MIDLAND NATIONAL®
Life Insurance Company
A Member of the Sammons Financial Group

8807

TELE-UNDERWRITING LIFE INSURANCE APPLICATION-PART 1 (Please Print and Use Black Ink)

1. PRIMARY PROPOSED INSURED ☐ SINGLE ☐ MARRIED	BIRTH DATE	STATE OF BIRTH	AGE	SEX	HEIGHT (FT. IN.)	WEIGHT (LBS.)
LAST NAME FIRST M.I.						

Social Security Number:	Driver's License Number:	State

Occupation:	Employer (Company Name and Address)	Annual Income	Net Worth

2. ADDITIONAL INSURED/SPOUSE PROPOSED for INSURANCE (or premium payer for juvenile policy)	BIRTH DATE MO.	DAY	YEAR	STATE OF BIRTH	AGE	SEX	HEIGHT (FT. IN.)	WEIGHT (LBS.)
LAST NAME FIRST M.I.								

Social Security Number:	Driver's License Number:	State

Occupation:	Employer (Company Name and Address)	Annual Income

DEPENDENT CHILDREN PROPOSED for INSURANCE	BIRTH DATE MO.	DAY	YEAR	STATE OF BIRTH	AGE	SEX	SOCIAL SECURITY NUMBER	HEIGHT (FT. IN.)	WEIGHT (LBS.)

3. RESIDENCE ADDRESS (Street, City, State, Zip)

3a. How long at this address? _____ Years _____ Months
If less than 2 years, provide previous address.

3b. MAILING ADDRESS (If other than residence)

4. CONTACT THE PROPOSED INSURED AT:	RESIDENCE TELEPHONE NUMBER	BUSINESS TELEPHONE NUMBER
☐ RESIDENCE ☐ BUSINESS _____ Time (CST) ☐ A.M. ☐ P.M.	Primary Insured ( ) Spouse ( ) Cell Phone ( )	Primary Insured ( ) Spouse ( ) Cell Phone ( )

5. Has anyone proposed for insurance ever smoked cigarettes, cigars, pipes, or used tobacco in any form, including smokeless tobacco, nicotine patch, gum or other substitutes?

5a. **Primary Insured:** ☐ Yes ☐ No If 'yes', provide: Type of product(s) used _____
Amount Used: _____ How often: Daily _____ Weekly _____ Monthly _____ Date of last use mm/yy _____

5b. **Additional Insured Rider/Spouse:** ☐ Yes ☐ No If 'yes', provide: Type of product(s) used _____
Amount Used: _____ How often: Daily _____ Weekly _____ Monthly _____ Date of last use mm/yy _____

6. AMOUNT $	PLAN OF PRIMARY POLICY	Agent Use Only A ☐ B ☐ C ☐

7. For UL/VUL: (check if applicable)	☐ Automatic Premium Loan (Whole Life Only)	Enhanced Corridor Percentage SVUL
☐ Option I ☐ Option II ☐ Rebalance ☐ Minimum Premium ☐ Target Premium		☐ Yes ☐ No

8. RIDERS

- ☐ Waiver of Premium/Waiver of Charges
- ☐ Flexible Disability $_____
- ☐ Living Needs Rider
- ☐ IPGR
- ☐ Waiver of Surrender Charge Option
- ☐ Accidental Death Benefit $ _____
- ☐ Children's Insurance Rider _____ Units
- ☐ Guaranteed Insurability _____ Units
- ☐ Estate Preservation Rider
- ☐ Guaranteed Death Benefit to Maturity Rider

Individual Life Rider
First ☐ Amount $ _____
Second ☐ Amount $ _____

☐ Pro Term Rider ☐ NLG-Option Period to Age _____

☐ Other Rider (Plan) _____ (Amount) _____

9. PREMIUM FREQUENCY: ☐ Annual ☐ Semi-Annual ☐ Quarterly ☐ Monthly

PREMIUM MODE: ☐ EFT ☐ List Billing ☐ Direct Billing (A, SA, Q) only ☐ Civil Service Allotment

