

Proposed Insured's Name (Last, First, Middle Initial)

Connor, Courtney N

**I. Alcohol Abuse or Addiction** (To be completed when the Proposed Insured selects Alcohol Abuse or Addiction (Section F, Question 3) on the base application.)

- 1. Date of diagnosis: \_\_\_\_\_
- 2. Have You had or been recommended to have in-patient alcohol treatment (excluding AA)?  Yes  No
  - a. If Yes, date of most recent treatment: \_\_\_\_\_
  - b. If No, have You abstained and been active in AA or another outpatient treatment?  Yes  No
    - i. If Yes, date treatment began: \_\_\_\_\_
- 3. Have You had or been recommended to have in-patient alcohol treatment more than once (excluding AA)?  Yes  No

**II. Drug Abuse or Addiction** (To be completed when the Proposed Insured selects Drug Abuse or Addiction (Section F, Question 3) on the base application.)

- 1. Date of diagnosis: \_\_\_\_\_
- 2. Are You currently using or within the past 5 years have You used illegal drugs or prescriptions drugs that were not prescribed for You?  Yes  No
- 3. Have You had or been recommended to have in-patient drug treatment or other counseling services **not yet completed** in the past 5 years?  Yes  No
- 4. Are you currently participating in an ongoing counseling program that began more than 5 years ago?  Yes  No

**III. Nervous, Mental, or Psychiatric Disease or Disorder** (To be completed when the Proposed Insured selects Nervous, Mental, or Psychiatric Disease or Disorder (Section F, Question 3) on the base application.)

- 1. Date of diagnosis: \_\_\_\_\_ 06/01/2015
- 2. Psychiatric Conditions – please indicate below any disease/disorder for which You have been diagnosed, treated, or been advised to seek treatment by a member of the medical profession in the past 5 years:
  - a. Schizophrenia?  Yes  No
  - b. Schizoaffective disorder?  Yes  No
  - c. Paranoia?  Yes  No
  - d. Psychosis?  Yes  No
  - e. Suicide attempt or self harm?  Yes  No
  - f. Cognitive impairment?  Yes  No
- 3. Diagnosed with bipolar disorder?  Yes  No
  - a. If Yes, how many years since diagnosis?  0-1  2  3  4  5+
  - b. Are You currently being treated with prescribed medications?  Yes  No
  - c. Are You currently or have You been treated in the past 24 months with Electroconvulsant Therapy (ECT)?  Yes  No
- 4. Diagnosed with PTSD (post-traumatic stress disorder)?  Yes  No
  - a. If Yes, how many years since diagnosis?  0-1  2  3  4  5+

**You agree to the following:**

- This supplemental application is made a part of the policy to which it applies.
- The answers and statements in the application for insurance are the basis for any policy issued by Americo and no information will be considered to have been given to Americo unless it is stated in the application.
- Your sales representative does not have Americo's authorization to waive the answer to any question in this application, nor decide on the insurability, nor waive any of the company's underwriting requirements, nor change any contract.
- All answers and statements in this application for insurance, as they pertain to You, are true and complete to the best of Your knowledge and belief. Consistent with state laws, any false answer may serve as a basis for denial of a claim and/or rescission of the policy.

**IMPORTANT FRAUD NOTICE: ANY PERSON WHO KNOWINGLY PRESENTS A FALSE STATEMENT IN AN APPLICATION FOR INSURANCE MAY BE GUILTY OF A CRIMINAL OFFENSE AND SUBJECT TO PENALTIES UNDER STATE LAW.**

Signed at (State) PA on (Month/Day/Year) 7/30/2025

Signed by Electronic Signature  
Signature of Proposed Insured (required)

Jon Schwartz

Signature of Witnessing Agent (required)

Signature of Owner (if different than the Proposed Insured)

Signed by Electronic Signature

Printed Name of Witnessing Agent (required)