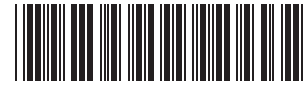

LEAVE WITH APPLICANT

ACCELERATED DEATH BENEFIT SUMMARY and DISCLOSURE STATEMENT

EFFECTIVE DATE – The Accelerated Death Benefit Endorsement takes effect on the Policy Date.

PREMIUM – There is no additional premium charge for the Accelerated Death Benefit Endorsement provided under this life insurance Policy. However, there is an administrative fee when an Accelerated Death Benefit Payment is made.

The accelerated death benefits provided under the endorsement of this life insurance Policy may provide benefits to pay for long-term care services but are NOT part of a long-term care or nursing home insurance Policy and the amount these products pay may not be enough to cover your medical, nursing home or other bills. Accelerated Death Benefit Payments used to pay for long-term care services are subject to limits imposed by the federal government and any amounts received in excess of these limits are includible in taxable income. You may use the money you receive as an accelerated death benefit for any purpose. Unlike conventional life insurance proceeds, amounts payable as accelerated death benefits COULD BE TAXABLE UNDER SOME CIRCUMSTANCES. We recommend that you consult your personal tax advisor prior to electing an accelerated death benefit.

If you already have long-term care insurance, Medicaid, or similar coverage, you should consider whether the accelerated death benefits provided under this Policy are suitable for your needs. Receipt of accelerated death benefits under this Policy MAY AFFECT YOUR ELIGIBILITY FOR MEDICAID, SUPPLEMENTAL SECURITY INCOME ("SSI"), OR OTHER GOVERNMENT BENEFITS OR ENTITLEMENTS. Contact the Medicaid Unit of your local Department of Public Welfare and the Social Security Administration Office for more information.

THE BENEFIT AND ITS EFFECT ON POLICY PROVISIONS

Upon written request by the owner ("You") of the Policy, the company will pay an Accelerated Death Benefit described below, subject to the limitations and requirements outlined in the Accelerated Death Benefit Endorsement. Any assignee or Irrevocable Beneficiary must consent before we make an Accelerated Death Benefit Payment. The maximum Accelerated Death Benefit that We will accelerate on the Policy is $1,000,000. Accelerated Death benefits paid under this Endorsement will reduce the Policy's Death Benefit and Policy values, if any, which include but are not limited to the Account Value, Net Cash Surrender Value, and loan value.

Accelerated Death Benefit for Terminal Illness: You may elect to receive advancement of the Death Benefit when the Survivor or Insured has a Terminal Illness while this Endorsement is in effect. A Survivor or Insured qualifies as being Terminally Ill if a Physician has certified that the Survivor's or Insured's life expectancy is 24 months or less.

The minimum Accelerated Death Benefit for Terminal Illness is the lesser of 10% of the Death Benefit on the Election Date or $100,000.

The maximum Accelerated Death Benefit for Terminal Illness is the lesser of 75% of the Death Benefit on the Election Date or $750,000.

The Accelerated Benefit Payment (hereinafter "Payment") will be determined upon Your election. Payment will be paid in a lump sum. We will pay the present value of the Policy Death Benefit that is being accelerated (the Accelerated Death Benefit). An actuarial discount based on mortality and interest will be applied to the Accelerated Death Benefit. This discount reflects the early payment of the Death Benefit that is being accelerated.

We will waive the Monthly Deductions following the Election of Accelerated Death Benefits for Terminal Illness. Upon Election, all Riders and Endorsements attached to the Policy will continue to be effective subject to the terms and conditions of each Rider or Endorsement. After You receive Accelerated Death Benefits for Terminal Illness under this Endorsement and as stated in Your Policy, You may take Withdrawals; elect to increase or decrease the Specified Amount or change the Death Benefit Option; and You may obtain loans as described under the Policy loan provision. A portion of the Accelerated Death Benefit Payment will be used to reduce any Policy Debt.

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Only one election can be made for Terminal Illness under this Endorsement. If the Survivor or Insured dies after You elect to receive Accelerated Death Benefits under this Endorsement, but before any Accelerated Death Benefit Payment is made, the Election will be cancelled and the Death Benefit will be paid as described in Your Policy.

Sample Illustration of Impact of Accelerated Death Benefits on Policy Provisions For Terminal Illness

Immediately Prior to initial Election:	
Death Benefit (DB)	$100,000
Account Value	$30,000
Policy Debt	$10,000
Net Cash Surrender Value	$20,000
Monthly Deductions	$300
Election:	
Limitations on Benefits	
Maximum Accelerated Death Benefit	$75,000
75% of DB or $750,000 if smaller	
Requested on Application for Election:	
Accelerated Death Benefit	$20,000
Immediately After Election:	
Death Benefit	$80,000
Reduced by Accelerated DB	
$100,000 - $20,000	
Account Value	$24,000
Reduced by Accelerated DB / DB	
Reduced by $20,000 - $100,000 = 20%	
$30,000 * (100% - 20%)	
Debt Repayment Amount	$2,000
Accelerated DB * Policy Debt / DB	
$20,000 * 10,000 / $100,000	
Policy Debt	$8,000
Reduced by Debt Repayment Amount	
$10,000 - $2,000	
Monthly Deductions	$0 (Waived)

Senior Notice - Your Rights Regarding In-home Meetings

California Legislation requires that you_________________________ (the senior addressed) be provided with this notice no less than 24 hours prior to a meeting in your home.

You have the right to have other persons present at the meeting, including family members, financial advisors or attorneys. During this visit or a follow up visit, you will be given a sales presentation on the following (indicate all that will apply)

life insurance including annuities and/or other insurance products (specify).

____

You have the right to end the meeting at any time. You have the right to contact the Department of Insurance for information or file a complaint. You may contact the Department of Insurance at the Consumer Hotline 800-927-4357 inside CA or outside CA (including area codes 213, 310, 818) 213-897-8921.

The following individuals will be coming to your home: (list all attendees, and insurance license information, if applicable)

____

____

____

____

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North American Company
for Life and Health Insurance
Since 1886

Community Property Release

ATTN: New Business ☐ Policy Change ☐

Pending Policy Number if assigned: ___________________

Please note important information concerning community property interest below.

If this transaction is subject to a community property interest, we strongly recommend that You obtain your spouse's signature on the line below to document his/her consent to this transaction. States that recognize community property interests in property held by married persons include Alaska, Arizona, California, Idaho, Louisiana, Nevada, New Mexico, Texas, Washington, and Wisconsin.

You understand and agree that the Company may presume that no community property interest exists if You have not obtained your spouse's signature below. Further, You understand and agree that the Company has no duty to inquire further about any such community property interest. As a result, You agree to indemnify and hold the Company harmless from any consequences relating to community property interests and this transaction.

Please note that the term"spouse" includes domestic partner or other partner permitted by civil union, domestic partnership or similar law.

Signature of Owner _________________________ Date _________________________

Signature of Owner's Spouse _________________________ Date _________________________

O-2827 R1 5/12

LEAVE WITH APPLICANT

CONSUMER PROTECTION NOTICES FOR THE PROPOSED INSURED

Investigative Consumer Report Notice

In connection with your application for insurance, an investigative consumer report may be prepared, in which information is obtained from public records and through personal interviews with your neighbors, friends, employers, business associates, financial sources, or others with whom you are acquainted. This inquiry includes information as to your character, general reputation, personal characteristics and mode of living. You may make a written request to be interviewed in connection with the preparation of this report and receive a copy of the report. Either of these written requests should be directed to the Underwriting Department at the above address.

Insurance Information Practices

Personal information we obtain during the underwriting process is private and confidential. We will not disclose such information to other person or organizations without your written authorization, except to the extent necessary to conduct our business, or as permitted or required by law. You have the right to be told about and obtain access to certain items of personal information in our files. You also have the right to request correction of information you believe to be inaccurate. You have the right to receive the specific reason for an adverse underwriting decision in writing upon your written request. If you would like to receive more detailed explanation of our information practices, please write to us at the above address.

Medical Information Bureau Notice

Information regarding your insurability will be treated as confidential. North American Company for Life and Health Insurance, or its reinsurers, may, however, make a brief report thereon to the MIB, INC., formerly known as Medical Information Bureau, a non-profit membership organization of life insurance companies, which operates an information exchange on behalf of its Members. If you apply to another MIB member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, MIB, upon request, will supply such company with the information in its file.

Upon receipt of a request from you, MIB will arrange disclosure of any information it may have in your file. Please contact MIB at 866 692-6901 (TTY 866-346-3642). If you question the accuracy of information in MIB's file, you may contact MIB and seek a correction in accordance with the procedures set forth in the federal Fair Credit Reporting Act. The address of MIB's information office is 50 Braintree Hill Park, Suite 400, Braintree, Massachusetts 02184-8734.

North American Company for Life and Health Insurance, or its reinsurers, may also release information in its file to other insurance companies to whom you may apply for life or health insurance, or to whom a claim for benefits may be submitted. Information for consumers about MIB may be obtained on its website at www.mib.com.

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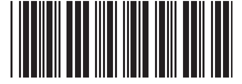

INDEXED UNIVERSAL LIFE INSURANCE

As a valued customer of North American Company for Life and Health Insurance, We want to make sure You understand the unique features of the indexed life insurance policy for which You have applied. The policy may earn interest based on the movement of the selected Index(es), but will never credit less than zero percent. While earnings are based on the Index(es) You select, premiums are not invested in stocks, bonds or equity investments, and the Index growth does not include dividends.

The policy for which you have applied is not registered as a security. Therefore, purchasing this indexed life insurance policy is not the same as making an investment directly in the stock market. This summary is not intended to be a full description of the policy. Please refer to your policy when issued for complete details and definitions.

ALLOCATION CHOICES

You may direct Your money among the Fixed Account and/or any combination of the following Indices:

1. The Standard & Poor's 500® Composite Stock Price Index (S&P 500®)
2. The Dow Jones Industrial Average℠ (DJIA℠) Composite Stock Price Index
3. The Nasdaq-100® Stock Price Index
4. The S&P MidCap 400®
5. The Russell 2000®
6. The EURO STOXX 50®
7. Uncapped S&P 500®
8. Multi-Index Group

INDEX CREDITING METHODS

The earnings credited to the selected Index(es) are calculated through the use of either the Daily Averaging method, the Annual Point-to-Point method, the Monthly Point-to-Point method. No Index Credits will be applied until the end of the Index Period and money withdrawn or surrendered prior to this time will not receive Index Credits.

- When the **Daily Averaging** method is chosen, the Index change is determined by calculating the difference between the Index Value on the first day of the Index Period and the average Index Value throughout the Index Period. The Index change is subject to the Index Participation Rate, Index Cap Rate, and Index Floor Rate. The Index Credit, if any, is credited and locked in at the end of the Index Period. The Daily Averaging crediting method is available for the S&P 500®, S&P MidCap 400®, Russell 2000® and DJIA℠.

- When the **Annual Point-to-Point** method is chosen, the Index credit is determined by calculating the change between the Index Value on the first day of the Index Period and last day of the Index Period. The Index growth is subject to the Index Cap Rate and any earnings are credited and locked in at the end of the 12 month Index Period. The rate credited will never be less than zero percent. The Annual Point-to-Point crediting method is available for the S&P 500®, S&P MidCap 400®, Russell 2000®, DJIA℠, EURO STOXX 50®, and NASDAQ-100®.

- When the **Monthly Point-to-Point** method is chosen, the Index credit is determined by calculating the 12 Monthly Index Returns which are determined by the change in the Index during the month. The Monthly Index Return cannot be greater than the Monthly Cap Rate and it can be a negative number. At the end of the 12 month Index Period, the 12 preceding Monthly Index Returns are added together to determine the Index Credit which is credited and locked in. The rate credited at the end of the Index Segment will never be less than zero percent, and will never be greater than 12 times the Monthly Cap Rate. The Monthly Point to Point crediting method is available for the S&P 500®.

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- When the **Multi-Index Annual Point-to-Point** method is chosen, the Index credit is determined by calculating a Multi-Index change between the first day of the Index Period and the last day of the Index Period. The Multi-Index change uses the following three indices – S&P 500®, EURO STOXX 50® and Russell 2000®**.** The annual point-to-point Index growth from each of the three individual indices derives the Multi-Index change. 50% of the best performing Index growth plus 30% of the second best performing Index growth plus 20% of the third best performing Index growth equals the Multi-Index change. The Multi-Index change is subject to the Index Cap Rate and any earning are credited and locked in at the end of the 12 month Index Period. The rate credited will never be less than zero percent.

IMPORTANT POLICY TERMS YOU SHOULD KNOW

- **Index Participation Rate** – the portion of the Index change that is used in the calculation of the Index Credit. This rate can be changed by North American Company but can never be less than the minimum shown in the policy.
- **Index Cap Rate** – the maximum interest rate that can be used in the calculation of the Index Credit. This rate can be changed by North American Company but can never be less than the minimum shown in the policy.
- **Index Floor Rate** – the minimum interest rate that can be used in the calculation of the Index Credit. This rate can be changed by North American Company but can never be less than zero.

PROPOSED OWNER/APPLICANT:

I acknowledge that I have read this disclosure material, received a copy and understand the following:

- **Any values shown, other than guaranteed minimum values, are not guarantees, promises or warranties.**
- **I am applying for an indexed life insurance policy, and even though the values of the policy may be affected by an external Index, the policy does not directly participate in any stock, bond or equity investments.**
- **The values of the external Indices do not reflect the payment of dividends.**
- **The policy applied for is not a registered security.**
- **Current illustrated values are based on past Index performance and are not intended to predict future performance.**
- **I understand that North American Company has the right to change Index Cap Rates, Index Floor Rates, Index Participation Rates and interest rates.**

PROPOSED OWNER'S SIGNATURE	DATE
X	

AGENT:
I certify I have provided a copy to and reviewed this disclosure material with the applicant. I have not made statements that differ from this material, nor have I made any promises about the future performance or values of any non-guaranteed elements of any indexed life insurance policy. I certify that I have completed the North American Company Indexed Universal Life Certification Training and passed the Agent Certification Exam.

AGENT'S SIGNATURE	DATE
X	

The term S&P 500® refers to **The STANDARD & POOR'S 500® COMPOSITE STOCK PRICE INDEX -** This Index does not include dividends paid by the underlying companies. S&P 500® and Standard & Poor's 500® are trademarks of The McGraw-Hill Companies, Inc. and have been licensed for use by North American Company. This product is not sponsored, endorsed, sold or promoted by Standard & Poor's® and Standard & Poor's® makes no representation regarding the advisability of purchasing this contract.

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The DOW JONES INDUSTRIAL AVERAGE℠ (DJIA℠) COMPOSITE STOCK PRICE INDEX - The Dow Jones Industrial Average℠ is a product of Dow Jones Indexes℠, the marketing name and a licensed trademark of CME Group Index Services LLC ("CME Indexes"), and has been licensed for use. "Dow Jones®", "Dow Jones Industrial Average℠", "DJIA℠" and "Dow Jones Indexes℠" are service marks of Dow Jones Trademark Holdings, LLC ("Dow Jones") and have been licensed to CME Indexes and sublicensed for use for certain purposes by North American Company. North American's Indexed Universal Life Insurance products, based on the Dow Jones Industrial Average℠, are not sponsored, endorsed, sold or promoted by Dow Jones, CME Indexes or their respective affiliates and none of them makes any representation regarding the advisability of investing in such products.

The EURO STOXX 50® is the intellectual property of (including registered trademarks) STOXX Limited, Zurich, Switzerland and/or Licensors the ("Licensors"), which is used under license. The index Accounts for this Product based on the Index are in no way sponsored, endorsed, sold or promoted by STOXX and it Licensors and neither of the Licensors shall have any liability with respect thereto.

The STANDARD & POOR'S 400® COMPOSITE STOCK PRICE INDEX
This Index does not include dividends paid by the underlying companies.

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The RUSSELL 2000® COMPOSITE STOCK PRICE INDEX
This Index does not include dividends paid by the underlying companies.

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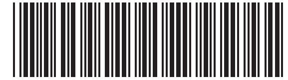
North American Company
for Life and Health Insurance
Since 1886



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NOTICE OF AIDS VIRUS (HIV) ANTIBODY TESTING AND CONSENT FOR TESTING

The Tests:

To evaluate your eligibility for insurance, the insurer named above has requested that you provide a sample of your blood, urine and/or other body fluid for testing and analysis to determine the presence of human Immunodeficiency virus (HIV) antibodies. By signing and dating this form you agree that this test may be done and that underwriting decisions will be based on the test result. A series of tests will be performed by a certified laboratory through medically accepted procedures.

Meaning of Test Results:

While positive HIV antibody test results do not mean that you have AIDS, they do mean that you are at seriously increased risk of developing AIDS or AIDS-related conditions. Federal authorities say that persons who are HIV antibody positive should be considered infected with the AIDS virus and capable of infecting others. Positive HIV antibody test results will adversely affect your insurance application. An HIV test will be considered positive only after confirmation by a laboratory procedure which is extremely reliable. Nonetheless, the HIV antibody test is not 100% accurate. Possible errors include:

False Positives: the test gives a positive result, even though you are not infected. This happens only rarely and is more common in persons who have not engaged in high risk behavior. Retesting should be done to help confirm the validity of a positive test.

False Negatives: the test gives a negative result, even though you are infected with HIV. This happens most commonly in recently infected persons; it takes at least 4-12 weeks for a positive test result to develop after a person is infected.

Side Effects:
A positive test result may cause you significant anxiety. A positive test may result in uninsurability for life or disability insurance policies you may apply for in the future. Although prohibited by law, discrimination in housing, employment, or public accommodations may result if your test results were to become known to others. A negative result may create a false sense of security.

AIDS:

Acquired Immunodeficiency Syndrome (AIDS) is a life-threatening disorder of the immune system, caused by a virus, HIV. The virus is transmitted by sexual contact with an infected person, from an infected mother to her newborn infant, or by exposure to infected blood (as in needle sharing during IV drug use). Persons at high risk of contacting AIDS include males who have had sexual contact with another man, intravenous drug users, hemophiliacs, and sexual contacts of any of these persons. AIDS does not typically develop until a person has been infected with HIV for several years. A person may remain free of symptoms for years after becoming infected. Infected persons have a 25-50% chance of developing AIDS over the next 10 years. Persons who have a history of high risk behavior should change these behaviors to prevent getting or giving AIDS, regardless of whether they are tested. Specific important changes in behavior include safe sex practices (including condom use for sexual contact with someone other than a long-term monogamous partner) and not sharing needles.

