

Ultra Protector				
Issue Age	Ultra Protector			
	Female		Male	
	Non-Smoker	Smoker	Non-Smoker	Smoker
55	27.00	33.92	36.00	49.82
56	28.00	34.98	38.00	51.94
57	30.00	37.10	39.00	54.06
58	31.00	38.16	41.00	57.24
59	33.00	40.28	43.00	59.36
60	34.00	42.40	45.00	62.54
61	36.00	44.52	47.00	64.66
62	38.00	46.64	50.00	67.84
63	40.00	48.76	52.00	72.08
64	42.00	50.88	55.00	75.26
65	44.00	53.00	58.00	79.50
66	46.00	55.12	61.00	83.74
67	48.00	58.30	65.00	89.04
68	51.00	60.42	69.00	93.28
69	53.00	63.60	73.00	98.58
70	56.00	66.78	78.00	104.94
71	60.00	69.96	83.00	111.30
72	63.00	74.20	89.00	117.66
73	68.00	79.50	95.00	124.02
74	72.00	83.74	101.00	130.38
75	78.00	90.10	108.00	137.80
76	86.99	96.46	118.41	145.22
77	95.98	103.88	128.82	152.64
78	104.98	111.30	139.24	160.06
79	113.97	120.84	149.65	168.54
80	122.96	129.32	160.06	177.02
81	133.56	---	170.66	---
82	144.16	---	182.32	---
83	156.88	---	195.04	---
84	169.60	---	207.76	---
85	183.38	---	221.54	---

Annual premium rates per \$1,000 face amount. Add \$40 annual policy fee

About Americo

For over 90 years, Americo Life, Inc., and its family of insurance companies have been committed to providing the insurance and financial products you need to protect your mortgage, family, and future.* We listen to what you want from an insurance policy or annuity and do our best to provide a proper solution for your situation.

Innovative thinking has helped us build a strong financial foundation for our business. Today, Americo Life, Inc., our holding company, is one of the largest independent, privately held insurance groups in the United States, with nearly eight hundred thousand policyholders, over \$37 billion of life insurance in force, and \$5 billion in assets according to the insurance companies' combined annual statements for year-end 2004.**

Refer to the Delivery Receipt/Disclosure Statement as well as your policy for the governing contractual provisions.

The company reserves the right to contest policies for up to two years due to any misrepresentations in the application. In the event of Insured's suicide while sane or insane, the company's liability is limited to a return of premiums during the first two years after the date of issue.

Products are underwritten by Americo Financial Life and Annuity Insurance Company and may vary in accordance with state laws. Some products and benefits may not be available in all states or for all periods. Certain restrictions apply. For further information, please refer to the policy.

**Americo Life, Inc., is a holding company and is not responsible for the financial condition or contractual obligations of its affiliate insurance companies.*

***"Admitted Assets, Top Life Writers-2004," A.M. Best Co., as of July 2005.*



Americo Financial Life and Annuity Insurance Company
Home Office: Dallas, Texas
Administrative Office: P.O. Box 410288, Kansas City, Missouri 64141-0288



ULTRA PROTECTOR



LIFE

Life insurance to help plan for future financial obligations

AMERICO

Americo Financial Life and Annuity Insurance Company

03-013-2-BB (04/06) © Americo

Policy Series 248

Affordable, guaranteed coverage that shows your loved ones how much you care.

Ultra Protector, offered by Americo Financial Life and Annuity Insurance Company (Americo), is a whole life insurance policy designed to help cover the financial obligations that your family may face when you're gone. With a simple application process, affordable premiums, and various premium payment methods, it is easy to protect your loved ones from the financial burden that they may face when you're gone.

