North American Company
for Life and Health Insurance
Principal Office: 4601 Westown Pkwy, Suite 300
West Des Moines, IA 50266
A Member of the Sammons Financial Group

L29781

LEAVE WITH APPLICANT

CONSUMER PROTECTION NOTICES FOR THE PROPOSED INSURED

Investigative Consumer Report Notice

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

Insurance Information Practices

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

Medical Information Bureau Notice

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

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

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

Mail To: New Business • P.O. Box 5089 • Sioux Falls, SD 57117-5089

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North American Company
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O-2724

AGENT'S REPORT

Proposed Insured's Name	Social Security Number

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

2. How well do you know the Proposed Insured? (Check all that apply) ☐Self ☐Relative (state relationship) _____ ☐Met very recently

☐Know slightly ☐Known well for _____ years Known through: ☐Business ☐Home ☐Church ☐Other _____

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

_____

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

_____

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

_____

6. What is the purpose of this insurance? ☐Family protection ☐Mortgage Protection ☐Other debt retirement ☐Estate liquidity

☐Business (Complete Business Supplement) ☐Other _____

7. Is the purpose of this policy to fund college expenses? ☐Yes ☐No

a. If yes, do you schedule and/or participate in college funding or planning seminars or meetings? ☐Yes ☐No

b. If yes to (a), have you submitted the college planning advertising including seminar materials to the compliance department for review and approval? ☐Yes ☐No

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

_____

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

_____

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

_____

11. What underwriting requirements have you scheduled? ☐Paramed Exam and HOS ☐DBS, HOS ☐SMA ☐EKG ☐MD Exam ☐Treadmill EKG

☐Other _____ Examiner Name _____ Telephone Number _____

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

Signature of Agent	Agent Code Number	Date

NORTH AMERICAN COMPANY • ADMINISTRATIVE OFFICE: P. O. BOX 5088, SIOUX FALLS, SD 57117 • PRINCIPAL OFFICE: WEST DES MOINES, IA
Phone: (877) 872-0757 • www.nacolah.com

North American Company
for Life and Health Insurance
A Member of the Sammons Financial Group

Clear Form Clear Kit

O9221

TRANSMITTAL REPORT

Gold Team Phone: 800-669-9100 Fax: 800-951-9430 email: nbgold@nacolah.com
Purple Team Phone: 866-606-2943 Fax: 800-978-7959 email: nbpurple@nacolah.com

PLEASE PRINT

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

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

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

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

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

Please complete the following:

☐ **BCX**

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

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

POLICY NUMBER: _____
(if applicable)

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

If "No" please mail to:

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

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

Date submitted:_____ By:_____

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

North American Company
for Life and Health Insurance
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L2966ANS

LEAVE WITH APPLICANT
ACCELERATED BENEFIT SUMMARY AND DISCLOSURE STATEMENT

EFFECTIVE DATE – The Accelerated Benefit Endorsement effective date is the same as the Policy Date shown in the Policy Schedule.

PREMIUM – There is no cost for this Endorsement.

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

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

BENEFIT – Under the terms of the Endorsement, we will provide a payment of this Benefit during the lifetime of the Insured if the Insured develops a terminal illness. This will be an advance on the death benefit of this Policy. Payment of an Accelerated Benefit will reduce the amount of proceeds payable to your beneficiary.

The maximum amount of accelerated benefit payable is 75% of the Death Benefit (not to exceed $250,000) of this Policy. Benefits will not be paid more than once for any terminal illness.

EFFECT OF THE BENEFIT – The Policy will stay in force. You must pay any required premium when due unless premiums are being waived under a waiver of premium rider. Where applicable, cash values and loan balances and paid-up insurance will be reduced in the same proportion as the amount of benefit paid under this Endorsement. The amount of insurance is the amount of life insurance coverage provided by the Policy to which this Endorsement is attached and may be defined in the policy as "Specified Amount", "Face Amount" or "Amount of Insurance".