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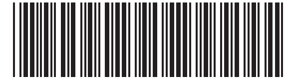


Disclosure of Test Results:

All test results will be treated confidentially. The results will be reported to the insurance company indicated above. The results may also be reported to that insurance company's affiliates, agents, or reinsurers in connection with insurance you have or have applied for. In addition, if your HIV antibody test is abnormal (positive), a generic code signifying a non-specific blood abnormality may be made known to the Medical Information Bureau (MIB, Inc.) as described in the notice given you at the time of application. The fact that the test has been done and the results of the test will not be otherwise disclosed except as may be required by law or as authorized by you. If your HIV antibody test is negative, no routine notification will be sent to you. If your test results are reported by the laboratory to the Company as being positive, you are entitled to that information.

You are asked to name a private physician so that the Company can have him or her tell you the test result and explain its meaning.

Name of physician for reporting a possible positive test result:

____

Address: ____

Consent:

I have read and I understand this Notice of AIDS Virus (HIV) Antibody Testing and Consent for Testing. For my information, I have been given written material about AIDS. I voluntarily consent to provide a sample of my blood, urine and/or other body fluid testing, and the disclosure of the test results as described above.

______________________________	______________________________
Name of Proposed Insured	Date
______________________________	______________________________
Signature of Proposed Insured	State of Residence

AIDS COUNSELING SERVICES

AIDS Project - East Bay
400 - 40th Street, Suite 20
Oakland, CA 94609 (415) 420-8181

AIDS Project Los Angeles
3670 Wilshire Boulevard, Suite 300
Los Angeles, CA 90010 (213) 380-2000

AIDS Services Foundation of Orange County
1685-A Babcock Street
Costa Mesa, CA 92627 (714) 646-0411

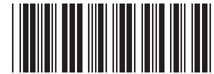
ARIS Project
595 Millich Drive, Suite 104
Campbell, CA 95008 (408) 370-3272

Central Valley AIDS Team
P.O. Box 4640
Fresno, CA 93744 (209) 264-2436

Sacramento AIDS Foundation
1900 "K" Street, Suite 201
Sacramento, CA 95814 (916) 448-2437

San Diego AIDS Project
3777 Fourth Avenue
San Diego, CA 92103 (619) 543-0300

San Francisco AIDS Foundation
25 Van Ness Avenue, Suite 660
San Francisco, CA 94102 (415) 864-5855



SUPPLEMENT TO LIFE INSURANCE APPLICATION

Life Insurance Qualification Test

Please indicate your election for the Life Insurance Qualification Test: [ ] Guideline Premium Test [ ] Cash Value Accumulation Test
(If not indicated, the Guideline Premium Test will be used.)

Initial Premium Allocation - Indexed Universal Life Insurance

Please indicate the percentage of premium you want allocated to each Selection. Percentages must be in whole numbers and total 100%.

INDEX SELECTION			PREMIUM ALLOCATION
Index Selection 1	S&P 500® – Annual Point to Point	(SPn)	%
Index Selection 2	S&P 500® – Monthly Point to Point	(SMn)	%
Index Selection 3	S&P 500® – Daily Averaging	(SDn)	%
Index Selection 4	Dow Jones Industrial Average℠ – Annual Point to Point	(DPn)	%
Index Selection 5	Dow Jones Industrial Average℠ – Daily Averaging	(DDn)	%
Index Selection 6	EURO STOXX 50® – Annual Point to Point	(EPn)	%
Index Selection 7	Uncapped S&P 500 – Annual Point to Point	(UPn)	%
Index Selection 8	Multi Index	(MPn)	%
Index Selection 9	NASDAQ -100 ® Annual Point to Point	(NPn)	%
Index Selection 10	S&P MidCap 400® - Annual Point to Point	(4Pn)	%
Index Selection 11	S&P MidCap 400® Daily Averaging	(4Dn)	%
Index Selection 12	Russell 2000® - Annual Point to Point	(RPn)	%
Index Selection 13	Russell 2000® - Daily Averaging	(RDn)	%
Fixed Selection	Fixed Account	(FAn)	%
	Total		**100 %**

TELEPHONE AUTHORIZATION (READ CAREFULLY) ☐ **YES** ☐ **NO**

I hereby authorize and direct North American Company for Life and Health Insurance (NA) to act on telephone instructions when proper identification has been furnished, to make transfers or change premium allocations of future premium payments. NA will employ reasonable procedures to confirm that telephone instructions are genuine; nonetheless, I agree that NA is not liable for any loss arising from any change in premium allocations of future premium payments or transfers by acting in accordance with these telephone instructions that NA believes to be genuine.

AUTHORIZATION FOR AGENT (READ CAREFULLY) ☐ **YES** ☐ **NO**

I hereby authorize and direct North American Company for Life and Health Insurance (NA) to act on telephone, written, or facsimile instructions communicated by the Agent of Record to make transfers or change the premium allocations of future premium payments. This authorization does not grant the Agent discretion to communicate any transaction without my prior approval. NA will employ reasonable procedures to confirm that instructions are genuine; nonetheless, I agree that NA is not liable for any loss arising from any change in premium allocations of future premium payments or transfers by acting in accordance with these instructions that NA believes to be genuine. This authorization will remain in effect until NA receives written notification of cancellation from the policyowner, or the named Agent is no longer contracted and appointed with NA.

Florida Residents: Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

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PROPOSED OWNER/APPLICANT: I have received a copy of the equity indexed disclosure material for the policy applied for. The undersigned hereby agree(s) that the statements made above shall be a part of the life insurance application as fully as though made in said application. **I understand I am applying for an indexed life insurance policy, and although any external index may affect the values of the policy, the policy does not directly participate in any stock, bond or equity investments and the values of the external Indices do not reflect the payment of dividends. North American Company for Life and Health Insurance has the right to change Index Caps, Index Participation Rates and interest rates as long as they do not go below the minimums shown in the policy. I understand that any values shown, other than guaranteed minimum values, are not guarantees, promises or warranties.**

AGENT: I certify that the equity indexed disclosure material has been presented to the Applicant. A copy was provided to the Applicant. I have not made statements which differ in any significant manner from this material. I have not made any promises or guarantees about the future values of any non-guarantee elements.

X ______________________________
Signature of Proposed Owner
(If Owner is corporation, trust, or other entity, include title of signee.)

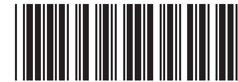
X ______________________________
Signature of Agent

____
Agent Number

____
Signed at (City) (State)

____
Date

North American Company
for Life and Health Insurance
Since 1886



AGENT'S REPORT

Proposed Insured's Name	Social Security Number

1. Do the Proposed Insured and/or Applicant want to save age? ☐Yes ☐No

2. How well do you know the Proposed Insured? (Check all that apply) ☐Self ☐Relative (state relationship) ____________ ☐Met very recently
   ☐Know slightly ☐Known well for ____ years Known through: ☐Business ☐Home ☐Church ☐Other ____________

3. Was this insurance suggested by someone other than you? (If "yes," who and what promped request?) ☐Yes ☐No
   ____

4. If the Proposed Insured and/or Applicant is married, give spouse's name and amount of spouse's insurance (in-force and applied for).
   ____

5. Is the Proposed Insured and/or Applicant fluent in the English language? ☐Yes ☐No If no, please explain how the application was completed, including the name and relationship of any translator involved in the application process.
   ____

6. What is the purpose of this insurance? ☐Family protection ☐Mortgage Protection ☐Other debt retirement ☐Estate liquidity
   ☐Business (Complete Business Supplement) ☐Other ____________

7. Is the purpose of this policy to fund college expenses? ☐Yes ☐No
   a. If yes, do you schedule and/or participate in college funding or planning seminars or meetings? ☐Yes ☐No
   b. If yes to (a), have you submitted the college planning advertising including seminar materials to the compliance department for review and approval? ☐Yes ☐No

8. Is the premium to be paid by a party other than the Proposed Insured? (If yes, please explain.) ☐Yes ☐No
   ____

9. Did you personally see all Proposed Insureds at the time the application was written? (If no, please explain.) ☐Yes ☐No
   ____

10. Did you ask each question on the application for each Proposed Insured and witness all signatures? (If no, please explain.) ☐Yes ☐No
    ____

11. What underwriting requirements have you scheduled? ☐Paramed Exam and HOS ☐DBS, HOS ☐SMA ☐EKG ☐MD Exam ☐Treadmill EKG
    ☐Other ____________ Examiner Name ____________ Telephone Number ____________

The answers given in the Agent's Report are complete and true to the best of my knowledge and belief. I have delivered the receipt and any notices required in this state, as applicable, to the Proposed Insured and/or Policy Owner. I certify that only sales materials approved by North American Company for Life and Health Insurance were used in conjunction with this transaction, and copies of all sales materials were left with the applicant. I recommend each Proposed Insured for the insurance applied for.

Signature of Agent	Agent Code Number	Date

O-2724 Rev. 6/10

LIFE INSURANCE APPLICATION

Part A

1. PRIMARY INSURED ☐ **Single** ☐ **Married**

Last Name	First	M.I.	Birthdate Mo. Day Year	State or Country of Birth	Sex	Height (Ft. In.)	Weight (Lbs)

Residence Address (Street, City, State, Zip):

Billing Address (If other than residence):

Citizenship status: ☐ U.S. or Permanent Visa/Greencard ☐ Other Country ____

# of Years in U.S.: Visa Type: Date Expires:

Occupation (Title and Duties):	Employer Name & Address:			
Social Security Number	Driver's License Number	State	Annual Earned Income $	Net Worth $
Daytime Phone:	Evening Phone:		Best Time To Call:	

2. OWNER INFORMATION (Complete only if other than Primary Insured)

Name of Owner(s) (If Trust, list all Trustees as well as Name and Date of Trust)

____

Address: ____

Relation to Primary Insured: Owner's Social Security or Tax ID#:

3. BENEFICIARY INFORMATION Provide Beneficiary(ies) Full Name(s) (If Trust, list Name and Date of Trust)	Relation to Primary Insured
Primary	
Contingent	

NOTE: If percentage shares are not given, proceeds will be in equal shares when more than one beneficiary is listed.

4. COVERAGE APPLIED FOR: ____ Face or Specified Amount: $____

Underwriting Class Quoted: ____(Best class available will be issued, subject to underwriting)

UL PLANS ONLY: Planned Premium $____ Death Benefit Option: ☐ Level ☐ Increasing

Return of Premium Benefit ☐ Single Pay ☐ Annual Pay (Available on selected UL plans only)

5. Premium Mode: ☐ Annual ☐ Semi-Annual ☐ Quarterly ☐ Monthly PAC ☐ Other ____

6. RIDERS

a. **Term Products**

- ☐ Additional Insured Rider Amount $____
- ☐ Base Return of Premium Rider
- ☐ Children's Term Rider Amount $____
- ☐ Guaranteed Insurability Rider Option Amount $____
- ☐ Monthly Income Endorsement: Initial Lump Sum ____;
  $____ Monthly for____ years; Final Lump Sum $____.
- ☐ Waiver of Premium Rider
- ☐ Other ____ Amount $____

Complete Supplemental Application For:

Primary Insured: ☐ Accident Disability Income Rider **OR** ☐ Disability Income Rider

Additional Insured: ☐ Accident Disability Income Rider **OR** ☐ Disability Income Rider

b. **Permanent Products**

- ☐ Accidental Death Benefit Rider Amount $____
- ☐ Additional Insured Rider Amount $____
- ☐ Children's Term Rider Amount $____
- ☐ Guaranteed Insurability Rider Option Amount $____
- ☐ Waiver of Monthly Deductions Rider
- ☐ Level Term Rider (Custom Extra Only):
  Amount $____
- ☐ Other____ Amount $____

NORTH AMERICAN COMPANY • NEW BUSINESS OFFICE: P. O. BOX 5089, SIOUX FALLS, SD 57117 • PRINCIPAL OFFICE: WEST DES MOINES, IA
Emerald Team: (800) 669-9100 Fax: (800) 951-9430 • Ruby Team: (866) 606-2943 Fax (800) 978-7959 • Sapphire Team (855) 288-8149 Fax (855) 288-8150 www.nacolah.com

7. ADDITIONAL INSURED/SPOUSE (Complete Separate Application for Business Associates and Multiple Additional Insureds)
Also complete Sections 8, 12, 13, 14, 15, 16 and Part B.

Last Name	First	M.I.	Birthdate Mo.	Day	Year	State or Country of Birth	Sex	Height (Ft. In.)	Weight (Lbs)

Citizenship status: ☐ U.S. or Permanent Visa/Greencard ☐ Other Country____________

\# of Years in U.S.: Visa Type: Date Expires:

Occupation (Title and Duties):	Employer Name & Address:			
Social Security Number	Driver's License Number	State	Annual Earned Income $	Net Worth $

Daytime Phone:	Evening Phone:	Best Time To Call:

8. BENEFICIARY INFORMATION FOR ADDITIONAL INSURED(S) (Complete Separate Application for Business Associates and Multiple Additional Insureds)

Name____________________ Amt $________

____________________ ____________________

Primary Beneficiary/Relationship Contingent Beneficiary/Relationship

9. CHILDREN (Children's Term Rider Only) Also complete Section 14.	Birthdate Mo.	Day	Year	State or Country of Birth	Sex	Social Security Number	Height (Ft. In.)	Weight (Lbs)

10. LIFE INSURANCE AND ANNUITIES INFORCE OR PENDING FOR ALL PERSONS COVERED UNDER THIS APPLICATION

a. DOES ANY PROPOSED INSURED HAVE ANY EXISTING POLICIES OR CONTRACTS OR OTHER LIFE INSURANCE APPLICATIONS PENDING WITH ANY COMPANY OR INTEND TO APPLY FOR ANY ADDITIONAL COVERAGE (This includes policies that have or will be sold, assigned or otherwise placed via life settlement, viatical or other agreements, or that you intend to replace, cancel, or sell)?............ ☐ Yes ☐ No
If pending, will all policies be placed?.. ☐ Yes ☐ No
If No, give details:____________________

b. WILL THE INSURANCE BEING APPLIED FOR REPLACE OR CHANGE ANY EXISTING LIFE INSURANCE OR ANNUITY CONTRACT?..... ☐ Yes ☐ No
If the answer to either a. or b. above is Yes, complete applicable Replacement Form. Use additional sheet if necessary. If this is a 1035 Exchange, also complete 1035 Exchange paperwork and submit with application.

11. THE FOLLOWING QUESTIONS APPLY TO THE OWNER OF THE COVERAGE BEING APPLIED FOR UNDER THIS APPLICATION:

a. Are any of the policies mentioned below being used to fund this policy? .... ☐ Yes ☐ No
b. Have you or will you be compensated in any way to purchase this policy?.. ☐ Yes ☐ No
c. Are you paying for this policy with your own funds?.. ☐ Yes ☐ No
d. Have you financed or do you intend to finance all or a portion of the premiums for this policy?.................... ☐ Yes ☐ No
(If Yes, complete applicable Disclosure and Acknowledgement Form and submit with application)
e. Have you entered into or are you considering any other agreement in regard to this policy including but not limited to an agreement to sell, transfer or assign any rights in the policy?.. ☐ Yes ☐ No

IF ANSWER IS 'YES' TO QUESTION 10a or 10b PROVIDE DETAILS BELOW.
*Indicate Type of Coverage: I = Individual; B = Business; or G = Group

Insured Name	Insurance Company	Policy No.	Amount	Type*	Pending	Issue Year	Intention to Replace or Change?
					☐		☐ Yes ☐ No
					☐		☐ Yes ☐ No
					☐		☐ Yes ☐ No
					☐		☐ Yes ☐ No

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IF THE ANSWER IS 'YES' TO QUESTIONS 11a, 11b, or 11e, PLEASE PROVIDE DETAILS BELOW. IF ANSWER TO QUESTION 11c IS 'NO' PLEASE PROVIDE DETAILS BELOW.

12. PRIMARY CARE PHYSICIAN INFORMATION **If NONE, CHECK HERE** ☐

Name	Physician Name/Address/Telephone	Reason seen and Results of Visit (Include Date Last Seen, Diagnosis, Treatment given, Medication prescribed)

13. NON-MEDICAL QUESTIONS - **Complete EXCEPT for Children's Term Rider**

Details of questions answered "yes". Include question number, full names and addresses of physicians, date diagnosed, prescription medications, and names of individuals to whom history pertains.

Have you or any person proposed for insurance:

		Yes	No
a.	Ever used tobacco and or nicotine products in any form?………………………………………………………………………….. *If Yes, provide Type of product, Amount used, and Date last used.*	☐	☐
b.	Ever consumed alcohol?…………………..………………………………… If Yes, provide Type of Alcohol, Date last consumed, Average number of drinks per occasion, and Total number of drinks consumed weekly.	☐	☐
c.	In the last 3 years, traveled or resided outside the U.S. or Canada or intend to do so in the future?………………………………………………… *If Yes, please complete Foreign Travel Questionnaire.*	☐	☐
d.	In the last 3 years, flown as any type of pilot, crewmember or in any other capacity other than as a fare-paying passenger or intend to do so in the future?…………………………………………………………………… *If Yes, please complete appropriate Questionnaire*	☐	☐
e.	In the last 3 years, done any underwater diving, parachuting, sky diving, hang gliding, ultralight, ballooning, mountain climbing, cave exploration, vehicle racing or engaged in any hazardous sports or avocations or intend to do so in the future?………………………………………………… *If Yes, please complete appropriate Questionnaire.*	☐	☐
f.	In the last 10 years, ever received a moving violation, driven under the influence of alcohol or drugs, refused a breathalizer test or had your driver's license suspended or revoked?…………………………………...	☐	☐
g.	Been arrested for or convicted of a felony?…….………………………………	☐	☐
h.	Been refused life insurance or charged an extra premium for life insurance?………………………………………………………………………….	☐	☐
i.	In the last 10 years, filed for bankruptcy?…………………………………… *If Yes, provide Type and Date of Discharge.*	☐	☐
j.	Are you actively at work?………………………………………………….. *If NO, provide details.*	☐	☐

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14. **PRELIMINARY HEALTH QUESTION** - **Complete EXCEPT for Children/s Term Rider** Within the past 10 years, have you or any person proposed for insurance been diagnosed or treated by a medical professional for any of the following: heart disease; stroke; cancer; brain or mental disease; or alcohol or drug abuse?…………………………………………………………..	Yes ☐	No ☐	**Details of questions answered "yes". Include question number, full names and addresses of physicians, date diagnosed, prescription medications, and names of individuals to whom history pertains.**
15. **FAMILY HISTORY –** Has any proposed insured's natural parent(s) or sibling(s) been diagnosed with or died from coronary artery disease, cancer, or mental disease? .... *If YES, provide parent(s) or sibling(s) age(s) and cause of death in Details.*	☐	☐	
16. **Has any proposed insured ever used a different name within the last 7 years?**………………………………………………………………………. *If Yes, state name of proposed insured(s) and different name(s) used in Details.*	☐	☐	
17. **CHILDREN'S TERM RIDER QUESTIONS** **Complete ONLY if applying for Children's Term Rider** a. Has any child proposed for insurance ever been diagnosed or treated by a medical professional for: heart disease; cancer; tumor; diabetes; jaundice; mental disease, bone or muscle disorder; respiratory disease; or alcohol or drug abuse or other chronic medical condition?………………………………………………………………………..	☐	☐	
b. Has any child proposed for insurance ever received a moving violation, driven under the influence of alcohol or drugs, or had their driver's license suspended or revoked?………………………………………..……...	☐	☐	

HOME OFFICE ENDORSEMENT(S)

SPECIAL REQUESTS

Part B - Complete for All Proposed Insureds, EXCEPT Children's Term Rider, Not Subject to Teleunderwriting or Paramed Exam

Details of questions answered "yes". Include question number, full names and addresses of physicians, date diagnosed, prescription medications, and names of individuals to whom history pertains.