List Bill Code _____

Make all checks payable to MIDLAND NATIONAL LIFE INSURANCE COMPANY

Amount of Modal Premium $ _____ Amount Paid with Application $ _____ **(Receipt valid only if amount paid with application is entered here.)**

10. FOR EFT ONLY:	ACCOUNT TYPE	AUTHORIZED SIGNATURE(S) OF ACCOUNT HOLDER(S)
DRAW DAY (1ST-28TH) ____ Month ____ Day	☐ Checking (attach voided check)	X _____
10a. Initial Draft ☐ Yes ☐ No	☐ Savings (must complete 10b)	X _____
10b. Routing Transit Number	Account Number	Financial Institution Name and Address

11. Please list all life insurance and annuities currently in force or pending on the life of any of the proposed insureds. 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: **If None, check here:** ☐

Name	Company	Policy #	Pending	Issue Yr.	Basic Amount	ADB Amount	WP Amount	Intention of Replacement or Change*
			☐					☐ Y ☐ N
			☐					☐ Y ☐ N
			☐					☐ Y ☐ N
			☐					☐ Y ☐ N
			☐					☐ Y ☐ N

*** If 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.

12. Are any of the above policies being used to fund this policy? ☐ Yes ☐ No

13. Have you or will you be compensated in any way to purchase this policy? ☐ Yes ☐ No

14. Are you paying for this policy with your own funds? ☐ Yes ☐ No

15. Have you financed or do you intend to finance all or a portion of the premiums for this policy? (If yes, complete applicable Disclosure and Acknowledgement Form and submit with application) ☐ Yes ☐ No

16. 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 the answer is 'Yes' to questions 12, 13, or 16 please provide details below. If answer to question 14 is 'No' please provide details below.

17. PRELIMINARY HEALTH QUESTION

Within the past 10 years, has any Proposed Insured been diagnosed or treated by a medical professional for diabetes, cancer, heart disease, stroke, alcoholism, drug abuse or high blood pressure or does any Proposed Insured have any health problems, habits, or hobbies that may affect insurability? (if yes, preferred rates are unlikely) ..... ☐ YES ☐ NO

18. OWNER IF OTHER THAN PROPOSED INSURED (Include relationship to proposed insured.)

Name	Address	Social Security Number	Relationship

19. PRIMARY BENEFICIARY–(Class 1) (Include relationship to proposed insured.)	20. CONTINGENT BENEFICIARY–(Class 2) (Include relationship to proposed insured.)
Beneficiary designations do not apply to others covered under Family/Children's Provision Riders.	

21. SPECIAL REQUESTS OR DETAILS

UNDERWRITING INSTRUCTIONS		
☐ I will schedule the Paramedical visit(s) on this case.	☐ I would like the Company to schedule the Paramedical visit(s) on the case. My preferred paramedical service is:	☐ Xpress Test administered by the Agent

IT IS DECLARED that statements and answers in this application, including statements by the Proposed Insured(s) in any medical questionnaire or supplement that become part of this application, are complete and true to the best knowledge and belief of the undersigned. IT IS AGREED THAT: (1) any waiver or modification of this application will not be effective unless in writing and signed by the President, or the Secretary; **(2) no insurance shall be in effect under this application (except as may be provided in the receipt bearing the same date as this application) unless and until the application has been approved and accepted by the Company at its Executive Office and the policy is delivered to and accepted by the Owner and the full first premium has been paid while each person proposed for insurance is alive and while the state of health and other conditions affecting insurability are as stated in this application and any required examination and additional information. (If a List Billing Authorization or Government Allotment is indicated in section 9 and has actually been signed and delivered for the correct amount, this shall be considered the same as payment of the full first premium);** (3) the acceptance of any policy issued on this application shall constitute a ratification of any correction or amendment made by the Company. No change in amount, classification, plan of insurance, or benefits shall be effective unless agreed to in writing by the applicant. I FURTHER AGREE to immediately advise the Company of any change to any of the responses contained in the application, including any change in the health or habits of any Proposed Insured(s), that arises or is discovered after completing this application, but before the Policy is effective, as defined herein.

