| | | | |
|---|---|---|---|
| *SERFF Tracking Number:* | *NALH-127174020* | *State:* | *Arkansas* |
| *Filing Company:* | *Midland National Life Insurance Company* | *State Tracking Number:* | *48833* |
| *Company Tracking Number:* | *LS134A* | | |
| *TOI:* | *L09I Individual Life - Flexible Premium Adjustable Life* | *Sub-TOI:* | *L09I.101 External Indexed - Single Life* |
| *Product Name:* | *LS134A* | | |
| *Project Name/Number:* | *LS134A/LS134A* | | |

## Filing at a Glance

Company: Midland National Life Insurance Company

| | | |
|---|---|---|
| Product Name: LS134A | SERFF Tr Num: NALH-127174020 | State: Arkansas |
| TOI: L09I Individual Life - Flexible Premium Adjustable Life | SERFF Status: Closed-Approved-Closed | State Tr Num: 48833 |
| Sub-TOI: L09I.101 External Indexed - Single Life | Co Tr Num: LS134A | State Status: Approved-Closed |
| Filing Type: Form | | Reviewer(s): Linda Bird |
| | Authors: Laurie Gruba, Paula Kunkel-White, Gayle Lovorn | Disposition Date: 05/25/2011 |
| | Date Submitted: 05/20/2011 | Disposition Status: Approved-Closed |
| Implementation Date Requested: On Approval | | Implementation Date: |

State Filing Description:

## General Information

| | |
|---|---|
| Project Name: LS134A | Status of Filing in Domicile: Authorized |
| Project Number: LS134A | Date Approved in Domicile: 05/19/2011 |
| Requested Filing Mode: Review & Approval | Domicile Status Comments: |
| Explanation for Combination/Other: | Market Type: Individual |
| Submission Type: New Submission | Individual Market Type: |
| Overall Rate Impact: | Filing Status Changed: 05/25/2011 |
| | State Status Changed: 05/25/2011 |
| Deemer Date: | Created By: Paula Kunkel-White |
| Submitted By: Paula Kunkel-White | Corresponding Filing Tracking Number: |

Filing Description:

NAIC# 431-66044 / FEIN# 46-0164570

New Schedule Page Form - LS134A
New Schedule Page Form - LS140A

Dear Reviewer:

| | | | |
|---|---|---|---|
| *SERFF Tracking Number:* | *NALH-127174020* | *State:* | *Arkansas* |
| *Filing Company:* | *Midland National Life Insurance Company* | *State Tracking Number:* | *48833* |
| *Company Tracking Number:* | *LS134A* | | |
| *TOI:* | *L09I Individual Life - Flexible Premium Adjustable Life* | *Sub-TOI:* | *L09I.101 External Indexed - Single Life* |
| *Product Name:* | *LS134A* | | |
| *Project Name/Number:* | *LS134A/LS134A* | | |

We are filing the above forms for your review and approval.

These forms will be laser printed and we reserve the right to change fonts and layouts. The minimum font size will never be less than 10 point type. Licensed agents of the Company will market these products on an individual basis. No part of this filing contains any unusual or possibly controversial items from normal Company or industry standards.

These are new Schedule of Policy Benefits for use with previously approved Flexible Premium Adjustable Life Insurance policy with Indexed Features Form L13403 and form L14003. The L13403 Policy and the L14003 Policy were approved by your Department on 2/21/2008, under state tracking number 38081, and 3/17/10, under state tracking number 44986, respectively. These are new forms and are not intended to replace any previously approved forms.

These new schedule page forms, LS134A and LS140A, reduce the Maximum Variable Loan Rate from 10% to 6% for new issues. In addition, the Dow Jones Industrial Average disclosure language has been revised. No other material changes between these new Schedule forms and the previous Schedule forms were made. Attached is the new Schedule of Policy Benefits Form LS134A andLS140A.

For informational purposes, the Statements of Variability which provides the variable ranges and variable text for each of these plans is attached.

Your review of this filing is appreciated.

## Company and Contact

**Filing Contact Information**

Paula Kunkel White, Contracts Analyst
525 W. VAN BUREN
CHICAGO, IL 60607

pwhite@nacolah.com
800-800-3656 [Phone] 27179 [Ext]
312-648-7780 [FAX]

**Filing Company Information**

Midland National Life Insurance Company
525 W. Van Buren Street
Chicago, IL 60607
(800) 800-3656 ext. [Phone]

CoCode: 66044
Group Code: 431
Group Name:
FEIN Number: 46-0164570

State of Domicile: Iowa
Company Type: Life and Annuity
State ID Number:

---

## Filing Fees

| | | | |
|---|---|---|---|
| *SERFF Tracking Number:* | *NALH-127174020* | *State:* | *Arkansas* |
| *Filing Company:* | *Midland National Life Insurance Company* | *State Tracking Number:* | *48833* |
| *Company Tracking Number:* | *LS134A* | | |
| *TOI:* | *L09I Individual Life - Flexible Premium Adjustable Life* | *Sub-TOI:* | *L09I.101 External Indexed - Single Life* |
| *Product Name:* | *LS134A* | | |
| *Project Name/Number:* | *LS134A/LS134A* | | |

| | |
|---|---|
| Fee Required? | Yes |
| Fee Amount: | $100.00 |
| Retaliatory? | No |
| Fee Explanation: | $50 per filed form X 2 = $100<br>Domicile state does not have filing fees. |
| Per Company: | No |

| COMPANY | AMOUNT | DATE PROCESSED | TRANSACTION # |
|---|---|---|---|
| Midland National Life Insurance Company | $100.00 | 05/20/2011 | 47831381 |

| | | | |
|---|---|---|---|
| *SERFF Tracking Number:* | *NALH-127174020* | *State:* | *Arkansas* |
| *Filing Company:* | *Midland National Life Insurance Company* | *State Tracking Number:* | *48833* |
| *Company Tracking Number:* | *LS134A* | | |
| *TOI:* | *L09I Individual Life - Flexible Premium Adjustable Life* | *Sub-TOI:* | *L09I.101 External Indexed - Single Life* |
| *Product Name:* | *LS134A* | | |
| *Project Name/Number:* | *LS134A/LS134A* | | |

# Correspondence Summary

### Dispositions

| Status | Created By | Created On | Date Submitted |
|---|---|---|---|
| Approved-Closed | Linda Bird | 05/25/2011 | 05/25/2011 |

| | | | |
|---|---|---|---|
| *SERFF Tracking Number:* | *NALH-127174020* | *State:* | *Arkansas* |
| *Filing Company:* | *Midland National Life Insurance Company* | *State Tracking Number:* | *48833* |
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| *TOI:* | *L09I Individual Life - Flexible Premium Adjustable Life* | *Sub-TOI:* | *L09I.101 External Indexed - Single Life* |
| *Product Name:* | *LS134A* | | |
| *Project Name/Number:* | *LS134A/LS134A* | | |

# Disposition

Disposition Date: 05/25/2011
Implementation Date:
Status: Approved-Closed
Comment:

Rate data does NOT apply to filing.

| | | | |
|---|---|---|---|
| *SERFF Tracking Number:* | *NALH-127174020* | *State:* | *Arkansas* |
| *Filing Company:* | *Midland National Life Insurance Company* | *State Tracking Number:* | *48833* |
| *Company Tracking Number:* | *LS134A* | | |
| *TOI:* | *L09I Individual Life - Flexible Premium Adjustable Life* | *Sub-TOI:* | *L09I.101 External Indexed - Single Life* |
| *Product Name:* | *LS134A* | | |
| *Project Name/Number:* | *LS134A/LS134A* | | |

| Schedule | Schedule Item | Schedule Item Status | Public Access |
|---|---|---|---|
| **Supporting Document** | Flesch Certification | | Yes |
| **Supporting Document** | Application | | Yes |
| **Supporting Document** | Health - Actuarial Justification | | No |
| **Supporting Document** | Outline of Coverage | | No |
| **Supporting Document** | Statements of variability | | Yes |
| **Form** | Schedule of Policy Benefits | | Yes |
| **Form** | Schedule of Policy Benefits | | Yes |

| | | | |
|---|---|---|---|
| *SERFF Tracking Number:* | *NALH-127174020* | *State:* | *Arkansas* |
| *Filing Company:* | *Midland National Life Insurance Company* | *State Tracking Number:* | *48833* |
| *Company Tracking Number:* | *LS134A* | | |
| *TOI:* | *L09I Individual Life - Flexible Premium Adjustable Life* | *Sub-TOI:* | *L09I.101 External Indexed - Single Life* |
| *Product Name:* | *LS134A* | | |
| *Project Name/Number:* | *LS134A/LS134A* | | |

# Form Schedule

**Lead Form Number: LS134A**

| Schedule Item Status | Form Number | Form Type | Form Name | Action | Action Specific Data | Readability | Attachment |
|---|---|---|---|---|---|---|---|
| | LS134A | Schedule Pages | Schedule of Policy Benefits | Initial | | 0.000 | LS134A Schedule Pages.pdf |
| | LS140A | Schedule Pages | Schedule of Policy Benefits | Initial | | 0.000 | LS140A Schedule Pages.pdf |

## SCHEDULE OF POLICY BENEFITS

| | | | |
|---|---|---|---|
| **OWNER:** | [Mary Doe] | **POLICY NUMBER:** | [12345678910] |
| **INSURED:** | [John Doe] | **POLICY DATE:** | [3/1/2008] |
| **SEX:** | [Male] | **ISSUE AGE:** | [35] |
| **MATURITY DATE:** | [3/1/2094]* | **SPECIFIED AMOUNT:** | $[100,000] |
| **PLANNED PERIODIC PREMIUM:** | [$728.00 annually] | **PREMIUM CLASS:** | [Non-Tobacco] |
| **NO LAPSE GUARANTEE PREMIUM:** | [$38.50 monthly] | **NO LAPSE GUARANTEE PERIOD:** | Ends [3/1/2023] |

**BENEFICIARY:** As specified in the Application unless changed as provided in this Policy

**DEATH BENEFIT OPTION:** [1][2][ROPDB]

**ROPDB GROWTH RATE**: [0%][Not Applicable]

**GUARANTEED INTEREST RATE:** 3.0% PER YEAR

**POLICY EXPENSE CHARGE:** MAXIMUM OF $[8.00] PER MONTH FOR [65] POLICY YEARS

**UNIT EXPENSE CHARGE:** MAXIMUM OF $[0.1475] PER MONTH FOR [65] POLICY YEARS**

**MAXIMUM PREMIUM LOAD:** [0]% OF PREMIUMS RECEIVED IN All POLICY YEARS

**PERCENT OF FUND CHARGE**: MAXIMUM OF [0.05%] PER MONTH FOR [65] POLICY YEARS

**INTEREST BONUS ON FIXED ACCOUNT:** [0.5%] IN POLICY YEARS [16 AND THEREAFTER]

**INDEX PERIOD:** 12 CONSECUTIVE CALENDAR MONTHS

**INDEX CREDIT BONUS ON INDEX ACCOUNT VALUE:** [0.5%] IN POLICY YEARS [16 AND THEREAFTER]

**INITIAL COMPARISON FOR MINIMUM POLICY FUND VALUE:** [03/01/2016]

**SUBSEQUENT COMPARISONS FOR MINIMUM POLICY FUND VALUE:** EVERY [8] POLICY YEARS THEREAFTER

**MAXIMUM STANDARD POLICY LOAN INTEREST RATE:** 6.00% PER YEAR PAYABLE IN ARREARS

**MAXIMUM VARIABLE LOAN INTEREST RATE:** 6% PER YEAR PAYABLE IN ARREARS

**INITIAL POLICY YEAR FOR ZERO COST LOANS:** [$6^{th}$]

**INITIAL POLICY YEAR FOR VARIABLE INTEREST LOANS:** [$6^{th}$]

| | | | |
|---|---|---|---|
| **MINIMUM SPECIFIED AMOUNT:** | [$100,000] | **MAXIMUM WITHDRAWAL CHARGE:** | [$25.00] |
| **MINIMUM INCREASE AMOUNT:** | [$25,000] | **MINIMUM WITHDRAWAL AMOUNT:** | [$500.00] |

**BASIS OF VALUES:** 2001 CSO, SEX DISTINCT, COMPOSITE, AGE LAST BIRTHDAY MORTALITY TABLE.

**WAIVER OF SURRENDER CHARGE MONTHLY RATE PER $1,000:** $[0.00]

**WAIVER OF SURRENDER CHARGE PERIOD ENDS:** [Not Applicable]

**LIFE INSURANCE QUALIFICATION TEST:** [Guideline Premium Test]

* It is possible that coverage will lapse prior to the Maturity Date shown, if premiums paid are insufficient to continue coverage to such date.