NOTICE AND PROOF OF CLAIM – To apply for this benefit, You must send Us the following:

1. Your written election of this option;
2. Your written designation of us as an irrevocable beneficiary for the portion of the policy death benefit proceeds equal to the Amount of the Accelerated Benefit;
3. Proof acceptable to us from a licensed physician other than the Insured or a member of his immediate family that:
   a. The Insured has been diagnosed as having a terminal illness;
   b. Such terminal illness was first diagnosed while the Insured was covered under this policy; and
   c. Such terminal illness is expected to result in death within two years.

We may require a second opinion and examination of the Insured at our expense by a physician designated by us.

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Purple Team: (866) 606-2943 • Fax: (800) 978-7959 • Gold Team: (800) 669-9100 • Fax: (800) 951-9430 • www.nacolah.com

We must receive a signed consent from any irrevocable beneficiaries and any assignees.

REINSTATEMENT OF ENDORSEMENT – If the base Policy terminated and is reinstated, the Endorsement may be included with the reinstated Policy, providing it was in force at the time of the Policy's termination.

Inquiries regarding this Summary should be directed to your agent, or to Us at:

North American Company for Life and Health Insurance
Administrative Office
P.O. Box 5088
Sioux Falls, South Dakota 57117-5088

Unless otherwise provided in the election of this option, the Payee may neither commute, anticipate, assign, alienate nor otherwise encumber any payment under this option. Proceeds under the policy and any rider and any payment under this endorsement will be exempt from the claims of creditors and from legal process to the extent permitted by law.

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North American Company
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West Des Moines, IA 50266
A Member of the Sammons Financial Group

L-31001

Authorization for Release of Health-Related Information

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

This Authorization complies with the HIPAA Privacy Rules

Name of Proposed Insured _____
(Please print)

Birth Date_____/_____/_____
Month Day Year

I authorize any health plan, physician, dental practitioner, health care professional, hospital, clinic, laboratory, pharmacy, medical facility, or other health care provider that has provided payment, treatment or services to me or on my behalf within the past 10 years ("My Providers") to disclose my entire medical record and any other protected health information concerning me to The North American Company for Life and Health Insurance and its agents, employees, and representatives. This includes information on the diagnosis or treatment of Human Immunodeficiency Virus (HIV) infection and sexually transmitted diseases. This also includes information on the diagnosis and treatment of mental illness and the use of alcohol, drugs, and tobacco, but excludes psychotherapy notes.

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

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

This Authorization shall remain in force for 30 months following the date of my signature below, and a copy of this Authorization is as valid as the original. I understand that I have the right to revoke this Authorization in writing, at any time, by sending a written request for revocation to North American Company for Life and Health Insurance at One Sammons Plaza, Sioux Falls, SD 57193, Attention: New Business. I understand that a revocation is not effective to the extent that any of My Providers has relied on this Authorization or to the extent that North American Company for Life and Health Insurance has a legal right to contest a claim under an insurance policy or to contest the policy itself.

Mail To: New Business • P.O. Box 5089 • Sioux Falls, SD 57117-5089

L-31002

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

_____

Signature of Proposed Insured or Personal Representative

_____

Date (MM/DD/YYYY)

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

_____

_____

North American Company
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L21531

NOTICE AND CONSENT FORM FOR AIDS VIRUS (HIV) TESTING

To evaluate your eligibility for insurance or insurance benefits, it is requested that you consent to be tested for the AIDS virus (HIV). By signing and dating this form, you agree that this test may be performed and that underwriting decisions will be based on the test results.

DISCLOSURE OF TEST RESULTS:

All test results will be treated confidentially. The results of the test will be reported to the insurer identified on this form. Results of the tests will not otherwise be disclosed except as allowed by law or as stated below.

MEANING OF TEST RESULTS:

While positive HIV antibody test results do not mean that you have AIDS, they do mean that you may be at increased risk of developing AIDS or AIDS-related conditions. The test is a test for antibodies of the HIV virus, the causative agent for AIDS, and shows whether you have been exposed to the virus.

Positive HIV antibody test results could adversely affect your application for insurance. This means that your application may be declined, that an increased premium may be charged, or that other policy changes may be necessary.