I also acknowledge receipt of Fair Credit Reporting Act and Medical Information Bureau Notifications.

TAX PAYER IDENTIFICATION NUMBER CERTIFICATION - Under penalties of perjury, I certify that:

1. The number shown on this form is my correct taxpayer identification number (or I am waiting for a number to be issued to me), **and**
2. I am not subject to backup withholding because: **(a)** ☐ I am exempt from backup withholding, or **(b)** ☐ I have not been notified by the Internal Revenue Service that I am subject to backup withholding as a result of a failure to report all interest or dividends, or **(c)** ☐ the IRS has notified me that I am no longer subject to backup withholding. **(Please check appropriate response.)**

FINANCIAL INSTITUTION DISCLOSURE - 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, and involve investment risk, including possible loss of value. The approval or disapproval of any extension of credit by the bank or an affiliate is not based on whether or not this insurance is purchased through the bank or through any particular source.

AUTHORIZATION: To determine eligibility for insurance, I authorize any physician, medical practitioner, health care professional, hospital, clinic, or other medically related facility, laboratory, pharmacy or pharmacy benefit manager, insurance or reinsuring company, the Medical Information Bureau, Inc., consumer reporting agency, insurance support organization, independent administrator, or other organization, institution, or person, or employer 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 any other nonmedical information of me or my minor children to give to Midland National Life Insurance Company (the Company) or its legal representative, any and all such information. I also authorize the Company to conduct a personal telephone interview in connection with my application; and 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. I understand that I may request to be interviewed in connection with the preparation of an investigative consumer report. I understand that I am entitled to receive a copy of the investigative consumer report upon request. This authorization is valid for 30 months from the date signed. 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.

FRAUD WARNING - AR, 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 contractholder or claimant for the purpose of defrauding or attempting to defraud the contractholder 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.

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.

SIGNED AT (City, State)	DATE

SIGNATURE OF PROPOSED INSURED if 15 YEARS OR OLDER	SIGNATURE OF PROPOSED ADDITIONAL INSURED/SPOUSE
X	X

SIGNATURE OF OWNER (If other than Proposed Insured)	SPOUSE SIGNATURE, IF BENEFICIARY IS OTHER THAN SPOUSE AND COMMUNITY PROPERTY LAWS APPLY

Soliciting Agent: Does the applicant(s) have any existing life insurance or annuities? . . . . . ☐ Yes ☐ No

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

If a replacement is involved, submit a copy of this application and applicable Replacement Notice to the existing insurer.

SIGNATURE OF SOLICITING AGENT	PRINT AGENT'S LAST NAME	CODE NO.	TELEPHONE NUMBER ( )
X			CELL PHONE NUMBER ( )

OTHER AGENT (Please Print)	% CREDIT	CODE NO.	GENERAL AGENT (Please Print)	CODE NO.

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Authorization for Release of Health-Related Information

This Authorization complies with the HIPAA Privacy Rules

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

I authorize any health plan, physician, dental practitioner, health care professional, hospital, clinic, laboratory, pharmacy, medical facility, or other health care provider 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 Midland National Life Insurance Company 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 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 Midland National Life Insurance Company 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 Midland National Life Insurance Company.

This Authorization shall remain in force for 30 months 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 Midland National Life Insurance Company at One Midland Plaza, Sioux Falls SD, 57193-0001, 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 Midland National Life Insurance Company 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 redisclosed 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, Midland National Life Insurance 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 have a right to receive, and have in fact received, a copy of this authorization

Signature of Proposed Insured or Personal Representative	Date (MM/DD/YYYY)

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:

SEND ORIGINAL WITH APPLICATION – GIVE A COPY TO PROPOSED INSURED

MIDLAND NATIONAL LIFE INSURANCE COMPANY • ONE MIDLAND PLAZA • SIOUX FALLS, SD 57193-0001
Phone: (605) 335-5700 • New Business Fax - Red Team: (605) 373-8571 Blue Team: (605) 335-7583 Green Team: (605) 373-8573 • Fax Center: (605) 335-3621 • Internet: www.MNLife.com

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ASSIGNMENT OF LIFE INSURANCE POLICY AS COLLATERAL

A. For Value Received the undersigned hereby assigns, transfers, and sets over as interest may appear to: _____

_____
(PRINT FULL NAME AND ADDRESS)

its successors and assigns, (herein called the "Assignee") Policy No. _____issued by Midland National Life Insurance Company (herein called the "Insurer") and any supplementary contracts issued in connection therewith (said policy and contracts being herein called the "policy"), upon the life of_____ and all claims, options, privileges, rights, title and interest therein and thereunder (except as provided in Paragraph C hereof), subject to all the terms and conditions of the policy and to all superior liens, if any, which the Insurer may have against the policy. The undersigned by this instrument jointly and severally agree and the Assignee by the acceptance of this assignment agrees to the conditions and provisions herein set forth.

B. It is expressly agreed that, without detracting from the generality of the foregoing, the following specific rights are included in this assignment and pass by virtue hereof:

1. The sole right to collect from the Insurer the net proceeds of the policy when it becomes a claim by death or maturity;
2. The sole right to surrender the policy and receive the surrender value thereof at any time provided by the terms of the policy and at such other items as the Insurer may allow;
3. The sole right to obtain one or more loans or advances on the policy, either from the Insurer or, at any time, from other persons, and to pledge or assign the policy as security for such loans or advances;
4. The sole right to collect and receive all distributions or shares of surplus, dividend deposits or additions to the policy now or hereafter made or apportioned thereto, and to exercise any and all options contained in the policy with respect thereto; provided, that unless and until the Assignee shall notify the Insurer in writing to the contrary, the distributions or shares of surplus, dividend deposits and additions shall continue on the plan in force at the time of this assignment; and
5. The sole right to exercise all nonforfeiture rights permitted by the terms of the policy or allowed by the Insurer and to receive all benefits and advantages derived therefrom.

C. It is expressly agreed that the following specific rights, so long as the policy has not been surrendered, are reserved and excluded from this assignment and do not pass by virtue hereof:

1. The right to collect from the Insurer any disability benefit payable in cash that does not reduce the amount of insurance;
2. The right to designate and change the beneficiary;
3. The right to elect any optional mode of settlement permitted by the policy or allowed by the Insurer; but the reservation of these rights shall in no way impair the right of the Assignee to surrender the policy completely with all its incidents or impair any other right of the Assignee hereunder, and any designation or change of beneficiary or election of a mode of settlement shall be made subject to this assignment and to the rights of the Assignee hereunder.

D. This assignment is made and the policy is to be held as collateral security for any and all liabilities of the undersigned, or any of them, to the Assignee, either now existing or that may hereafter arise in the ordinary course of business between any of the undersigned and the Assignee (all of which liabilities secured or to become secured are herein called "Liabilities").

E. The Assignee covenants and agreed with the undersigned as follows:

1. That any balance of sums received hereunder from the Insurer remaining after payment of the then existing Liabilities, matured or unmatured, shall be paid by the Assignee to the persons entitled thereto under the terms of the policy had this assignment not been executed;
2. That the Assignee will not exercise either the right to surrender the policy or (except for the purpose of paying premiums) the right to obtain policy loans from the Insurer, until there has been default in any of the Liabilities or a failure to pay any premium when due, nor until twenty days after the Assignee shall have mailed, by first-class mail, to the undersigned at the addresses last supplied in writing to the Assignee specifically referring to this assignment, notice of intention to exercise such right; and
3. That the Assignee will upon request forward without unreasonable delay to the Insurer the policy for endorsement of any designation or change of beneficiary or any election of an optional mode of settlement.