Ultra Protector offers you and your family these valuable benefits:

- An income tax-free death benefit paid directly to your chosen beneficiary.
- Guaranteed level premiums for the life of the policy (subject to minimums).
- Minimum face amount \$5,000.
- Maximum face amount \$30,000.
- Access to cash through the policy's tax-free loan provisions (certain restrictions apply).
- A level (full) death benefit.
- A lump-sum advance of a portion of the death benefit should you become terminally ill.
- Ultra Protector issued to ages 55 – 85 (55 – 80 for smokers).
- The security of life insurance from a financially strong company.

Ultra Protector

Ultra Protector provides a (full) death benefit up to \$30,000. You select the amount needed for your particular situation. This death benefit will ultimately pass to your beneficiaries on a tax-free basis to cover the financial obligations they may face in your absence. As long as the guaranteed level premiums are paid as scheduled, this level death benefit will be guaranteed (less any advances or loans that may have been taken on the policy).

Access to cash

With Ultra Protector your policy builds a cash value. When your policy has cash value built up, you will have access to that money through tax-free policy loans. And there are never restrictions on how the death benefit or loan proceeds are used. It's the perfect way to protect the future of your loved ones and plan for your final expenses.

Valuable benefit at no extra cost

Ultra Protector includes a Terminal Illness Accelerated Death Benefit Rider that allows for a lump-sum advance of up to 50% of the death benefit should you become terminally ill. This benefit provides you with access to cash when you may need it most.

Some benefits may not be available in all states. Certain restrictions apply.

Costs to Consider

Use this worksheet to estimate some of the future financial obligations your loved ones may face.

Credit Card Balances	_____
Other Outstanding Debt	_____
College Costs	_____
Funeral Expenses:	
Funeral Home	_____
Cemetery Plot	_____
Transportation	_____
Casket & Vault	_____
Church & Flowers	_____
Medical Expenses	_____
Probate	_____
Other	_____
TOTAL	=====

Proceeds from your Ultra Protector policy may be used for any purpose.

Calculate Your Premium

Use the worksheet below to calculate your premium:

Annual Rate per Thousand	\$ _____
Number of 1,000's	(x) _____
Premium Amount	\$ _____
Annual Policy Fee	(+) \$ 40.00 _____
Total Premium	\$ _____
Modal Factor	(x) _____
Modal Premium	\$ _____

Calculated premium may vary slightly due to rounding.

Modal Factors Available

To determine your modal premium, multiply the corresponding modal factor times the total premium.

Mode	Factor	Mode	Factor
Annual	1.00	Quarterly	.28
Semi-annual	.52	Monthly PAC	.087

The total amount of premiums paid each year on this policy and any riders will be higher if the premiums are paid on a semi-annual, quarterly, or monthly mode than if paid on an annual mode.

Americo Financial Life and Annuity Insurance Company

Home Office: Dallas, Texas • Administrative Office: P.O. Box 410288, Kansas City, MO 64141-0288

Life Insurance Application

ABB5091(01/06)

1. Proposed Insured's Name (Last, First, Middle Initial)			8. Place of Birth (City, State)		9. Height	10. Weight
2. Proposed Insured's Address			11. Owner's Name (Last, First, Middle Initial)			
City, State, Zip			12. Owner's Address			
3. Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	4. Telephone Number		City, State, Zip			
5. Insured's SS# or Tax ID	6. Age	7. Date of Birth	13. Relationship to Insured		14. Owner's SS# or Tax ID	

15. Primary Beneficiary Name		Relationship		16. Contingent Beneficiary Name		Relationship	
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17. Plan Name <input type="checkbox"/> Ultra Protector I <input type="checkbox"/> Ultra Protector II	18. Face Amount (check one) <input type="checkbox"/> Solve for Face Amount <input type="checkbox"/> Face Amount \$ _____	19. Frequency:* <input type="checkbox"/> Monthly (PAC) <input type="checkbox"/> Quarterly (Direct Bill) <input type="checkbox"/> Semi-Annually (Direct Bill) <input type="checkbox"/> Annually (Direct Bill)		20. Modal Premium: \$ _____	21. Automatic Premium Loan Elected? <input type="checkbox"/> Yes <input type="checkbox"/> No	
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22. Do you have any existing life insurance or annuities? Yes No

23. Will this life insurance policy replace any existing life insurance or annuities now in force? Yes No

If Yes to either question, be sure to include insured's name, policy number, and insurer in "Remarks/Special Requests". Replacement forms may be required by state law.