1. MEDICAL QUESTIONS

Have you or any person proposed for insurance:	Yes	No
a. Gained or lost more than 15 pounds in the last year?	☐	☐
b. Attempted suicide or had counseling for suicide prevention?	☐	☐
c. Had or been advised to have treatment for alcohol or drug use or used narcotics, cocaine or other habit forming drugs, except as prescribed by a physician?	☐	☐
d. Been advised by a medical professional to decrease alcohol consumption?	☐	☐
e. Had military service deferment, rejection or discharge because of a physical or mental condition?	☐	☐
f. Requested or received a pension, benefits, or payment because of injury, sickness, or disability?	☐	☐
g. Currently taking any prescription drugs or took any prescription drugs within the last year?	☐	☐
h. Within the last 10 years, had or been treated by a medical physician for:		
1) Cancer, tumor, leukemia, lymphoma, or any other abnormal or malignant growth?	☐	☐
2) High blood pressure, stroke, chest pains, heart attack or failure, coronary artery disease, heart murmur, irregular heart beat, poor circulation, or any other disease or disorder of the heart or blood vessels?	☐	☐
3) Epilepsy, narcolepsy, convulsions, nervous breakdown, emotional or mental condition, neuritis, paralysis, or any other disease or disorder of the brain or nervous system?	☐	☐
4) Ulcer, colitis, hepatitis or any other disease or disorder of the liver, gallbladder, pancreas, rectum, stomach, or intestines?	☐	☐
5) Asthma, bronchitis, emphysema, tuberculosis, or any other disease or disorder of the lungs, or respiratory system?	☐	☐
6) Sugar, albumin or blood in the urine, kidney stone, sexually transmitted disease, or any other disease or disorder of the kidneys, bladder, urinary system, or reproductive system?	☐	☐
7) Anemia, bleeding disorder, or high cholesterol or any other disease or disorder of the blood?	☐	☐
8) Diabetes, lymph, thyroid, pituitary, or any other glandular disease or disorder?	☐	☐
9) Allergies, or any other disease or disorder of the eyes, ears, nose, throat, or skin?	☐	☐
10) Severe injuries, amputation, arthritis, gout or any other disease, disorder or abnormalities of the spine, bones, joints or muscles?	☐	☐
11) Sleep apnea, abnormal sleep study, or polysomnography?	☐	☐
12) AIDS (Acquired Immunodeficiency Syndrome) or HIV (Human Immunodeficiency Virus) infection?	☐	☐
i. Within the last 5 years:		
1) Consulted, been examined, or treated by any physician or medical professional, or had observation or treatment at a hospital?	☐	☐
2) Had an x-ray, resting or exercise electrocardiogram, any other diagnostic or laboratory tests (other than test for HIV or AIDS), or surgery done or advised not previously stated on this application?	☐	☐
j. If you are a female:		
1) Ever had any disorder of menstruation, pregnancy, or of the female organs or breasts?	☐	☐
2) To the best of your knowledge, are you currently pregnant? *If YES, provide number of months in Details.*	☐	☐

The Owner Understands And Agrees As Follows:

Statements in the Application –All statements in this application are true and complete to the best of my knowledge and belief and were correctly recorded before I signed my name. Statements in this application, including statements by any person proposed for insurance in any medical questionnaire that become a part of this application, will be the basis of any insurance issued. **False statements or misrepresentation in this application may result in loss of coverage under the contract.**

Effective Date – Any insurance issued as a result of this application will either: (1) not take effect until the full first premium is paid and the contract is delivered to and accepted by the Owner during the lifetime of any person proposed for insurance and while such person is in the state of health described in all parts of this application; or (2) take effect only as specified in the Temporary Insurance Agreement, if issued.

Limitation of Authority – No agent, broker, telephone application interviewer, or medical examiner is authorized to determine insurability, modify or waive any terms of this application or waive any of the Company's rights or requirements. Knowledge of any fact not disclosed in this application on the part of any agent, broker, telephone application interviewer, medical examiner, or other person will not be considered knowledge by the Company.

Payment of Premium – (check one) ☐ This application is C.O.D.; ☐ PAC; or ☐ I have paid $____________________ with this application in consideration of a Temporary Insurance Agreement. I have read, understand, and agree to the terms of the Temporary Insurance Agreement.

Taxpayer ID Certification: As Owner of this contract, I certify under penalties of perjury that: (1) the taxpayer identification number shown on this application is correct; and (2) I am not subject to IRS backup withholding. NOTE: Check this box ☐ if you are currently subject to backup withholding. The Internal Revenue Service does not require your consent to any provision of this document other than the certification required to avoid backup withholding.

U.S. Patriot Act – To help fight the funding of terrorism and money-laundering activities, the U.S. government has passed the USA PATRIOT Act, which requires financial institutions, including insurance companies, to obtain, verify and record information that identifies persons who engage in certain transactions with or through our company. This means that we will verify the name, residential or street address, date of birth and social security number or other tax identification number on the proposed owner of all insurance applications. We may also ask to see a driver's license, passport or other identifying documents from you.

A copy of the Consumer Protection Notices was read and received.

Insurance products and annuities are not a deposit or other obligation of, or guaranteed by a bank, any affiliate of a bank, or savings association and are not insured by the Federal Deposit Insurance Corporation (FDIC) or any other agency of the United States, a bank, any affiliate of a bank, or savings association.

PRE-AUTHORIZED CHECK (PAC) PLAN - Attach one preprinted, blank, voided check

Select Option Payment Frequency: ☐ Monthly; ☐ Quarterly; ☐ Semi-annually

Payment Option **1**: ☐ Deduct the **first and future** premium payments. (The first deduction will occur on or after the Policy Date and then at the interval selected above.) A completed and signed Temporary Insurance Agreement must be submitted.

Payment Option **2**: ☐ Deduct **future** premium payments only. (The initial premium payment is to be made by check. The day of the month in your Policy Date will be used to initiate future deductions at the intervals indicated above. Or, you may choose a specific day of the month between the 1*st* and 28*th* ____________________. Premium is due on or before the due date. For monthly deductions, selecting a day of the month that is after the Policy Date may initially result in deductions to pay both the current month and next month premiums.)

Financial Institution Information Routing Transit No. (if known)____________________

Bank Name ____________________ Account No.____________________

Account Holder (Payer) Name (Please print.) ____________________

Authorization - I authorize the Company to initiate an automatic electronic payment from my account indicated above at the financial institution (Bank) indicated above and I authorize my Bank to honor the withdrawal(s). I authorize the adjustment of the dollar amount transferred from my account to correspond to periodic changes in the payment due under the terms of the policy. I understand that this authorization is to remain in effect until cancelled in writing either by me, the Company, or the Bank. Notice of five business days is required to change or terminate this authorization.

Payer Signature X____________________ Date____________________

Terms and Conditions
If your automatic payment is to be taken on a weekend or holiday, such payment will be deducted on the next business day. Information as to each charge will be provided by an entry on your bank statement or by other advice from the bank. Deductions will be made on or about (after) the date requested. In the event a charge is inadvertently not made, the Company may charge the account at a later date. You will be notified prior to an increase in the deduction which may occur due to periodic changes in the premium due under the terms of the policy, if any. The Company may terminate this payment method if any charge is not paid upon presentation, or if more than two changes are requested in any 12 month period.

Medical Authorization – To determine eligibility for insurance, I authorize: (1) any physician, medical practitioner, health care professional, hospital, clinic, or other medical or medically related facility, laboratory, pharmacy or pharmacy benefit manager, insurance or reinsuring company, viatical company, viatical broker or provider, the Medical Information Bureau, Inc., consumer reporting agency, insurance support organization, independent administrator, or pharmacy, governmental agency, group policyholder, employer or benefit plan administrator having information available as to diagnosis, prescription history, medications prescribed, treatment and prognosis with respect to information regarding alcoholism, drug abuse, and psychiatric care or any physical or mental condition and/or treatment of me or my minor children and financial, avocation, hazardous sports, aviation, driving, arrest, and credit information of me or my minor children, to give to North American Company for Life and Health Insurance ("the Company"), its representatives or reinsurers, any and all such data; (2) the Company to conduct a personal telephone interview in connection with my application; and (3) the Company to release any such data to its reinsurers, the Medical Information Bureau, or other persons or organizations performing business or legal services in connection with my application, or as required by law when given a copy of this authorization. Data released may include results of my medical examination or tests requested by the Company. I understand that I may request to be interviewed in connection with the preparation of an investigative consumer report and that I am entitled to receive a copy of such report upon request. This authorization is valid for the time period required by the state where the application is written from the earlier of: (1) the date signed, or (2) the Policy Date. I may revoke this authorization for information not then obtained by notifying the Company in writing. Such revocation will not be effective until received by the Company. I understand that I or any authorized representative will receive a copy of this authorization upon request.

Accelerated Death Benefit – If insurance coverage includes an accelerated death benefit, I understand receipt of such benefits may affect eligibility for public assistance programs and may be taxable. There is no separate premium or cost for this benefit. Payment of this benefit will reduce my death benefit. I acknowledge receipt of the Accelerated Benefit Summary and Disclosure, if applicable.

AR, KY, LA, NM, and OH Residents: 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.

CO Residents: It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete or misleading facts or information to a contract holder or claimant for the purpose of defrauding or attempting to defraud the contract holder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

DC and TN Residents: Warning: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.

PA Residents: 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 a person to criminal and civil penalties.

SIGNATURES

Signed at ______________________________ (City, State) On ______________ (Date)

X ______________________________
***Signature* of Primary Insured, or Legal Guardian** if Primary Insured is a Minor

X ______________________________
***Signature* of Proposed Additional Insured/Spouse**

X ______________________________
***Signature* of Owner**, if other than Primary Insured (If Owner is corporation, trust, or other entity, include title of signee.)

X ______________________________
***Signature* of Proposed Additional Insured/Spouse**

X ______________________________
***Signature* of Witness** (Required when agent not present)

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Agent Certification

Does any person covered under this application have any existing life insurance or annuities? .... ☐ Yes ☐ No

Is any insurance applied for in this application intended to replace any existing life insurance or annuity? .... ☐ Yes ☐ No

If a replacement is involved, the applicable Replacement Notice will be sent to the existing insurer.

Accelerated Death Benefit – If insurance coverage includes an accelerated death benefit, I have provided the Accelerated Benefit Summary and Disclosure to the applicant(s), if applicable.

Please indicate the form of ID presented and used to verify this owner's identity:

Natural Person / Trust Accounts				
	Driver's License	State:	Number:	Exp. Date:
	State Issued ID	State:	Number:	Exp. Date:
	Military ID		Number:	Exp. Date:
	Passport		Country:	Exp. Date:
	Alien Registration Card		Country:	Exp. Date:

Non-Natural Person / Business or Corporation			
	Partnership or Trust Agreement		Date:
	Certificate of Incorporation	State:	Date:
	Business License	State:	Number:

Signature of Soliciting Agent X ______________________________

Print Agent Name______________________________ Agent Code # ____________

Print Other Agent Name (if applicable)______________________________ % Credit______ Agent Code # ____________

Authorization for Release of Health-Related Information
This Authorization complies with the HIPAA Privacy Rules

Send Information to: New Business & Administrative Office
One Sammons Plaza, Sioux Falls, SD 57193-0001

Name of Proposed Insured (Please print)	Birth Date Month / Day / Year

I authorize any licensed physician, medical practitioner, health care professional, hospital, clinic, or other medically related facility, laboratory, pharmacy, pharmacy benefit manager, insurance or reinsuring company, viatical company, viatical broker or provider, the Medical Information Bureau, Inc., consumer reporting agency, insurance support organization, independent administrator, governmental agency, or group policyholder, or employer having information available as to diagnosis, prescription history, medications prescribed and that has provided payment, treatment or services to me or on my behalf within the past 10 years ("My Providers") to disclose my entire medical record and any other protected health information concerning me to The North American Company for Life and Health Insurance and its agents, employees, and representatives. This includes information on the diagnosis or treatment of Human Immunodeficiency Virus (HIV) infection and sexually transmitted diseases. This also includes information on the diagnosis, prognosis and treatment of mental illness and the use of alcohol, drugs, and tobacco, but excludes psychotherapy notes.

By my signature below, I acknowledge that any agreements I have made to restrict my protected health information do not apply to this Authorization and I instruct My Providers to release and disclose my entire medical record without restriction.

This protected health information is to be disclosed under this Authorization so that North American Company for Life and Health Insurance may: 1) underwrite my application for coverage, determine eligibility, risk rating, policy issuance and enrollment determinations; 2) obtain reinsurance; 3) administer claims and determine or fulfill responsibility for coverage and provision of benefits; 4) administer coverage; and 5) conduct other legally permissible activities that relate to any coverage I have or have applied for with North American Company for Life and Health Insurance.

NORTH AMERICAN COMPANY • NEW BUSINESS OFFICE: P. O. BOX 5089, SIOUX FALLS, SD 57117 • PRINCIPAL OFFICE: WEST DES MOINES, IA
Emerald Team: (800) 669-9100 Fax: (800) 951-9430 • Ruby Team: (866) 606-2943 Fax (800) 978-7959 • Sapphire Team (855) 288-8149 Fax (855) 288-8150 ww.nacolah.com

This Authorization is valid for 30 months (24 months in KS, KY, ND, NE, NM, OK, WV & WY) following the date of my signature below, and a copy of this Authorization is as valid as the original. I understand that I have the right to revoke this Authorization in writing, at any time, by sending a written request for revocation to North American Company for Life and Health Insurance, One Sammons Plaza, Sioux Falls, SD 57193, Attention: New Business.

I understand that a revocation is not effective to the extent that any of My Providers has relied on this Authorization or to the extent that North American Company for Life and Health Insurance has a legal right to contest a claim under an insurance policy or to contest the policy itself.

I understand that any information that is disclosed pursuant to this Authorization may be re-disclosed and no longer covered by federal rules governing privacy and confidentiality of health information.
I understand that My Providers cannot deny me treatment or payment for health care services if I refuse to sign this authorization. I further understand that if I alter, revoke, or refuse to sign this Authorization to release my complete medical record, North American Company for Life and Health Insurance the Company may not be able to process my application, or if coverage has been issued may not be able to make any benefit payments. I acknowledge by my signature below, that I or my Personal Representative has a right to receive, and have in fact received, a copy of this authorization.

Signature Proposed Insured or Personal Representative	Date

If you are the Personal Representative of the Proposed Insured, describe the scope and/or basis of your authority to act on the Insured's behalf:

____

____

NO-LAPSE GUARANTEE PROVISION DISCLOSURE

This policy is guaranteed to stay in force for a number of years as long as you have paid at least as much as the required premiums. This is called a no-lapse guarantee.

Even though it contains a no-lapse guarantee, this policy may provide nonforfeiture benefits (such as cash surrender values) which are less than those that would be provided if the no-lapse guarantee were issued as a separate policy (for example, as a term policy). However, the premiums for the term policy might be higher than those for the no-lapse guarantee in this policy.

When considering the purchase of this policy, you should consider the value to you of higher nonforfeiture benefits versus the level of the premiums required to keep your insurance coverage in force.

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Together, we can save a life

TESTING FOR HIV INFECTION

Deciding to be tested for HIV, the *human immunodeficiency virus*, may not be easy. If you or someone you know has questions about being tested for HIV, here are some facts that may help.

What tests are most commonly used to detect HIV infection?

There are three types of HIV tests commonly used.

1. The **ELISA** is the standard screening test used to detect HIV antibodies in a sample of blood, urine or saliva. If HIV antibodies are detected by an ELISA, the test is repeated. If the second test reacts to the presence of HIV antibodies, the sample is tested using the Western blot and IFA to confirm. Results from this type of HIV test are usually available within one to two weeks.
2. The **rapid** HIV test detects antibodies to HIV-1. A small sample of blood is taken using a "fingerstick" or small pin prick to the finger. A positive test result suggests that antibodies to HIV are present. If HIV antibodies are not present in the blood, the test result is interpreted as negative. These preliminary results may be available in less than 30 minutes, after which a confirmatory test must be conducted. The confirmatory results are available within one to two weeks.
3. **Oral** HIV testing is an alternative to blood testing. The oral HIV test uses a sample of mouth tissue taken from the cheek and gum. This tissue contains high levels of antibodies and is free of most of the contaminants found in saliva. If a test result is positive, another test on the same sample is conducted automatically to confirm HIV infection. No needle or blood is involved in this type of HIV test. Test results are usually available within three days.

How long should I wait before being tested?

Before getting tested, it is important to wait three months from the time you think that HIV exposure may have occurred. This is enough time for most people to develop antibodies to HIV. The average time for HIV antibodies to appear is 25 days. Otherwise, a person may test negative even though they have HIV. This is called the "window period." During the "window period" and prior to HIV testing, you should avoid behavior that puts others at risk for HIV, including unprotected vaginal, anal or oral sexual intercourse and blood-to-blood contact, as in sharing needles.

Should I be tested?

If you think you might have been exposed to HIV, you are encouraged to seek individual counseling and testing. It is possible for people to be infected for years and to look and feel healthy, not knowing they are infected with HIV.

You may be at risk for HIV infection if you have—

- Shared needles and syringes.
- Had sex with anyone who injects drugs.
- Had sex with men who have had sex with other men.
- Had sex with multiple partners.

What is the difference between anonymous and confidential testing?