RELEASE OF RESULTS:

The results of this test may be released to the following:

(1) the proposed insured;
(2) the person legally authorized to consent to the test;
(3) a licensed physician, medical practitioner, or other person designated by the proposed insured;
(4) an insurance medical information exchange under procedures that are designed to assure confidentiality, including the use of general codes that also cover results of tests for other diseases or conditions not related to AIDS, or for the preparation of statistical reports that do not disclose the identity of any particular proposed insured;
(5) a reinsurer, if the reinsurer is involved in the underwriting process, under procedures that are designed to assure confidentiality;
(6) persons who have the responsibility to make underwriting decisions on behalf of the insurer; or
(7) insurer's legal counsel who needs such information to effectively represent the insurer in regard to matters concerning the proposed insured.

The insurer may contact you for the name of a physician or other health care provider to whom you may authorize disclosure and with whom you may want to discuss the results.

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CONSENT:

I have read and I understand this Notice and Consent Form. I voluntarily consent to testing and disclosure as described above. I understand that I have the right to request and receive a copy of this form. A photocopy of this form will be as valid as the original.

Date:_____

Signature of Proposed Insured or Parent/Guardian

Copy – Company Copy – Insured's Copy

Mail To: New Business • P.O. Box 5089 • Sioux Falls, SD 57117-5089

North American Company
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Clear Form | Clear Kit

L3182

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 ☐ Business _____ (CST) ☐ A.M. ☐ P.M.	Primary Insured ( ) Additional Insured ( ) Cell Phone ( )	Primary Insured ( ) Additional Insured ( ) Cell Phone ( )

PLAN INFORMATION

5. Amount Applied For	Proposed Plan of Insurance	6. For UL: (check if applicable)
$		☐ Level ☐ Increasing ☐ Return of Premium

7. RIDERS

a. Term Products

- ☐ Additional Insured Rider $ _____
- ☐ Children's Term Insurance Rider (CTR) _____ units
- ☐ Guaranteed Insurability Rider _____ units
- ☐ Monthly Income Endorsement: Initial Lump Sum $ _____
  $ _____ Monthly for _____ years; Final Lump Sum $ _____
- ☐ Waiver of Premium Rider
- ☐ Other _____ $ _____

b. Permanent Products

- ☐ Accidental Death Benefit $ _____
- ☐ Additional Insured Rider $ _____
- ☐ Automatic Distribution Option
- ☐ Children's Term Insurance Rider (CTR) _____ units
- ☐ Estate Preservation Rider
- ☐ Guaranteed Insurability Rider _____ units
- ☐ Premium Guarantee Rider
- ☐ Waiver of Monthly Deductions Rider
- ☐ Waiver of Surrender Charge Option
- ☐ Other _____ $ _____

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 _____ Other _____

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: NORTH AMERICAN COMPANY FOR LIFE & HEALTH INSURANCE

16. For EFT Only:	Account Type	Authorized Signature(s) of Account Holder(s)
Draw Day (1st - 28th) _____ Month _____ Day	☐ Checking (attach voided check)	X
16a. Initial Draft ☐ Yes ☐ No	☐ Savings (must complete 16b)	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 CTR. 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 CTR, 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, 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 North American Company for Life and Health Insurance (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) X	Signature of Proposed Additional Insured 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 X	Print Agent's Last Name	Agent Code	Telephone Number ( ) Cell Phone Number ( )	
Other Agent (Print)			% Credit	Agent Code
Other Agent (Print)			% Credit	Agent Code

Clear Form Clear Kit

North American Company
for Life and Health Insurance
A Member of the Sammons Financial Group

L16831

Electronic Fund Transfer Authorization

Attach one preprinted, blank, voided check

Step 1. Applicant/Insured (Last Name, First, M.I)	Social Security No.	Policy Number (if known)

Step 2A. New Applicants - Select Option

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

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

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

☐ Address Change New Address _____

_____

Step 2B. Existing Policy Owners/Payers

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

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

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

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

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

Bank Name _____ Account No._____

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

Enclose one preprinted, blank, voided check

Step 4. Authorization

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

Payer Signature _____ Date _____

Terms and Conditions

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

FOR OFFICE USE ONLY

Processed by: _____Date:_____ Control #:_____

NORTH AMERICAN COMPANY • ADMINISTRATIVE OFFICE: P. O. BOX 5088, SIOUX FALLS, SD 57117 • PRINCIPAL OFFICE: WEST DES MOINES, IA
Phone: (877) 872-0757 • www.nacolah.com

North American Company
for Life and Health Insurance
Principal Office: 4601 Westown Pkwy, Suite 300
West Des Moines, IA 50266
A Member of the Sammons Financial Group

Clear Form Clear Kit

L29681

IMPORTANT NOTICE:
REPLACEMENT OF LIFE INSURANCE OR ANNUITIES

This document must be signed by the applicant and the producer, if there is one, and a copy left with the applicant.

