APPLICATION NUMBER

HABITS ADDENDUM FOR AMERICAN INCOME LIFE INSURANCE COMPANY

PO BOX 2608
WACO, TX 76797

PLEASE INDICATE APPROPRIATE APPLICANT'S NAME IN THE SHADED AREA

PRIOR OR CURRENT ALCOHOL OR DRUG USE NAME _____

1. Have you ever been charged with drinking while driving? ☐ Yes ☐ No
   Number of arrest(s) _____
   Dates: 1. _____ 2. _____ 3. _____
2. Do you currently drink? ☐ Yes ☐ No
   If no longer drinking, date of your last drink? _____
   Do/did you drink? ☐ Almost daily ☐ 1-2 times a week ☐ 1-2 times a month ☐ less than 1-2 times a month
   Approximately how many drinks in one day? ☐ 1-2 ☐ 3-4 ☐ 5-6 ☐ 7+
3. Have you ever been a member of a support group for alcohol use (example A.A.)? ☐ Yes ☐ No
   Why did you join? _____
   ☐ Voluntary ☐ Court Ordered
   Do you currently attend a support group for alcohol use? ☐ Yes ☐ No
4. Have you ever received treatment for alcohol use? ☐ Yes ☐ No
   Dates of treatment _____
   Treatment Facility & Address _____
   Were you confined? ☐ Inpatient ☐ Outpatient
   ☐ Voluntary ☐ Court Ordered
   How long were you in treatment? _____
5. Have you used marijuana within the last 2 years? ☐ Yes ☐ No If yes, last date used _____
   How often? ☐ Daily use ☐ 3-4 times per week ☐ 1-2 times per week ☐ Less than once per week
6. Have you ever used street drugs or abused prescription drugs? ☐ Yes ☐ No
   Type of drug _____ Date began _____ Date stopped _____
   Type of drug _____ Date began _____ Date stopped _____
   Type of drug _____ Date began _____ Date stopped _____
7. Have you ever used intravenously injected drugs? ☐ Yes ☐ No
8. Have you ever been treated for drug abuse? ☐ Yes ☐ No
   Treatment date(s): _____ _____
   Treatment facility: _____

ARREST NAME _____

1. For arrest other than DWI, complete below:

	ARREST 1	ARREST 2	ARREST 3
Arrest date			
City, State			
Description of the incident and charge			
Felony or Misdemeanor			
Conviction Date			
Length of Sentence			
Amount of Jail Time			
Amount of Prison Time			
Parole Start Date			
Parole Finish Date			
Probation Start Date			
Probation Finish Date			
Amount of Fines Paid			

X _____ Signature of Applicant _____ Date
X _____ Signature of Spouse _____ Date
X _____ Signature of Agent _____ Date

BACK / JOINT

NAME _____

1. Where is the location of the injury? (back, knee, left, right, etc.?) _____
   Injury Date: _____ Description: _____
   Injury Date: _____ Description: _____
2. What was the physician's diagnosis? (strain, muscle pull, pinched nerve, ruptured disc, etc.) _____
   Name, address & phone number of the physician with the most recent records: _____
3. Were you hospitalized? ☐ Yes ☐ No Date: _____ Duration: _____
   Name, address & phone number of hospital: _____
4. Did you have surgery? ☐ Yes ☐ No Date: _____
5. Any pain, problems or medication since then? ☐ Yes ☐ No
   If "yes," details: _____
6. Were you off of work? ☐ Yes ☐ No Duration: _____
7. Are you currently disabled due to this injury? ☐ Yes ☐ No
8. Have you ever been disabled due to this injury? ☐ Yes ☐ No
   If "yes," give details and date: _____
9. For backs only - Are you currently treated by a chiropractor? ☐ Yes ☐ No If "yes," date last seen: _____
   Name, address & phone number of chiropractor treating you: _____

HEPATITIS

NAME _____

1. Have you ever had or been treated for hepatitis? ☐ Yes ☐ No Date diagnosed: _____
   Which type: (Circle) A B C Chronic Other _____
   If Type A Only, answer no further questions

Medications	Dosage	Frequency	Date Began	Date Ended

2. Were you hospitalized? ☐ Yes ☐ No Date: _____ Duration: _____
   Name, address & phone number of hospital: _____
3. Are you fully recovered? ☐ Yes ☐ No
4. Have you had liver function tests performed since the diagnosis of hepatitis? ☐ Yes ☐ No
   If "yes," test date(s): _____
5. Were the test results normal? ☐ Yes ☐ No
   If "no," give results: _____
6. Have you had a liver biopsy performed? ☐ Yes ☐ No
   If "yes," test date: _____ What were the test results? _____
7. Do you currently drink alcohol? ☐ Yes ☐ No
8. Have you ever used IV drugs? ☐ Yes ☐ No
   If "yes," date: _____
9. Name, address & phone number of physician who treated hepatitis: _____
   Date last seen: _____

X _____ _____ X _____ _____ X _____ _____
Signature of Applicant Date Signature of Spouse Date Signature of Agent Date