Anonymous testing ensures the privacy of the person being tested. This means that neither names nor any other identifying information that could link a person to their results is recorded. Instead, code names or numbers are used so that only the person who gets the HIV test can find out their test result.

Confidential testing ensures that no one can be given the results of an HIV test without the test taker's written permission, except as required by state law. Test results become part of a person's medical files at the facility where the test was administered. States that require HIV-positive test results to be reported are required by law to keep the information confidential.

Why is counseling recommended both before and after taking an HIV test?

Deciding whether or not to get an HIV test is not easy. Fear and worry about the test are very common feelings, both before the test and while waiting for the results. Many people fear the reactions of family, friends, employers and others if test results are positive. Counseling may help you decide what to do and how to respond to the results of the test.

Pretest counseling is important for a clear understanding of what the test is and what the test can and cannot tell you. It will help you understand if you are at risk for HIV infection and how to prevent the spread of HIV. Pretest counseling may vary from one test site to another.

Post-test counseling can help you understand what your test results mean. It can give you information about how to protect yourself and others from HIV, no matter what the test result is. If your result is positive for HIV infection, a counselor can also refer you for medical, legal and emotional support services, as needed, and can tell you about the kinds of services that are available in your area for people living with HIV infection.

What does a negative test result mean?

A negative test result shows that no HIV antibodies were found in your blood at the time the test was taken. A negative test result can mean either that you are not infected with HIV or that you are infected, but your body has not yet produced enough antibodies to show up on the test.

If you are advised to have the test repeated, avoid behaviors that put you and others at risk of HIV infection. Then, if you test negative six months later, you probably do not have HIV. To stay uninfected, you can take steps to protect yourself by not having sex without using a latex (or polyurethane) condom and by not sharing needles and syringes.

What does a positive test result mean?

A positive antibody test result means that you have HIV antibodies in your blood and you are infected with HIV. However, it does not mean that you have developed AIDS. The test cannot tell if or when you will develop AIDS.

A positive test result means that you can infect other people with HIV through sex (vaginal, anal or oral) or by sharing needles and syringes. Also, a pregnant woman who has HIV can infect her baby during pregnancy or birth or through breast feeding.

Your health care provider or HIV/AIDS counselor will talk to you in detail about your test results. He or she can also advise you about taking care of your health and about living with HIV infection. Several types of treatments are available that have helped people living with HIV stay healthy for many years. The goal of most treatments is to extend and improve the quality of life for people with HIV and AIDS by suppressing enough of the virus over time to avoid damage to the immune system. Although not a cure, many treatments have brought hope and new strength to people living with HIV and AIDS.

People living with HIV can get help in notifying sex or needle-sharing partners of their possible exposure to HIV through partner notification programs, which provide prevention counseling, HIV testing and referrals to other services. To learn about partner notification services in your area, contact your state or local public health department.

What else do I need to know?

- **Costs**—The cost for HIV testing varies. Some clinics offer free testing or request a small donation. Fees for tests given by private health care providers may be higher.
- **Laws**—Laws and regulations for reporting test results vary from state to state. Anonymous testing is not available everywhere. In some states, positive HIV test results must be reported to the local public health department, where they are kept confidential.

What about donating blood to get tested?

Do **not** donate blood to find out your HIV status. The Red Cross tests blood to safeguard the blood supply, not to provide a testing service for people who want to know their HIV status. Because these tests may not detect HIV infection in its earliest stages, people who think they may be infected could be putting other people at risk by donating blood. To find out where HIV testing services are available, call your local Red Cross chapter or station, health department or AIDS service organization.

How is HIV spread?

HIV is spread by—

- Having vaginal, oral or anal sex with someone who has HIV.
- Sharing needles or syringes with someone who has HIV.
- Pregnancy, birth or breast feeding, if the mother has HIV.

For more information, contact—

- Your local American Red Cross chapter or station. To locate the one closest to you, go to *www.redcross.org.*
- The CDC National AIDS Hotline (toll free): 1-800-342-AIDS. For Spanish-speaking persons, Línea Nacional del SIDA: 1-800-344-7432. For deaf and hearing-impaired persons, TTY-TDD Hotline: 1-800-243-7889.
- The CDC National Prevention Information Network (toll free): 1-800-458-5231, or at *www.cdcnpin.org*.
- The CDC Web site for recently revised guidelines on HIV counseling and testing. These guidelines are available at *wwwcdc.gov/hiv/pubs/rt-counseling.htm*.
- Your doctor or your health care provider.
- Your state or local public health department.
- Your local AIDS service organization.

American Red Cross HIV/AIDS Programs

The American Red Cross has Basic, African American, Hispanic and Workplace HIV/AIDS programs. Youth materials, including *Act SMART,* "The Party" and "Don't Forget Sherrie," are also available. Contact your local American Red Cross chapter or station for additional information.

All people share the responsibility to protect themselves and others from HIV infection.

American Red Cross

Together, we can save a life

This publication was supported by Cooperative Agreement No. U62/CCU 303031 from the Centers for Disease Control and Prevention (CDC) of the U.S. Public Health Service. Its contents are solely the responsibility of the American Red Cross and do not necessarily represent the official views of the CDC.

North American Company
for Life and Health Insurance
Since 1886

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TRANSMITTAL REPORT

Emerald Team	Phone: 800-669-9100	Fax: 800-951-9430	email: emerald@sfgmembers.com
Ruby Team	Phone: 866-606-2943	Fax: 800-978-7959	email: ruby@sfgmembers.com
Sapphire Team	Phone: 855-288-8149	Fax: 855-288-8150	email: sapphire@sfgmembers.com

PLEASE PRINT

Agency Name		Producer Code	Contact Person/E-mail Address
Address			Fax Number
City	State	Zip Code	Phone No.
Writing Agent	Phone No.		Agent Code

Proposed Insured (1)		
Proposed Insured (2)		
Plan of Insurance	Face Amount (1)	Face Amount (2)

PREMIUM SUBMITTED $ ______________________ **Please attach a copy of Illustration**

Please indicate by placing an O if ordered or A if attached next to the requirement.

Proposed Insured (1)	Requirement	Proposed Insured (2)
______	Paramedical Exam	______
	Date ordered ______	
______	Physical Measurements/Vitals	______
______	MD Exam	______
______	EKG	______
______	Treadmill	______
______	APS Dr.______	______
	Date ordered ______	
	Vendor Name ______	
______	APS Dr.______	______
	Date ordered ______	
	Vendor Name ______	
______	Confidential Financial Statement	______
______	Urine/HIV	______
______	Full Blood Profile	______
______	Replacement Forms	______
______	Illustration	______
______	Cover Letter	______
______	Underwriter Checklist	______
______	Other (describe)	______

Please complete the following:

☐ **BCX**

☐ TeleMed Interview. (**The best day, time and number to call must be indicated on Part I of the application).**

☐ No TeleMed Interview **(Complete Entire Application)**

POLICY NUMBER: ______________________
(if applicable)

HAS THIS APPLICATION BEEN FAXED ? ☐ **YES** ☐ **NO**

If "No" please mail to:

New Business Department
North American Company
One Sammons Plaza
Sioux Falls, SD 57193

Special Requests/Remarks (i.e. Policy Date, Trust Date, 1035 Information etc. Include cover letter for financial justification or special circumstances)

Date submitted: ______________________ By: ______________________

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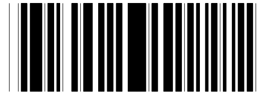

ASSIGNMENT AND SURRENDER FOR §1035 EXCHANGE

NOTE: COMPLETE ONE FORM FOR EACH POLICY OR CONTRACT TO BE EXCHANGED

Policy/Annuity Number________________________________ Insured/Annuitant ____

Issuing Company Name____ Owner____

Issuing Company Address ____

ASSIGNMENT:

For value received, the undersigned hereby assigns and transfers all right, title and interest in the above policy to North American Company for Life and Health Insurance of Des Moines, Iowa (NACOLAH). In making this assignment, the undersigned warrants and represents that the policy noted above: (i) currently is in force; (ii) is not subject to any prior assignment; (iii) is not subject to proceedings in bankruptcy, Federal Tax levy, or collection proceedings resulting from an unpaid assessment, or any other legal action; (iv) is subject to [ ] is not subject to [ ] an outstanding loan; (v) is not subject to any interest of any other person, firm or corporation.

The undersigned intends this assignment to be part of an exchange of insurance policies under Internal Revenue Code Section 1035. The, undersigned is aware that NACOLAH intends to surrender this policy for its cash surrender value and specifically authorizes and approves of NACOLAH surrendering the policy for its cash surrender value, without in any way limiting the rights transferred under this assignment.

The issuing Company is authorized to recognize NACOLAH's claim to rights under this assignment without investigation. An authorized signature on behalf of NACOLAH shall be sufficient for the exercise of NACOLAH's right of surrender. Any check for the surrender value of this policy shall be drawn to the exclusive order of NACOLAH if, when and in such amounts as may be requested by NACOLAH.

In addition to but without limitation of all rights, title and interests assigned under this assignment, the undersigned specifically assigns the above policy as collateral security for the amount of the policy's cash surrender value with the right of NACOLAH to collect either the proceeds at death or at maturity, or the cash surrender value of the policy paying the balance, if any, after payment of such cash surrender value, to the persons entitled thereto under the policy.

The undersigned represents and agrees that NACOLAH is furnishing this form and is participating in this transaction at the undersigned's specific request and as an accommodation to the undersigned. **The undersigned represents and agrees that NACOLAH makes no representations concerning the undersigned's tax treatment under Internal Revenue Code Section 1035 or otherwise and the Company has no responsibility or liability for the validity of this assignment or the undersigned's tax treatment under Internal Revenue Code Section 1035 or otherwise.**

If this transaction is subject to a **community property** interest, we strongly recommend that You obtain Your spouse's signature on this application to document his/her consent to this transaction. States that recognize community property interests in property held by married persons include Alaska, Arizona, California, Idaho, Louisiana, Nevada, New Mexico, Texas, Washington and Wisconsin.

You understand and agree that the Company may presume that no community property exists if You have not obtained your spouse's signature below. Further, you understand and agree that the Company has no duty to inquire further about any such community property interest. As a result, You agree to indemnify and hold the Company harmless from any consequences relating to community property interests and this transaction.

Please note that the term "spouse" includes domestic partner or other partner as permitted by civil union, domestic partnership or similar law.

The undersigned further represents and agrees that a photographic copy of this original shall be as valid as the original. The undersigned also acknowledges and agrees that this assignment is not effective unless accepted by NACOLAH and such acceptance is evidence by being recorded on this form.

Date at________________________________ Date:________________/____________/______________

Witness	Owner
Witness	Owner's Spouse if Community Property State
Agent where required by law	Irrevocable Beneficiary, if any

COPY 1 – ADMINISTRATIVE OFFICE COPY 2 – APPLICANT COPY 3- AGENT

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North American Company
for Life and Health Insurance
Since 1886

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FOR HOME OFFICE USE ONLY

NACOLAH hereby accepts the assignment and ownership of the above referenced policy, Date:__________/_____/______

______________________________by its ______________________________
Authorized Signature/Title

CASH SURRENDER REQUEST:

As the Assignee under an assignment for 1035 Exchange dated________________, North American Company for Life and Health Insurance, Des Moines, Iowa (NACOLAH) hereby requests the cancellation of the above policy and the immediate cash surrender of all cash values, dividends, prorated premiums and any other available funds attributable to it.

The purposed of this surrender is to complete an exchange of insurance policies under Internal Revenue Code Section 1035. Your check drawn

to the exclusive order of NACOLAH will be applied to NACOLAH policy________________on the life of the insured. This payment should be mailed to:

North American Company for Life and Health Insurance
New Business Underwriting Service Center
P. O. Box 5088
Sioux Falls, SD 57117-5088

Payment of the requested surrender value is acknowledged as full settlement of any and all claims under this policy.

Such cancellation shall be effective immediately, and no premium paid for any period beyond the date of this request should be used for any purpose other than computing the surrender value.

It is warranted that the undersigned officer of NACOLAH has the specific and actual authority to sign this request on NACOLAH's behalf and to negotiate any check received in connection with this surrender for the purpose of completing an exchange of policies.

Date________/______/______ ______________________________
Authorized Signature/Title

To effect this exchange under Internal Revenue Code Section 1035 your old policy is to be assigned to North American Company for Life and Health Insurance, hereinafter called "NACOLAH".

This assignment will not be valid until accepted by NACOLAH. Should a death occur prior to NACOLAH accepting the assignment, your existing coverage under your old pol- icy will be in force. If application to NACOLAH is declined or issued on other than a stan- dard basis, NACOLAH will not proceed with the assignment and both your old policy and this assignment form will be returned to you.

Please be aware that when NACOLAH has accepted the assignment, it must exchange your old policy with the other company. This exchange between insurance companies could take, depending on company procedures, up to six months. Therefore please remember NACOLAH cannot credit interest until funds are received at its offices.

Please make sure:

- Assignment is signed and witnessed.
- First 2 copies are sent to NACOLAH.
- Old policy is sent to NACOLAH.

Should more than one policy be involved make sure an assignment for each policy is completed.

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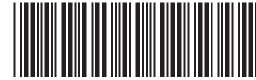
North American Company
for Life and Health Insurance
Principal Office: 4601 Westown Pkwy, Suite 300
West Des Moines, IA 50266
A Member of the Sammons Financial Group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**DISCLOSURE FOR PERSONS
RESIDING IN CALIFORNIA AGE 65 OR OLDER**

The sale or liquidation of any stock, bond, IRA, certificate of deposit, mutual fund, annuity or other asset to fund the purchase of an annuity or life insurance product may have tax consequences, early withdrawal penalties or other costs or penalties.

You may wish to consult independent legal or financial advice before selling or liquidating any assets and prior to the purchase of any life or annuity products being solicited, offered for sale or sold.

Mail To: Administrative Office • P.O. Box 5088 • Sioux Falls, SD 57117-5088

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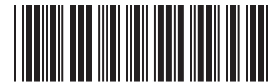

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CERTIFICATION OF TRUST AGREEMENT

Please complete using information from the Trust Document

Policy No(s): *Please state pending if this form is being submitted with a new application.		
Name of Insured(s): First Name	MI	Last Name
First Name	MI	Last Name
Full Name of Trust:		
Trust Effective Date:		Trust Identification Number/Tax ID Number:
Which state law governs this Trust?		
Preparer of Trust:		Preparer's Telephone Number:
Preparer's Address: Street	City	State Zip

If Trust is a beneficiary, is it a testamentary trust? ☐Yes ☐ No If yes, please sign and date (signature) ______ (date) ______ (policy owner) and return the form (form is complete). If no, please complete the remainder of the form.

Name of Grantor(s)/Settlor(s): First Name:	MI	Last Name
First Name:	MI	Last Name

Name/Address of Trustee(s):* Please attach additional pages if insufficient space has been provided.
Name/Address of SuccessorTrustee(s):* Please attach additional pages if insufficient space has been provided.

1. The above referenced Trust Agreement (the "Trust") requires that: (Please mark the appropriate box.)
   ☐ all Trustees ☐ a majority of Trustees ☐ any Trustee ☐ Trust only has one Trustee
   must sign documents pertaining to the above-referenced Policy which require a signature.

2. The insurance agent or any person affiliated with the insurance agent is not a beneficiary of the above referenced trust.
   ☐ Agree ☐ Disagree
   **If marked disagree, please attach an explanation of why your agent or person affiliated with your agent is named as a beneficiary of the trust.*

Note: Under the laws of most states, an agent is restricted in, or prohibited from, having a beneficial interest in a contract sold by the agent, unless that agent is a family member, or has a recognized insurable interest. Additionally, our Company policy prohibits our agents from serving in any capacity that may be construed as creating a direct or indirect conflict of interest with regard to a contract or contracts for which they are or have been the agent(s) of record.

3. The relationship of the Trust Beneficiary(ies) to the Insured is:
   ☐ Spouse ☐ Children ☐ Grandchildren ☐ Other:______________________
   Please Explain.

4. Was the Trust validly executed, and is it in full force and effect? ☐ Yes ☐ No

Please be advised that the Insurer reserves the right to request and receive a copy of the Trust documents if it determines that it is necessary to do so. Before the Insurer pays proceeds at the death of the Owner/Insured of the Policy(s) it may also require proof that the Trust is then in full force and effect.

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DECLARATION BY TRUSTEE(S)

The Trustee(s) states and agrees that if the Trust is named as owner, it is authorized under the terms of the Trust to purchase and hold insurance; that if the Trust is named as beneficiary of the Policy(s), it is authorized to receive insurance proceeds. The Trustee represents that they have determined the suitability of the Policy for the Trust.

The Trustee agrees that the Insurer's sole obligation it to perform under the terms of the Policy(s). The Trustee also agrees that the Insurer may rely on the signature(s) of the Trustee(s) on behalf of the Trust in the same regard as if they were the actual owner or beneficiary of the Policy(s); the Insurer may rely solely on this Certification as well as the statements and representations made in the associated application, as a basis for issuing and/or performing obligations of the above-referenced Policy and to determine the trust is in effect and the information provided is accurate; the Insurer has no obligation to investigate the terms of the Trust or the authority of the Trustee(s) and will not be accountable for knowledge about the terms of the Trust beyond this Certification; the Insurer expressly denies responsibility regarding the use and applications of any payments to the Trustee(s); the Insurer has no obligation to determine the Policy's conformance to income distribution requirements of the Trust agreement.

The Trustee(s) declares they have had an opportunity to consult with their own independent legal, tax and trust advisors concerning the appropriateness of the Policy(s) for the Trust and they have the authority to execute this Agreement and bind the Trust to the terms therein. Furthermore, they will, as Trustee(s), and on behalf of the Trust, hold the Insurer and its agents, employees, and other representatives harmless from any action the Insurer takes at the directions of the Trustee(s).

The Trustee(s) declares, solely in its capacity as trustee and not individually and on behalf of the Trust, that each and every Trustee and successor Trustee are bound by this declaration. It is further understood that the Insurer may rely upon the direction of the named Trustee(s) and any named successor Trustee(s) until the Insurer receives written notification at its Executive Office, of a change of Trustee. The Trustee(s) agrees to notify the Insurer within a reasonable time after such a change occurs.

The Trustee further acknowledges and agrees that:

a) Neither the Insurer or agents are authorized by the Company to recommend or sell Trusts while acting in their capacity as an agent for the company and that any trust recommendation should be provided by a qualified advisor;

b) neither the company nor any of its agents, employees or representatives are authorized to give tax or legal advice;

c) the Trustee(s) has not relied upon any representation or advice of any of the Insurer's agents, employees or representatives with respect to the terms of validity of the Trust or the utilization of the Trust as the owner and/or beneficiary of the Policy; and

d) the purchase of this Policy is not required in conjunction with the establishment of the Trust and that any fees, costs and/or expenses associated with the establishment of the Trust are independent of any premium paid for the purchase of this Policy.

