



New Business:
 PO Box 9304
 Des Moines, IA 50306-9304
 Phone 888-221-1234
 Fax 515-221-9450
 www.american-equity.com

Annuity Application

American Equity Investment Life Insurance Company
 Overnight - 5000 Westown Parkway, Suite 440, West Des Moines, IA 50266

ANNUITANT
 Name _____ Sex _____
 Birth date ___/___/___ Soc. Sec. No. _____
 Address _____
 City _____ State _____ Zip _____

JOINT ANNUITANT
 Name _____ Sex _____
 Birth date ___/___/___ Soc. Sec. No. _____
 Address _____
 City _____ State _____ Zip _____

OWNER (if other than annuitant)
 Name _____ Sex _____
 Birth date ___/___/___ SSN# or Tax ID# _____
 Address _____
 City _____ State _____ Zip _____

JOINT OWNER
 Name _____ Sex _____
 Birth date ___/___/___ SSN# or Tax ID# _____
 Address _____
 City _____ State _____ Zip _____

OWNER'S BENEFICIARY - Annuitant, unless otherwise stated
 _____ Relationship: _____

ANNUITANT'S BENEFICIARY
 Primary: _____ Relationship to Annuitant: _____
 Contingent: _____ relationship to Annuitant: _____

1. Contract form: _____
 Settlement option (Immediate annuity only): _____

2. Tax status: Non-Qualified
 Roth IRA IRA Sec. 401(k)
 SEP/IRA Sec. 457 Sec. 403(b)
 Simple IRA H.R. 10 Corp Pension/Profit Sharing

3. Do you have any existing insurance or annuities in this or any other company? Yes No
If "Yes", complete replacement form(s).

4. Premium submitted with application: \$ _____
 Is this a rollover? (Qualified plans only) Yes No

5. Will initial premium be a 1035 Exchange, or Direct Transfer?
 Yes No
 If Yes, from what company? _____
 Anticipated amount: \$ _____

6. Billing information (Flexible contracts only):
 Amount: \$ _____

Mode	Type
<input type="checkbox"/> Monthly	<input type="checkbox"/> ABC* (Automatic Bank Check)
<input type="checkbox"/> Quarterly	<input type="checkbox"/> Direct Bill
<input type="checkbox"/> Semi-Annual	<input type="checkbox"/> List Bill
<input type="checkbox"/> Annual	<input type="checkbox"/> Government Allotment

7. Remarks and/or Special Billing Address (i.e., List Bills): _____

* Form 4067 required.

Do you have any reason to believe that applicant has any existing insurance or annuities? Yes No

If "Yes", complete replacement form(s).

 Agent's Name/Number (Please Print)

 Agent's E-mail Address

 Agent's Signature/Phone Number

 Resident Agent's Countersignature/Phone Number
 (where required)

Within a reasonable time of receiving a request from You, We are required to provide You with reasonable factual information regarding the benefits and provisions of the Contract for which You are applying. If for any reason You are not satisfied with the Contract, You may return it to Your agent or Our home office for up to 15 days after You receive it, 30 days if You are 65 or older at Application. Within 10 days We will refund any premium paid. The Contract will then be void.

Signed a on _____ Date _____
 City/State _____

 Owner's Signature/Phone Number

 Joint Owner's Signature/Phone Number