24. Has the Proposed Insured smoked cigarettes within the last 12 months? Yes No

HEALTH QUESTIONS (No coverage is available if the answer to any of the health questions is "Yes")

	Yes	No
1. Is the Proposed Insured currently: hospitalized, bedridden, confined to a nursing facility, receiving hospice or home health care, using oxygen to assist in breathing, confined to a wheelchair, waiting for an organ transplant, or paralyzed?	<input type="checkbox"/>	<input type="checkbox"/>
2. Has the Proposed Insured ever:		
a. Had, been told they have, been treated for, or been prescribed medication for Alzheimer's disease, dementia, memory loss, muscular dystrophy, or ALS (Lou Gehrig's Disease)?	<input type="checkbox"/>	<input type="checkbox"/>
b. Been diagnosed as having or been treated by a medical professional for, or tested positive for, Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC), or the Human Immunodeficiency Virus (HIV)?	<input type="checkbox"/>	<input type="checkbox"/>
3. In the past 5 years, has the Proposed Insured been told they have or been treated by surgery, chemotherapy, radiation, or prescribed medication for internal cancer, leukemia, or malignant melanoma other than basal cell skin cancer?	<input type="checkbox"/>	<input type="checkbox"/>
4. In the past 2 years, has the Proposed Insured had, been told they have, been treated for, or taken medication or had surgery for:		
a. Heart bypass, angioplasty (balloon procedure), stent placement, heart valve disorder, heart attack, angina (chest pain), congestive heart failure, stroke, circulation or blood clot problems in the legs or to the heart or brain, systemic lupus, chronic kidney disease, or kidney failure?	<input type="checkbox"/>	<input type="checkbox"/>
b. Drug or alcohol abuse/dependency or addiction?	<input type="checkbox"/>	<input type="checkbox"/>
5. Has the Proposed Insured ever been told they have, been treated for, or taken medication for Parkinson's disease, cirrhosis of the liver, or other liver diseases or disorders?	<input type="checkbox"/>	<input type="checkbox"/>
6. a. In the past 2 years, has the Proposed Insured taken insulin for diabetes or experienced complications of diabetes including amputation, eye, or kidney problems?	<input type="checkbox"/>	<input type="checkbox"/>
b. Does the Proposed Insured experience periods of their blood sugar not being controlled (in excess of 175)?	<input type="checkbox"/>	<input type="checkbox"/>
7. In the past 2 years, has the Proposed Insured had, or been told they have, been treated for, or been prescribed medication for multiple sclerosis or heart disease not including high blood pressure?	<input type="checkbox"/>	<input type="checkbox"/>
8. In the past 2 years, has the Proposed Insured had, been told they have, been treated for, or taken medication for emphysema, chronic bronchitis that is not seasonal, or any other chronic respiratory or lung problem excluding allergies or asthma?	<input type="checkbox"/>	<input type="checkbox"/>

Health Question Details (attach a separate sheet if more space is needed):

Remarks/Special Requests:

Authorization and Acknowledgment

By completing and signing this application, I/We authorize any licensed physician, medical practitioner, hospital, clinic, pharmacy or other medical related facility, insurance company, the Medical Information Bureau, Inc. (MIB), Social Security Administration or other health care provider or governmental agency to provide Americo Financial Life and Annuity Insurance Company (the "Company") or its reinsurers any and all medical records or knowledge about the Proposed Insured, including entire medical records, to determine insurance and claim eligibility. This authorization will be valid for 24 months from the date signed. It is the Company's practice to prohibit third parties who lawfully receive nonpublic health information from redisclosing or reusing the disclosed information. A photographic copy of this authorization shall be as valid as the original. I/We understand that a copy of this authorization will be provided, upon request, to me/us or a person authorized on my/our behalf.