Note: The number of Trustees indicated in Question 1 must sign below.

By:		By:	
Trustee Signature	Date	Trustee Signature	Date
By:		By:	
Trustee Signature	Date	Trustee Signature	Date

For Corporate Trustees:

Title/Capacity of Signatory: ______________________________

Trustee Name: ______________________________
(Please Print or Type)

Trustee Signature: **X** ______________________________ Date: ______/______/______

NOTICE OF EMPLOYER INTENT TO APPLY FOR OR CHANGE INSURANCE ON EMPLOYEE'S LIFE

(IMPORTANT: DEATH BENEFIT MAY BE FULLY TAXABLE TO POLICYOWNER UNLESS CONSENTS ARE COMPLETED AT OR BEFORE APPLICATION OR CHANGE REQUEST IS SIGNED)

TO: ______________________________ ("Employee/Director") **DATE OF BIRTH:** ______________

☐ New contract
☐ Existing contract(s) list policy number(s) of existing Midland contract ____________________________

As required by Internal Revenue Code Section 101(j), ________________________________ ("Employer") is
[Name of employer or Trust Sponsored by Employer]
hereby providing you with the following Notice:

1. Employer is applying for, or requesting a material change to, one or more life insurance contracts on your life described above.
2. The maximum face amount of life insurance that could be provided on your life at the time of the issuance or material change of each of the Contracts is ______________. (Note that the maximum face amount may be higher than the actual face amount.)
3. Employer will be a direct or indirect beneficiary of any proceeds payable under the Contracts at the time of your death.

EMPLOYEE CONSENT TO ISSUANCE OR CHANGE OF EMPLOYER-OWNED LIFE INSURANCE

I understand that Employer is applying for, or requesting a material change to, one or more life insurance contracts on my life described above. I have read and understand the Notice provided above and, accordingly, make the following representations:

1. I consent to being insured under the Contracts and to future increases in the face amounts of the Contracts not to exceed the maximum aggregate face amounts shown above.
2. I consent to the coverage provided by the Contracts continuing after my employment with, or status as a Director of, Employer terminates.
3. I understand that Employer will be a direct or indirect beneficiary of death proceeds payable under the Contracts at my death.
4. The Employer has an insurable interest in my life.
5. I understand the Employer is the Owner and neither I nor my estate, administrators, heirs, or assignees have any rights in the Contract or in any Contract proceeds, unless Employer notifies the insurer otherwise in writing.

______________________________ ______________________
Signature of Employee or Director Date

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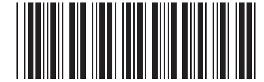

L28561

CREDIT CARD BILLING AUTHORIZATION

I request and authorize the Company to charge my Visa®/MasterCard®/Discover® account electronically, or by any other commercially accepted method, for payment to the Company of: (1) an amount equal to premiums (initial and/or renewal premiums) for the proposed policy and amount of life insurance applied for on the application to which this authorization is attached and/or any premiums that subsequently become due on any policy(ies) issued based on that application as indicated below and/or; (2) premiums due under any other policies identified below (together hereinafter the "Policy").

I agree that the use of this method of payment does not alter any Policy provision. The Company agrees to accept this authorization as it would a check or draft provided it is honored when first presented. I agree that if this authorization applies to an application for new life insurance, that coverage, if any, will only become effective as defined in the application or the receipt attached to the application, if issued.

1) The effective date of this premium payment plan (the "Plan") for the Policy will be the Policy date if it applies to a new Policy, otherwise it will be determined by the Company. The premium payment frequency will be as elected below.
2) The first charge will be made on or about the Policy date for a new Policy. Subsequent charges will be made on or about the same day of the month at the frequency checked below. In the event a charge is inadvertently not made, the Company may charge the account at a later date.
3) If the Policy has been backdated to save age, the Company may bill up to six (6) additional premiums to this account as necessary.
4) Should circumstances require that a new credit card account number be assigned, this authorization is intended to apply and will continue in effect with respect to the new account number when it is provided by you or by the issuing bank to the Company.
5) This authorization will remain in effect until it is terminated by the accountholder or by the Company upon 30 days advance written notice to the other party. In addition, the Company may immediately terminate this Plan if any charge is not honored upon presentation.
6) If this Plan is terminated, Policy premiums will be timely payable directly to the Company and will be determined on the basis of the Company's premium rates applicable to the Policy for the billing method and frequency elected by the policyowner from those permitted by the Company. Premium notices will be sent to the policyowner's address on record with the Company at that time, or to an alternate address as specified in advance by the policyowner.
7) I further authorize the Company to adjust the amount of the charge to my account to correspond to any periodic changes in the payment due under the terms of the Policy.

POLICY NUMBER ________ INSURED NAME ________

CREDIT CARD INFORMATION

CARD TYPE: Visa ○ Master Card ○ Discover ○

OPTION	PAYMENT FREQUENCY (CHECK ONE ONLY)**			
	ANNUAL	SEMI-ANNUAL	QUARTERLY	MONTHLY
INITIAL & RENEWAL	N/A	○	○	○
RENEWAL ONLY	N/A	○	○	○
*INITIAL PREMIUM ONLY	○			

* Indicate method of premium payment after initial charge to credit card.
** If no payment frequency is specified, premiums will be debited monthly.
Annual charges are available on initial premium only

Credit Card Account Number ________ Expiration Date ________

Cardholder Name (Print) ________

Authorized Cardholder Signature ________ Date ________ Phone Number ( )________

For premium billing service regarding the policy, please contact your agent or North American Company at (877) 872-0757.

You may request to receive notice if your charge will differ from the previous charge .

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North American Company
for Life and Health Insurance
Since 1886

L16831

Electronic Fund Transfer Authorization

Attach one preprinted, blank, voided check

Step 1. Applicant/Insured

(Last Name, First, M.I)	Social Security No.	Policy Number (if known)

Step 2A. New Applicants - Select Option

Payment Frequency ☐ Monthly; ☐ Quarterly; ☐ Semi-annually

Payment Option **1**: ☐ Deduct the **first and future** premium payments. (The first deduction will occur on or after the policy date and then at the intervals selected above.)

Payment Option **2**: ☐ Deduct **future** premium payments only. (The initial premium payment is to be made by check. The day of the month in your policy date will be used to initiate future deductions at the intervals indicated above. Or, you may choose a specific day of the month between the 1*st* and 28*th* ______________. Premium is due on or before the due date. For monthly deductions, selecting a day of the month that is after the policy day may initially result in deductions to pay both the current month and next month premiums.)

☐ Address Change New Address ____

____

Step 2B. Existing Policy Owners/Payers

a. Payment Frequency ☐ Monthly; ☐ Quarterly; ☐ Semi-annually

b. Withdrawal Day of the Month (1*st* - 28*th* only): __________ Beginning: ________________MM/YY
(Note: If a specific day of the month is not indicated, the day in your policy date will be used. Premium is due on or before the due date. For monthly deductions, selecting a day of the month that is after the policy day may initially result in deductions to pay both the current and next month premiums.)

c. Withdrawal Amount: $____________________ *(For flexible premium policies only.)*

d. Loan repayment amount: $________________ (Note: requires a minimum of $1.00 billed for premium.)

Step 3. Financial Institution Information Routing Transit No. (if known)______________________________________

Bank Name ______________________________________ Account No.______________________________________

Account Holder (Payer)Name (Please print.) ____

Enclose one preprinted, blank, voided check

Step 4. Authorization

I authorize the Company to initiate an automatic electronic payment from my account indicated above at the financial institution (Bank) indicated above and I authorize my Bank to honor the withdrawal(s). I authorize the adjustment of the dollar amount transferred from my account to correspond to periodic changes in the payment due under the terms of the policy. I understand that this authorization is to remain in effect until cancelled in writing either by me, the Company, or the Bank. Notice of five business days is required to change or terminate this authorization.

Payer Signature ______________________________ Date __________________________

Terms and Conditions

If your automatic payment is to be taken on a weekend or holiday, such payment will be deducted on the next business day. Information as to each charge will be provided by an entry on your bank statement or by other advice from the bank. Deductions will be made on or about (after) the date requested. In the event a charge is inadvertently not made, the Company may charge the account at a later date. You will be notified prior to an increase in the deduction which may occur due to periodic changes in the premium due under the terms of the policy, if any. The Company may terminate this payment method if any charge is not paid upon presentation, or if more than two changes are requested in any 12 month period.

FOR OFFICE USE ONLY

Processed by: ____________________Date:________ Control #:__________________________________

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North American Company
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O-27581

AUTHORIZATION

Insured	Policy Number
Policy Owner (Complete if other than Insured.)	Policy Owner Social Security/Tax ID Number
Policy Owner's Address	

☐ **POLICY OWNER TELEPHONE AUTHORIZATION (READ CAREFULLY)**
I hereby authorize and direct North American Company for Life and Health Insurance (NA) to act on telephone instructions when proper identification has been furnished, to make transfers or change premium allocations of future premium payments. NA will employ reasonable procedures to confirm that telephone instructions are genuine; nonetheless, I agree that NA is not liable for any loss arising from any change in premium allocations of future premium payments or transfers by acting in accordance with these telephone instructions.

☐ **AGENT AUTHORIZATION (READ CAREFULLY)**
I hereby authorize and direct North American Company for Life and Health Insurance (NA) to act on telephone, written, or facsimile instructions communicated by the Agent of Record to make transfers or change the premium allocations of future premium payments. This authorization does not grant the Agent discretion to communicate any transaction without my prior approval. NA will employ reasonable procedures to confirm that instructions are genuine; nonetheless, I agree that NA is not liable for any loss arising from any change in premium allocations of future premium payments or transfers by acting in accordance with these instructions. This authorization will remain in effect until NA receives written notification of cancellation from the policy Owner, or the named Agent is no longer contracted and appointed with NA.

I understand that a letter to confirm all transactions will be mailed to me at the address of record provided to North American Company for Life and Health Insurance (North American). I acknowledge that I am responsible for promptly reviewing all confirmation letters. I agree to notify North American of any erroneous or unauthorized transaction within five days of my receipt of such confirmation letter. This authorization will be no longer be in effect as of the date the ownership of the policy changes.

Signature of Policy Owner		Date
Signature of Agent	Agent Code	Date

Copy 1 - Company | Copy 2 – Leave with Applicant | Copy 3 – Agent

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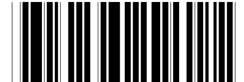


L3204

Military Sales Disclosure

Information to Agents: This form must be provided to any purchasers or prospective purchasers who are an active duty (full-time) Service member (officer or enlisted) of the United States Armed Forces, (Army, Navy, Air Force, Marine Corps, and Coast Guard) or dependent thereof. This includes National Guard and Reserve members while serving under published orders for active duty or full-time training, for a period of 31 or more calendar days.

Information to Service members: If you are a Service member carefully review the information below before purchasing one of our annuity or life insurance products. The information below provides important information about the annuity product or life insurance you are applying for as well as information about life insurance products available to you directly from the U.S. Federal Government.

1. Subsidized life insurance is available to Service members of the Armed Forces from the U.S. Federal Government under the Service members' Group Life Insurance Program ("SGLI"), which is authorized pursuant to subchapter III of Chapter 19 of Title 38, United States Code.
2. Under the SGLI program, Service members are eligible to purchase up to $400,000 of coverage in $50,000 increments from the U.S. Federal Government. Effective July 1, 2008, the SGLI premium rate is $.065 per thousand, of insurance, regardless of the member's age. Additional coverage information can be found at: http://www.insurance.va.gov/sglisite/SGLI/SGLI.htm
3. The North American Company for Life and Health Insurance ("North American") life insurance or annuity product you are applying for is not offered or provided by the U.S. Federal Government, and the U.S. Federal Government has in no way sanctioned, recommended, or encouraged the sale of the life insurance or annuity product being offered to you.
4. If you are applying for a North American life insurance product, that life insurance product may include a provision that permits you to elect to pay future premiums by applying the cash value of the life insurance product to those future premium payments. If you elect to do this, the cash value of the life insurance product will be reduced.
5. Only licensed insurance producers who are appointed with North American receive any compensation from North American as a result of the sale of a life insurance or annuity product, including the one for which you are applying.
6. If you are applying for or have purchased a North American life insurance or annuity product on Federal land or facilities located outside of the U.S. and you have complaints or issues that you cannot resolve directly with the insurance producer or with North American, you should contact the State Insurance Commissioner of the state from which the policy was issued. You may obtain this information at: http://www.naic.org/state_web_map.htm
7. Were you provided the Personal Commercial Solicitation Evaluation form (DD FORM 2885) to complete and give to your commanding officer? ☐ YES ☐ NO

Right to Examine the Policy: The Right to Examine provision is outlined on the front page of your policy or contract.

Prior to the purchase of life insurance or an annuity product, you are required to complete this disclosure.
By signing below, you acknowledge that you have read and understand the information stated in this disclosure.

Owner Name and Military Base Location: (Please Print)	
Owner Signature X	Date

☐ As agent, I certify by checking the box that I provided the Personal Commercial Solicitation Evaluation form (DD FORM 2885) to the Service member.

Agent Name (Please Print)	Agent Number
Agent Signature X	Date

L-3204 01/12

Instructions: Provide One Copy of this Form to Applicant with Personal Commercial Solicitation Evaluation Form (DD FORM 2885)
Submit One copy of this Form to Company without Personal Commercial Solicitation Evaluation Form (DD FORM 2885)

PERSONAL COMMERCIAL SOLICITATION EVALUATION

PRIVACY ACT STATEMENT

AUTHORITY: Section 301 of Title 5 U.S.C.

PRINCIPAL PURPOSE(S): Information on this form will be used to document the experience with the sales representative who provides the Service member with this evaluation. This information will be maintained at the installation level. It may be forwarded to officials within the Department of Defense responsible for oversight of personal commercial solicitation practices if further action is required. These officials may need to make contact concerning the solicitation described in questions 2, 3, and 4. Service member response will help ensure sales representatives conduct themselves fairly and in accordance with DoD Instruction 1344.07. This information will be maintained as part of a case file in the event proceedings are considered necessary to deny or withdraw permission for the sales representative and/or the company to solicit on one or more installations.

ROUTINE USE(S): None.

DISCLOSURE: Voluntary. There is no consequence to the Service member for not completing this evaluation.

Please take a moment to respond to the following questions concerning your experience with the sales representative who provided you this evaluation. Your response will help ensure sales representatives conduct themselves fairly and according to the policies outlined in DoD Instruction 1344.07.
When you have completed this evaluation, please send it to the Installation Commander or his/her designated representative. Please do not give the completed evaluation back to the sales representative to mail for you.

1. SALES REPRESENTATIVE WHO CONTACTED YOU AND HIS OR HER COMPANY

a. NAME OF SALES REPRESENTATIVE	b. COMPANY NAME

2. MAKING THE APPOINTMENT *(Mark (X) "Yes" if any of the following are true)*	YES	NO
a. The sales representative failed to make an appointment in advance to see me.		
b. The initial contact to schedule an appointment occurred while I was on duty (during normal duty hours).		
c. My initial contact with the sales representative was in response to a notice in an official installation bulletin, marquee, announcement or newsletter that said he or she would be on the installation during a specific time or at a specific place.		
d. A superior in my chain of command advised or required me to meet with the sales representative.		
e. The sales representative made initial contact with me via a government phone, fax, or computer.		

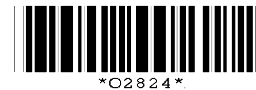
3. TIME AND PLACE OF THE APPOINTMENT *(Mark (X) "Yes" if any of the following are true)*	YES	NO
a. The sales presentation took place on the installation while I was on duty (during normal duty hours).		
b. The sales presentation took place during a mandatory group meeting with other DoD personnel or as part of a military service sponsored financial education program.		
c. The sales presentation took place in an unauthorized or restricted area.		
d. The sales representative used an on-base facility as a showroom to display his or her product or services. (This does not include displays conducted by military family members in their on-base residence.)		

4. CONDUCT DURING THE APPOINTMENT *(Mark (X) "Yes" if any of the following are true)*	YES	NO
a. I was unduly pressured to buy the product or service.		
b. I was not given the adequate facts, or was induced to purchase based on factors other than the merits of the product or service.		
c. I was offered an incentive to meet with the sales representative, purchase the product or service, or drop a competing offer.		
d. The sales representative is a DoD employee of senior rank.		
e. The sales representative implied that he or she is sponsored or endorsed by the military, the installation or my unit. **(For example, the representative used an official or unofficial title such as "unit advisor" or "installation consultant.")**		
f. The sales representative had a military pay allotment or direct deposit form in his/her possession, or requested "MyPay" account access or PIN number.		

5. YOUR CONTACT INFORMATION

a. NAME *(Last, First, Middle Initial)*	b. HOME TELEPHONE NUMBER *(Include area code)*	c. WORK TELEPHONE NUMBER *(Include area code)*

d. E-MAIL ADDRESS	e. UNIT ADDRESS



NON-RESIDENT VERIFICATION FORM

For questions, please contact North American New Business Department or Policy Change.
Phone: New Business Emerald Team: (800) 669-9100, Ruby Team: (866) 606-2943, Sapphire Team: (855) 288-8149
Phone: Policy Change (877) 872-0757 ext 32720 **Mail to:** One Sammons Plaza, Sioux Falls, SD 57193
Attn: New Business ☐ or Policy Change ☐
Policy Change or New Business Policy #:____
This form can be used to assist you in providing the required documentation if an application is signed in a state other than the Policy Owner "Resident State."

DEFINITIONS

Resident State – is defined for this purpose as the state where the Policy Owner has his or her residence and receives mail on a regular basis. A residence can be a primary residence or vacation home. Please note, that a "Time Share" will be considered a temporary residence and therefore does not qualify for a primary residence under this form.

For Business Entity – "Resident State" is defined as the state where the business is located and receives mail.

For Trust Entity – "Resident State" is defined as the state where the trust is domiciled or where the trustee has an office or primary residence.

Application State – is where the Policy Owner signed the application, the policy is solicited and the policy or certificate is delivered. The "Application State" must be a state where the agent is licensed and the product is approved.

When a product is not available for sale in the owner's resident state, a resident is only allowed to purchase the product in another state if they provide a valid reason to be in the non-resident state, other than solely to purchase the policy/certificate.

I ____________________________ (Owner/Joint Owner) am a resident of the state of ____________________.