** The Unit Expense Charge may change based upon increases in the Specified Amount.

**SCHEDULE OF POLICY BENEFITS (CONTINUED)**

**INDEX SELECTIONS:**

| INDEX SELECTION | INDEX | INDEX CREDITING METHOD | MINIMUM INDEX PARTICIPATION RATE [1] | MINIMUM INDEX CAP RATE [1] |
|---|---|---|---|---|
| 1 | [S&P 500®] | [ANNUAL POINT-to-POINT] | [100%] | [4%] |
| 2 | [S&P 500®] | [MONTHLY POINT-to-POINT] | [100%] | [1.25%] |
| 3 | [S&P 500®] | [DAILY AVERAGING] | [40%] | [N/A] |
| 4 | [DJIA℠] | [ANNUAL POINT-to-POINT] | [100%] | [4%] |
| 5 | [DJIA℠] | [DAILY AVERAGING] | [40%] | [N/A] |
| 6 | [NASDAQ-100®] | [ANNUAL POINT-to-POINT] | [100%] | [3%] |
| 7 | [S&P MidCap 400®] | [ANNUAL POINT-to-POINT] | [100%] | [3%] |
| 8 | [S&P MidCap 400®] | [DAILY AVERAGING] | [30%] | [N/A] |
| 9 | [Russell 2000®] | [ANNUAL POINT-to-POINT] | [100%] | [3%] |
| 10 | [Russell 2000®] | [DAILY AVERAGING] | [30%] | [N/A] |
| 11 | [EURO STOXX 50® ] | [ANNUAL POINT-to-POINT] | [100%] | [3%] |
| 12 | [Uncapped S&P 500®] | [ANNUAL POINT-to-POINT] | [10%] | [N/A] |
| 13 | [Multi-Index Group:]<br>[S&P 500®]<br>[EURO STOXX 50®]<br>[Russell 2000®] | [MULTI-INDEX ANNUAL ][POINT-to-POINT]<br>[Multi-Index Weight]<br>[Best-Performing Index Weight: 50%]<br>[Second-Best Performing Index Weight: 30%]<br>[Third-Best Performing Index Weight: 20% ] | [100%] | [3%] |

[1]Guaranteed while this Policy remains in effect.

**[The term "S&P 500®"** refers to **THE STANDARD & POOR'S 500® COMPOSITE STOCK PRICE INDEX**
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- Consider the needs of this product or the owners of this product in determining, composing or calculating the DJIA or have any obligation to do so.
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  - The merchantability and the fitness for a particular purpose or use of the DJIA or its data;
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**]**

## SCHEDULE OF POLICY BENEFITS (CONTINUED)

### TABLE OF SURRENDER CHARGES PER $1,000

| Policy Year | Surrender Charge Factor | Policy Year | Surrender Charge Factor |
|---|---|---|---|
| 1 | [$13.50 | 9 | [$12.15 |
| 2 | 13.50 | 10 | 10.80 |
| 3 | 13.50 | 11 | 9.45 |
| 4 | 13.50 | 12 | 8.10 |
| 5 | 13.50 | 13 | 6.75 |
| 6 | 13.50 | 14 | 4.05 |
| 7 | 13.50 | 15+ | 0.00] |
| 8 | 13.50] | | |

### CORRIDOR PERCENTAGE TABLE

| Policy Age | Percentage | Policy Age | Percentage |
|---|---|---|---|
| [0-40 | 250% | 60 | 130% |
| 41 | 243% | 61 | 128% |
| 42 | 236% | 62 | 126% |
| 43 | 229% | 63 | 124% |
| 44 | 222% | 64 | 122% |
| 45 | 215% | 65 | 120% |
| 46 | 209% | 66 | 119% |
| 47 | 203% | 67 | 118% |
| 48 | 197% | 68 | 117% |
| 49 | 191% | 69 | 116% |
| 50 | 185% | 70 | 115% |
| 51 | 178% | 71 | 113% |
| 52 | 171% | 72 | 111% |
| 53 | 164% | 73 | 109% |
| 54 | 157% | 74 | 107% |
| 55 | 150% | 75 – 90 | 105% |
| 56 | 146% | 91 | 104% |
| 57 | 142% | 92 | 103% |
| 58 | 138% | 93 | 102% |
| 59 | 134% | 94 | 101% |
| | | 95+ | 100%] |

## SCHEDULE OF POLICY BENEFITS (CONTINUED)

### TABLE OF GUARANTEED COST OF INSURANCE RATES
### MAXIMUM MONTHLY COST OF INSURANCE PER $1,000

| Policy Age | MALE<br>All Classes | FEMALE<br>All Classes |
|---|---|---|
| 0 | 0.06 | 0.04 |
| 1 | 0.04 | 0.03 |
| 2 | 0.03 | 0.02 |
| 3 | 0.02 | 0.02 |
| 4 | 0.02 | 0.02 |
| 5 | 0.02 | 0.02 |
| 6 | 0.02 | 0.02 |
| 7 | 0.02 | 0.02 |
| 8 | 0.02 | 0.02 |
| 9 | 0.02 | 0.02 |
| 10 | 0.02 | 0.02 |
| 11 | 0.02 | 0.02 |
| 12 | 0.03 | 0.02 |
| 13 | 0.03 | 0.03 |
| 14 | 0.04 | 0.03 |
| 15 | 0.06 | 0.03 |
| 16 | 0.07 | 0.03 |
| 17 | 0.07 | 0.03 |
| 18 | 0.08 | 0.04 |
| 19 | 0.08 | 0.04 |
| 20 | 0.08 | 0.04 |
| 21 | 0.08 | 0.04 |
| 22 | 0.09 | 0.04 |
| 23 | 0.09 | 0.04 |
| 24 | 0.09 | 0.04 |
| 25 | 0.09 | 0.05 |
| 26 | 0.10 | 0.05 |
| 27 | 0.10 | 0.05 |
| 28 | 0.10 | 0.05 |
| 29 | 0.10 | 0.06 |
| 30 | 0.10 | 0.06 |
| 31 | 0.09 | 0.06 |
| 32 | 0.10 | 0.07 |
| 33 | 0.10 | 0.07 |
| 34 | 0.10 | 0.08 |
| 35 | 0.10 | 0.08 |
| 36 | 0.11 | 0.09 |
| 37 | 0.12 | 0.10 |
| 38 | 0.12 | 0.10 |
| 39 | 0.13 | 0.11 |
| 40 | 0.14 | 0.11 |
| 41 | 0.16 | 0.12 |
| 42 | 0.17 | 0.13 |
| 43 | 0.19 | 0.14 |
| 44 | 0.21 | 0.15 |
| 45 | 0.23 | 0.16 |
| 46 | 0.25 | 0.18 |
| 47 | 0.27 | 0.20 |
| 48 | 0.29 | 0.22 |
| 49 | 0.30 | 0.24 |
| 50 | 0.33 | 0.27 |

## SCHEDULE OF POLICY BENEFITS (CONTINUED)

### TABLE OF GUARANTEED COST OF INSURANCE RATES (continued)
### MAXIMUM MONTHLY COST OF INSURANCE PER $1,000

| | MALE | FEMALE |
|---|---|---|
| Policy Age | All Classes | All Classes |
| 51 | 0.36 | 0.30 |
| 52 | 0.39 | 0.33 |
| 53 | 0.44 | 0.37 |
| 54 | 0.49 | 0.41 |
| 55 | 0.54 | 0.45 |
| 56 | 0.61 | 0.49 |
| 57 | 0.66 | 0.54 |
| 58 | 0.72 | 0.59 |
| 59 | 0.79 | 0.64 |
| 60 | 0.87 | 0.70 |
| 61 | 0.97 | 0.76 |
| 62 | 1.09 | 0.82 |
| 63 | 1.21 | 0.88 |
| 64 | 1.35 | 0.96 |
| 65 | 1.48 | 1.03 |
| 66 | 1.62 | 1.12 |
| 67 | 1.76 | 1.21 |
| 68 | 1.92 | 1.32 |
| 69 | 2.08 | 1.43 |
| 70 | 2.27 | 1.57 |
| 71 | 2.51 | 1.71 |
| 72 | 2.79 | 1.88 |
| 73 | 3.08 | 2.06 |
| 74 | 3.39 | 2.25 |
| 75 | 3.74 | 2.47 |
| 76 | 4.13 | 2.70 |
| 77 | 4.59 | 2.96 |
| 78 | 5.12 | 3.25 |
| 79 | 5.72 | 3.56 |
| 80 | 6.39 | 3.95 |
| 81 | 7.12 | 4.44 |
| 82 | 7.90 | 4.95 |
| 83 | 8.76 | 5.49 |
| 84 | 9.73 | 6.10 |
| 85 | 10.82 | 6.71 |
| 86 | 12.03 | 7.44 |
| 87 | 13.35 | 8.35 |
| 88 | 14.78 | 9.32 |
| 89 | 16.30 | 10.29 |
| 90 | 17.84 | 10.99 |
| 91 | 19.38 | 11.68 |
| 92 | 21.01 | 12.85 |
| 93 | 22.77 | 14.44 |
| 94 | 24.65 | 16.49 |
| 95 | 26.57 | 18.78 |
| 96 | 28.47 | 21.09 |
| 97 | 30.55 | 22.62 |
| 98 | 32.82 | 23.45 |
| 99 | 35.30 | 25.22 |
| 100+ | 0.00 | 0.00 |

## SCHEDULE OF POLICY BENEFITS (CONTINUED)

### ADDITIONAL BENEFITS PROVIDED BY ENDORSEMENT OR RIDER

| DESCRIPTION OF ADDITIONAL POLICY BENEFITS | YEARS PAYABLE/ EXPIRY DATE | BENEFIT UNITS OR AMOUNT | ANNUAL PREMIUM |
|---|---|---|---|
| [MULTI-INDEX RIDER | N/A | N/A | N/A] |
| [RETURN OF PREMIUM DEATH BENEFIT OPTION ENDORSEMENT] | N/A | N/A | N/A |

INQUIRIES REGARDING YOUR POLICY SHOULD BE DIRECTED TO YOUR AGENT, OR, IF HE OR SHE IS NOT AVAILABLE TO OUR EXECUTIVE OFFICE AT THE FOLLOWING ADDRESS:

MIDLAND NATIONAL LIFE INSURANCE COMPANY
ATTN: CLIENT COMMUNICATIONS
ONE MIDLAND PLAZA
SIOUX FALLS, SD 57193
TOLLFREE 1-800-923-3223

## SCHEDULE OF POLICY BENEFITS

| | | | |
|---|---|---|---|
| **OWNER:** | [MARY DOE] | **POLICY NUMBER:** | [12345678910] |
| **INSURED:** | [JOHN DOE] | **POLICY DATE:** | [01/01/2010] |
| **SEX:** | [MALE] | **ISSUE AGE:** | [35] |
| **MATURITY DATE:** | [01/01/2095] * | **SPECIFIED AMOUNT:** | $[100,000] |
| **PLANNED PERIODIC PREMIUM:** | $[1,815.00 Annually] | **PREMIUM CLASS:** | [NON-TOBACCO] |
| **PLANNED INITIAL PREMIUM:** | $[1,815.00] | | |
| **NO LAPSE GUARANTEE PREMIUM:** | $[109.38 Monthly] | **NO LAPSE GUARANTEE PERIOD: Ends** | [1/1/2030] |

**[**Premium includes a $1.00 per month Civil Service Allotment fee, for a total annual increase of $12.00.**]**

INQUIRIES REGARDING YOUR POLICY SHOULD BE DIRECTED TO YOUR AGENT OR, IF HE OR SHE IS NOT AVAILABLE, TO OUR EXECUTIVE OFFICE AT THE FOLLOWING ADDRESS:

MIDLAND NATIONAL LIFE INSURANCE COMPANY
ATTN: CLIENT COMMUNICATION
ONE SAMMONS PLAZA
SIOUX FALLS, SD 57193
TOLLFREE 1-800-923-3223

THE INSURANCE DEPARTMENT OF THE STATE IN WHICH THIS POLICY WAS DELIVERED MAY BE CONTACTED BY CALLING: [ (XXX) XXX-XXX) ]

**BENEFICIARY:** As Specified In The Application Unless Changed As Provided In This Policy

**DEATH BENEFIT OPTION:** [Level][Increasing]

**GUARANTEED INTEREST RATE:** 3.00% Per Year

**POLICY EXPENSE CHARGE:** [ $8.00] Per Month To Policy Age 100

**UNIT EXPENSE CHARGE:** [$0.1600] Per Month Per $1000 For [20] Policy Years. This Unit Expense Charge Applies Only If There Are No Changes To Specified Amount. The Maximum Unit Expense Charge is $1.85 Per Month Per $1000.