I/We acknowledge receipt of the Information Practices Notice and MIB, Inc. Pre-Notice.

I/We understand that disclosure of information to the Company may subject the information to redisclosure in accordance with the Company's privacy policy and MIB, Inc. rules. This authorization may be revoked; however, it may not be revoked during the contestability period of the policy or to the extent the Company has taken action in reliance on this authorization. Notice of revocation may be sent, in writing, to the Company at its Administrative Office address.

Residents of Arkansas, District of Columbia, Kentucky, Louisiana, Maine, Maryland, New Mexico, Ohio, Pennsylvania, Tennessee, Texas: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

NO AGENT OR MEDICAL EXAMINER CAN WAIVE THE ANSWER TO ANY QUESTION IN THIS APPLICATION NOR DECIDE ON INSURABILITY NOR WAIVE ANY OF THE COMPANY'S UNDERWRITING REQUIREMENTS NOR MAKE OR CHANGE ANY CONTRACT. THE COMPANY SHALL HAVE NO KNOWLEDGE OF STATEMENTS MADE BY OR TO THE AGENT OR MEDICAL EXAMINER UNLESS SUCH STATEMENTS ARE SHOWN ON THE APPLICATION.

REQUEST FOR OWNER'S TAXPAYER IDENTIFICATION NUMBER AND CERTIFICATION

Certification – Under penalties of perjury, I, as the Owner, certify that the number shown on this form is my correct taxpayer identification number (or I am waiting for a number to be issued to me).

I/We represent that the statements and answers given in this application are true, complete and correctly recorded, to the best of my knowledge and belief. I/We agree that the Company can rely on these statements. Any policy issued on this application will be deemed to be delivered in and governed by the laws of the jurisdiction in which this application was signed.

Signed at _____

Date _____

✕ _____
Signature of Proposed Insured

✕ _____
Signature of Owner

Agent's Statement

Does the Proposed Insured have existing life insurance policies or annuities in force? Yes No
 Will the life insurance policy applied for replace, or otherwise reduce in value, any life insurance or annuity now in force? Yes No
 If Yes to either question, complete applicable replacement form(s). Copies of replacements forms are to be provided to both the owner and the company.

I hereby certify that I have personally asked each question on this application to the Proposed Insured(s), and I have truly and accurately recorded on the application the information supplied by him/her.

Agent Signature(s)	Print Agent Name(s)	Agent Phone Number(s)	Agent Number(s)	%
✕				
✕				

IMPORTANT NOTICE — PLEASE READ CAREFULLY!
NO INSURANCE WILL BE PROVIDED UNLESS ALL TERMS STATED BELOW ARE MET EXACTLY AND IN FULL!
NO AGENT OR BROKER HAS THE AUTHORITY TO CHANGE OR WAIVE ANY OF THESE TERMS.
NO INSURANCE PREMIUMS HAVE BEEN RECEIVED WITH THIS APPLICATION.

1. ALL OF THE FOLLOWING TERMS MUST BE MET EXACTLY AND IN FULL BEFORE COVERAGE WILL BEGIN:
 - (A) Payment of the full first modal premium is received by the Company;
 - (B) All medical examinations, X-rays, tests, physicians' statements and any other underwriting requirements of the Company must be received; and
 - (C) The Proposed Insured in the application must be acceptable to the Company without change on the Effective Date under its rules for insurance (1) on the Plan applied for (2) in the amount and (3) in a class of risks not less favorable than standard.
2. IF PREMIUM PAYMENT IS RECEIVED BY THE COMPANY AND ALL OF THE REQUIREMENTS IN (B) ABOVE ARE NOT RECEIVED BY THE COMPANY WITHIN THE FOLLOWING 60 DAYS, THE APPLICATION WILL BE VOID AND THE PREMIUM WILL BE RETURNED.
3. IF ANY OF THE ABOVE REQUIREMENTS IS NOT MET, THE COMPANY'S ONLY LIABILITY WILL BE TO REFUND PREMIUM RECEIVED, IF ANY.
4. If all requirements are met the "Effective Date" will be the later of: (1) the date all of the above required information is received by the Company or (2) the date of issue, if any, requested in the application.