My valid reason for being in the Application Signed State of ________________ is (other than to purchase insurance)

____

____

____

ACKNOWLEDGMENTS

- All communications, sales material and negotiations of the application occurred in the Application State.
- The application was signed by the owner and the agent in the Application State.
- The owner will take delivery of the policy or certificate issued in the Application State.

I understand that the solicitation for this policy or certificate occurred in the Application State and that the laws of the Application State will govern all legal rights and obligations under the policy/certificate applied for.

Owner Signature:		Date:
Agent Signature:		Date:

**State Restrictions – Alabama, Massachusetts, Minnesota, Oregon, Utah and Washington – Purchases of products outside these resident states are not allowed if they are not available for sale in the resident state.*

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Policy Change: (877) 872-0757 ext 32720 Fax: 877-841-6710

PENSION MAX DISCLOSURE STATEMENT

NORTH AMERICAN COMPANY FOR LIFE AND HEALTH INSURANCE

I understand that the Pension Max concept is a retirement strategy whereby a single life income option is chosen from my defined benefit pension plan to provide the maximum monthly income and all or a portion of the difference between the income provided with single life option and the income provided by the joint and survivor life option is used to purchase a life insurance policy. The death benefit proceeds provided by the life insurance policy are designated to replace the lost survivor benefit in the event of my death, if my spouse survives me. If my spouse predeceases me, I will continue to receive the higher income payout from my defined benefit pension plan and I can name a new beneficiary to receive the proceeds from the life insurance policy upon my death. I will also have access to the accumulated cash value in the life insurance policy in the event an emergency arises or supplemental retirement income is needed.

I have chosen to purchase a life insurance policy from North American Company for Life and Health Insurance (North American) for this purpose.

I understand that:

Initials
Owner Spouse

☐ ☐ North American nor any of its directors, officers, employees, contracted independent agents, General Agents or other representatives have offered or has the authority to offer any financial, legal, or tax advice concerning purchase of this life insurance policy or the retirement income planning/pension maximization strategy. We have been advised to consult with and rely on our own financial, legal, and tax advisors prior to making a purchasing decision.

☐ ☐ North American will be responsible solely for the promises contained in its life insurance contracts.

We attest that we have evaluated the suitability and appropriateness of this transaction and have fully considered the following items:

Initials
Owner Spouse

☐ ☐ **Reduced Income**-If I select the joint and survivor benefit and my spouse should predecease me, in most cases the reduced income I choose will continue at its reduced level, even though the survivor benefit is no longer needed.

☐ ☐ **End of Pension Payments**-Regardless of which election I make, the pension payments end at either my death or the death of my spouse. There may be nothing left for our heirs.

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Initials
Owner Spouse

Irrevocable Decision-Once I have elected an income option from my defined benefit pension, it cannot be changed. My election is irreversible.

Loss of Medical Benefits and/or Cost of Living Adjustments-My spouse's medical benefits and cost of living adjustments that may be available under the joint and survivor income option of my defined benefit pension plan may be tied to the income option. Election of the single life income option may eliminate those survivor benefits upon my death. I have evaluated the possible negative impact that the loss of these post-retirement benefits may have on my surviving spouse before committing to this transaction.

Qualification for Life Insurance-I understand that the issuance of a policy is dependent on successful completion of the underwriting process and approval of a life insurance policy is not guaranteed. If I am uninsurable, my only option may be the joint and survivor benefit income option available under my defined pension plan. I will not elect an income option for my defined benefit pension plan until I am certain that I qualify for the life insurance policy I have applied for and I have been notified by the company that the policy has been issued.

Appropriate Amount of Life Insurance-I have been advised to consider a policy with a guaranteed death benefit. It is important that a sufficient amount of coverage is in place at my death in order to provide an income to my surviving spouse.

Settlement Option-I have been advised to consider a policy settlement option for the death benefit proceeds rather than a lump-sum death benefit paid to my surviving spouse.

Appropriate Premium-I understand that the amount of premium required to keep the life insurance policy in force should not be more than the difference between the amount of the single life pension option and the joint and survivor life pension option.

Payment of Premiums –I understand that premium payments are due throughout my entire life. If at any time I fail to make premium payments, the life insurance policy could lapse prior to my death. If my spouse is still living at the time of my death and the life insurance policy has lapsed, all or a portion of the death benefit intended to provide an income stream to my surviving spouse will not be paid.

Owner ______________ Date

Spouse ______________ Date

Agent ______________ Date

North American Company
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O21322

POLICY CHANGE REQUEST

Part 1

PLEASE PRINT LEGIBLY OR USE TYPEWRITER **If additional space is required, use "OTHER" section below**	NEW ADDRESS GIVEN BELOW? ☐ NO ☐ INSURED'S ☐ OWNER'S	POLICY NUMBER		
INSURED 1	ADDRESS	CITY	STATE	ZIP CODE
INSURED 2	ADDRESS	CITY	STATE	ZIP CODE

SECTION A — Change Request (New policy specifics)

NEW PLAN	UNDERWRITING CLASS	DEATH BENEFIT OPTION	☐ Option A ☐ Option B ☐ Option C ________% increase ☐ Option D ________% increase______years

TYPE OF CONVERSION	☐ Basic Plan ☐ Term Rider ☐ Full ☐ Partial	CARRY BENEFITS OVER TO THE NEW POLICY ☐ Yes ☐ No REMAINING INSURANCE AFTER PARTIAL CONVERSION TO BE ☐ Continued ☐ Discontinued

CHANGE EXISTING POLICY

CHANGE FACE AMOUNT (If increasing, complete reverse side)	☐ Increase to $ ☐ Decrease to $	☐ FREEZE ☐ THAW

☐ RE-ENTRY (Complete reverse side)	☐ CONSIDER CLASS CHANGE TO ☐ CONSIDER RATE REDUCTION TO (complete reverse side)

☐ EXERCISE OPAI
(If original plan does not have smoking classification, answer question #7 on reverse side)

SUPPLEMENTARY BENEFITS CHANGE (If adding complete reverse side)

ADD	DELETE		ADD	DELETE	State # of units
☐	☐	WAIVER OF PREMIUM	☐	☐	FAMILY PROTECTION (S & C)
☐	☐	ACCIDENTAL DEATH BENEFIT	☐	☐	FAMILY PROTECTION (C ONLY)
☐	☐	OPAI	☐	☐	SPOUSE COVERAGE

☐ CHANGE DEATH BENEFIT OPTION TO:
☐ Option A (increasing) ☐ Option C__________% increase
☐ Option B (level) ☐ Option D________% increase for _______ years
(complete reverse side when going to A, C, D)

OTHER:

PAYMENT SUBMITTED WITH THIS CHANGE REQUEST $	
PLANNED PERIODIC PREMIUM $	☐ ANNUAL ☐ SEMI-ANNUAL ☐ QUARTERLY ☐ LIST BILL ☐ MGA
☐ PAC COMPLETED REQUEST FOR PRE-AUTHORIZED CHECK (PAC) PLAN FORM OR L-1683 WITH A VOIDED SAMPLE CHECK, MUST BE SUBMITTED WITH THIS CONVERSION/CHANGE REQUEST.	DRAFT START DATE

SECTION C — Home Office Endorsement (change made by the Company)

O-2132-2 Note: Section G and H apply to Part 1 and Part 2 of this Policy Change Request Rev.2/08

Continuation of Application for Policy Change - Evidence of Insurability — Part 2

SECTION D - Questions for the Insured - complete fully (If policy insures more than one life, complete Part 2 on each insured)

1. INSURED: (Print full name) ☐ Male ☐ Female	2. BIRTHDATE	3. BIRTHPLACE	4. OCCUPATION: (Give title/Duties)

5. a. Height: _____ft. _____ in. Weight:_________ lbs. b. Weight loss of more than 10 lbs. in last 12 months? ☐ Yes ☐ NO
   c. Name and address of personal physician/health care facility: (If none, check here___________ and omit d, e, and f)

   d. Date last consulted:_______________________ e. Reason _______________________
   f. Any medication or treatment? ☐ Yes ☐ No If Yes, describe_______________________

6. Other than this policy, state your total amount of life insurance inforce? ☐ None ☐ $ _______________________

7. Tobacco use — Have you used tobacco in any form during the past 12 months? ☐ Yes ☐ No (Answer a or b below)
   a. If Yes, forms used ? ☐ Cigarettes ☐ Other:_____________ No. per day? __________ For how long? __________ years.
   b. If No, ☐ Never used ☐ Quit — give month year If cigarettes, used __________ per day for years.

SECTION E - Complete if other persons are proposed for insurance

1. Spouse and children: Note - for family or children insurance include all dependent natural children, legally adopted and stepchildren under age 24.

Proposed	Print full name	Sex	Age	Birthdate	Birthplace	Height	Weight
Spouse						ft. in.	lbs.
Child #1						ft. in.	lbs.
Child #2						ft. in.	lbs.
Child #3						ft. in.	lbs.
Child #4						ft. in.	lbs.

2. Spouse's occupation: (give title and duties)

SECTION F — Questions for the insured and all other persons proposed for insurance on this application

	Yes	No
1. Has any person proposed for insurance:		
a. Any intention of traveling or residing outside of the continental United States?__________	☐	☐
b. Any other application for new life insurance or changes to any existing policy pending or contemplated? __________	☐	☐
c. Had an application for life or health insurance or reinstatement declined, rated, or modified in any way? __________	☐	☐
d. Been convicted within the last 3 years for a moving violation, or driving while under the influence, or had a driver's license suspended or revoked? (If yes, give driver's license number and state issued in REMARKS)__________	☐	☐
e. Within the last 3 years, flown as a pilot or crewmember of any aircraft, done any underwater diving, parachuting, mountain climbing, vehicle racing of any kind or intend to do so?__________	☐	☐
2. Has any person proposed for insurance ever been diagnosed as having, been treated for or been told by any physician or other medical professional that they had:		
a. Cancer, tumor, or other malignancy, high blood pressure, heart or circulatory disease, heart murmur, stroke, epilepsy, brain, nervous or mental disorder, ulcers, hepatitis, or other disorder of the stomach, liver or intestines, tuberculosis, lung or other respiratory disorder, kidney, bladder or venereal disease, blood or glandular disorder, arthritis or other bone or joint disorder or diabetes? ____	☐	☐
b. AIDS (Acquired Immune Deficiency Syndrome) or HIV infection or disease __________	☐	☐
3. Within the past five years has any person proposed for insurance:		
a. Consulted, been examined or treated by any physician or medical professional, or been admitted to or treated at a hospital or other facility for any disease or condition not indicated in question #2 above? __________	☐	☐
b. Had an X-ray, EKG or other heart study, laboratory test, or been advised to have a surgical operation?__________	☐	☐
c. Been treated for alcoholism or substance (drug) abuse, or been a regular or frequent user of cocaine or other stimulants, hallucinogens or narcotics not prescribed by a physician? __________	☐	☐

4. REMARKS: Give details of Yes answers above including dates, durations, treatment, names and address of physicians and medical facilities and give the names of the person(s) they apply to:

SECTION G — Agreement, Authorization and Disclosure Information

IT IS UNDERSTOOD AND AGREED THAT:

1. This application shall be considered an amendment to the original application and shall form a part of the policy.
2. The change requested shall not be effective until approved and any required additional premium has been paid.
3. That acceptance of premium DOES NOT create coverage or imply that the change requested is in effect.
4. The same ownership and beneficiary designation on the original policy will remain in effect unless otherwise requested on title change request form L-2402.

I(We) agree that: (1) all statements and answers recorded on this policy change application and any required supplement or amendment are true and complete to the best of my(our) knowledge and belief and that they shall be the basis of any changes made to the policy(s); (2) if evidence of insurability is required for the policy change, the Suicide Exclusion and/or Incontestability Provisions of the policy will be amended by endorsement based upon the type of change approved; (3) if I am applying for an increase in coverage to a life insurance plan with flexible premium and adjustability provisions, expense and/or surrender charges may be assessed as to the increase on the same basis as the initial coverage.

AUTHORIZATION — For the purpose of determining the insurability of the persons proposed for insurance on this application, I(we) authorize any licensed physician, medical practitioner, hospital, clinic or other medical or medically related facility, insurance company, the Medical Information Bureau or any other organization, institution or person, that has any records or knowledge of me(us) or my(our) health to give to the North American Company for Life and Health Insurance, or its reinsurers, any such information. A photographic copy of this authorization shall be as valid as the original. This authorization is effective for thirty months from the date it is signed.

SECTION H — Signatures

SIGNED AT TOWN/CITY	STATE	DATE
PROPOSED INSURED/APPLICANT		
*POLICYOWNER (Include owner ID)		
SPOUSE CONSENT (AK, AZ, CA, ID, LA, NM, NV, TX, WA, WI)	COLLATERAL ASSIGNEE	
WITNESS	AGENTS SIGNATURE	WRITING AGENT NO·

When owner is a corporation, trust, or other entity, write the title of the signee next to the signature.

SECTION I — Consumer Protection Notice (Detach, read and retain for your record)

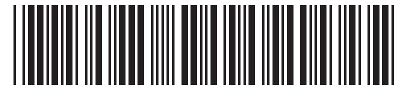
CONSUMER PROTECTION NOTICES FOR THE PROPOSED INSURED/APPLICANT

Investigative Consumer Report Notice — In connection with your application for insurance, an investigative consumer report may be prepared, in which information is obtained from public records and through personal interviews with your neighbors, friends, employers, business associates, financial sources, or others with whom you are acquainted. This inquiry includes information as to your character, general reputation, personal characteristics and mode of living, except as may be related directly or indirectly to your sexual orientation. You may make a written request to be interviewed in connection with the preparation of this report. You have the right to make a written request within a reasonable period of time to receive additional, detailed information about the nature and scope of this investigation. Either of these written requests should be directed to the Underwriting Department, North American Company for Life and Health Insurance, P.O. Box 5089, Sioux Falls, SD 57117-5089.

MIB, Inc. Notice — Information regarding your insurability will be treated as confidential. North American Company for Life and Health Insurance, 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 on 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 a company, the Bureau, upon request, will supply such company with the information in its file.

Upon receipt of a request from you, the Bureau will arrange disclosure of any information it may have in your file. If you question the accuracy of information in the Bureau's file, you may contact the Bureau and seek a correction in accordance with the procedures set forth in the Federal Fair Credit Reporting Act. The address of the Bureau's information office is 50 Braintree Hill, Braintree, MA 02184-8734, telephone number (617) 426-3660.

North American Company for Life and Health Insurance, 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, or to whom a claim for benefits may be submitted.



NOTICE REGARDING REPLACEMENT

REPLACING YOUR LIFE INSURANCE POLICY OR ANNUITY?

Are you thinking about buying a new life insurance policy or annuity and discontinuing or changing an existing one? If you are, your decision could be a good one — or a mistake. You will not know for sure unless you make a careful comparison of your existing benefits and the proposed benefits.

Make sure you understand the facts. You should ask the company or agent that sold you your existing policy to give you information about it.

Hear both sides before you decide. This way you can be sure you are making a decision that is in **your** best interest.

We are required by law to notify your existing company that you may be replacing their policy.

Applicant's Signature ______________________ Date ______________________

Agent's Signature ______________________ Date ______________________

COPY 1 - Applicant   COPY 2 - Company   COPY 3 - Agent

O-2309 (26)   Rev. 11/99

North American Company
for Life and Health Insurance
Since 1886

Request to Exchange Coverage

I (We) hereby notify North American, my (our) intention to exchange existing coverage to NACOLAH.

Instructions:

1. To be competed any time an internal exchange of product is being requested.
2. Complete a separate form for each product exchanged.
3. Applicable replacement forms need to be completed.
4. 1035 Exchange form is required if the money transferred is to be applied to the new policy as a 1035 Exchange.

Owner's Name	Social Security Number/Tax ID Number(s)
Applicant Name: (if different than owner's)	Security Number/Tax ID Number(s)
Product to be replaced	
I (We) originally purchased the above product on or around:	Please print the name of the Representative that you bought the product from: (if known)

Approximate net value to be received from exchanged product: $____________________	Surrender charge that may be incurred on this transaction: $____________________	Front End Load (if any) at time of original product purchase: $ _______________ or _________________%
It is my (our) intention to reinvest the net value received from this transaction into: ☐ Universal Life ☐ Indexed ☐ Other	Will this transaction result in a taxable event? ☐ Yes ☐ No	Does this transaction qualify as a non-taxable exchange under IRC Section 1035 rules? Complete 1035 papers ☐ Yes ☐ No

The reason for changing the product MUST be provided. Please be specific, and clearly show the advantages of this transaction to the policyholder.

I (We) have discussed and understand the option of transferring y (our) account value. I (We) understand, I (We) may pay a surrender charge on my (our) original purchase and that, when I (we) purchase a new product that the surrender charge and other applicable product provisions will start anew. In the event that new policy is not accepted during the free look period. all value will be returned to the original policy and treated in accordance with its provisions.

If this transaction is subject to **a community property** interest, we strongly recommend that You obtain your spouse's signature on the line below to document his/her consent to this transaction. States that recognize community property interests in property held by married persons include Alaska, Arizona, California, Idaho, Louisiana, Nevada, New Mexico, Texas, Washington, and Wisconsin.

You understand and agree that the Company may presume that no community property interest exists if You have not obtained your spouse's signature below. Further, You understand and agree that the Company has no duty to inquire further about any such community property interest. As a result, You agree to indemnify and hold the Company harmless from any consequences relating to community property interests and this transaction.

Please note that the term 'spouse' includes domestic partner or other partner permitted by civil union, domestic partnership or similar law.

Owner(s) Signature	Date
Spouse Consent (AK, AZ, CA, ID, LA, NM, NV, TX, WA, WI)	Date
Agent Name (Print)	Agent Code
Agent (Signature)	Date

To be included with North American Universal Life, Indexed and Term Exchanges.