**PREMIUM LOAD:** [5.00]% Of Premiums Received To Policy Age 100

**PERCENT OF ACCOUNT VALUE CHARGE**: Maximum Of [ 0.050 ]% Per Month To Policy Age 100

**INTEREST BONUS ON THE FIXED ACCOUNT:** [0.75] % In Policy Years [11 and Thereafter] **

**INDEX PERIOD:** [12] Consecutive Calendar Months

**INTEREST BONUS ON THE INDEX ACCOUNT VALUE:** [0.75] % In Policy Years [11 and Thereafter]

**INITIAL COMPARISON FOR MINIMUM ACCOUNT VALUE:** [01/01/2017]

**SUBSEQUENT COMPARISONS FOR MINIMUM ACCOUNT VALUE:** Every [8] Policy Years Thereafter

**MAXIMUM STANDARD POLICY LOAN INTEREST RATE:** 6.00% Per Year Payable In Arrears

**MAXIMUM VARIABLE INTEREST POLICY LOAN INTEREST RATE:** 6.00% Per Year Payable In Arrears

**INITIAL POLICY YEAR FOR NET ZERO COST POLICY LOANS:** [ $6^{th}$ ]

**INITIAL POLICY YEAR FOR VARIABLE INTEREST POLICY LOANS:** [ 6th ]

**INITIAL POLICY YEAR FOR STANDARD POLICY LOANS:** [ 1st ]

**MINIMUM UNSCHEDULED PREMIUM PAYMENT:** [ $25.00]

**MINIMUM SPECIFIED AMOUNT:** [$200,000] **WITHDRAWAL PROCESSING FEE:** [$25.00]

**MINIMUM INCREASE AMOUNT:** [$25,000] **MINIMUM WITHDRAWAL AMOUNT**: [$500.00]

**MAXIMUM WITHDRAWAL PERCENTAGE:** 50% In First Policy Year; 90% Thereafter

**BASIS OF VALUES:** 2001 CSO, Sex Distinct, Composite, Age Last Birthday Mortality Tables

**LIFE INSURANCE QUALIFICATION TEST:** [Guideline Premium Test]

* Even if Planned Periodic Premiums are paid, this Policy may terminate prior to the Maturity Date because the current Cost of Insurance and interest rates are not guaranteed, Policy Loans and Withdrawals may be taken, and You may change your Death Benefit Option, or because of other requested changes to the Specified Amount. We will pay the Net Cash Surrender Value on the Maturity Date. If coverage continues to the Maturity Date, there may be little or no Net Cash Surrender Value payable.

** Conditions may apply. See Section 6.2.3: Interest Bonus on the Fixed Account for details.

**SCHEDULE OF POLICY BENEFITS (CONTINUED)**

**INDEX SELECTIONS:**

| INDEX SELECTION | INDEX | INDEX CREDITING METHOD | MINIMUM INDEX PARTICIPATION RATE [1] | MINIMUM INDEX CAP RATE [1] |
|---|---|---|---|---|
| 1 | S&P 500® | ANNUAL POINT-to-POINT | 100% | 4% |
| 2 | S&P 500® | MONTHLY POINT-to-POINT | 100% | 1.25% |
| 3 | S&P 500® | DAILY AVERAGING | 40% | N/A |
| 4 | S&P 500® | ANNUAL INVERSE POINT-to-POINT | 100% | 3% |
| 5 | Uncapped S&P 500® | ANNUAL POINT-to-POINT | 10% | N/A |
| 6 | DJIA℠ | ANNUAL POINT-to-POINT | 100% | 4% |
| 7 | DJIA℠ | DAILY AVERAGING | 40% | N/A |
| 8 | NASDAQ-100® | ANNUAL POINT-to-POINT | 100% | 3% |
| 9 | S&P MidCap 400® | ANNUAL POINT-to-POINT | 100% | 3% |
| 10 | S&P MidCap 400® | DAILY AVERAGING | 30% | N/A |
| 11 | Russell 2000® | ANNUAL POINT-to-POINT | 100% | 3% |
| 12 | Russell 2000® | DAILY AVERAGING | 30% | N/A |
| 13 | EURO STOXX 50® | ANNUAL POINT-to-POINT | 100% | 3% |
| 14 | Multi-Index Group:<br>S&P 500®<br>EURO STOXX 50®<br>Russell 2000® | MULTI-INDEX ANNUAL POINT-to-POINT<br>Multi-Index Weight<br>Best-Performing Index Weight: 50%<br>Second-Best Performing Index Weight: 30%<br>Third-Best Performing Index Weight: 20% | 100% | 3% |

[1]Guaranteed while this Policy remains in effect.

**[The term "S&P 500®"** refers to **THE STANDARD & POOR'S 500® COMPOSITE STOCK PRICE INDEX**
This Index does not include dividends paid by the underlying companies.

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**INDEX SELECTIONS (continued)**

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**]**

## SCHEDULE OF POLICY BENEFITS (CONTINUED)

### TABLE OF SURRENDER CHARGES PER $1,000

| Policy Year | Surrender Charge Factor | Policy Year | Surrender Charge Factor |
|---|---|---|---|
| 1 | [$20.50 | 12 | [$9.02 |
| 2 | 20.09 | 13 | 6.97 |
| 3 | 19.68 | 14 | 4.51 |
| 4 | 18.86 | 15 | 2.05 |
| 5 | 18.04 | 16+ | 0.00] |
| 6 | 17.22 | | |
| 7 | 16.40 | | |
| 8 | 15.17 | | |
| 9 | 13.94 | | |
| 10 | 12.71 | | |
| 11 | 11.07] | | |

### CORRIDOR PERCENTAGE TABLE

| Policy Age | Corridor Percentage | Policy Age | Corridor Percentage |
|---|---|---|---|
| 0-40 | [250% | 60 | [130% |
| 41 | 243% | 61 | 128% |
| 42 | 236% | 62 | 126% |
| 43 | 229% | 63 | 124% |
| 44 | 222% | 64 | 122% |
| 45 | 215% | 65 | 120% |
| 46 | 209% | 66 | 119% |
| 47 | 203% | 67 | 118% |
| 48 | 197% | 68 | 117% |
| 49 | 191% | 69 | 116% |
| 50 | 185% | 70 | 115% |
| 51 | 178% | 71 | 113% |
| 52 | 171% | 72 | 111% |
| 53 | 164% | 73 | 109% |
| 54 | 157% | 74 | 107% |
| 55 | 150% | 75 – 90 | 105% |
| 56 | 146% | 91 | 104% |
| 57 | 142% | 92 | 103% |
| 58 | 138% | 93 | 102% |
| 59 | 134%] | 94 | 101% |
| | | 95+ | 100%] |

## SCHEDULE OF POLICY BENEFITS (CONTINUED)

### TABLE OF GUARANTEED COST OF INSURANCE RATES
### MAXIMUM MONTHLY COST OF INSURANCE RATES PER $1,000 OF NET AMOUNT OF RISK

| Policy Age | MALE All Classes | FEMALE All Classes |
|---|---|---|
| 0 | 0.06 | 0.04 |
| 1 | 0.04 | 0.03 |
| 2 | 0.03 | 0.02 |
| 3 | 0.02 | 0.02 |
| 4 | 0.02 | 0.02 |
| 5 | 0.02 | 0.02 |
| 6 | 0.02 | 0.02 |
| 7 | 0.02 | 0.02 |
| 8 | 0.02 | 0.02 |
| 9 | 0.02 | 0.02 |
| 10 | 0.02 | 0.02 |
| 11 | 0.02 | 0.02 |
| 12 | 0.03 | 0.02 |
| 13 | 0.03 | 0.03 |
| 14 | 0.04 | 0.03 |
| 15 | 0.06 | 0.03 |
| 16 | 0.07 | 0.03 |
| 17 | 0.07 | 0.03 |
| 18 | 0.08 | 0.04 |
| 19 | 0.08 | 0.04 |
| 20 | 0.08 | 0.04 |
| 21 | 0.08 | 0.04 |
| 22 | 0.09 | 0.04 |
| 23 | 0.09 | 0.04 |
| 24 | 0.09 | 0.04 |
| 25 | 0.09 | 0.05 |
| 26 | 0.10 | 0.05 |
| 27 | 0.10 | 0.05 |
| 28 | 0.10 | 0.05 |
| 29 | 0.10 | 0.06 |
| 30 | 0.10 | 0.06 |
| 31 | 0.09 | 0.06 |
| 32 | 0.10 | 0.07 |
| 33 | 0.10 | 0.07 |
| 34 | 0.10 | 0.08 |
| 35 | 0.10 | 0.08 |
| 36 | 0.11 | 0.09 |
| 37 | 0.12 | 0.10 |
| 38 | 0.12 | 0.10 |
| 39 | 0.13 | 0.11 |
| 40 | 0.14 | 0.11 |
| 41 | 0.16 | 0.12 |
| 42 | 0.17 | 0.13 |
| 43 | 0.19 | 0.14 |
| 44 | 0.21 | 0.15 |
| 45 | 0.23 | 0.16 |
| 46 | 0.25 | 0.18 |
| 47 | 0.27 | 0.20 |
| 48 | 0.29 | 0.22 |
| 49 | 0.30 | 0.24 |
| 50 | 0.33 | 0.27 |

## SCHEDULE OF POLICY BENEFITS (CONTINUED)

### TABLE OF GUARANTEED COST OF INSURANCE RATES
### MAXIMUM MONTHLY COST OF INSURANCE RATES PER $1,000 OF NET AMOUNT OF RISK

| Policy Age | MALE All Classes | FEMALE All Classes |
|---|---|---|
| 51 | 0.36 | 0.30 |
| 52 | 0.39 | 0.33 |
| 53 | 0.44 | 0.37 |
| 54 | 0.49 | 0.41 |
| 55 | 0.54 | 0.45 |
| 56 | 0.61 | 0.49 |
| 57 | 0.66 | 0.54 |
| 58 | 0.72 | 0.59 |
| 59 | 0.79 | 0.64 |
| 60 | 0.87 | 0.70 |
| 61 | 0.97 | 0.76 |
| 62 | 1.09 | 0.82 |
| 63 | 1.21 | 0.88 |
| 64 | 1.35 | 0.96 |
| 65 | 1.48 | 1.03 |
| 66 | 1.62 | 1.12 |
| 67 | 1.76 | 1.21 |
| 68 | 1.92 | 1.32 |
| 69 | 2.08 | 1.43 |
| 70 | 2.27 | 1.57 |
| 71 | 2.51 | 1.71 |
| 72 | 2.79 | 1.88 |
| 73 | 3.08 | 2.06 |
| 74 | 3.39 | 2.25 |
| 75 | 3.74 | 2.47 |
| 76 | 4.13 | 2.70 |
| 77 | 4.59 | 2.96 |
| 78 | 5.12 | 3.25 |
| 79 | 5.72 | 3.56 |
| 80 | 6.39 | 3.95 |
| 81 | 7.12 | 4.44 |
| 82 | 7.90 | 4.95 |
| 83 | 8.76 | 5.49 |
| 84 | 9.73 | 6.10 |
| 85 | 10.82 | 6.71 |
| 86 | 12.03 | 7.44 |
| 87 | 13.35 | 8.35 |
| 88 | 14.78 | 9.32 |
| 89 | 16.30 | 10.29 |
| 90 | 17.84 | 10.99 |
| 91 | 19.38 | 11.68 |
| 92 | 21.01 | 12.85 |
| 93 | 22.77 | 14.44 |
| 94 | 24.65 | 16.49 |
| 95 | 26.57 | 18.78 |
| 96 | 28.47 | 21.09 |
| 97 | 30.55 | 22.62 |
| 98 | 32.82 | 23.45 |
| 99 | 35.30 | 25.22 |
| 100+ | 0.00 | 0.00 |

## SCHEDULE OF POLICY BENEFITS (CONTINUED)

## ADDITIONAL BENEFITS PROVIDED BY ENDORSEMENT OR RIDER

| DESCRIPTION OF ADDITIONAL POLICY BENEFITS | YEARS PAYABLE/ EXPIRY DATE | BENEFIT UNITS OR AMOUNT | ANNUAL PREMIUM |
|---|---|---|---|
| [Accidental Death Benefit] | [01/01/2035] | $[100,000.00] | $[84.00] |
| [Children's Insurance Term Rider ] | [01/01/2030] | [5.00 Units] | $[30.00] |
| [Waiver of Charges ] | [01/01/2035] | [N/A] | $[11.80] |
| [Guaranteed Insurability Rider] | [01/01/2015] | $[20,000.00] | $[39.96] |
| [Flexible Disability Benefit 2] | [01/01/2045] | $[1,250.00 Monthly] | $[600.00] |
| Accelerated Benefit Endorsement | [01/01/2095] | [N/A] | [NONE] |

Maximum Accelerated Death Benefit: $1,000,000

Terminal Illness:
Maximum Election:
The Smaller Of 75% Of The Death Benefit On Election Date Or $750,000
Life Expectancy To Qualify For Benefits:
24 months Or Less

Chronic Illness:
Maximum of Each Election:
The Smaller Of 24% Of The Death Benefit On Initial Election Date Or $240,000

Cumulative Accelerated Benefit Percentage: [50%]

## SCHEDULE OF PROTECTED DEATH BENEFIT AMOUNTS

The amounts shown in this Schedule are used only in the determination of the Protected Death Benefit Account. The Protected Death Benefit Account does NOT represent an independent dollar account that can be accessed by You. The Protected Death Benefit Account is not an addition to Your Account Value, Cash Surrender Value or any other Account described in the Policy.

