



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.



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 prompted 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 |
|--------------------|-------------------|------|



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 | | |

| <p>Please indicate by placing an O if ordered or A if attached next to the requirement.</p> <table style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="text-align: left;">Proposed Insured (1)</th> <th style="text-align: left;">Requirement</th> <th style="text-align: left;">Proposed Insured (2)</th> </tr> </thead> <tbody> <tr><td>_____</td><td>Paramedical Exam</td><td>_____</td></tr> <tr><td>_____</td><td>Date ordered _____</td><td>_____</td></tr> <tr><td>_____</td><td>Physical Measurements/Vitals</td><td>_____</td></tr> <tr><td>_____</td><td>MD Exam</td><td>_____</td></tr> <tr><td>_____</td><td>EKG</td><td>_____</td></tr> <tr><td>_____</td><td>Treadmill</td><td>_____</td></tr> <tr><td>_____</td><td>APS Dr. _____</td><td>_____</td></tr> <tr><td>_____</td><td>Date ordered _____</td><td>_____</td></tr> <tr><td>_____</td><td>Vendor Name _____</td><td>_____</td></tr> <tr><td>_____</td><td>APS Dr. _____</td><td>_____</td></tr> <tr><td>_____</td><td>Date ordered _____</td><td>_____</td></tr> <tr><td>_____</td><td>Vendor Name _____</td><td>_____</td></tr> <tr><td>_____</td><td>Confidential Financial Statement</td><td>_____</td></tr> <tr><td>_____</td><td>Urine/HIV</td><td>_____</td></tr> <tr><td>_____</td><td>Full Blood Profile</td><td>_____</td></tr> <tr><td>_____</td><td>Replacement Forms</td><td>_____</td></tr> <tr><td>_____</td><td>Illustration</td><td>_____</td></tr> <tr><td>_____</td><td>Cover Letter</td><td>_____</td></tr> <tr><td>_____</td><td>Underwriter Checklist</td><td>_____</td></tr> <tr><td>_____</td><td>Other (describe) _____</td><td>_____</td></tr> </tbody> </table> | 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) _____ | _____ | <p>Please complete the following:</p> <p><input type="checkbox"/> BCX</p> <p><input type="checkbox"/> TeleMed Interview. (The best day, time and number to call must be indicated on Part I of the application).</p> <p><input type="checkbox"/> No TeleMed Interview (Complete Entire Application)</p> <p>POLICY NUMBER: _____ (if applicable)</p> <p>HAS THIS APPLICATION BEEN FAXED ? <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>If "No" please mail to:</p> <p style="text-align: center;">New Business Department North American Company One Sammons Plaza Sioux Falls, SD 57193</p> <hr/> <p>Special Requests/Remarks (i.e. Policy Date, Trust Date, 1035 Information etc. Include cover letter for financial justification or special circumstances)</p> |
|--|----------------------------------|----------------------|----------------------|-------|------------------|-------|-------|--------------------|-------|-------|------------------------------|-------|-------|---------|-------|-------|-----|-------|-------|-----------|-------|-------|---------------|-------|-------|--------------------|-------|-------|-------------------|-------|-------|---------------|-------|-------|--------------------|-------|-------|-------------------|-------|-------|----------------------------------|-------|-------|-----------|-------|-------|--------------------|-------|-------|-------------------|-------|-------|--------------|-------|-------|--------------|-------|-------|-----------------------|-------|-------|------------------------|-------|---|
| 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) _____ | _____ | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |

Date submitted: _____

By: _____



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.



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:



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

The Tests:

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

Meaning of Test Results:

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

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

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

Side Effects:

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

AIDS:

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



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Disclosure of Test Results:

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

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

Name of physician for reporting a possible positive test result:

Address: _____

Consent:

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

Name of Proposed Insured

Date

Signature of Proposed Insured

State of Residence

AIDS COUNSELING SERVICES

AIDS Project - East Bay

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

Central Valley AIDS Team

P.O. Box 4640
Fresno, CA 93744 (209) 264-2436

AIDS Project Los Angeles

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

Sacramento AIDS Foundation

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

AIDS Services Foundation of Orange County

1685-A Babcock Street
Costa Mesa, CA 92627 (714) 646-0411

San Diego AIDS Project

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

ARIS Project

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

San Francisco AIDS Foundation

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



Senior Notice - Your Rights Regarding In-home Meetings

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

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

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

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

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



LIFE INSURANCE APPLICATION

Part A
1. PRIMARY INSURED Single Married

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

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

Billing Address (If other than residence):

Citizenship status: U.S. or Permanent Visa/Greencard Other Country _____
of Years in U.S.: _____ Visa Type: _____ Date Expires: _____

Occupation (Title and Duties): _____ Employer Name & Address: _____

| | | | | |
|------------------------|-------------------------|-------|----------------------|-----------|
| Social Security Number | Driver's License Number | State | Annual Earned Income | Net Worth |
| | | | \$ | \$ |