F. The Insurer is hereby authorized to recognize the Assignee's claims to rights hereunder without investigating the reason for any action taken by the Assignee, or the validity or the amount of the Liabilities or the existence of any default therein, or the giving of any notice under Paragraph E (2) above or otherwise, or the application to be made by the Assignee of any amounts to be paid to the Assignee. The sole signature of the Assignee shall be sufficient for the exercise of any rights under the policy assigned hereby and the sole receipt of the Assignee for any sums received shall be a full discharge and release therefore to the Insurer. Checks for all or any part of the sums payable under the policy and assigned herein, shall be drawn to the exclusive order of the Assignee if, when, and in such amounts as may be, requested by the Assignee.

G. The Assignee shall be under no obligation to pay any premium, or the principal of or interest on any loans or advances on the policy whether or not obtained by the Assignee, or any other charges on the policy, but any such amounts so paid by the Assignee from its own funds, shall become a part of the Liabilities hereby secured, shall be due immediately, and shall draw interest at a rate fixed by the Assignee from time to time not exceeding 6% per annum.

H. The exercise of any right, option, privilege or power given herein to the Assignee shall be at the option of the Assignee, but [except as restricted by paragraph E (2) above] the Assignee may exercise any such right, option, privilege or power without notice to, or assent by, or affecting the liability of, or releasing any interest hereby assigned by the undersigned, or any of them.

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I. The Assignee may take or release other security, may release any party primarily or secondarily liable for any of the Liabilities, may grant extensions, renewals or indulgences with respect to the Liabilities, or may apply to the Liabilities in such order as the Assignee shall determine, the proceeds of the policy hereby assigned or any amount received on account of the policy by the exercise of any right permitted under this assignment, without resorting or regard to other security.

J. In the event of any conflict between the provisions of this assignment and provisions of the note or other evidence of any Liability, with respect to the policy or rights of collateral security therein, the provisions of this assignment shall prevail.

K. Each of the undersigned declares that no proceedings in bankruptcy are pending against him and that his property is not subject to any assignment for the benefit of creditors.

Date Signed _____.

WITNESS	OWNER'S SIGNATURE (with title if owned by a Company)
IRREVOCABLE BENEFICIARY (If applicable)	JOINT OWNER'S SIGNATURE (with title if owned by a Company)
OWNER'S SPOUSE SIGNATURE (Required if issue or resident state is AK, AZ, CA, ID, LA, NV, NM,TX, WA, WI)	ADDRESS

**When the policyowner is a corporation or other entity, write the company name above the signature and the title of the signing officer next to the signature.*

(INDIVIDUAL ACKNOWLEDGMENT)

STATE OF _____ }
COUNTY OF _____ } ss:

On (Date) _____, before me personally came _____, to me known to be the individuals described in and who executed the assignment hereof and acknowledged to me that he/she executed the same.

NOTARY PUBLIC

My commission expires _____

(CORPORATE ACKNOWLEDGMENT)

STATE OF _____ }
COUNTY OF _____ } ss:

On (Date) _____, before me personally came _____, who being by me duly sworn, did depose and say that he resides in _____ that he is the _____ of _____, the corporation described in and which executed the assignment hereof, that he knows the seal of said corporation; that the seal affixed to said assignment is such corporate seal; that it was so affixed by order of the Board of Directors of said corporation, and that he signed his name thereto by life order.

NOTARY PUBLIC

My commission expires _____

Original received and filed at the Administrative Office of the Insurer in_____(Date)_____.

By AUTHORIZED OFFICER

RELEASE OF ASSIGNMENT (FOR ASSIGNEE'S ONLY)

The undersigned hereby releases all right, title and interest in and to the insurance policy specified and the assignment of such policy noted above is hereby released, cancelled and discharged.

Dated At (City and State)	Date	Assignee Signature/Title

Midland Acknowledgement. This release has been approved and recorded by the Company at the address indicated below.	Date of Appoval	Vice President, Policy Administration Signature

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FINANCIAL SUPPLEMENT TO THE APPLICATION

PERSONAL INSURANCE – Complete #1-4
BUSINESS INSURANCE – Complete #1-5

Name	Date of Birth	Social Security Number	Application Number

1. The following financial disclosures are made for the purposes of establishing insurability in connection with the life insurance application on my life. They are furnished, as a true and accurate statement of my financial condition as of _____, _____.