**Protected Death Benefit Interest Rate:** [4.00%] Per Year For All Policy Years

**Protected Death Benefit Minimum Age:** [65]

**Protected Death Benefit Expense Charge:** [$8] Per Month

**TABLE OF PROTECTED DEATH BENEFIT PERCENTAGES:**

| Policy Age | Percentage |
|---|---|
| [ 65 | [ 87% |
| 66 | 87% |
| 67 | 87% |
| 68 | 87% |
| 69 | 87% |
| 70 | 87% |
| 71 | 87% |
| 72 | 87% |
| 73 | 87% |
| 74 | 87% |
| 75+ ] | 91% ] |

## SCHEDULE OF PROTECTED DEATH BENEFIT AMOUNTS (CONTINUED)

### TABLE OF GUARANTEED PROTECTED DEATH BENEFIT MONTHLY COST OF INSURANCE RATES PER $1,000

| | MALE | | | | | FEMALE | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| Policy Age | [Pref. Plus. NT] | [Pref. NT] | [Non Tobacco] | [Pref. Tobacco] | [Standard Tobacco] | [Pref. Plus. NT] | [Pref. NT] | [Non Tobacco] | [Pref. Tobacco] | [Standard Tobacco] |
| [65 | [1.29 | [1.29 | [1.29 | [2.26 | [2.26 | [0.90 | [0.90 | [0.90 | [1.70 | [1.70 |
| 66 | 1.42 | 1.42 | 1.42 | 2.44 | 2.44 | 0.98 | 0.98 | 0.98 | 1.83 | 1.83 |
| 67 | 1.56 | 1.56 | 1.56 | 2.62 | 2.62 | 1.07 | 1.07 | 1.07 | 1.98 | 1.98 |
| 68 | 1.70 | 1.70 | 1.70 | 2.81 | 2.81 | 1.16 | 1.16 | 1.16 | 2.14 | 2.14 |
| 69 | 1.85 | 1.85 | 1.85 | 3.00 | 3.00 | 1.27 | 1.27 | 1.27 | 2.31 | 2.31 |
| 70 | 2.03 | 2.03 | 2.03 | 3.22 | 3.22 | 1.39 | 1.39 | 1.39 | 2.51 | 2.51 |
| 71 | 2.24 | 2.24 | 2.24 | 3.47 | 3.47 | 1.53 | 1.53 | 1.53 | 2.73 | 2.73 |
| 72 | 2.51 | 2.51 | 2.51 | 3.82 | 3.82 | 1.68 | 1.68 | 1.68 | 2.98 | 2.98 |
| 73 | 2.80 | 2.80 | 2.80 | 4.16 | 4.16 | 1.85 | 1.85 | 1.85 | 3.25 | 3.25 |
| 74 | 3.10 | 3.10 | 3.10 | 4.51 | 4.51 | 2.03 | 2.03 | 2.03 | 3.55 | 3.55 |
| 75 | 3.44 | 3.44 | 3.44 | 4.92 | 4.92 | 2.23 | 2.23 | 2.23 | 3.85 | 3.85 |
| 76 | 3.78 | 3.78 | 3.78 | 5.33 | 5.33 | 2.44 | 2.44 | 2.44 | 4.15 | 4.15 |
| 77 | 4.18 | 4.18 | 4.18 | 5.81 | 5.81 | 2.68 | 2.68 | 2.68 | 4.48 | 4.48 |
| 78 | 4.65 | 4.65 | 4.65 | 6.38 | 6.38 | 2.93 | 2.93 | 2.93 | 4.84 | 4.84 |
| 79 | 5.20 | 5.20 | 5.20 | 7.02 | 7.02 | 3.21 | 3.21 | 3.21 | 5.22 | 5.22 |
| 80 | 5.80 | 5.80 | 5.80 | 7.70 | 7.70 | 3.51 | 3.51 | 3.51 | 5.63 | 5.63 |
| 81 | 6.48 | 6.48 | 6.48 | 8.48 | 8.48 | 3.94 | 3.94 | 3.94 | 6.23 | 6.23 |
| 82 | 7.18 | 7.18 | 7.18 | 9.25 | 9.25 | 4.42 | 4.42 | 4.42 | 6.89 | 6.89 |
| 83 | 7.94 | 7.94 | 7.94 | 10.06 | 10.06 | 4.90 | 4.90 | 4.90 | 7.52 | 7.52 |
| 84 | 8.78 | 8.78 | 8.78 | 10.94 | 10.94 | 5.42 | 5.42 | 5.42 | 8.19 | 8.19 |
| 85 | 9.73 | 9.73 | 9.73 | 12.00 | 12.00 | 6.02 | 6.02 | 6.02 | 8.87 | 8.87 |
| 86 | 10.78 | 10.78 | 10.78 | 13.16 | 13.16 | 6.54 | 6.54 | 6.54 | 9.42 | 9.42 |
| 87 | 11.94 | 11.94 | 11.94 | 14.42 | 14.42 | 7.36 | 7.36 | 7.36 | 10.33 | 10.33 |
| 88 | 13.18 | 13.18 | 13.18 | 15.75 | 15.75 | 8.22 | 8.22 | 8.22 | 11.24 | 11.24 |
| 89 | 14.49 | 14.49 | 14.49 | 17.13 | 17.13 | 9.13 | 9.13 | 9.13 | 12.15 | 12.15 |
| 90 | 15.87 | 15.87 | 15.87 | 18.55 | 18.55 | 9.95 | 9.95 | 9.95 | 12.86 | 12.86 |
| 91 | 17.14 | 17.14 | 17.14 | 19.80 | 19.80 | 10.28 | 10.28 | 10.28 | 12.89 | 12.89 |
| 92 | 18.47 | 18.47 | 18.47 | 21.07 | 21.07 | 11.06 | 11.06 | 11.06 | 13.46 | 13.46 |
| 93 | 19.87 | 19.87 | 19.87 | 22.40 | 22.40 | 12.28 | 12.28 | 12.28 | 14.48 | 14.48 |
| 94 | 21.36 | 21.36 | 21.36 | 23.77 | 23.77 | 13.87 | 13.87 | 13.87 | 15.81 | 15.81 |
| 95 | 22.93 | 22.93 | 22.93 | 25.31 | 25.31 | 15.89 | 15.89 | 15.89 | 17.96 | 17.96 |
| 96 | 24.49 | 24.49 | 24.49 | 26.77 | 26.77 | 17.92 | 17.92 | 17.92 | 20.02 | 20.02 |
| 97 | 26.16 | 26.16 | 26.16 | 28.32 | 28.32 | 20.06 | 20.06 | 20.06 | 22.14 | 22.14 |
| 98 | 27.97 | 27.97 | 27.97 | 29.97 | 29.97 | 20.27 | 20.27 | 20.27 | 22.07 | 22.07 |
| 99 | 29.93 | 29.93 | 29.93 | 31.73 | 31.73 | 21.37 | 21.37 | 21.37 | 22.96 | 22.96 |
| 100+] | 0.00] | 0.00] | 0.00] | 0.00] | 0.00] | 0.00] | 0.00] | 0.00] | 0.00] | 0.00] |

| | | | |
|---|---|---|---|
| *SERFF Tracking Number:* | *NALH-127174020* | *State:* | *Arkansas* |
| *Filing Company:* | *Midland National Life Insurance Company* | *State Tracking Number:* | *48833* |
| *Company Tracking Number:* | *LS134A* | | |
| *TOI:* | *L09I Individual Life - Flexible Premium Adjustable Life* | *Sub-TOI:* | *L09I.101 External Indexed - Single Life* |
| *Product Name:* | *LS134A* | | |
| *Project Name/Number:* | *LS134A/LS134A* | | |

# Supporting Document Schedules

**Item Status:** **Status Date:**

**Satisfied - Item:** Flesch Certification

**Comments:**

**Attachment:**

STATE OF ARKANSAS certifications.pdf

**Item Status:** **Status Date:**

**Satisfied - Item:** Application

**Comments:**

Application 9400 approved 9/15/09 under state tracking number 43479
Application 1032C approved 2/24/10, under state tracking number 44966
Application 8807 approved 4/12/06, under state tracking number 32383

**Attachments:**

9400 nationwide 11-09.pdf
1032C.pdf
Application 8807.pdf

**Item Status:** **Status Date:**

**Satisfied - Item:** Statements of variability

**Comments:**

**Attachments:**

Stmnt of Variability L13403 w-LS134A.pdf
Statement of Variability L14003 w-LS140A.pdf

# STATE OF ARKANSAS

## Certificate of Compliance

**Forms LS134A and LS140A**

**On behalf of Midland National Life Insurance Company, I certify the company is in compliance with:**

**Rule and Regulation 19.**

**Rule and Regulation 34 for Universal Life Insurance.**

**Rule and Regulation 49 – each policyholder will be provided a life and health guaranty notice at time of issue.**

**A.C.A. § 23-79-138 for Policy Information Requirements – each policy will contain the contact information of the policyholder's service office, soliciting agent and the state insurance department.**

Paula Kunkel-White

**Paula Kunkel-White, CLU, FALU, FLMI, AIRC, ALHC**
**Senior Contracts Analyst**

**Date: 5/20/2011**

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

*9400*

**GENERAL PURPOSE LIFE APPLICATION Part I (Print and Use Black Ink)**

## PRIMARY INSURED PROPOSED FOR INSURANCE

1. Last Name | First Name | M.I.

1a. Are you a U.S. Citizen or do you have a permanent Visa? ☐ Yes ☐ No ( If no, complete Foreign Travel and Residence Questionnaire)

| Sex: ☐ Male ☐ Female | Date of Birth | Age | Place of Birth - State / Country | Height (FT. IN.) | Weight (LBS.) | Marital Status |
|---|---|---|---|---|---|---|
| | | | | | | |

| Social Security Number/Tax ID# | Driver's License Number | Expiration Date | State |
|---|---|---|---|
| | | | |

2. Residence Address (If P. O. Box include Street Address) | Street | City | State | Zip Code

2a. How long at this address? (If less than 2 years, provide previous address.)

_____ Years _____ Months

2b. Billing Address (If other than residence) | Street | City | State | Zip Code

2c. Secondary Addressee Billing ☐ Yes ☐ No If Yes, Provide Secondary Addressee's Name, Street Address, City, State & Zip Code
(Agent cannot qualify as Secondary Addressee)

3. Employer (Company Name and Address)

| Occupation (Title and Duties) | Annual Income | Net Worth |
|---|---|---|
| | $ | $ |

| 4. Contact The Proposed Insured At: | Residence Telephone Number: | Business Telephone Number: |
|---|---|---|
| ☐ Residence<br>☐ Business _____ (CST) ☐ A.M. ☐ P.M. | Primary Insured ( )<br>Additional Insured ( )<br>Cell Phone ( ) | Primary Insured ( )<br>Additional Insured ( )<br>Cell Phone ( ) |

## PLAN INFORMATION

| 5. Amount Applied For | Proposed Plan of Insurance | Agent Use Only | Type of Underwriting |
|---|---|---|---|
| $ | | A ☐ B ☐ C ☐ | ☐ Traditional ☐ X-Press |

6. For UL/VUL: (check if applicable)
☐ Option I - Level ☐ Option II - Increasing ☐ Option III - Return of Premium
☐ Minimum Premium ☐ Target Premium ☐ Rebalance

For Applicable Products Only:
☐ Guideline Level Premium Test
☐ Cash Value Accumulation Test

## 7. RIDERS

a. **Term Products**

☐ Accidental Death Benefit $_____
☐ Children's Term Insurance Rider (CIR) _____ units
☐ Other Insured Rider $_____
☐ Premium Deposit Agreement $_____
☐ Waiver of Premium Rider
☐ Other Rider _____ (Plan) _____ (Amount)

b. **Permanent Products**

☐ Accidental Death Benefit $ _____
☐ Children's Term Insurance Rider (CIR) _____ units
☐ Estate Preservation Rider
☐ Flexible Disability Benefit $ _____
☐ Guaranteed Insurability Rider _____ units
☐ Premium Deposit Agreement $ _____
☐ Premium Guarantee Rider
☐ Waiver of Charges
☐ Waiver of Surrender Charge Option
☐ Automatic Premium Loan **(Whole Life Products Only)**
☐ Other Rider_____ (Plan) _____ (Amount)



MIDLAND NATIONAL LIFE INSURANCE COMPANY • EXECUTIVE OFFICE: ONE SAMMONS PLAZA, SIOUX FALLS, SD 57193 • PRINCIPAL OFFICE: WEST DES MOINES, IA
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 • www.mnlife.com

**ADDITIONAL INSURED PROPOSED for INSURANCE** **(Complete Separate Application for Business Associates and Additional Insureds)**

8. Last Name | First Name | M.I.

8a. Are you a U.S. Citizen or do you have a permanent Visa? ☐ Yes ☐ No ( If no, complete Foreign Travel and Residence Questionnaire)

| Sex: ☐ Male ☐ Female | Date of Birth | Age | Place of Birth - State / Country | Height (FT. IN.) | Weight (LBS.) | Relationship to Insured |
|---|---|---|---|---|---|---|
| | | | | | | |

| Social Security Number/Tax ID# | Driver's License Number | Expiration Date | State |
|---|---|---|---|
| | | | |

9. Employer (Company Name and Address)

| Occupation (Title and Duties) | Annual Income $ |
|---|---|
| | |

**10. DEPENDENT CHILDREN PROPOSED for INSURANCE**

| Name | Date of Birth | Place of Birth State/Country | Age | Sex | Social Security Number/Tax ID# | Height (FT. IN.) | Weight (LBS.) | Relationship to Proposed Insured |
|---|---|---|---|---|---|---|---|---|
| | | | | | | | | |
| | | | | | | | | |
| | | | | | | | | |

**11. OWNER INFORMATION (Complete only if other than Proposed Primary Insured)**

Name of Owner(s): If Trust, list all Trustees as well as Name and Date of Trust and complete **Trust Form**. If Owner is a business, complete **Company/Corporate Owned Life Insurance (COLI) Form**.