Daytime Phone: _____ Evening Phone: _____ Best Time To Call: _____

2. OWNER INFORMATION (Complete only if other than Primary Insured)
Name of Owner(s) (If Trust, list all Trustees as well as Name and Date of Trust)

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

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

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

4. COVERAGE APPLIED FOR: _____ Face or Specified Amount: \$ _____
Underwriting Class Quoted: _____ (Best class available will be issued, subject to underwriting)
UL PLANS ONLY: Planned Premium \$ _____ Death Benefit Option: Level Increasing
Return of Premium Benefit Single Pay Annual Pay (Available on selected UL plans only)

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

6. RIDERS

| | |
|---|--|
| <p>a. Term Products</p> <input type="checkbox"/> Additional Insured Rider Amount \$ _____ <input type="checkbox"/> Base Return of Premium Rider <input type="checkbox"/> Children's Term Rider Amount \$ _____ <input type="checkbox"/> Guaranteed Insurability Rider Option Amount \$ _____ <input type="checkbox"/> Monthly Income Endorsement: Initial Lump Sum _____; \$ _____ Monthly for _____ years; Final Lump Sum \$ _____ <input type="checkbox"/> Waiver of Premium Rider <input type="checkbox"/> Other _____ Amount \$ _____ <p>Complete Supplemental Application For: Primary Insured: <input type="checkbox"/> Accident Disability Income Rider OR <input type="checkbox"/> Disability Income Rider Additional Insured: <input type="checkbox"/> Accident Disability Income Rider OR <input type="checkbox"/> Disability Income Rider</p> | <p>b. Permanent Products</p> <input type="checkbox"/> Accidental Death Benefit Rider Amount \$ _____ <input type="checkbox"/> Additional Insured Rider Amount \$ _____ <input type="checkbox"/> Children's Term Rider Amount \$ _____ <input type="checkbox"/> Guaranteed Insurability Rider Option Amount \$ _____ <input type="checkbox"/> Waiver of Monthly Deductions Rider <input type="checkbox"/> Level Term Rider (Custom Extra Only): Amount \$ _____ <input type="checkbox"/> Other _____ Amount \$ _____ |
|---|--|



7. ADDITIONAL INSURED/SPOUSE (Complete Separate Application for Business Associates and Multiple Additional Insureds)

Also complete Sections 8, 12, 13, 14, 15, 16 and Part B.

Form for Section 7 containing fields for Last Name, Birthdate, State or Country of Birth, Sex, Height, Weight, Citizenship status, Visa Type, Date Expires, Occupation, Employer Name & Address, Social Security Number, Driver's License Number, State, Annual Earned Income, Net Worth, Daytime Phone, Evening Phone, and Best Time To Call.

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

Form for Section 8 containing fields for Name, Amt \$, Primary Beneficiary/Relationship, and Contingent Beneficiary/Relationship.

9. CHILDREN (Children's Term Rider Only) Also complete Section 14.

Table for Section 9 with columns: Birthdate (Mo., Day, Year), State or Country of Birth, Sex, Social Security Number, Height (Ft. In.), Weight (Lbs).

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

- a. DOES ANY PROPOSED INSURED HAVE ANY EXISTING POLICIES OR CONTRACTS OR OTHER LIFE INSURANCE APPLICATIONS PENDING WITH ANY COMPANY OR INTEND TO APPLY FOR ANY ADDITIONAL COVERAGE...
b. WILL THE INSURANCE BEING APPLIED FOR REPLACE OR CHANGE ANY EXISTING LIFE INSURANCE OR ANNUITY CONTRACT?...

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

- a. Are any of the policies mentioned below being used to fund this policy?
b. Have you or will you be compensated in any way to purchase this policy?
c. Are you paying for this policy with your own funds?
d. Have you financed or do you intend to finance all or a portion of the premiums for this policy?
e. Have you entered into or are you considering any other agreement in regard to this policy including but not limited to an agreement to sell, transfer or assign any rights in the policy?...

IF ANSWER IS 'YES' TO QUESTION 10a or 10b PROVIDE DETAILS BELOW.

*Indicate Type of Coverage: I = Individual; B = Business; or G = Group

Table for Section 11 with columns: Insured Name, Insurance Company, Policy No., Amount, Type*, Pending, Issue Year, Intention to Replace or Change? (Yes/No).