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North American Company
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Since 1886

L2977R

TEMPORARY LIFE INSURANCE AGREEMENT

Proposed Primary Insured	Proposed Additional Insured(s)

Premium or authorization for initial EFT draft has been received from ___________________________ in the amount of $_____________ in payment of one full monthly premium for an insurance policy applied for on the life (lives) of the above named (Proposed Primary Insured/ Proposed Additional Insured(s)), for whom an application (the "Application") dated ___________ has been made to North American Company for Life and Health Insurance (the "Company"). **This Temporary Life Insurance Agreement does not provide any coverage except as provided herein. If any of the below representations are answered YES or LEFT BLANK, the agent is not authorized to accept any premium or authorization for initial EFT draft, and there will be NO COVERAGE. There will also be no coverage under this receipt if Section 1035 exchange paperwork is received without premium payment. Premium may be paid by check or authorized withdrawal.**

I. REPRESENTATIONS

Has any person listed above as a Proposed Primary Insured or Proposed Additional Insured(s): **Yes** **No**

1. In the past five years, been diagnosed, treated for, or been advised to be treated for: heart disease; vascular disease stroke; cancer; leukemia; malignant tumor; alcohol or drug dependence or abuse; insulin dependent diabetes; or disorder of the brain or immune system? . . . . ☐ ☐
2. In the past five years, had any unintentional weight loss or any symptoms of a disease or an impairment for which a physician has not been consulted? . . . . ☐ ☐
3. In the past 90 days, been admitted, or medically advised by a member of the medical profession to be admitted, to a hospital or other licensed health care facility, had surgery performed or recommended, or been medically advised to have any diagnostic test that has not been completed? . . . . ☐ ☐
4. In the past ten years, been convicted of any criminal activity, or been held or served time in any type of incarceration, jail, penitentiary, prison, probation, or parole program? Or have any criminal charges pending against him/her at this time? . . . . ☐ ☐
5. Is any person proposed for insurance under 15 days of age or over 70 years of age? . . . . ☐ ☐

II. TERMS AND CONDITIONS

1. AMOUNT OF COVERAGE APPLIED FOR: $1,000,000 MAXIMUM FOR ALL APPLICATIONS OR AGREEMENTS

If one full monthly premium for the insurance applied for in the application for life insurance has been received as consideration by the Company from the Proposed Owner as advance payment for the life insurance and a Proposed Insured(s) dies while this Agreement is in effect, upon receipt of due proof of death, the Company will pay to the designated beneficiary the LESSER of
(a) the amount of all death benefits applied for in the Application; or (b) $1,000,000.

This total benefit applies to all insurance applied for under this and any other applications to the Company including any other temporary life insurance agreements.

2. DATE TEMPORARY COVERAGE BEGINS

Any temporary insurance under this Agreement will begin on the date the application is signed only if the Application is completed and signed by the Proposed Insured(s) and the Proposed Owner bearing the same date as this Temporary Life Insurance Agreement; one full monthly premium is collected; and all of the questions in the above Section of this Temporary Life Insurance Agreement are truthfully and completely answered "NO".

3. DATE TEMPORARY COVERAGE TERMINATES

The Temporary Life Insurance under this Agreement will terminate automatically on the earliest of:

(a) 90 days from the date the Application was signed;
(b) the date that insurance takes effect under the insurance contract(s) as applied for in the Application;
(c) the date an insurance contract(s) other than as applied for in the Application, is offered to the Proposed Owner; or
(d) the date the Company mails notice of termination of coverage and refunds the advance premium payment to the Proposed Owner at the address shown in the Application. The Company may cancel this coverage at any time.

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Agent Instruction: Provide the Proposed Owner a copy of this form; submit one copy to the Administrative Office

4. SPECIAL LIMITATIONS

(a) Fraud or material misrepresentation in the Application or in this Agreement shall invalidate this Agreement and the Company's only liability is to refund any advance premium payment made.
(b) There is no insurance under this Agreement if the check or initial EFT draft is not honored when presented.
(c) If the Proposed Insured(s) dies by suicide, the Company's liability under this Agreement is limited to a refund of any advance premium payment made.
(d) No agent or other person is authorized to accept money on a Proposed Insured under 15 days of age or over 70 years of age (age nearest birthday) from the date of this Agreement, nor will any insurance take effect for such person.
(e) No agent is authorized to modify any of the provisions of this agreement.
(f) The total of the amount payable under this and any other Temporary Life Insurance Agreement or application with the Company will not exceed $1,000,000 for each life proposed for insurance.

5. GENERAL

Premium(s) will be returned if a policy is not delivered and no benefit is paid under this Agreement. If a policy is delivered, premium(s) will be applied to the first policy premium. Premiums are billed from the policy date. If the policy date is prior to the delivery date premiums will be based on the policy date.

I, the PROPOSED OWNER/PRIMARY INSURED/ADDITIONAL INSURED(S), declare that I have fully read and understand all the questions and **the answers given in this Agreement and the Application and, that the answers I gave are true and complete. I, the Proposed Owner, agree that they are to be relied on for this coverage and declare that I have received a copy of this Agreement and that I have read and understand this Agreement. I agree to all the provisions, terms and limitations of this Agreement and acknowledge that I do not expect any insurance to become effective based on the application or under this Agreement other than as stated in the application and in this Agreement. I agree to be bound by all the answers, statements, and representations made in the Application and this Agreement.**

Proposed Owner Name (Print)	Date
Proposed Owner Signature	Signed At (City/State)
Proposed Primary Insured Name (if other than owner) (Print)	Date
Proposed Primary Insured Signature	Signed At (City/State)
Proposed Additional Insured Name (Print)	Date
Proposed Additional Insured Signature	Signed At (City/State)
Agent Name (Print)	Agent Phone Number
Agent Signature	Date

All premium checks must be made payable to North American Company for Life and Health insurance. Do not make checks payable to the agent or leave the payee space blank. No agent or other person is authorized to accept money on any application in excess of $1,000,000. A temporary life insurance agreement cannot be accepted on any application in excess of $1,000,000.

North American Company
for Life and Health Insurance
Since 1886

Alcohol Use Questionnaire

Name: ______________________________ Date of Birth: ______________________________

1. Do you presently use alcoholic beverages? ☐ Yes ☐ No If No, date of last drink: ____________________
   If Yes, please indicate Quantity (please specify by either ounces and/or number of drinks):

	Beer	Wine	Liquor
Daily			
Weekly			
Monthly			

2. Did you ever drink more than at present? ☐ Yes ☐ No If Yes, complete below:
   Dates: From ______________________ to ______________________

	Beer	Wine	Liquor
Daily			
Weekly			
Monthly			

   Why did you change your drinking habits? ______________________________

3. Are you active in Alcoholics Anonymous or other support or recovery groups? .... ☐ Yes ☐ No
   If Yes, how long? ______________________________

4. Have you ever been advised to, and/or have you ever, consulted a doctor or received treatment and/or counseling because of your alcohol use? .... ☐ Yes ☐ No
   If Yes, indicate name and address of any doctor, hospital or treatment center and dates of treatment:
   ____
   ____

5. Are you presently taking, or have you ever taken, Antabuse or any other medication to control your drinking? ...... ☐ Yes ☐ No
   If Yes, please indicate date last used and name and address of doctor who prescribed it:
   ____
   ____

6. Have you ever been arrested for, ticketed for, and/or charged with driving under the influence of alcohol?............ ☐ Yes ☐ No
   If Yes, give dates and driver's license number: ______________________________

7. Have you ever used any other drugs, except over-the-counter drugs or those prescribed by a physician?................ ☐ Yes ☐ No
   If Yes, please complete Drug Usage Questionnaire.

8. Remarks: ______________________________
   ____
   ____

I hereby agree that all statements and answers to the above questions are true and complete to the best of my knowledge and belief. A copy of this form will be attached to and made a part of my application for insurance.

Signed at ______________________________ Date ______________________________

Witness ______________________________ Signature of Proposed Insured ______________________________

If more space is needed attach additional page, please sign and date each additional page

L-2998A Prt. 7/02

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Ballooning Questionnaire

Name of Proposed Insured:_______________________ Date of Birth:_______________

1. Are you a member of an Association or club? Yes ☐ No ☐
2. Are you a student balloonist? Yes ☐ No ☐
3. How long have you been ballooning? ____________ years.
4. Do you have any special licenses or certificates? Yes ☐ No ☐
   If Yes, please list:_______________________
5. Do you instruct and/or receive payment? Yes ☐ No ☐
   If Yes, explain: _______________________
6. Do you fly a blimp or other steerable or self-propelled balloon? Yes ☐ No ☐
   If Yes, explain: _______________________
7. Do you fly a gas powered balloon? Yes ☐ No ☐
8. Do you fly a hot air balloon? Yes ☐ No ☐ If Yes, do you fly tethered? Yes ☐ No ☐ Free flight? Yes ☐ No ☐
9. Do you fly over lakes and oceans? Yes ☐ No ☐
   If Yes, explain (include amount of time over water): _______________________
10. Have you, or do you intend any height, distance or duration records? Yes ☐ No ☐
    If Yes, provide details: _______________________
11. Have you, or do you intend to fly experimental equipment? Yes ☐ No ☐
    If Yes, provide details: _______________________
12. Remarks: _______________________

I hereby agree that all statements and answers to the above questions are true and complete to the best of my knowledge and belief. A copy of this form will be attached to and made a part of my application for insurance.

Signed at _______________________ Date _______________________

Witness

Signature of Proposed Insured

L-3122A *If more space is needed attach additional page, please sign and date each additional page* 06/04

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North American Company
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Since 1886

Business Insurance Supplement to the Application

Financial Statement Attached: ☐ Yes ☐ No

Name of Proposed Insured	Date of Birth	Social Security Number	Application Number

Part 1. Personal Finances

a.) Please give your total income: $_______________ Income previous year: $_________________

b.) Please give your estimate of your net worth: $________________

Part 2. Explain the need and purpose of the coverage applied for:

☐ Keyman ☐ BuySell ☐ Stock Redemption ☐ Business Loan

Other (Please explain): ____

____

Part 3. Have you or your company ever filed for bankruptcy? ☐ Yes ☐ No
If Yes, provide type and filing and discharge date as well as details:___________________________________

____

Part 4. Business Finances (Complete if the coverage applied for is for business purposes.)
a.) Total Assets $_______________ b.) Total Liabilities $_______________ c.) Net Worth $_______________

d.) Gross Income or Revenue: Last Year: $___________ Previous Year: $____________ Two Years Ago: $____________

e.) Net Income or Revenue: Last Year: $___________ Previous Year: $____________ Two Years Ago: $____________

f.) Net Profit after Taxes: Last Year: $___________ Previous Year: $____________ Two Years Ago: $____________

g.) Is the business a: ☐ Corporation ☐ Partnership ☐ Proprietorship ☐ LLC ☐ O C Corporation

☐ O S Corporation (if so, please list distributions amounts $______________________)

h.) Describe type of business (activities):____

i.) How long has the business been established? ____

j.) What is your percentage ownership in the firm? ____

k.) Is there business insurance applied for or in force on other key members of this firm? ☐ Yes ☐ No

If Yes, provide details. If No, explain why: ____

l.) If business less than 2 years old how much personal equity investment was made? ___________________

m.) How was Market Valuation arrived at? (please attach copy if available) ___________________________

____

Comments:

I understand that the Company will rely on the above statements in determining the need and justification for the insurance applied for, and I represent that all answers are true and accurate statements to the best of my knowledge and believe as of the date of application for life insurance. A photographic copy of this statement will be attached to and made part of any insurance contract issued.

Signature of Proposed Insured	Date:
Signature of Owner (if other than Proposed Insured)	Date:

L-3123A *If more space is needed attach additional page, please sign and date each additional page* 06/04

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Civilian Aviation Questionnaire

Please answer all questions and provide details where requested.

Name of Proposed Insured:________________________________ Date of Birth:______________________

1. Are you a student Pilot?
   ☐ Yes
   ☐ No
2. Are you a licensed Pilot?
   ☐ Yes
   ☐ No
3. Please check all appropriate certificates:
   ☐ Private
   ☐ Commercial
   ☐ Airline Transport
   ☐ Flight Instructor
4. What is your medical certificate?
   ☐ I
   ☐ II
   ☐ III
5. Are you Instrument Flight Rated (IFR)?
   ☐ Yes
   ☐ No
6. What is the purpose of your flying? (check all that apply)
   ☐ Pleasure ☐ Business
   ☐ Charter ☐ Acrobatic
   ☐ Air Taxi ☐ Corporate
   ☐ Crop Dusting ☐ Flight Instructor
7. How many hours have you flown in the last?
   12 months ☐1-20 ☐21-50 ☐51-100 ☐101-200 ☐201-400 ☐401up
   24 months ☐1-20 ☐21-50 ☐51-100 ☐101-200 ☐201-400 ☐401up
   36 months ☐1-20 ☐21-50 ☐51-100 ☐101-200 ☐201-400 ☐401up
8. What is your total hours flown?
   ☐1-25 ☐26-100 ☐101-200 ☐201-400 ☐401 up
   If more than 400 hours, approximately how many?
   ____
9. How many solo hours have you flown?
   ☐1-25 ☐26-100 ☐101-200 ☐201-400 ☐401 up
10. How many solo hours in the last 12 months?
    ☐1-25 ☐26-100 ☐101-200 ☐201-400 ☐401 up
11. What do you anticipate your flying time to be in the next 12 months?
    ☐1-25 ☐26-100 ☐101-200 ☐201-400 ☐401 up
12. Have you had any flying related accidents, been grounded, or reprimanded for violation of air regulations?
    ☐ Yes
    ☐ No
    If yes, please provide details:
    ____
    ____
    ____
13. Do you fly for pay?
    ☐ Yes
    ☐ No
    If yes, in what capacity?
    ____
14. Have you ever flown experimental aircraft, gliders, hang gliders, ultralites, and homebuilt aircraft or do you intend to do so in the future?
    ☐ Yes
    ☐ No
    If yes, please provide details:
    ____
    ____
    ____
15. What type of aircraft do you fly? (check all that apply)
    ☐ Fixed Wing
    ☐ Helicopter
    ☐ Single Engine
    ☐ MultiEngine
    ☐ Home Built
    ☐ Glider
    ☐ Ultralight
    ☐ Built for aerial application
    ☐ Converted for aerial application
16. Do you fly outside the United States or plan to in the future?
    ☐ Yes
    ☐ No
    If yes, please provide details:
    ____
    ____
    ____

I hereby agree that all statements and answers to the above questions are true and complete to the best of my knowledge and belief. A copy of this form will be attached to and made a part of my application for insurance.

Signed at ________________________________ Date ________________________________

Witness

Signature of Proposed Insured

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North American Company
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L3124A1

Confidential Personal Financial Supplement to the Application

Financial Statement Attached: ☐ Yes ☐ No

Name of Proposed Insured	Date of Birth	Social Security Number	Application Number

Part 1. Personal Finances (Complete for Personal Business Application)

a.) Please give your estimate of your net worth: $______________ b.) Please give your total income: $________________

This is determined by:

Cash and other assets	$_______________	Salary	$_______________
Personal Property	_______________	Bonuses	_______________
Real Estate	_______________	Investment Income	_______________
Investments	_______________	Other	_______________
Total Assets	$_______________	Total Income	$_______________
Less:		Income Previous Year	$_______________
Mortgages	$_______________		
Other Liabilities	_______________		
Net Worth	$_______________		

Need and Purpose of Coverage Applied For:

☐ Income Replacement ☐ Estate Conservation ☐ Debt Repayment

☐ Other (Please explain):

____

____

Part 2. Have you or your company ever filed for bankruptcy? ☐ Yes ☐ No If Yes, provide type and filing and discharge as well as details:

____

____

____

Comments:

I understand that the Company will rely on the above statements in determining the need and justification for the insurance applied for, and I represent that all answers are true and accurate statements to the best of my knowledge and believe as of the date of application for life insurance. A photographic copy of this statement will be attached to and made part of any insurance contract issued.

Signature of Proposed Insured	Date:
Signature of Owner (if other than Proposed Insured)	Date:

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L3185

CONVULSIVE QUESTIONNAIRE

TO BE COMPLETED BY THE APPLICANT

Date of First Seizure/Convulsion	Date of Birth	Height

Name of Doctor Supervising Your Condition	Address of Doctor
How Long Have You Been Under His Care?	Date of Last Visit

Are You Taking Medication for This Condition?	
What Kind?	How Often?

Have You Been Treated by Any Other Doctor?	When?

What is the Duration of Seizures? (In Minutes)	What Was the Date of Your Last Seizure?	
How Many Seizures Have You Had? Total	Last Year?	Two to Three Years Ago?

Do You Lose Consciousness During a Seizure?

What is Your Present Occupation?	Length of Employment? Yrs. Mos.
Please Describe Your Duties	

Do You Now or Have You Ever Used Alcoholic Beverages?	
If Yes, How Often?	Quantity?

Has Your Condition Been Classed as:	Petit Mal?	Grand Mal?	Jacksonian?
Other?	If Other, Please Describe		

Are You Aware of or Have You Ever Been Told That You Have Any Other Impairments?
If Yes, Please Describe

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FL residents: Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

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ME residents: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or denial of insurance benefits.

PA residents: 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.

WA residents: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

I hereby represent that the above answers and statements are complete and true to the best of my knowledge and belief. A copy of this form will be attached to and made part of my application for insurance.

Witness	Signature of Proposed Insured	Date

If more space is needed, attach an additional page and please sign and date each additional page.

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L3113A1

Drug Questionnaire

Name of Proposed Insured:________________________ Date of Birth:________________

1. Do you now, or have you in the past, used any of the following substances:	Yes	No	Date Last Used	Present	Amount	Length of Time
A) Opiates: Heroin, Codeine, Morphine, Methadone, Demerol, etc.	☐	☐				
B) Barbituates: Amytal, Phenobarbital, Seconal, Nembutal, etc.	☐	☐				
C) Non-Barbituates: Phacidyl, Doriden, Quaalude, etc.	☐	☐				
D) Amphetamines: Benzedrine, Dexedrine Methedrine, Designer Drugs, etc.	☐	☐				
E) Methamphetamine: Cocaine, Crack, Ice, etc.	☐	☐				
F) Hallucinogens: LSD, Peyote, Psilocybin, MDA, Mescaline, etc.	☐	☐				
G) Cannibus: Marijuana, Hashish, etc.	☐	☐				
H) Any other substances not listed above? Substance Name:________	☐	☐				

2. Have you ever seen a doctor or sought or been advised to seek medical treatment or counseling for drug abuse?
☐ Yes ☐ No
Dates/Details:

3. Have you ever been charged with driving under the influence or had other traffic violations/accidents where drugs were involved? ☐ Yes ☐ No
Dates/Details:

4. Have you ever been arrested or charged with possession, use, or sale or distribution of illegal substances?
☐ Yes ☐ No
Dates/Details:

5. Are you now, or were you ever, a member of Alcoholics Anonymous, Narcotics Anonymous or similar organization?
☐ Yes ☐ No If yes, how long a member? ____________ How often attended? ________________

I hereby agree that all statements and answers to the above questions are true and complete to the best of my knowledge and belief. A copy of this form will be attached to and made a part of my application for insurance.