Owner's Address | Street | City | State | Zip Code

| Relationship to Primary Insured | Owner's Social Security/Tax ID # | ☐ U.S. Citizen ☐ Resident Alien - Country _____ ☐ Nonresident Alien - Country _____ |
|---|---|---|
| Name of Contingent Owner(s) | | Contingent Owner's Social Security/Tax ID # |

**12. PRIMARY BENEFICIARY** **If percentage shares are not listed below, they will be divided equally among the beneficiaries. Provide Beneficiary(ies) Full Name(s) (If Trust, list Name and Date of Trust and complete Trust Form)**

| Name | Percent | Relationship to Proposed Primary Insured | Social Security Number/Tax ID# |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| **Total** | **100** | Beneficiary designations do not apply to others covered under Children's Insurance Riders. | |

**13. CONTINGENT BENEFICIARY** **If percentage shares are not listed below, they will be divided equally among the beneficiaries. Provide Beneficiary(ies) Full Name(s) (If Trust, list Name and Date of Trust and complete Trust Form)**

| Name | Percent | Relationship to Proposed Primary Insured | Social Security Number/Tax ID# |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| **Total** | **100** | | |

**14. 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? Respond Below:**

14a. **Proposed 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 _____

14b. **Additional Insured Rider:** ☐ Yes ☐ No If 'yes', provide: Type of product(s) used _____

Amount Used: _____ How often: Daily _____ Weekly _____ Monthly _____ Date of last use: mm/yy _____

## PREMIUM INFORMATION

15. Premium Frequency: ☐ Annual ☐ Semi-Annual ☐ Quarterly ☐ Monthly ☐ Single Pay ☐ Lump Sum $ _____

Premium Mode: ☐ EFT ☐ List Billing ☐ Direct Billing (A, SA, Q) only ☐ Civil Service Allotment ☐ Military Government Allotment

List Bill Code _____

**For term and whole life policies, if you elect to pay premium on a basis other than annual, you may pay more premium than would be required if you paid premium on an annual basis.**

Amount of Modal Premium $ _____ Amount Paid with Application $ _____

**Make all checks payable to: MIDLAND NATIONAL LIFE INSURANCE COMPANY**

| 16. For EFT Only:<br>Draw Day _____ _____<br>(1st - 28th) Month Day<br>16a. Initial Draft<br>☐ Yes ☐ No | Account Type<br>☐ Checking (attach voided check)<br>☐ Savings (must complete 16b) | Authorized Signature(s) of Account Holder(s)<br>X<br>X |
|---|---|---|
| 16b. Routing Transit Number | Account Number | Financial Institution Name and Address |

## REPLACEMENT INFORMATION

17. **Does any person proposed for coverage have any life insurance or annuities currently in force or pending? (This includes policies that have or will be sold, assigned or otherwise placed via life settlement, viatical or other agreements.)** ..... ☐ **Yes** ☐ **No** **If yes, list below:**

| Name | Company | Policy # | Pending | Issue Yr. | Basic Amount | ADB Amount | WP Amount | Intention of Replacement or Change* |
|---|---|---|---|---|---|---|---|---|
| 17a. | | | ☐ | | | | | 18a. ☐ Yes ☐ No |
| 17b. | | | ☐ | | | | | 18b. ☐ Yes ☐ No |
| 17c. | | | ☐ | | | | | 18c. ☐ Yes ☐ No |
| 17d. | | | ☐ | | | | | 18d. ☐ Yes ☐ No |

***Replacement means that the insurance applied for may replace, change or use any value of an existing or pending life insurance policy or annuity. If replacement may be involved, complete applicable replacement form and submit with application.**

**If this is a 1035 Exchange, also complete 1035 Exchange paperwork and submit with application.**

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

20. Has, or will, any person proposed for insurance, or owner of this policy, been compensated in any way to purchase this policy? ..... ☐ Yes ☐ No

21. Is the proposed insured(s), or owner of this policy, paying for this policy with his/her own funds? ..... ☐ Yes ☐ No

22. Will the proceeds of a home equity loan or reverse mortgage transaction be used to pay the premiums on this policy? ..... ☐ Yes ☐ No

23. Has any person proposed for insurance, or owner of this policy, financed, or intend to finance, all or a portion of the premiums for this policy? If yes, complete Disclosure and Acknowledgement Form for premium financing and submit with application ..... ☐ Yes ☐ No

24. Has the policy owner, beneficiary, or person proposed for insurance entered into or considering any other agreement with a third party, trust, or other entity, in regard to this policy, including, but not limited to, an agreement to sell, transfer or assign the policy or any policy rights or beneficial interests? ..... ☐ Yes ☐ No

If the answer is 'Yes' to questions 19, 20, 22 or 24 provide details below. If answer to question 21 is 'No' provide details below.

## TO BE COMPLETED BY SOLICITING AGENT

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 the policy being applied for includes an accelerated death benefit(s), the agent provided the Proposed Primary Insured the Accelerated Benefit Summary and Disclosure Statement(s) prior to or concurrent with this application?..... ☐ Yes ☐ No

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

**25. SPECIAL REQUESTS or DETAILS**

**TO BE COMPLETED FOR MILITARY PERSONNEL (Including National Guard and Reserves )**

26. Permanent Home of Record | Street | City | State | Zip Code

27. Military Address | Street | City | State | Zip Code

28. Job Duties

29. Are you currently drawing extra duty or hazard pay? ☐ Yes ☐ No

30. Military Information ☐ USA ☐ USN ☐ USAF ☐ Other (Specify) Military ID _____

Pay Grade _____ Rotation Date _____ Expected Discharge Date _____

31. Has the Proposed Insured, applied to be a member of, or been a member of a special forces, special or hazardous duty organization? ☐ Yes ☐ No
If yes, provide specific details.

32. Has the Proposed Insured been alerted to, volunteered for, or received formal orders to a hazardous area or overseas assignment? ☐ Yes ☐ No
If yes, provide specific details.

**UNDERWRITING QUESTIONS**

**Question 33 must be completed for all proposed insureds, including CIR. Details to "Yes" answers are to be provided in the Details Section below.**

| 33. Has any person proposed for insurance: | Yes | No |
|---|---|---|
| (a) In the past 10 years used barbiturates, hallucinatory drugs, narcotics including crack, ecstasy, opium derivatives, marijuana, LSD, PCP, or any derivatives of these drugs, or been advised by a licensed medical professional to get, or undergone any treatment, counseling or hospitalization for drug abuse? If yes, complete Drug Questionnaire | ☐ | ☐ |
| (b) In the past 10 years been advised by a licensed medical professional to limit your alcohol use or been advised to get, or undergone any treatment or counseling or hospitalization for alcoholism, excessive alcohol use or abuse? Or, have you subsequently consumed alcohol after receiving counseling or treatment for alcohol use? Or, drink on average more than 3 alcoholic drinks per day? If yes, complete Alcohol Questionnaire | ☐ | ☐ |
| (c) In the past 10 years had their driver's license revoked or suspended or been convicted of reckless driving, driving without a valid license, or for driving while under the influence of alcohol or drugs (DWI, DUI)? | ☐ | ☐ |
| (d) Had more than one speeding violation, or any motor vehicle moving violations or accidents or been arrested for driving under the influence of alcohol within the past five years? | ☐ | ☐ |
| (e) In the past 10 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 them at this time? | ☐ | ☐ |
| (f) Flown a plane in the past 24 months or plan to fly in the next 12 months as a pilot, copilot, student pilot, military pilot, engineer or in any other capacity except as a regularly scheduled commercial airline pilot or fare-paying passenger? If yes, complete Aviation Questionnaire. | ☐ | ☐ |
| (g) In the past 12 months or in the next 12 months, engaged in or plan to engage in activities including: hang gliding, skydiving, motor vehicle/cycle racing, rock climbing, ballooning, bungee jumping, mountain climbing, motor boat racing, snowmobile racing, ultra light aircraft flying, scuba diving to more than 50 feet in depth, or in caves, ship wrecks or deep seas or other extreme sports? If yes, please complete applicable Underwriting Questionnaire. | ☐ | ☐ |
| (h) In the past 10 years been refused for life insurance or charged an extra premium for life insurance? | ☐ | ☐ |
| (i) Traveled to or resided for more than 30 days outside of the U.S., U.S. territories, Canada, or Japan within the past 12 months or plan to travel to or reside outside of the U.S., U.S. territories, Canada, or Japan in the next 12 months? If yes, complete the Foreign Travel and Residence Questionnaire. | ☐ | ☐ |
| (j) Have any bankruptcy pending or expect to file bankruptcy in the next 12 months? | ☐ | ☐ |

**DETAILS TO 'YES' ANSWERS FOR QUESTIONS FROM SECTION 33(a) THROUGH 33(j)**

| Question # | Proposed Insured's Name | Dates and Details |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |

**Questions 34 through 37 must be completed for all proposed insureds, including CIR, not subject to a full paramedical exam. Details to "Yes" answers are to be provided in the Details Section below.**

| | Yes | No |
|---|---|---|
| 34. In the past 10 years, has any person proposed for insurance been diagnosed by a licensed medical professional, treated or advised to get treatment from a licensed medical professional, hospitalized, or presently taking prescription(s) or medication(s) for any of the following disease(s) or disorder(s): | | |
| (a) Angina, chest pain, heart attack, heart failure, heart surgery, irregular heartbeat, abnormal EKG, coronary artery bypass, angioplasty, stents, peripheral vascular disease, poor circulation, valvular heart disease, cardiomyopathy or heart murmur? | ☐ | ☐ |
| (b) High blood pressure, hypertension or abnormal cholesterol levels? | ☐ | ☐ |
| (c) Stroke, seizures, epilepsy, dizziness, fainting, memory disorder or any other neurological or brain disorder? | ☐ | ☐ |
| (d) Multiple Sclerosis, neuritis, neuropathy, paralysis, muscular dystrophy, Parkinson's disease or any other disorder of the muscles? | ☐ | ☐ |
| (e) Arthritis, chronic pain, fibromyalgia, connective tissue disease, lupus or scleroderma? | ☐ | ☐ |
| (f) Cancer, malignancy, tumor, melanoma, lymphoma, Hodgkin's disease or leukemia? | ☐ | ☐ |
| (g) Chronic obstructive pulmonary or lung disease, chronic bronchitis, emphysema, sarcoidosis, asthma, shortness of breath, tuberculosis or sleep apnea? | ☐ | ☐ |
| (h) Diabetes, abnormal blood sugar, sugar in the urine, disease or disorders of the adrenal, parathyroid, pituitary or thyroid glands? | ☐ | ☐ |
| (i) Disorder of the kidney, bladder or urinary system, abnormal PSA, abnormal PAP smear without subsequent normal PAP smear or protein or blood in the urine? | ☐ | ☐ |
| (j) Anemia, hemophilia, clotting disorder or any other disorder of the blood? | ☐ | ☐ |
| (k) Immune Deficiency disorder (Acquired Immune Deficiency Syndrome (AIDS)), AIDS related complex (ARC) or been told test results indicate exposure to the AIDS virus? | ☐ | ☐ |
| (l) Colitis, ulcerative colitis, Crohn's, esophageal varices, peptic or gastric ulcer, intestinal or rectal bleeding, diverticulitis, colon polyps, cirrhosis, hepatitis, liver failure, liver impairment, loss of bowel function or other disease or disorder of the liver or pancreas? | ☐ | ☐ |
| (m) Depression, anxiety, stress, eating disorder or any other nervous, mental or emotional condition? | ☐ | ☐ |
| (n) Any mental or physical disorder or medically or surgically treated condition not listed above? | ☐ | ☐ |
| 35. Other than indicated above, has any person proposed for insurance: | | |
| (a) Had a parent or sibling who before age 60 was diagnosed with or died from cardiovascular disease, stroke, cancer (except basal or squamous cell cancer of the skin), Huntington's Chorea, familial polyposis or polycystic kidney disease? If yes, provide age at onset and current age if living. If deceased, age at death. | ☐ | ☐ |
| (b) Had a weight gain or loss of 10 or more pounds within the past 12 months for any reason other than pregnancy? | ☐ | ☐ |
| (c) In the past 12 months been advised by a licensed medical professional to have a check up, EKG, X-ray, blood or urine test or any other diagnostic test or are you now planning to seek medical advice or treatment for any reason? | ☐ | ☐ |
| (d) In the past 12 months been advised by a licensed medical professional to be admitted to a hospital, medical facility, nursing home or assisted living facility? | ☐ | ☐ |
| 36. Is any person proposed for insurance currently taking any prescription medications, herbal remedies or non-prescription medications for any disease or disorder not listed above? If yes, list the medications and remedies and the reasons for which they are taken. | ☐ | ☐ |
| 37. Is any person proposed for insurance currently receiving or have an application pending for any illness or disability benefits or compensation? | ☐ | ☐ |

