ DAYS						
DAY BENEFITS COMMENCE	_____ DAY						

LIMITS OF COVERAGE – PER INDIVIDUAL

Age Eligibility: Minimum 18, Maximum 65 at issue, and Maximum Age 66 at Insurance Expiration Date for life, and Maximum 66 at Insurance Expiration Date for disability

Insurance: Maximum Life Insurance per Certificate = \$100,000. Maximum Certificate Disability benefit per Certificate = \$1,000 monthly payment.

Terms: Partial Disability Not Covered
Maximum 120 months Life Term.
Maximum 120 months Disability Term.

THE FULL TERM OF YOUR LOAN MAY NOT BE COVERED IF YOU HAVE TRUNCATED COVERAGE

YOU HAVE THE RIGHT TO CANCEL THE CREDIT INSURANCE SELECTED ABOVE WITHIN 30 DAYS. UPON CANCELLATION ALL CREDIT INSURANCE PREMIUMS WILL BE CREDITED TO YOUR ACCOUNT.

PRE-EXISTING CONDITIONS ARE NOT COVERED FOR DISABILITY INSURANCE
(See the certificate for details)

APPLICATION FOR CREDIT INSURANCE

UNDERWRITING QUESTIONNAIRE: Please INITIAL appropriate box for each question answered.

First Debtor: Height _____ Weight _____ Occupation _____
 Second Debtor: Height _____ Weight _____ Occupation _____

FOR AMOUNTS OF LIFE INSURANCE OF \$50,001 OR MORE	First Debtor Applicant		Joint Debtor Applicant	
	YES	NO	YES	NO
1. Have you had within the last 5 years: (Please Initial)				
a. heart attack, heart disease or disorder, stroke, high blood pressure, heart murmur?				
b. diabetes, kidney or urinary disorders, cancer or tumors?				
c. emphysema, or any disease of the lungs, blood, brain, liver?				
d. AIDS, ARC, anemia, immunological disorder or tested positive for the antibodies to the AIDS virus?				
e. any back, neck or knee disorder, rupture or hernia, any deformity or loss of limb, sight or hearing?				
f. nervous, mental or emotional disorder, depression, ulcer, paralysis or alcohol or drug use?				
2. Are you actively and gainfully working for wage or profit on a full time basis, at least 30 hours each week for the past 12 months?				
3. Have you consulted a physician or hospital or are you under treatment for any condition not listed above?				
Proportional Joint Disability Percent contribution to family income (percentages should equal 100%)	NA %		NA %	
Provide details to any "yes" answer, giving type of illness, name and address of physicians, clinics, hospitals, dates of treatment. If Joint, please clarify as to First Debtor or Second Debtor. Any underwriting decision based on the required evidence of insurability shall be made within 60 days of the application for insurance.				

Your signature(s) below means:

- You represent that you are not over age 65 and will not attain age 66 for life coverage before the expiration of this contract, and not over age 65 and will not attain age 66 for disability coverage before the expiration of this contract.
- The above are true and accurate.

Application is hereby made to American Modern Life Insurance Company for Credit Insurance on the life or lives of the Proposed Debtor(s) named above. If the Proposed Debtor(s) is/are found to be uninsurable according to the standard underwriting procedures of American Modern Life Insurance Company or its Reinsurers, or if material misrepresentations are made above to obtain insurance, no coverage will be provided and a refund will be made to the Proposed Debtor(s) of any premium paid.

By this form of authorization (or a photographic copy of it), I/we do hereby authorize any medical professional, medical-care institution or insurance institution that has any medical information or knowledge thereof concerning myself/ourselves, to disclose such information or knowledge to the American Modern Life Insurance Company or its Reinsurers to be used in connection with insurance applications and policy matters, or to testify with reference thereto to the extent permitted by applicable laws governing access and disclosure of the insurance information and privacy protection in insurance transactions. This authorization shall remain valid unless revoked in writing with notice to American Modern Life Insurance Company, either for thirty (30) months from the date signed or the date a claim has been legally concluded, whichever occurs first.

Signed at _____
(City, State)

_____ Date of Application

_____ Signature of First Debtor Applicant

_____ Signature of Licensed Resident Agent Witness

_____ Signature of Joint Debtor Applicant

_____ Type of Print Name of Licensed Resident Agent Witness

WARNING: ANY PERSON WHO, WITH INTENT TO DEFRAUD OR KNOWING HE IS FACILITATING A FRAUD AGAINST AN INSURER, SUBMITS AN APPLICATION OR FILES A CLAIM CONTAINING A FALSE OR DECEPTIVE STATEMENT IS GUILTY OF INSURANCE FRAUD.

MEDICAL INFORMATION BUREAU NOTIFICATION

Information regarding your insurability will be treated as confidential. American Modern Life Insurance Company or its Reinsurers 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 in 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 company, the Bureau, upon request, will supply such company with the information it may have 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 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 Post Office Box 105, Essex Station, Boston, Massachusetts 02112, telephone number (617) 426-3680.

American Modern 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 and to whom a claim for benefits may be submitted.

INVESTIGATIVE CONSUMER REPORT

An investigative report may be obtained whereby information is secured through personal interviews with your friends, neighbors and others with whom you are acquainted. The report, if obtained, will include information as to character, general reputation, personal characteristics, job details, whichever is applicable of any person to be insured. Upon written request, a complete and accurate disclosure of the nature and scope of the investigative consumer report will be provided to you.

IN RESIDENTS – Your satisfaction is very important to us. Should you have a valid claim, we fully expect to provide a fair settlement in a timely fashion. If you have a question, please call American Modern Life Insurance Company, 70000 Midland Blvd, Amelia, OH (800) 890-6980. If you feel you are not being treated fairly, we want you to know you may contact the IN Dept. of Insurance with your complaint and seek assistance from the governmental agency that regulates insurance. To contact the Dept., write or call: Public Information/Market Conduct, IN Dept. of Insurance, 311 W. Washington St., Suite 300, Indianapolis, IN 46204-2787, Consumer Hotline (800) 622-4461, Indianapolis area (317) 232-2395.