You are contemplating the purchase of a life insurance policy or annuity contract. In some cases, this purchase may involve discontinuing or changing an existing policy or contract. If so, a replacement is occurring. Financed purchases are also considered replacements.

A *replacement* occurs when a new policy or contract is purchased and, in connection with the sale, you discontinue making premium payments on the existing policy or contract, or an existing policy or contract is surrendered, forfeited, assigned to the replacing insurer, or otherwise terminated or used in a financed purchase.

A *financed purchase* occurs when the purchase of a new policy involves the use of funds obtained by the withdrawal or surrender of or by borrowing some or all of the policy values, including accumulated dividends, of an existing policy, to pay all or part of any premium or payment due on the new policy. A financed purchase is a replacement.

You should carefully consider whether a replacement is in your best interest. You will pay acquisition costs and there may be surrender costs deducted from your policy or contract. You may be able to make changes to your existing policy or contract to meet your insurance needs at less cost. A financed purchase will reduce the value of your existing policy and may reduce the amount paid upon the death of the insured.

We want you to understand the effects of replacements before you make your purchase decision and ask that you answer the following questions and consider the questions on the back of this form.

1. Are you considering discontinuing making premium payments, surrendering, forfeiting, assigning to the insurer, or otherwise terminating your existing policy or contract? ☐ YES ☐NO
2. Are you considering using funds from your existing policies or contracts to pay premiums due on the new policy or contract? ☐YES ☐NO

If you answered "yes" to either of the above questions, list each existing policy or contract you are contemplating replacing (include the name of the insurer, the insured or annuitant and the policy or contract number if available) and whether each policy or contract will be replaced or used as a source of financing:

INSURER NAME	CONTRACT OR POLICY #	INSURED OR ANNUITANT	REPLACED (R) OR FINANCING (F)
1.			
2.			
3.			

Make sure you know the facts. Contact your existing company or its agent for information about the old policy or contract. If you request one, an in-force illustration, policy summary or available disclosure documents must be sent to you by the existing insurer. Ask for and retain all sales material used by the agent in the sales presentation. Be sure that you are making an informed decision.

The existing policy or contract is being replaced because _____.

I certify that the responses herein are, to the best of my knowledge, accurate:

_____ _____
Applicant's Signature and Printed Name Date

_____ _____
Producer's Signature and Printed Name Date

I do not want this notice read aloud to me. _____ (Applicants must initial only if they do not want the notice read aloud.)

Producer's Statement

I certify that only sales materials approved by North American Company for Life and Health Insurance were used in conjunction with this transaction, and copies of all sales materials including this Important Notice were left with the applicant. If applicable, electronically presented sales materials shall be provided in printed form to the applicant no later than at the time of policy or contract delivery.

_____ _____
Producer's Signature and Printed Name Date

Mail To: New Business • P.O. Box 5089 • Sioux Falls, SD 57117-5089

L29682

A replacement may not be in your best interest, or your decision could be a good one. You should make a careful comparison of the costs and benefits of your existing policy or contract and the proposed policy or contract. One way to do this is to ask the company or agent that sold you your existing policy or contract to provide you with information concerning your existing policy or contract. This may include an illustration of how your existing policy or contract is working now and how it would perform in the future based on certain assumptions. Illustrations should not, however, be used as a sole basis to compare policies or contracts. You should discuss the following with your agent to determine whether replacement or financing your purchase makes sense:

PREMIUMS:

Are they affordable?

Could they change?

You're older--are premiums higher for the proposed new policy?

How long will you have to pay premiums on the new policy? On the old policy?

POLICY VALUES:

New policies usually take longer to build cash values and to pay dividends.

Acquisition costs for the old policy may have been paid; you will incur costs for the new one.