**DETAILS TO 'YES' ANSWERS FOR QUESTION 34 THROUGH 37**

| Question # | Proposed Insured's Name | Date, Diagnosis, Treatment, Results and Duration | Name, Address and Phone # of Attending Physician and Hospital |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

38. If not listed above, please provide full name, address and phone numbers of licensed medical professional(s) consulted in the past five years for each person proposed for coverage.

a. Date and findings of last visit:

b. Tests performed and treatment received:

**CUSTOMER IDENTIFICATION**

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

## A. Owner #1

Natural Person/Trust Accounts (info on trustee)

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

## B. Owner #2

Natural Person/Trust Accounts (info on trustee)

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

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 of our Company; (2) 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(s).The undersigned FURTHER AGREES 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.

**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.**

Payment of Premium - (check one) ☐ This application is C.O.D.; ☐ I have elected initial EFT 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.

The undersigned applicant(s) acknowledges receipt of the Fair Credit Reporting Act Notice/MIB, Inc. Notice and Notice of Insurance of Information Practices.

**TAX PAYER IDENTIFICATION NUMBER CERTIFICATION -** Under penalties of perjury, the undersigned applicant(s) (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, the undersigned applicant(s) (I) authorize any licensed physician, medical practitioner, health care professional, hospital, clinic, or other 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 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 (24 months in KS, KY, ND, NE, NH, NM, OK, WV & WY) 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, KY, NM, OH and PA Residents:** Any person who knowingly, and with intent to defraud any insurance company or other person, files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

**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.

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

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

**Accelerated Death Benefit:** If the policy being applied for includes an accelerated death benefit(s), the Proposed Primary Insured understands and acknowledges: (1) Receipt of such benefits may affect eligibility for public assistance programs and benefits may be taxable; (2) Payment of this benefit will reduce the Insured's death benefit; (3) There is no additional premium for this benefit; and (4) The agent provided the Proposed Primary Insured the Accelerated Benefit Summary and Disclosure Statement(s) prior to or concurrent with this application.

**SIGNATURES**

| Signed At (City, State) | Date |
|---|---|
| | |

| Signature of Proposed Primary Insured (If 15 Years or Older), or Legal Guardian (If Primary Proposed Insured is a Minor) | Signature of Proposed Additional Insured |
|---|---|
| **X** | **X** |

Signature of Owner (If other than Proposed Primary Insured) (If Owner is Corporation, Trust, or other Entity, include Title of Signee.)

**X**

| Signature of Soliciting Agent | Print Agent's Last Name | Agent Code | Telephone Number ( ) |
|---|---|---|---|
| **X** | | | Cell Phone Number ( ) |

| Other Agent (Print) | % Credit | Agent Code | General Agent (Print) | Agent Code |
|---|---|---|---|---|
| | | | | |
| Other Agent (Print) | % Credit | Agent Code | General Agent (Print) | Agent Code |
| | | | | |

**Application for Policy or Certificate, Conversion, Change, or Reinstatement**

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

*1032C*

**1. Instructions/Information**

- Answer Medical/Insurability questions if: (a) reinstating; (b) increasing face amount; (c) adding benefits or riders; (d) requesting change to non smoker status (or if original plan did not distinguish between smokers and non-smokers and non-smoker rates are desired); (e) Death Benefit Option; (f) rating reduction/removal; and (g) Exchanging.
- Must remit full modal premium or EFT authorization to complete the change.
- Be certain to obtain Owner's signature.

**Section A - To be completed for ALL requests. Check appropriate box.**

☐ **Change** ☐ **Review Rating** ☐ **Reinstatement** ☐ **Conversion** ☐ **Class Change**
☐ **Increase** ☐ **Add Rider** ☐ **Decrease** ☐ **Option Change** ☐ **Exchange**

EXISTING COVERAGE: ☐ Universal Life ☐ Index Universal Life ☐ Variable Universal Life ☐ Whole Life ☐ Term ☐ Rider ☐ Mizer

Policy/Certificate Number

**PRIMARY PROPOSED INSURED**

**2.** Last Name | First Name | Middle Initial

**2a.** Are you a U.S. Citizen or do you have a permanent Visa? ☐ Yes ☐ No

| Sex: ☐ Male ☐ Female | Date of Birth | Age | Place of Birth – State / Country | Height (FT. IN) | Weight (LBS.) | Marital Status |
|---|---|---|---|---|---|---|
| | | | | | | |

| Social Security Number | Driver's License Number | Expiration Date | State |
|---|---|---|---|
| | | | |

**3.** RESIDENCE ADDRESS Street City State Zip Code

**3 a.** How long at this address? (If less than 2 years, provide previous address.)

_____ Years _____ Months

**3b.** BILLING ADDRESS (If other than residence) Street City State Zip Code

**3c.** SECONDARY ADDRESS Street City State Zip Code

**4.** Employer (Company Name and Address)

| Occupation (Title and Duties) | Net Income $ | Annual Income $ | Net Worth $ |
|---|---|---|---|
| | | | |

**5.** CONTACT THE PROPOSED INSURED AT:
☐ RESIDENCE
_____ (CST) ☐ AM ☐ PM
☐ BUSINESS

RESIDENCE TELEPHONE NUMBER
Primary Insured ( ) _____
Additional Insured ( ) _____
Cell Phone ( ) _____

BUSINESS TELEPHONE NUMBER
Primary Insured ( ) _____
Additional Insured ( ) _____
Cell Phone ( ) _____

**Section B – To be completed for Changes and Conversions**

**6.** Death Benefit Option
☐ Level ☐ Increasing ☐ Return of Premium

For Conversions, the balance of the Plan or Rider is to be:
☐ continued in force ☐ terminated ☐ decreased

| Name of New Plan | New Policy/Certificate Date | $ Amount of Insurance |
|---|---|---|
| | _____ Mo. _____ Yr. | |

For Applicable Products Only:
☐ Guideline Level Premium Test
☐ Cash Value Accumulation Test

☐ Preferred Plus Non-Smoker
☐ Preferred Non-Smoker
☐ Non Smoker
☐ Preferred Smoker
☐ Smoker
☐ Tobacco
☐ Preferred Tobacco
☐ Non-Tobacco
☐ Preferred Plus Non-Tobacco
☐ Preferred Non-Tobacco

Tele-Interview: ☐ Yes ☐ No

Exchange Commission Option (Agent use only) ☐ A ☐ B

Product Commission Option ☐ A ☐ B ☐ C

**6a. In the boxes below, enter the amount of changes only. NOTE: The Total Amount/Units column should reflect the new TOTAL after the change.**

| RIDER/BENEFIT | ADD | DELETE | TRANSFER | INCREASE BY | DECREASE BY | CONVERT | OTHER | Total Amount |
|---|---|---|---|---|---|---|---|---|
| Base Plan * | | | | | | | | |
| CIR | | | | | | | | |
| LNR | | | | | | | | |
| OIR/AIR | | | | | | | | |
| WP/WC | | | | | | | | |
| ADB | | | | | | | | |
| APL (Whole Life Only) | | | | | | | | |
| IPGR/XPGR | | | | | | | | |
| GIR.OPAI | | | | | | | | |
| Return of Premium Rider | | | | | | | | |
| ABR-C/ABR-T | | | | | | | | |
| WOSC | | | | | | | | |
| Other | | | | | | | | |

(CIR) Childrens Rider
(LNR Living Needs Rider
(OIR) Other Insured Rider / (AIR) Add'l Insured Rider
(WP/WC) Waiver of Premium / Waiver of Charges
(ADB) Accidental Death Benefit
(APL) Automatic Premium Loans Whole Life Only
(IPGR) Innovation Premium Guarantee / (XPGR) Premium Guarantee Rider
(GIR) Guaranteed Insurability Rider / (OPAI) Option to Purchase Add'l Insurance
(ABR-C) Accelerated Benefits – Chronic Illness / (ABR-T)Accelerated Benefits – Terminal
(WOSC) Waiver of Charges

*** Please review your policy or certificate contract as a decrease may result in a surrender charge being assessed.**

**ADDITIONAL INSURED PROPOSED FOR INSURANCE** (Complete Separate Application for Business Associates and Multiple/Additional Insureds)

**7.** Last Name | First Name | Middle Initial

**7a.** Are you a U.S. Citizen or do you have a permanent Visa? ☐ Yes ☐ No

| Sex: ☐Male ☐Female | Date of Birth | Age | Place of Birth – State / Country | Height (FT. IN) | Weight (LBS.) | Relationship to Insured |
|---|---|---|---|---|---|---|
| | | | | | | |

| Social Security Number | Driver's License Number | Expiration Date | State |
|---|---|---|---|
| | | | |

**8.** Employer (Company Name and Address)

Occupation (Title and Duties) | Annual Income $

**9. DEPENDENT CHILDREN PROPOSED FOR INSURANCE**

| Name | Date of Birth | Place of Birth State/Country | Age | Sex | Social Security Number | Height (FT. IN) | Weight (LBS.) | Relationship To Proposed Insured |
|---|---|---|---|---|---|---|---|---|
| | | | | | | | | |
| | | | | | | | | |
| | | | | | | | | |
| | | | | | | | | |
| | | | | | | | | |

**10. 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 and complete Trust Form.

OWNER ADDRESS Street | City | State | Zip Code

| Relationship to Primary Insured | Owner's Social Security Number or Tax ID # |
|---|---|
| | |

**11. PRIMARY BENEFICIARY** If percentage shares are not listed below, they will be divided equally among the beneficiaries. Provide Beneficiary(ies) Full Name(s). (If Trust, list Name and Date of Trust and complete Trust Form.)

| Name | Percent | Relationship to Primary Insured | Social Security Number or Tax ID # |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |
| **Total** | **100** | | |

NOTE: PRIMARY BENEFICIARY designations do not apply to others covered under Family/Children's Insurance riders.