2. PERSONAL FINANCES (Complete for Personal and Business applications)

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			
Mortgages	$ _____		
Other Liabilities	_____		
Net Worth	$ _____		

3. Explain the need and purpose of the coverage applied for:

_____

_____

4. Have you or your company ever filed for bankruptcy? ☐ Yes ☐ No If yes, provide details:

_____

_____

5. BUSINESS FINANCES (Complete if the coverage applied for is for business purposes.)

a.) Total Assets $ _____ b.) Total Liabilities $ _____ c.) Net Worth $ _____

	Last Year: $	Previous Year: $	Two Years Ago: $
d.) Net Sales, Income or Revenue	_____	_____	_____
e.) Net Profit After Taxes	_____	_____	_____

f.) Is the business a: ☐ Corporation ☐ Partnership ☐ Proprietorship ☐ LLC

g.) How long has the business been established?_____

h.) What is your percentage ownership of this firm? _____

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

If yes, provide details; If no, why not? _____

_____

_____

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 belief as of the date of application for life insurance. A photographic copy of this statement may be attached to and made part of any insurance contract issued.

Signature of Proposed Insured	Date

Fair Credit Reporting Act Notification
As part of our underwriting procedure, and investigative consumer report may be made which will provide applicable information concerning residence verification, employment, occupation, general health, habits, reputation, personal characteristics and mode of living, except as may be related directly or indirectly to your sexual orientation. Such information for the investigative consumer report may be obtained through personal interviews with your friends, neighbors, and associates. Upon written request, you can receive a copy of the report and a complete and accurate disclosure of the nature and scope of the investigative consumer report.

Medical Information Bureau Notification
Information regarding your insurability will be treated as confidential. Midland National Life Insurance Company, 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, 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 the MIB 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 the MIB information office is Post Office Box 105, Essex Station, Boston, Massachusetts 02112. Midland National Life Insurance Company, 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 of 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. We have established procedures to give you access to all personal information collected. You may request correction of such information in our files which you believe to be inaccurate.

A more complete description of the information practices of Midland National Life Insurance Company will be provided upon your request in accordance with requirements of the Insurance Information and Privacy Protection Law in effect in your state of residence.

Premium checks must be payable to Midland National Life Insurance Company. Do not make checks payable to the Agent or leave the Payee blank.

RECEIPT ☐ Check ☐ List Billing Authorization or Government Allotment

Received from _____ the sum of $ _____ for application made this date to MIDLAND NATIONAL LIFE INSURANCE COMPANY. If after investigation and the completion of all required medical examinations and studies, the Company shall be satisfied that on the date of the application or medical examination, whichever is later, each person proposed for insurance was insurable and entitled under the Company's rules and standards to insurance on the plan and for the amount and at the rate of premium applied for, the insurance protection applied for shall by reason of such payment take effect from the date of application or such medical examination or the date specifically requested in the application, whichever is later, if the sum paid is equal to or greater than 1/12th of the annual premium required for the policy applied for. Unless every condition specified in this receipt is fulfilled exactly, no insurance shall be considered in effect unless and until the application has been approved and accepted by the Company and the policy delivered to and accepted by the Owner, and the full first premium has been paid while each person proposed for insurance is alive and while the state of health and other conditions affecting insurability are as stated in this application or examination, if required. This receipt will be void if any acknowledged authorization is cancelled before payment or if any check or draft is not honored when presented. This receipt will be void if altered or modified in any respect. No agent of the Company and no broker is authorized to alter or waive any of such conditions. Failure of the Company to issue a policy within 90 days from the date of this receipt shall automatically be deemed a declination without further notice.