What surrender charges do the policies have?

What expense and sales charges will you pay on the new policy?

Does the new policy provide more insurance coverage?

INSURABILITY:

If your health has changed since you bought your old policy, the new one could cost you more, or you could be turned down.

You may need a medical exam for a new policy.

Claims on most new policies for up to the first two years can be denied based on inaccurate statements.

Suicide limitations may begin anew on the new coverage.

IF YOU ARE KEEPING THE OLD POLICY AS WELL AS THE NEW POLICY:

How are premiums for both policies being paid?

How will the premiums on your existing policy be affected?

Will a loan be deducted from death benefits?

What values form the old policy are being used to pay premiums?

IF YOU ARE SURRENDERING AN ANNUITY OR INTEREST SENSITIVE LIFE PRODUCT:

Will you pay surrender charges on your old contract?

What are the interest rate guarantees for the new contract?

Have you compared the contract charges or other policy expenses?

OTHER ISSUES TO CONSIDER FOR ALL TRANSACTIONS:

What are the tax consequences of buying the new policy?

Is this a tax-free exchange? (See your tax advisor.)

Is there a benefit from favorable "grandfathered" treatment of the old policy under the federal tax code?

Will the existing insurer be willing to modify the old policy?

How does the quality and financial stability of the new company compare with your existing company?

RIGHT TO EXAMINE POLICY – It is important to us that you are satisfied with your policy and that if meets your insurance goals. Read it carefully. If you are not satisfied with it, you may return it to our Home Office or to your agent within 30 days after you received it. We will then void it and refund all premiums paid .

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L2977R

TEMPORARY LIFE INSURANCE AGREEMENT

Proposed Primary Insured	Proposed Additional Insured(s)

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

I. REPRESENTATIONS

Has any person listed above as a Proposed Primary Insured or Proposed Additional Insured(s):	Yes	No
1. In the past five years, been diagnosed, treated for, or been advised to be treated for: heart disease; vascular disease; stroke; cancer; leukemia; malignant tumor; alcohol or drug dependence or abuse; insulin dependent diabetes; or disorder of the brain or immune system?	☐	☐
2. In the past five years, had any unintentional weight loss or any symptoms of a disease or an impairment for which a physician has not been consulted?	☐	☐
3. In the past 90 days, been admitted, or medically advised by a member of the medical profession to be admitted, to a hospital or other licensed health care facility, had surgery performed or recommended, or been medically advised to have any diagnostic test that has not been completed?	☐	☐
4. In the past ten years, been convicted of any criminal activity, or been held or served time in any type of incarceration, jail, penitentiary, prison, probation, or parole program? Or have any criminal charges pending against him/her at this time?	☐	☐
5. Is any person proposed for insurance under 15 days of age or over 70 years of age?	☐	☐

II. TERMS AND CONDITIONS

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

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

(a) the amount of all death benefits applied for in the Application; or
(b) $1,000,000.

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

2. DATE TEMPORARY COVERAGE BEGINS

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

3. DATE TEMPORARY COVERAGE TERMINATES

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

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

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

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

4. SPECIAL LIMITATIONS

(a) Fraud or material misrepresentation in the Application or in this Agreement shall invalidate this Agreement and the Company's only liability is to refund any advance premium payment made.

(b) There is no insurance under this Agreement if the check, initial EFT draft or credit card authorization is not honored when presented.

(c) If the Proposed Insured(s) dies by suicide, the Company's liability under this Agreement is limited to a refund of any advance premium payment made.

(d) No agent or other person is authorized to accept money on a Proposed Insured under 15 days of age or over 70 years of age (age nearest birthday) from the date of this Agreement, nor will any insurance take effect for such person.

(e) No agent is authorized to modify any of the provisions of this agreement.

(f) The total of the amount payable under this and any other Temporary Life Insurance Agreement or application with the Company will not exceed $1,000,000 for each life proposed for insurance.

5. General

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

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

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

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

NORTH AMERICAN COMPANY • NEW BUSINESS OFFICE: P. O. BOX 5089 • SIOUX FALLS, SD 57117-5089 • PRINCIPAL OFFICE: WEST DES MOINES, IA
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