Signed at ______________________ Date ______________________

Witness | Signature of Proposed Insured

L-3113A *If more space is needed attach additional page, please sign and date each additional page* 06/04

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L2992B

FOREIGN TRAVEL AND RESIDENCE QUESTIONNAIRE

Name: **Date of Birth:**

SECTION A: CITIZENSHIP

1. Are you a citizen of the U.S.? ☐ Yes (If Yes, go to Section C.) ☐ No (If No, go to Section B.)

SECTION B: NON-U.S. CITIZEN

1. What country are you now a citizen? ____________
2. Indicate type of visa: ☐ Permanent Visa (Give Alien Registration #) ____________
   ☐ Temporary Visa (Give Expiration Date) ____________
   ☐ No Visa (Provide complete details) ____________
3. Indicate purpose of visa (work, student, government employee, etc.): ____________
4. Have you applied for U.S. citizenship? ☐ Yes ☐ No
5. Do you also maintain a foreign residence? ☐ Yes ☐ No
   If so, what is the address? ____________
6. Where does your immediate family (spouse and children) reside? ____________
7. When do you plan to return to your native country (duration and expected frequency)? ____________

8. How long have you lived in the U.S.? ____________
9. Complete Section C.

SECTION C: FOREIGN TRAVEL OR RESIDENCE

1. Did you live or travel outside the U.S. in the past 12 months? ☐ Yes ☐ No

City	Country	Purpose (give full details)	Date	Length of Stay

2. Do you plan to live or travel outside the U.S. in the next 12 months? ☐ Yes ☐ No

City	Country	Purpose (give full details)	Date	Length of Stay

3. Indicate type of foreign environment (Metropolitan, Rural/Agricultural, Primitive/Native, etc.):
4. Comments: ____________

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I hereby agree that all the above statements and answers to the above questions are complete and true to the best of my knowledge and belief. A copy of this form will be attached to and made a part of my application for insurance.

Signed at ______________________________ Date ______________________________

Witness	Signature of Proposed Insured

L-2992B

Prt. 11/09

Hang Gliding or Ultralight Aircraft Questionnaire

Name of Proposed Insured:______________________________ Date of Birth:____________________

1. Do you participate in: Hang Gliding Yes ☐ No ☐ Ultralight Aircraft? Yes ☐ No ☐
2. Are you a member of an Association or hang gliding club? Yes ☐ No ☐
3. Any special licenses or certificates? Yes ☐ No ☐ If Yes, please list: ______________________________
4. How long have you been participating? ______________ years.
5. Do you instruct and/or fly professionally? Yes ☐ No ☐
6. Do you fly powered? Yes ☐ No ☐ non-powered? Yes ☐ No ☐
7. Number of flights: Last 12 months __________ 1-2 years ago__________ Estimated next 12 months__________
8. What is the USUAL height __________ (feet), distance __________ (miles) and duration __________ (hrs.) which you have flown?
9. What is the GREATEST height __________ (feet), distance __________ (miles) and duration __________ (hrs.) which you have flown?
10. Have you, or do you intend any height, distance or duration records? Yes ☐ No ☐

    If Yes, provide details:______________________________
11. Have you ever flown or do you intend to fly experimental equipment? Yes ☐ No ☐

    If Yes, provide details:______________________________
12. Remarks: ______________________________

I hereby agree that all statements and answers to the above questions are true and complete to the best of my knowledge and belief. A copy of this form will be attached to and made a part of my application for insurance.

Signed at ______________________________ Date ______________________________

Witness

Signature of Proposed Insured

L-3120A *If more space is needed attach additional page, please sign and date each additional page* 06/04

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Military Status Questionnaire

Name of Proposed Insured:______________________________ Date of Birth:________________

(If YES to any questions, give specifics in Details section below)

		YES	**NO**
1a.	Are you a member of the Army, Navy, Air Force, Marine Corps, Coast Guard, National Guard or the active or inactive reserve of any of the armed forces of the United States or any other country?	☐	☐
b.	If Yes, give specifics: Branch of Service: ______________ Active ☐ Inactive ☐ Rank or Grade: ______________		
2a.	Have you been alerted to or received orders for service abroad in any area outside of the U. S. or Canada? Probable Location: ______________	☐	☐
b.	Are you a member of any special forces, special or hazardous duty organization?	☐	☐
c.	Are you receiving any kind of hazardous or extra duty pay?	☐	☐
3.	If you are a member of the National Guard or Reserves, have you been alerted or called for active duty or volunteered for active duty?	☐	☐
4.	Please list any special training or schooling in the Details section below.		
5.	Have you ever been a pilot, navigator or crew member; and/or received any type of in-flight instruction or plan to receive instruction?	☐	☐
6.	Do you currently hold a pilot license, student permit or other certificate? (If flying as a civilian, please complete a civilian aviation form)	☐	☐

7. Summary of Flight Activity: Indicate as Pilot (P); Navigator (N); or Crew Member (C)

Type of Flying	Type Aircraft	Total Flights	Hours flown in past			Estimate hrs.
			Last 12 mos.	1-2 years	2-3 years	next 12 months
Regular						
MAC						
Nat'l Guard/Res						
Other (explain)						

		YES	**NO**
8.	Have you ever been involved in an aircraft accident?	☐	☐
9.	Have you ever been grounded for any flight violation or medical reason?	☐	☐
10.	Do you anticipate any change in your flight activity in the near future?	☐	☐
11.	Are you involved in any flight instruction?	☐	☐

Details:

I hereby agree that all statements and answers to the above questions are true and complete to the best of my knowledge and belief. A copy of this form will be attached to and made a part of my application for insurance.

Signed at ______________________ Date ______________________

Witness Signature of Proposed Insured

L-3114A *If more space is needed attach additional page, please sign and date each additional page* 06/04

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Miscellaneous Avocation Questionnaire

Name of Proposed Insured:____ Date of Birth:_______________________

1. Name of activity or sport in which you participate: ____

2. Fully describe the activity or sport: ____

   ____

3. Do you require any special equipment for this activity or sport? Yes ☐ No ☐

   If Yes, please describe: ____

4. Are you a member of a club or association that sponsors this activity or sport? Yes ☐ No ☐ If Yes, name of club or association: ____

   Website address: ____

5. How long have you been participating in this activity or sport? ___________ years.

6. Do you have any special licenses or certificates for this activity or sport? Yes ☐ No ☐ If Yes, give full details:

   ____

7. Do you instruct and/or receive payment? Yes ☐ No ☐ If Yes, give full details:___________________________

   ____

8. Have you had any accidents or injuries while participating in this activity or sport? Yes ☐ No ☐
   If Yes, give full details:____

   ____

   ____

9. Remarks: ____

   ____

   ____

   ____

I hereby agree that all statements and answers to the above questions are true and complete to the best of my knowledge and belief. A copy of this form will be attached to and made a part of my application for insurance.

Signed at ______________________________________ Date ____

Witness

Signature of Proposed Insured

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Mountaineering/Climbing Questionnaire

Name of Proposed Insured:______________________ Date of Birth:______________

1. Type(s) of Climbing: ☐ Trail ☐ Rock ☐ Snow & Ice ☐ Mountain

   Other (explain): ______________________

   Frequency of each: ______________________

2. Date and location of last climb? ______________________
3. How long have you been climbing? ______________________
4. What courses have you completed and in what year(s)? ______________________
5. Do you ever climb alone? ☐ Yes ☐ No

   If No, how many other people are normally in your party? ______________________

   What would their climbing experience usually be? ______________________

6. Name geographical locations(s) where you have climbed over the past 3 years, type of climbing, and level (Yosemite Decimal System):______________________

   ____

7. Time of year you climb: ______________________
8. List the equipment you normally carry: ______________________
9. On your average climb, how many hours/days would you be climbing? ______________________

   What would your average heights be? ______________________

   What would be your level(s) of difficulty? ______________________

10. What was your highest climb, level and date? ______________________
11. What are your future climbing goals and climbing locations? ______________________
12. Additional Comments: ______________________

    ____

    ____

    ____

I hereby agree that all statements and answers to the above questions are true and complete to the best of my knowledge and belief. A copy of this form will be attached to and made a part of my application for insurance.

Signed at ______________________ Date ______________________

Witness | Signature of Proposed Insured

L-3119A *If more space is needed attach additional page, please sign and date each additional page* 06/04

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Parachuting/Sky Diving Questionnaire

Name of Proposed Insured:______________________________ Date of Birth:____________________

1. Check all activities that you participate in:
   - ☐ sky diving ☐ stunt or baton passing ☐ base jumping ☐ para kiting
   - ☐ formation jumping ☐ para sailing ☐ para scuba ☐ para skier
   - ☐ other (explain): ______________________________

2. Do you belong to a club affiliated with the United States Parachute Association? ☐ Yes ☐ No. If No, explain:
   ____

3. Do you follow the regulations and safety standards established by the United States Parachute Association?
   ☐ Yes ☐ No

4. How long have you been parachuting/sky diving? ____________years.
5. Number of jumps last 12 months? ________ 1-2 years ago ________ Estimated the next 12 months ________

6. Do you take part in exhibitions or competitions? ☐ Yes ☐ No If Yes, please describe the nature of the events:
   ____

7. Do you instruct, receive payment and/or participate in experimental jumping? ☐ Yes ☐ No If Yes, give full details:
   ____

8. Have you had any accidents or injuries connected with the above activities? ☐ Yes ☐ No If Yes, give full details including dates: ______________________________

9. Remarks:______________________________
   ____
   ____
   ____
   ____

I hereby agree that all statements and answers to the above questions are true and complete to the best of my knowledge and belief. A copy of this form will be attached to and made a part of my application for insurance.

Signed at ______________________________ Date ______________________________

Witness	Signature of Proposed Insured

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Racing Questionnaire

Name of Proposed Insured:_________________________ Date of Birth:_________________

1. Have you engaged in or do you contemplate engaging in any of the following form(s) of racing? If Yes, give details in chart below.

   Automobile/Truck Yes ☐ No ☐
   Motorboat Yes ☐ No ☐
   Motorcycle Yes ☐ No ☐
   Other(s) Specify _______________ Yes ☐ No ☐

Types of Racing*	1-2 Years Ago		Last 12 Months		Average Speed of Fastest Race	Top Speed Attained	Elapsed Time of Races	Contemplated Next 12 Months	
	Number of races	Typical miles per race	Number of races	Typical miles per race				Number of races	Estimated miles per race

<u>* Examples of Types of Racing:</u>
Automobile/Truck — midget, sports/stock car, championship/Indy, drag, kart, monster truck, demolition derby, etc.
Motorcycle — hill climbing, cross country, circular track, etc.
Motorboat — unmodified, modified, experimental, etc.
Unlimited hydroplane — jet, other

2. What type of competitive vehicle do you drive? Make: _______________ Model: _______________

   Engine size: _______________ Fuel used: _______________

3. Over what period of the year do you race? (e. g., month, six months, entire year)

   ____

4. Have you ever competed or do you contemplate competing outside the United States? Yes ☐ No ☐
   If Yes, give details:____

5. Describe size and type of track you race on (e. g., oval, simulated, drag, asphalt, dirt, etc.).

   ____

6. Do you race professionally and/or for cash prizes, or for pleasure?
   Explain: ____

7. Are you affiliated with any racing organization and/or under what sanctioning body do you normally compete?
   (e.g., AMA, NHRA, SCCA, USAC, etc.) Yes ☐ No ☐ If Yes, please list: _______________

8. Have you ever been injured while participating in a race? Yes ☐ No ☐
   If Yes, give details:____

Additional remarks clarifying answers to above questions:

I hereby agree that all statements and answers to the above questions are true and complete to the best of my knowledge and belief. A copy of this form will be attached to and made a part of my application for insurance.

Signed at _______________________ Date _______________________

Witness

Signature of Proposed Insured

L-3115A *If more space is needed attach additional page, please sign and date each additional page* 06/04

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Respiratory Questionnaire

Name of Proposed Insured:______________________________ Date of Birth:__________________

1. Have you had or have you ever been told you had:
☐ Asthma ☐ Emphysema ☐ Chronic Cough ☐ Pneumonia ☐ Tuberculosis ☐ Chronic Bronchitis
☐ Allergy: seasonal or chronic ☐ Other (explain): ______________________________

2. Please provide the following details for each condition checked above.

Condition			
Onset Date			
Frequency of Attack			
Duration of Attack			
Date of Last Attack			
Medications: Give Dosage and Frequency of Use			

3. Have you lost time from work due to respiratory illness or condition? ☐ YES ☐ NO
If YES, please state when and how long you were off work. ______________________________

4. Have you ever been hospitalized for any of the above conditions? ☐ YES ☐ NO
If YES, please state when, where, how long, and why:
____

5. Have you ever been to the Emergency Room for any of the above conditions? ☐ YES ☐ NO
If YES, please say when, where, how long, and why:
____

6. Do you experience: ☐ Shortness of breath ☐ Wheezing ☐ Cough producing blood, phlegm or sputum
Other (explain): ______________________________

7. How often do these symptoms occur? ______________________________

8. What causes or contributes to your symptoms? ______________________________

9. Do you use tobacco in any form? ☐ YES: Amount and Type ____________________ ☐ NO
Past user ☐ YES: Number of years used, Date last used __________ / __________ ☐ NO

Names of all health care practitioners consulted	Address(es)	Date (MM/DD/YY)	Symptoms, Diagnosis and Treatment

Please use this space to enter any additional details regarding your condition:

I hereby agree that all statements and answers to the above questions are true and complete to the best of my knowledge and belief. A copy of this form will be attached to and made a part of my application for insurance.

Signed at ______________________________ Date ______________________________

Witness

Signature of Proposed Insured

L-3112A *If more space is needed attach additional page, please sign and date each additional page* 06/04

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L3116B

Scuba & Skin Diving Questionnaire

Name of Proposed Insured:	Date of Birth:

Please complete if you have engaged in or contemplate engaging in any form or skin or scuba diving in the future.

Depth of Dives (feet)	Pleasure				Commercial			
	Last 12 Months		Next 12 Months		Last 12 Months		Next 12 Months	
	Number of dives	Average time per dive	Number of dives	Average time per dive	Number of dives	Average time per dive	Number of dives	Average time per dive
Less than 50 ft.								
51 - 100 ft.								
101 - 130 ft.								
Greater than 130 ft.								

1. Level of Certification: ☐ Basic ☐ Open Water ☐ Advanced Open Water ☐ Master Diver
   ☐ Other: ______
2. Date of last Certification: ______
3. Do you engage in specialty/technical diving? Yes ☐ No ☐
   If Yes, have you received special training? Yes ☐ No ☐ If Yes, go to question #4. If No, go to question #5.
4. Specialty/Technical Certification: ☐ Cave ☐ Wreck ☐ Ice ☐ Deep ☐ Mixed Gas Equipment (Nitrox, Trimix, or Heliox)
   ☐ Other: ______
5. What organization did you receive your certification from? ☐ PADI ☐ NAUI ☐ YMCA
   ☐ Other: ______
6. Total number of dives: ______
7. Date of last dive: ______
8. Location of Dives ☐ Ocean/Sea ☐ Inland Waters ☐ Lakes ☐ Rivers ☐ High Altitudes (i.e. mountains, lakes)
   ☐ Other: ______
9. Purpose for Diving: ☐ Recreation ☐ Commercial ☐ Instruction ☐ Photography ☐ Hunting
   ☐ Wreck/Salvage Retrieval ☐ Depth Records Attempts ☐ Other: ______
10. Do you ever dive for profit? Yes ☐ No ☐ If Yes, please explain: ______
11. Do you dive alone? Yes ☐ No ☐
    If Yes, please explain: ______
12. Have you ever experienced or been treated for Decompression Illness, including Decompression Sickness (DCS) or Arterial Gas Embolism (AGE-also known as air embolism)? Yes ☐ No ☐
    If Yes, please explain: ______
13. Have you ever had a diving accident? Yes ☐ No ☐
    If Yes, please explain: ______

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Signed at:	Date:
Witness:	Signature of Proposed Insured:

If more space is needed attach additional page, please sign and date each additional page.

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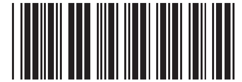

STATEMENT OF HEALTH AND INSURABILITY

(To be completed by Proposed Insured or Additional Insured)

Completed as a condition to the delivery or change of:

Name of Proposed Insured	Policy Number

1. Since the date of the original application or examination, whichever is earlier, for the above policy, no person to be covered by the policy:

	Yes	No
A. Has had any change in health (list any exceptions).	☐	☐
B. Has consulted, been examined, or treated by a physician or medical practitioner (list any exceptions).	☐	☐
C. Has made any change in occupation, the use of tobacco or drugs, participation in hazardous sports or flying or been arrested for any reason (list any exceptions).	☐	☐
D. Has made application to another life insurance company (list any exceptions).	☐	☐

	Yes	No
2. Have you been declined, postponed or issued a life insurance policy on a modified basis?	☐	☐

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DC Residents: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

LA and RI Residents: Any person who knowingly and willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly and willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

OH Residents: Any person who knowingly, and with intent to defraud any insurance company or other persons, 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.

TN Residents: Warning: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits, if false information materially related to a claim was provided by the applicant.

VA Residents: It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines, and denial of insurance benefits.

IT IS DECLARED that all the above statements are complete and true. Unless all questions are truthfully answered No, it is understood that no coverage will take effect until the Health Statement is reviewed and accepted by the company.

PROPOSED INSURED IF 15 YEARS OR OLDER (Signature)	SIGNED AT (City, State)	DATE
PARENT OR GUARDIAN IF PROPOSED INSURED UNDER AGE 15 (Signature)	SIGNATURE OF PROPOSED ADDITIONAL INSURED	
APPLICANT SOCIAL SECURITY NUMBER	SOLICITING AGENT (Signature)	
OWNER'S SIGNATURE		

Tobacco/Nicotine Use Questionnaire

Name of Proposed Insured:________________________ Date of Birth:________________

1. Have you used any tobacco/nicotine products within the last 12 months? ☐ Yes ☐ No

   If Yes, list type and amount per day: ________________________

2. Have you ever used any tobacco/nicotine products? ☐ Yes ☐ No

   If Yes, list type and date you last quit using them: ________________________

3. Have you ever had any medical problems as a result of Tobacco/Nicotine use? ☐ Yes ☐ No

   If Yes, please explain:________________________

4. Has a doctor ever advised you to quit? ☐ Yes ☐ No

   If Yes, please advise date and details:________________________

5. Additional Comments: ________________________

I hereby agree that all statements and answers to the above questions are true and complete to the best of my knowledge and belief. A copy of this form will be attached to and made a part of my application for insurance.

Signed at ________________________ Date ________________________

Witness

Signature of Proposed Insured

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