EVEN IF EVERY CONDITION SPECIFIED IN THIS RECEIPT IS FULFILLED EXACTLY, THE COMPANY'S MAXIMUM LIABILITY PRIOR TO THE ACTUAL ISSUANCE AND DELIVERY OF THE POLICY SHALL NOT EXCEED $250,000.

Agent Signature	Date

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CUSTOMER IDENTIFICATION PROGRAM NOTICE
U.S.A. PATRIOT ACT

To help the government fight the funding of terrorism and money laundering activities, the U.S. government passed the USA PATRIOT Act, requiring 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 need to obtain certain information that allows us to verify your identity. The following information is required for all individuals who are listed as an owner or co-owner on an insurance application or will be signing on behalf of a legal entity.

- Name
- Residential/Street Address (P. O. Box not accepted; APO/FPO accepted)
- Date of Birth
- Social Security Number (SSN), Employee Identification Number (EIN) or Tax Identification Number (TIN)
- We will review and verify a current government issued photo ID for each owner listed on the insurance application. The type of identification use (one required), number and expiration date must be recorded below and may be used to further verify the customer's identity using third party sources.

If the owner of the policy is a Trust, Corporation or other entity, we will need:

- Name of entity
- Residential or Business Street address (P. O. Box will not be accepted)
- Corporation Resolution and certified Articles of Incorporation
- Partnership or trust agreement with date of incorporation or trust date
- Social Security Number (SSN), Employer Identification Number (EIN) or Tax Identification Number (TIN)

What happens if I don't provide the information requested or my identity can't be verified?
Our company may not be able to accept your application for insurance.

We thank you for your patience and hope that you will support the financial industry's efforts to deny terrorists and money launderers access to America's financial system.

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Customer Identification Form

A. Owner #1

Name (owner/co-owner, custodian, trustee, entity or power of attorney)	SSN, EIN, TIN	Date of Birth

Address	☐ U.S. Citizen ☐ Resident Alien - Country _____ ☐ Nonresident Alien - Country _____

Please indicate the form of ID presented and used to verify this owner's identity.
Natural Person/Trust Accounts (info on trustee)

Driver's License	State:	Number:	Exp Date:
State-issued ID	State:	Number:	Exp Date:
Military ID		Number:	Exp Date:
Passport	Country:	Number:	Exp Date:
Alien Registration Card	Country:	Number:	Exp Date:
Non-Natural/Business or Corporation			
Partner or Trust Agreement		Date:	
Certificate of Incorporation	State:	Date:	
Business License	State:	Number:	

B. Owner #2

Name (owner/co-owner, custodian, trustee, entity or power of attorney)	SSN, EIN, TIN	Date of Birth

Address	☐ U.S. Citizen ☐ Resident Alien - Country _____ ☐ Nonresident Alien - Country _____

Please indicate the form of ID presented and used to verify this owner's identity.
Natural Person/Trust Accounts (info on trustee)

Driver's License	State:	Number:	Exp Date:
State-issued ID	State:	Number:	Exp Date:
Military ID		Number:	Exp Date:
Passport	Country:	Number:	Exp Date:
Alien Registration Card	Country:	Number:	Exp Date:
Non-Natural/Business or Corporation			
Partner or Trust Agreement		Date:	
Certificate of Incorporation	State:	Date:	
Business License	State:	Number:	

C. Owner(s) Signatures: All owners must sign. Attach additional pages if necessary.

By signing this form, I certify that the information provided is accurate. I understand that Midland National Life will use this information only to attempt to verify my identity. Midland National may request a copy of the articles of incorporation, partnership documents, trust agreements or other similar documents solely for the purpose of attempting to verify my identity as required by federal law. Midland National is not assuming any responsibility for monitoring, maintaining, interpreting or enforcing any terms or provisions of those documents.

Signature	Date
X	
Signature	Date
X	

I attest to the fact that I have viewed the above identified documentation. I also attest that the documents did not appear altered and the picture indentification supplied appeared to be that of the owner(s).

Agent's Name	Agent's Number
Agent's Signature	Date