Dated at _____ this _____ day of _____, _____

Applicant's Signature
AAA8393

Agent's Signature

THIS IMPORTANT NOTICE IS APPLICABLE IF NO PREMIUM IS RECEIVED WITH THE APPLICATION.

THIS IS A CONDITIONAL RECEIPT — PLEASE READ CAREFULLY!
NO INSURANCE WILL BE PROVIDED BY YOUR FIRST PAYMENT UNLESS ALL TERMS
IN PARAGRAPH "FIRST" ARE MET EXACTLY AND IN FULL!
NO AGENT OR BROKER HAS THE AUTHORITY TO CHANGE OR WAIVE ANY OF THESE TERMS.

Received from _____ this _____ day of _____, _____ \$ _____

_____ by cash or check, preauthorized order for withdrawal, or salary deduction plan. This payment is the amount of the first full modal premium for the policy applied for in the application for life insurance to Americo Financial Life and Annuity Insurance Company having the same number and date as this Conditional Receipt. This payment is made and accepted under the terms of this Conditional Receipt. This Conditional Receipt cannot be transferred. ANY PAYMENT BY CHECK MUST BE MADE PAYABLE TO AMERICO FINANCIAL LIFE AND ANNUITY INSURANCE COMPANY. DO NOT MAKE ANY CHECK PAYABLE TO THE AGENT OR LEAVE THE PAYEE BLANK. If your check or draft is not honored when first presented for payment, this Conditional Receipt will not be valid.

FIRST: TERMS ALLOWING INSURANCE TO BECOME EFFECTIVE BEFORE POLICY DELIVERY: If ALL of the following terms are met exactly and in full, insurance under the terms of the policy applied for, if then being sold by the Company, will become effective on the Effective Date subject to the limitations in Paragraph "SECOND": (1) All representations made in the application must be true and complete in all material respects; (2) all medical examinations, X-rays, tests, physician's statements and any other underwriting requirements of the Company must be completed and received not later than 60 days from the date the application is signed; (3) all persons proposed for insurance in the application must be acceptable to the Company without change on the Effective Date under its rules for insurance (A) on the Plan applied for (B) in the amount and (C) in a class of risks not less favorable than standard; and (4) the amount shown above must be equal to at least the first full modal premium for insurance.

IF ALL OF THE TERMS IN PARAGRAPH "FIRST" ARE NOT MET EXACTLY AND IN FULL, THE COMPANY'S ONLY LIABILITY WILL BE TO REFUND THE AMOUNT FOR WHICH THIS CONDITIONAL RECEIPT WAS GIVEN. "Effective Date" means the latest of: (1) the date the application is signed; (2) the date all required information is completed and received by the Company; and (3) the date of issue, if any, requested in the application.

SECOND: LIMITS OF LIABILITY — MAXIMUM AMOUNT OF INSURANCE AND PERIOD OF TIME WHICH INSURANCE CAN BECOME EFFECTIVE BEFORE POLICY DELIVERY. The Company's liability for insurance under this Conditional Receipt plus all insurance which is in force or is pending in the Company on any Proposed Insured can never exceed \$250,000 of life insurance including (a) Accidental Death Benefits, and (b) any coverage in force. The time for which the Company can be liable under this Conditional Receipt can never exceed a period of 60 days from the date this Receipt was signed.