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

12. PRIMARY CARE PHYSICIAN INFORMATION IF NONE, CHECK HERE

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

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

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

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



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



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

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

1. MEDICAL QUESTIONS

Have you or any person proposed for insurance: Yes No

- a. Gained or lost more than 15 pounds in the last year?
- b. Attempted suicide or had counseling for suicide prevention?.....
- c. Had or been advised to have treatment for alcohol or drug use or used narcotics, cocaine or other habit forming drugs, except as prescribed by a physician?.....
- d. Been advised by a medical professional to decrease alcohol consumption?
- e. Had military service deferment, rejection or discharge because of a physical or mental condition?.....
- f. Requested or received a pension, benefits, or payment because of injury, sickness, or disability?
- g. Currently taking any prescription drugs or took any prescription drugs within the last year?.....
- h. Within the last 10 years, had or been treated by a medical physician for:
 - 1) Cancer, tumor, leukemia, lymphoma, or any other abnormal or malignant growth?
 - 2) High blood pressure, stroke, chest pains, heart attack or failure, coronary artery disease, heart murmur, irregular heart beat, poor circulation, or any other disease or disorder of the heart or blood vessels?.....
 - 3) Epilepsy, narcolepsy, convulsions, nervous breakdown, emotional or mental condition, neuritis, paralysis, or any other disease or disorder of the brain or nervous system?
 - 4) Ulcer, colitis, hepatitis or any other disease or disorder of the liver, gallbladder, pancreas, rectum, stomach, or intestines?
 - 5) Asthma, bronchitis, emphysema, tuberculosis, or any other disease or disorder of the lungs, or respiratory system?
 - 6) Sugar, albumin or blood in the urine, kidney stone, sexually transmitted disease, or any other disease or disorder of the kidneys, bladder, urinary system, or reproductive system?.....
 - 7) Anemia, bleeding disorder, or high cholesterol or any other disease or disorder of the blood?.....
 - 8) Diabetes, lymph, thyroid, pituitary, or any other glandular disease or disorder?.....
 - 9) Allergies, or any other disease or disorder of the eyes, ears, nose, throat, or skin?.....
 - 10) Severe injuries, amputation, arthritis, gout or any other disease, disorder or abnormalities of the spine, bones, joints or muscles?...
 - 11) Sleep apnea, abnormal sleep study, or polysomnography?.....
 - 12) AIDS (Acquired Immunodeficiency Syndrome) or HIV (Human Immunodeficiency Virus) infection?.....
- i. Within the last 5 years:
 - 1) Consulted, been examined, or treated by any physician or medical professional, or had observation or treatment at a hospital?.....
 - 2) Had an x-ray, resting or exercise electrocardiogram, any other diagnostic or laboratory tests (other than test for HIV or AIDS), or surgery done or advised not previously stated on this application? .
- j. If you are a female:
 - 1) Ever had any disorder of menstruation, pregnancy, or of the female organs or breasts?.....
 - 2) To the best of your knowledge, are you currently pregnant?.....

If YES, provide number of months in Details.



The Owner Understands And Agrees As Follows:

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

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

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

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

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

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

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

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

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

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

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

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

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

Bank Name _____ Account No. _____

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

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

Payer Signature X _____ Date _____

Terms and Conditions

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



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

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

AR, KY, LA, NM, and OH Residents: Any person who knowingly, and with intent to defraud any insurance company or other person, files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

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

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

PA Residents: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such a person to criminal and civil penalties.

SIGNATURES

Signed at _____ (City, State) On _____ (Date)

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

X _____
Signature of Proposed Additional Insured/Spouse

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

X _____
Signature of Proposed Additional Insured/Spouse

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



Agent Certification

Does any person covered under this application have any existing life insurance or annuities?..... Yes No
Is any insurance applied for in this application intended to replace any existing life insurance or annuity? Yes No
If a replacement is involved, the applicable Replacement Notice will be sent to the existing insurer.

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

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

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

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

Signature of Soliciting Agent X _____

Print Agent Name _____ Agent Code # _____

Print Other Agent Name (if applicable) _____ % Credit _____ Agent Code # _____



Together, we can save a life

TESTING FOR HIV INFECTION



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

What tests are most commonly used to detect HIV infection?

There are three types of HIV tests commonly used.

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

How long should I wait before being tested?

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

Should I be tested?

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

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

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

What is the difference between anonymous and confidential testing?

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

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

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

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

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

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

What does a negative test result mean?

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

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

What does a positive test result mean?

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

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

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

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

What else do I need to know?

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

What about donating blood to get tested?

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

How is HIV spread?

HIV is spread by—

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

For more information, contact—

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

American Red Cross HIV/AIDS Programs

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

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



American Red Cross

Together, we can save a life

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



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 1st and 28th _____. 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 (1st - 28th 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 #: _____ |



NOTICE REGARDING REPLACEMENT

REPLACING YOUR LIFE INSURANCE POLICY OR ANNUITY?

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

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

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

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

Applicant's Signature

Date

Agent's Signature

Date



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

- | | Yes | No |
|---|--------------------------|--------------------------|
| Has any person listed above as a Proposed Primary Insured or Proposed Additional Insured(s): | | |
| 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? | <input type="checkbox"/> | <input type="checkbox"/> |
| 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? | <input type="checkbox"/> | <input type="checkbox"/> |
| 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?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 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? | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Is any person proposed for insurance under 15 days of age or over 70 years of age? | <input type="checkbox"/> | <input type="checkbox"/> |

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.

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.**