**12. CONTINGENT BENEFICIARY** If percentage shares are not listed below, they will be divided equally among the beneficiaries. Provide Beneficiary(ies) Full Name(s). (If Trust, list Name and Date of Trust and complete Trust Form.)

| Name | Percent | Relationship to Primary Insured | Social Security Number or Tax ID # |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |
| **Total** | **100** | | |

**13. 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?**

**13a. 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 _____

**13b. Additional Insured Rider ☐ Yes ☐ No If "yes", provide: Type of product(s) used:** _____

Amount Used: _____ How Often: Daily ___ Weekly ____ Monthly ____ Date of last use: mm/yy _____

**PREMIUM INFORMATION**

**14.** Premium Frequency: ☐ Annual ☐ Semi-Annual ☐ Quarterly ☐ Monthly ☐ Single Pay ☐ Lump Sum $_____

Premium Mode: ☐ EFT ☐ List Billing ☐ Direct Billing (A, SA, Q) Only ☐ Civil Service Allotment ☐ Military Government Allotment

List Bill Code _____ Other _____

**For term and whole life policies or certificates, if you elect to pay premium on a basis other than annual, you may pay more premium than would be required if you paid premium on an annual basis.**

Amount of Modal Premium $ _____ Amount Paid with Application $ _____

**Make all checks payable to: MIDLAND NATIONAL LIFE INSURANCE COMPANY**

| | | |
|---|---|---|
| **15**. FOR EFT ONLY:<br>DRAW DATE ____ ____<br>(1ST –28TH) Month Day | ACCOUNT TYPE<br>☐ Checking (attach voided check) | AUTHORIZED SIGNATURE(S) OF ACCOUNT HOLDER(S)<br>**X** |
| **15a**. Initial Draft ☐ Yes ☐ No | ☐ Savings (must completed 15b) | **X** |
| **15b**. Routing Transit Number | Account Number | Financial Institution Name and Address |

## REPLACEMENT INFORMATION

**16.** Does any person proposed for coverage have any life insurance or annuities currently in force or pending? ☐ Yes ☐ No If Yes, list below. (This includes policies or certificates 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.)

| Name | Company | Policy/Certificate Number | Pending | Issue Yr. | Basic Amount | ADB Amount | WP Amount | Intention of Replacement Or Change * |
|---|---|---|---|---|---|---|---|---|
| **16a.** | | | ☐ | | | | | **17a.** ☐ Yes ☐ No |
| **16b.** | | | ☐ | | | | | **17b.** ☐ Yes ☐ No |
| **16c.** | | | ☐ | | | | | **17c.** ☐ Yes ☐ No |
| **16d.** | | | ☐ | | | | | **17d.** ☐ Yes ☐ No |

* Replacement means that the insurance applied for may replace, change or use any value of an existing or pending life insurance policy or certificate or annuity. If replacement may be involved, complete applicable replacement form and submit with application. Also complete Section 18 below. If this is a 1035 Exchange, also complete 1035 Exchange paperwork and submit with application.

**18.** I(We) originally purchased the above insurance on or around (date):

Please print the name of the Agent that you bought the original insurance from, if known.

Approximate net value to be received from exchange product: $ _____

Surrender charge that may be incurred on This transaction: $ _____

Front End Load (if any) at time of original product purchase:
$ _____ or _____ %

It is my (Our) intention to reinvest the net value received from this transaction into:
☐ Universal Life ☐ Variable Life ☐ Other

Will this transaction result in a taxable event?
☐ Yes ☐ No

Does this transaction qualify as a non-taxable exchange under IRS Section 1035 rules?
☐ Yes ☐ No
If yes, complete 1035 Exchange paperwork.

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

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

**19.** Are any of the above policies or certificates being used to fund this policy or certificate? ..... ☐ Yes ☐ No

**20.** Has, or will, any person proposed for insurance, or owner of this policy or certificate, been compensated in any way to purchase this policy or certificate? ..... ☐ Yes ☐ No

**21.** Is the proposed insured(s), or owner of this policy or certificate, paying for this policy or certificate with his/her own funds? ..... ☐ Yes ☐ No

**22.** Will the proceeds of a home equity loan or reverse mortgage transaction be used to pay the premiums on this policy or certificate? ..... ☐ Yes ☐ No

**23.** Has the person proposed for insurance, or owner of this policy or certificate, financed, or intend to finance, all or a portion of the premiums for this policy or certificate? If yes, complete Disclosure and Acknowledgement Form for premium financing and submit with application. ..... ☐ Yes ☐ No

**24.** Has the policy owner or certificate owner, beneficiary, or any person proposed for insurance entered into or considering any other agreement with a third party, trust, or other entity, in regard to this policy or certificate, including, but not limited to, an agreement to sell, transfer or assign the policy or certificate or any policy or certificate rights or beneficial interests? ..... ☐ Yes ☐ No

If the answer is 'Yes' to questions 19, 20, 22 or 24 provide details below. If answer to question 21 is 'No' provide details below.

## TO BE COMPLETED BY SOLICITING AGENT

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 the policy or certificate being applied for includes an accelerated death benefit(s), the agent provided the Proposed Primary Insured the Accelerated Benefit Summary and Disclosure Statement(s) prior to or concurrent with this application? ..... ☐ Yes ☐ No

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

**25. SPECIAL REQUESTS OR DETAILS**

**TO BE COMPLETED FOR MILITARY PERSONNEL (Including National Guard and Reserves)**

**26.** Permanent Home of Record — Street — City — State — Zip Code

**27.** Military Address — Street — City — State — Zip Code

**28. Job Duties**

**29.** Are you currently drawing extra duty or hazard pay? ☐ Yes ☐ No

**30.** Military Information ☐ USA ☐ USN ☐ USAF ☐ Other (Specify) _____ Military ID _____
Pay Grade _____ Rotation Date _____ Expected Discharge Date _____

**31.** Has the Proposed Insured, applied to be a member of, or been a member of a special forces, special or hazardous duty organization? ☐ Yes ☐ No
If Yes, provide specific details.

**32.** Has the Proposed Insured been alerted to, volunteered for, or received formal orders to a hazardous area or overseas assignment? ☐ Yes ☐ No
If Yes, provide specific details.

**UNDERWRITING QUESTIONS**

**Questions 33 must be completed for ALL Proposed Insureds, including CIR. Details to "Yes" answers are to be provided in the Details Section below.**

| **33.** Has any person proposed for insurance: | **Yes** | **No** |
|---|---|---|
| (a) In the past 10 years used barbiturates, hallucinatory drugs, narcotics including crack, ecstasy, opium derivatives, marijuana, LSD, PCP, or any derivatives of these drugs, or been advised by a licensed medical professional to get, or undergone any treatment, counseling or hospitalization for drug abuse? | ☐ | ☐ |
| (b) In the past 10 years been advised by a licensed medical professional to limit your alcohol use or been advised to get, or undergone any treatment or counseling or hospitalization for alcoholism, excessive alcohol use or abuse? Or, have you subsequently consumed alcohol after receiving counseling or treatment for alcohol use? Or, drink on average more than 3 alcoholic drinks per day? | ☐ | ☐ |
| (c) In the past 10 years had their driver's license revoked or suspended or been convicted of reckless driving, driving without a valid license, or for driving while under the influence of alcohol or drugs (DWI, DUI)? | ☐ | ☐ |
| (d) Had more than one speeding violation, or any motor vehicle moving violations or accidents or been arrested for driving under the influence of alcohol within the past 5 years? | ☐ | ☐ |
| (e) In the past 10 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 them at this time? | ☐ | ☐ |
| (f) Flown a plane in the past 24 months or plan to fly in the next 12 months as a pilot, copilot, student pilot, military pilot, engineer or in any other capacity except as a regularly scheduled commercial airline pilot or fare-paying passenger? | ☐ | ☐ |
| (g) In the past 12 months or in the next 12 months, engaged in or plan to engage in activities including: hang gliding, skydiving, motor vehicle/cycle racing, rock climbing, ballooning, bungee jumping, mountain climbing, motor boat racing, snowmobile racing, ultra light aircraft flying, scuba diving to more than 50 feet in depth, or in caves, ship wrecks or deep seas or other extreme sports? | ☐ | ☐ |
| (h) In the past 10 years been refused for life insurance or charged an extra premium for life insurance? | ☐ | ☐ |
| (i) Traveled to or resided for more than 30 days outside of the U.S., U.S. territories, Canada, or Japan within the past 12 months or plan to travel to or reside outside of the U.S., U.S. territories, Canada, or Japan in the next 12 months? | ☐ | ☐ |
| (j) Have any bankruptcy pending or expect to file bankruptcy in the next 12 months? | ☐ | ☐ |

**DETAILS TO 'YES' ANSWERS FOR QUESTIONS FROM SECTION 33(a) THROUGH 33(j)**

| Question # | Proposed Insured's Name | Dates and Details |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |

**Questions 34 through 37 must be completed for ALL Proposed Insureds, including CIR, not subject to a full paramedical exam. Details to "Yes" answers are to be provided in the Details Section below.**

| | | Yes | No |
|---|---|---|---|
| **34.** | In the past 10 years, has any person proposed for insurance been diagnosed by a licensed medical professional, treated or advised to get treatment from a licensed medical professional, hospitalized, or presently taking prescription(s) or medication(s) for any of the following disease(s) or disorder(s): | | |
| | (a) Angina, chest pain, heart attack, heart failure, heart surgery, irregular heartbeat, abnormal EKG, coronary artery bypass, angioplasty, stents, peripheral vascular disease, poor circulation, valvular heart disease, cardiomyopathy or heart murmur?.... | ☐ | ☐ |
| | (b) High blood pressure, hypertension or abnormal cholesterol levels? ..... | ☐ | ☐ |
| | (c) Stroke, seizures, epilepsy, dizziness, fainting, memory disorder or any other neurological or brain disorder? ..... | ☐ | ☐ |
| | (d) Multiple Sclerosis, neuritis, neuropathy, paralysis, muscular dystrophy, Parkinson's disease or any other disorder of the muscles? ..... | ☐ | ☐ |
| | (e) Arthritis, chronic pain, fibromyalgia, connective tissue disease, lupus or scleroderma? ..... | ☐ | ☐ |
| | (f) Cancer, malignancy, tumor, melanoma, lymphoma, Hodgkin's disease or leukemia? ..... | ☐ | ☐ |
| | (g) Chronic obstructive pulmonary or lung disease, chronic bronchitis, emphysema, sarcoidosis, asthma, shortness of breath, tuberculosis or sleep apnea? ..... | ☐ | ☐ |
| | (h) Diabetes, abnormal blood sugar, sugar in the urine, disease or disorders of the adrenal, parathyroid, pituitary or thyroid glands? .... | ☐ | ☐ |
| | (i) Disorder of the kidney, bladder or urinary system, abnormal PSA, abnormal pap smear without subsequent normal pap smear or protein or blood in the urine? ..... | ☐ | ☐ |
| | (j) Anemia, hemophilia, clotting disorder or any other disorder of the blood? ..... | ☐ | ☐ |
| | (k) Immune Deficiency disorder (Acquired Immune Deficiency Syndrome (AIDS)), AIDS related complex (ARC) or been told test results indicate exposure to the AIDS virus? ..... | ☐ | ☐ |
| | (l) Colitis, ulcerative colitis, Crohn's, esophageal varices, peptic or gastric ulcer, intestinal or rectal bleeding, diverticulitis, colon polyps, cirrhosis, hepatitis, liver failure, liver impairment, loss of bowel function or other disease or disorder of the liver or pancreas? ..... | ☐ | ☐ |
| | (m) Depression, anxiety, stress, eating disorder or any other nervous, mental or emotional condition? ..... | ☐ | ☐ |
| | (n) Any mental or physical disorder or medically or surgically treated condition not listed above? ..... | ☐ | ☐ |
| **35.** | Other than indicated above, has any person proposed for insurance: | | |
| | (a) Had a parent or sibling who before age 60 was diagnosed with or died from cardiovascular disease, stroke, cancer (except basal or squamous cell cancer of the skin), Huntington's Chorea, familial polyposis or polycystic kidney disease? ..... If yes, provide age at onset and current age if living. If deceased, age at death. | ☐ | ☐ |
| | (b) Had a weight gain or loss of 10 or more pounds within the past 12 months for any reason other than pregnancy? ..... | ☐ | ☐ |
| | (c) In the past 12 months been advised by a licensed medical professional to have a check up, EKG, X-ray, blood or urine test or any other diagnostic test or are you now planning to seek medical advise or treatment for any reason? ..... | ☐ | ☐ |
| | (d) In the past 12 months been advised by a licensed medical professional to be admitted to a hospital, medical facility, nursing home or assisted living facility? ..... | ☐ | ☐ |
| **36.** | Is any person proposed for insurance currently taking any prescription medications, herbal remedies or non-prescription medications for any disease or disorder not listed above? ..... If yes, list the medications and remedies and the reasons for which they are taken. | ☐ | ☐ |
| **37.** | Is any person proposed for insurance currently receiving or have an application pending for any illness or disability benefits or compensation? ..... | ☐ | ☐ |

**DETAILS TO 'YES' ANSWERS FOR QUESTIONS 34 THROUGH 37**

| Question # | Proposed Insured's Name | Date, Diagnosis, Treatment, Results and Duration | Name, Address and Phone # of Attending Physician and Hospital |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

**38.** If not listed above, please provide full name, address and phone numbers of personal physician(s) and any other physician(s) consulted in the past five years for each person proposed for coverage.

(a) Date and findings of last visit:

(b) Tests performed and treatment received:

**CUSTOMER IDENTIFICATION**

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

## A. Owner #1

Natural Person/Trust Accounts (info on trustee)

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

## B. Owner #2

Natural Person/Trust Accounts (info on trustee)

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

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) the acceptance of any policy or certificate or policy change or certificate change 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(s).The undersigned FURTHER AGREES 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 or Certificate or policy change or certificate change is effective, as defined herein.

