North American Company for Life and Health Insurance

L3199TINS

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 Monthly Deduction or premium charge for the Accelerated Death Benefit Endorsement, however, there is an administrative fee required each time an Election for Terminal Illness is made.

The accelerated death benefits 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 are suitable for your needs. Receipt of accelerated death benefits 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
For the purposes of this disclosure "Policy" is the same as Certificate and "Account Value" is the same as Policy Fund when referenced in any Policy, Endorsement, Rider or other communications.

For policies covering two lives where the insurance proceeds are payable upon the death of the Survivor, benefits under the Endorsement may only be elected after the death of the first Insured during the lifetime of the Survivor. The Survivor, not the first Insured, is the "Insured" for purposes of the Endorsement.

Upon written request by the Owner ("You" or "Your") of the Policy, the company ("We") will pay an Accelerated Death Benefit as described below, subject to the limitations and requirements described 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 will reduce the Death Benefit and Policy values, if any, which include but are not limited to the Account Value, Net Cash Surrender Value, and Policy Loan Value.

Accelerated Death Benefit for Terminal Illness: You may elect to receive advancement of the Death Benefit when the Insured has a Terminal Illness while the Endorsement is in effect.

An Insured qualifies as being Terminally Ill if a Physician has certified that the Insured's life expectancy is 24 months or less. The Terminal Illness benefit is not subject to underwriting eligibility requirements

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

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

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The Accelerated Benefit Payment will be determined upon Your Election and will be paid in a lump sum. We will pay the present value of the Accelerated Death Benefit. An actuarial discount based on mortality and interest will be applied to the Accelerated Death Benefit and this discount reflects the early payment of the Death Benefit that is being accelerated. On the Election Date, the Accelerated Death Benefit Payment and the Policy Debt will be reduced by the Debt Repayment Amount.

We will waive the Monthly Deductions following the Election of Accelerated Death Benefits for Terminal Illness. Upon Election, all Endorsements and Riders attached to the Policy will continue to be effective subject to the terms and conditions of each Endorsement or Rider. After You receive Accelerated Death Benefits for Terminal, You may take Withdrawals; elect to increase or decrease the Specified Amount or change the Death Benefit Option; and obtain Policy Loans as described in the Policy.

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

Sample Illustrations of the Impact of Accelerated Death Benefits on Policy Provisions.

	Terminal Illness
Accelerated Death Benefit	$375,000
Lump Sum Accelerated Death Benefit Payment	$338,374
Administrative Fee	$200

Values Before Accelerated Death Benefit	**Terminal Illness**
Death Benefit	$500,000
Death Benefit Proceeds	$480,000
Account Value	$100,000
Net Cash Surrender Value	$80,000
Cost of Insurance or Premium	$300
Outstanding Policy Debt	$20,000
Residual Death Benefit:	N/A

Values After Accelerated Death Benefit	**Terminal Illness**
Death Benefit	$125,000
Death Benefit Proceeds	$120,000
Account Value	$25,000
Net Cash Surrender Value	$20,000
Cost of Insurance or Premium	$0
Outstanding Policy Debt	$5,000
Residual Death Benefit	N/A

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Since 1886

L 3107 A

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 or no more than 14 days prior to a meeting in your home.

I am a licensed insurance agent. My purpose for coming to your home is to sell, discuss, and/or deliver one of the following:
(Indicate all that will apply.)

- ❑ **Life Insurance, including annuities**
- ❑ **Other insurance products (specify)** _____
List Type of Insurance Contract

You have the right to have other persons present at the meeting, including family members, financial advisors or attorneys. You have the right to end the meeting at any time. You have the right to contact the Department of Insurance for information or to file a complaint. You may contact the Department of Insurance at 1-800-927-HELP (4357).

The following individual(s) will be coming to your home:
(List all attendees, including license information, if applicable.)

	*Agent's full name	*Agent's License #	*Agent's mailing address & phone #
1.			
2.			
3.			
4.			
5.			
6.			

***As it appears on California insurance license**

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Life Division: P.O. Box 5088, Sioux Falls, SD 57117-5088 • Phone: 877-872-0757 • Fax: 877-595-8254
Annuity Service Center: P.O. Box 79905, Des Moines, Iowa 50325-0905 • Phone: 866-322-7068 • Fax: 866-322-7072

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O2827

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

North American Company for Life and Health Insurance

L2978

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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L2412CA1

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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L2412CA2

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

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O-2724

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

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L3159A1

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 $_____

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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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	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.
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?……..	☐	☐	
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

L3159A5

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

1. MEDICAL QUESTIONS

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. 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.*	☐	☐

L3159A6

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.

L3159A7

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 or its reinsurers to make a brief report of my personal health information to Medical Information Bureau, Inc.; (3) the Company to conduct a personal telephone interview in connection with my application; and (4) 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 _____ On _____
(City, State) (Date)

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

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

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

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

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

L3159A8

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 # _____

North American Company
for Life and Health Insurance

L3100

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 Processing Center: P. O. Box 5089, Sioux Falls, SD 57117 • Principal Office: West Des Moines, IA
Phone: (800) 669-9100 Fax: (800) 951-9430 • www.NorthAmericanCompany.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:

_____

_____

North American Company
for Life and Health Insurance
Since 1886

L2924A1

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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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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Phone: (877) 872-0757 • Fax: (877) 208-6136 • NorthAmericanCompany.com

North American Company
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Since 1886

O2309261

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
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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.