Dated at _____ this _____ day of _____, _____

Applicant's Signature

Agent's Signature

If the application is not approved and accepted within 60 days from the date it was signed,
the Company shall have no liability except for the return of this payment on surrender of this Receipt

INFORMATION PRACTICES NOTICE
THIS NOTIFICATION MUST BE DELIVERED TO THE PROPOSED INSURED/ADDITIONAL PROPOSED INSURED
WHEN THE APPLICATION IS COMPLETED.

Thank you for your application. As a part of our underwriting procedure, a routine investigative consumer report may be made during the next few days. This report typically concerns information on an applicant's character, general reputation, personal characteristics and mode of living except as may be related directly or indirectly to your sexual orientation. This information will be obtained through personal interviews with your friends, neighbors, and associates. We will be pleased to provide you with further information on the nature and scope of such a report, if one is made, upon receipt of your written request. Should you wish to contact us about questions you may have, please write to: Americo Financial Life and Annuity Insurance Company, P.O. Box 410288, Kansas City, MO 64141-0288, Attention: Underwriting/New Business Department.

MIB, INC. PRE-NOTICE

Information regarding your insurability will be treated as confidential. However, Americo Financial Life and Annuity Insurance Company or its reinsurers may make a brief report to the MIB, Inc. a nonprofit membership organization of life insurance companies operating as an information exchange for its members. If you apply to another MIB member company for life or health insurance or a claim is submitted to such a company, upon request the MIB will supply the company with the information it has in its file.

Upon receipt of a request from you, the MIB, Inc., will arrange disclosure of any information it has in your file. If you question the accuracy of information in the file, you may contact the MIB and seek a correction in accordance with the procedures in the Fair Credit Reporting Act. The MIB's information office address is P.O. Box 105, Essex Station, Boston, Massachusetts 02112, (617) 426-3660.

The Company and its reinsurers may release information in its file to its reinsurers and to other life and health insurance companies to whom you apply for insurance or to whom a claim is submitted.

AAA8405

INFORMATION PRACTICES NOTICE
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COMPLETED.

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The Company and its reinsurers may release information in its file to its reinsurers and to other life and health insurance companies to whom you apply for insurance or to whom a claim is submitted.

AAA8405

Americo Financial Life and Annuity Insurance Company

Home Office: Dallas, Texas • Administrative Office: P. O. Box 410288, Kansas City, MO 64141-0288

Authorization Agreement for Prearranged Payments

As a convenience to me, I hereby request and authorize the banking institution below (the "Bank") to pay and charge to my account drafts on my account by and payable to the order of the company who issued or assumed the policy listed below (the "Company") administering my insurance policy provided there are sufficient collected funds in said account to pay the same upon presentation. I agree that the Bank's rights in respect to such draft shall be the same as if it were a check drawn on the bank and signed personally by me. This authority is to remain in effect until revoked by me in writing and until the Bank actually receives such notice. I agree that the Bank shall be fully protected in honoring any such draft. I further agree that if any such draft be dishonored, whether with or without cause and whether intentionally or inadvertently, the Bank shall be under no liability whatsoever. Should any draft not be honored by the Bank upon presentation, I understand that this method of payment may be terminated.

I understand also that my insurance policy may lapse if said draft is returned unpaid by my Bank or if I discontinue payments prior to receiving confirmation of draft processing from the Company.

Checking
(attach voided check)

Savings
(attach deposit slip)

Draft start date: _____ (Bank drafts cannot occur on the 29th, 30th, or 31st of the month. If not completed, premium will be drafted from your account immediately upon policy issuance.)

Proposed Insured's Name	Account Holder's Name (if different from Proposed Insured)
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Bank Name

Bank Routing Number	Bank Account Number
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Payor's Information (complete only when payor is different than Proposed Insured or Owner)

Name

Address (If mailing address is a P.O. Box, a street address is also required)
--

How long at current address? _____ (If less than 5 years at current address, previous address required):

Relationship to Proposed Insured	Social Security Number
---	-------------------------------

Signature (as it appears on bank records)	Date
--	-------------

Please attach a voided check (for checking account) or
deposit slip (for savings account) here.