**Effective Date - Any insurance issued as a result of this application will not take effect until approved by the Company and 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.**

The undersigned applicant(s) acknowledges receipt of the Fair Credit Reporting Act notice/MIB, Inc., Notice and Notice of Insurance of Information Practices.

**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, the undersigned applicant(s) authorize any licensed physician, medical practitioner, health care professional, hospital, clinic, or other 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 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 (24 months in KS, KY, ND, NE, NH, NM, OK, WV & WY) 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, KY, NM 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.

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

**Accelerated Death Benefit:** If the policy or certificate being applied for includes an accelerated death benefit(s), the undersigned applicant(s) understands and acknowledges: (1) Receipt of such benefits may affect eligibility for public assistance programs and benefits may be taxable; (2) Payment of this benefit will reduce the Insured's death benefit; (3) There is no additional premium for this benefit; and (4) The agent or I, the applicant was provided the Accelerated Benefit Summary and Disclosure Statement(s) prior to or concurrent with this application.

**NOTE: IF APPLYING FOR VARIABLE LIFE INSURANCE: THE DEATH BENEFIT MAY BE VARIABLE OR FIXED UNDER CERTAIN CONDITIONS. CASH VALUES MAY INCREASE OR DECREASE, EVEN TO THE EXTENT OF BEING REDUCED TO ZERO, IN ACCORDANCE WITH THE EXPERIENCE OF THE SEPARATE ACCOUNT (SUBJECT TO ANY SPECIFIED MINIMUM GUARANTEES).**

| **SIGNATURES** | | | | | |
|---|---|---|---|---|---|
| Signed At (City, State) | | | | Date | |
| Signature of Proposed Primary Insured (If 15 Years or Older), or Legal Guardian (If Primary Proposed Insured is a Minor)<br>**X** | | Signature of Proposed Additional Insured<br>**X** | | | |
| Signatures of Owner(s) (If other than Proposed Primary Insured) (If Owner is Corporation, Trust or other Entity, include Title of Signee.)<br>**X** | | | | | |
| Signature of Soliciting Agent<br>**X** | Print Agent's Last Name | Agent Code | Telephone Number ( )<br>Cell Phone Number ( ) | | |
| Other Agent (Print) | % Credit | Agent Code | General Agent (Print) | Agent Code | |

**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 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 | 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
☐ BUSINESS
_____ Time (CST) ☐ A.M. ☐ P.M.

RESIDENCE TELEPHONE NUMBER
Primary Insured ( )
Spouse ( )
Cell Phone ( )

BUSINESS TELEPHONE NUMBER
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)
☐ Option I ☐ Option II ☐ Rebalance
☐ Minimum Premium ☐ Target Premium

☐ Automatic Premium Loan (Whole Life Only)

Enhanced Corridor Percentage SVUL
☐ 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 BENFICIARY 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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**Statement of Variability - Policy Form L13403 with Schedule Pages LS134A**

With the exception of the variables specific to the individual policyholder, the following is a list of bracketed items and the corresponding range of text and/or values. Some items are bracketed for future flexibility

| Bracketed Item | Variable Text/Range |
|---|---|
| Premium Class | Preferred Plus, Preferred Non-Tobacco, Non-Tobacco, Preferred Tobacco, and Tobacco |
| Death Benefit Option | 1 (Level), 2 (Increasing) |
| Policy Expense Charge | $0 - $8 per month for 0-100 policy years (length varies by issue age) |
| Unit Expense Charge | $0 - $2.00 per month for 0-100 policy years (varies by issue age and Premium Class) |
| Maximum Premium Load | 0% - 2% of premiums received for All policy years |
| Percent of Fund Charge | 0% - 0.07% per month for 0-100 policy years (length varies by issue age) |
| Interest Bonus on Fixed Account | 0% - 0.5% in policy years 21+ |
| Index Credit Bonus on Index Account Value | 0% - 0.5% in policy years 21+ |
| Initial Policy Year for Zero Cost Loans | 0-10 |
| Subsequent Comparisons For Minimum Policy Fund Value | Every 1-12 policy years thereafter |
| Initial Policy Year for Variable Interest Loans | 0-10 |
| Minimum Specified Amount | $25,000 -1025,000 |
| Minimum Increase Amount | $10,000 - $25,000 |
| Maximum Withdrawal Charge | $0 - $25 |
| Minimum Withdrawal Amount | $100 - $1000 |
| Waiver of Surrender Charge Monthly Rate Per $1,000 | $0 to $0.08 (varies by issue age) |
| Life Insurance Qualification Test | Guideline Premium Test or Cash Value Accumulation Test |
| Surrender Charges | Varies by Sex, Issue Age, Premium Class, Policy Year |
| Index | The Indexes have been bracketed in the event an Index is discontinued or substantially changed and can no longer be utilized by the company. If this occurs the index name and corresponding disclosure will not print for future issues of the policy. If a new Index is added, it will be submitted along with the revised schedule pages to the Department for prior approval, if required. |
| Minimum Index Participation Rate – Annual Point to Point, Monthly Point-to-Point, & Multi-Index Annual Point-to-Point | 50% - 120% |
| Minimum Index Participation Rate – Daily Averaging | 10% - 75% |
| Minimum Index Cap Rate – Annual Point-to-Point & Multi-Index Annual Point-to-Point | 2% - 8% |
| Minimum Index Cap Rate – Monthly Point-to-Point | 1% - 3% |
| Index Disclosures | This text is prescribed by each Index and is bracketed in the event the Index changes the required disclosure text. This text will not be changed unless required by the Index. |
| Best-Performing Index Weight – Multi-Index Annual Point-to-Point | 0% - 100% |
| Second-Best-Performing Index Weight – Multi-Index Annual Pointto-Point | 0% - 100% |
| Third-Best-Performing Index Weight – Multi-Index Annual Point-to-Point | 0% - 100% |

**Statement of Variability - Policy Form Series L14003 w/Schedule Pages LS140A**

The following is a list of bracketed items and the corresponding range of text and/or values. Some of the items are bracketed for future flexibility.

The following criteria are used to determine the value of each bracketed item:
- Consumer demands and preferences
- The market conditions and the competitive environment.
- The economic environment and its impact on our investment portfolio.
- The Company's experience for lapses, mortality and expenses

| Bracketed Item | Variable Text/Range |
|---|---|
| **Owner** | Varies with consumer |
| **Policy Number** | Varies with consumer |
| **Insured** | Varies with consumer |
| **Policy Date** | Varies with consumer |
| **Sex** | Varies with consumer |
| **Issue Age** | Varies with consumer |
| **Maturity Date** | Varies with consumer |
| **Specified Amount** | Varies with consumer |
| **Planned Periodic Premium** | Amount varies by consumer; annually, semi-annual, quarterly, monthly |
| **Premium Class** | Preferred Plus Non tobacco, Preferred Non Tobacco, Preferred Tobacco, Non Tobacco, Standard Tobacco.<br>If a policy is table rated, additional text applies: Rated Tobacco, Rated Non-Tobacco The monthly cost of insurance is increased by xx%. The annual cost of insurance is increased by $x.xx per thousand of Specified Amount until xx/xx/xxxx. If the policy has a flat extra rating, additional text applies: The annual cost of insurance is increased by $x.xx per thousand of Specified Amount until xx/xx/xxxx The dollar range for the Flat extra is $1.00-$200.00 The table rating range is 25% - 400% |
| **Initial Premium Received** | Varies with consumer |
| **No Lapse Guarantee Premium** | Varies with consumer (varies by Issue Age, Sex, Premium Class, and Specified Amount) |
| **No Lapse Guarantee Period End Date** | 5-20 Years from Policy Date (varies by Issue Age of the Insured) |
| **Civil Service Allotment** | Premium includes a $1.00 per month Civil Service Allotment fee, for a total annual increase of $12.00.<br>This sentence will print on the schedule if the insured chooses Civil Service Allotment as a premium mode. |
| **Death Benefit Option** | The consumer can choose one of two Death Benefit Options: Level or Increasing |
| **Policy Expense Charge** | This charge is currently the same for all consumers and is bracketed for future flexibility. Range of Variability: $0 - $10 per month |
| **Unit Expense Charge** | Range of Variability: $0.0225 - $2.40 per month (varies by Issue Age, Sex, Premium Class, and Specified Amount) |

| | |
|---|---|
| **Premium Load** | This load is currently the same for all consumers and is bracketed for future flexibility. Range of Variability: 0% - 20% |
| **Percent of Account Charge** | 0% - 0. 50% per month for 0-100 policy years (length varies by issue age) |
| **Interest Bonus on the Fixed Account** | 0.25% - 1.00% Policy Years 10-100 |
| **Index Period** | Range of Variability 1 month to 24 months |
| **Index Bonus on the Index Account Value** | 0.25% - 1.00% Policy Years 10-100 |
| **Initial Comparisons for Minimum Account Value** | 5-10 policy years |
| **Subsequent Comparisons for Minimum Account Value** | Every 5-10 policy years after initial comparison |
| **Initial Policy Year for Net Zero Loans** | This item is bracketed for future flexibility. The Company currently permits Net Zero Cost Loans beginning in Policy Year 6.<br>Range of Variability: 6-11 |
| **Initial Policy Year for Variable Interest Loans** | 1-10 The bracketing of the initial year is intended to allow the flexibility of which type of policy loan would be available in what year.<br>Either a Variable Interest Loan or Standard Loan or both will be available when there is cash surrender value. |
| **Initial Policy Year for Standard Loans** | 1-10 The bracketing of the initial year is intended to allow the flexibility of which type of policy loan would be available in what year<br>Either a Variable Interest Loan or Standard Loan or both will be available when there is cash surrender value. |
| **Minimum Unscheduled Premium Payment** | $0 -$100 |
| **Minimum Specified Amount** | $25,000 - $250,000 |
| **Withdrawal Processing Fee** | $0 - $50 |
| **Minimum Increase Amount** | $10,000 - $50,000 |
| **Minimum Withdrawal Amount** | $100 - $1,000 |
| **Life Insurance Qualification Test** | Guideline Premium Test or Cash Value Accumulation Test |
| **Index Selections** | The Indexes have been bracketed in the event an Index is discontinued or substantially changed and can no longer be utilized by the company. If this occurs the index name and corresponding disclosure will not print for future issues of the policy. If a new Index is added, it will be submitted along with the revised schedule pages to the Department for prior approval, if required. |
| **Minimum Index Participation Rate – Annual Point to Point, Annual Inverse Point-to-Point, Monthly Point-to-Point, & Multi-Index Annual Point-to-Point** | 50% - 120% |
| **Minimum Index Participation Rate – Daily Averaging** | 10% - 40% |
| **Minimum Index Cap Rate – Annual Point-to-Point, Annual Inverse Point-to-Point & Multi-Index Annual Point-to-Point** | 2% - 4% |

| | |
|---|---|
| **Minimum Index Cap Rate – Monthly Point-to-Point** | 1% - 2% |
| **Best-Performing Index Weight – Multi-Index Annual Point-to-Point** | 0% - 100% |
| **Second-Best-Performing Index Weight – Multi-Index Annual Point to-Point** | 0% - 100% |
| **Third-Best-Performing Index Weight – Multi-Index Annual Point-to-Point** | 0% - 100% |
| **Index Disclosures** | This text is prescribed by each Index and is bracketed in the event the Index changes to the required disclosure text. This text will not be changed unless required by the Index. |
| **Surrender Charge Factor** | Range of Variability: $0 - $60 (Varies by Issue Age, Sex, Premium Class and Policy Year) |
| **Corridor Percentage** | Varies with consumer |
| **Guaranteed Cost of Insurance Rates** | Varies with consumer |
| **Additional Benefits Provided by Endorsement or Rider** | Endorsements and Riders are optional and/or specific underwriting criteria must be met for the insured. The expiry date, benefit units and annual premium would vary by insured.<br>Accelerated Benefit Endorsement<br>Chronic Illness - specific underwriting criteria must be met.<br>Cumulative Accelerated Benefit Percentage = Range of Variability 25% -75%<br><br>Previously approved riders may be added to this policy in the future. |
| **Schedule of Protected Death Benefit Amounts** | |
| **Protected Death Benefit Interest Rate** | 2% - 5% |
| **Protected Death Benefit Minimum Age** | 45 to 65 |
| **Protected Death Benefit Expense Charge** | $5 to $15 |
| **Protected Death Benefit Percentages** | 40% to 91% |
| **Premium Classes** | Preferred Plus Non tobacco, Preferred Non Tobacco, Preferred Tobacco, Non Tobacco, Standard Tobacco |
| **Guaranteed Protected Death Benefit Monthly Cost of Insurance Rates** | Varies with consumer |