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

L3191TI

LEAVE WITH APPLICANT

ACCELERATED DEATH BENEFIT SUMMARY and DISCLOSURE STATEMENT

EFFECTIVE DATE – The Accelerated Death Benefit Endorsement takes effect on the Policy Date.

PREMIUM – There is no additional premium charge for the Accelerated Death Benefit Endorsement provided under this life insurance Policy. However, there is an administrative fee when an Accelerated Death Benefit Payment is made.

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.

THE BENEFIT AND ITS EFFECT ON POLICY PROVISIONS

Upon written request by the owner ("You") of the Policy, the company will pay an Accelerated Death Benefit described below, subject to the limitations and requirements outlined in the Accelerated Death Benefit Endorsement. Any assignee or Irrevocable Beneficiary must consent before we make an Accelerated Death Benefit Payment. The maximum Accelerated Death Benefit that We will accelerate on the Policy is $1,000,000. Accelerated Death benefits paid under this Endorsement will reduce the Policy's Death Benefit and Policy values, if any, which include but are not limited to the Account Value, Net Cash Surrender Value, and loan value.

Accelerated Death Benefit for Terminal Illness: You may elect to receive advancement of the Death Benefit when the Survivor or Insured has a Terminal Illness while this Endorsement is in effect. A Survivor or Insured qualifies as being Terminally Ill if a Physician has certified that the Survivor's or Insured's life expectancy is 24 months or less.

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

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

The Accelerated Benefit Payment (hereinafter "Payment") will be determined upon Your election. Payment will be paid in a lump sum. We will pay the present value of the Policy Death Benefit that is being accelerated (the Accelerated Death Benefit). An actuarial discount based on mortality and interest will be applied to the Accelerated Death Benefit. This discount reflects the early payment of the Death Benefit that is being accelerated.

We will waive the Monthly Deductions following the Election of Accelerated Death Benefits for Terminal Illness. Upon Election, all Riders and Endorsements attached to the Policy will continue to be effective subject to the terms and conditions of each Rider or Endorsement. After You receive Accelerated Death Benefits for Terminal Illness under this Endorsement and as stated in Your Policy, You may take Withdrawals; elect to increase or decrease the Specified Amount or change the Death Benefit Option; and You may obtain loans as described under the Policy loan provision. A portion of the Accelerated Death Benefit Payment will be used to reduce any Policy Debt.

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

Sample Illustration of Impact of Accelerated Death Benefits on Policy Provisions For Terminal Illness

Immediately Prior to initial Election:	
Death Benefit (DB)	$100,000
Account Value	$30,000
Policy Debt	$10,000
Net Cash Surrender Value	$20,000
Monthly Deductions	$300
Election:	
Limitations on Benefits	
Maximum Accelerated Death Benefit	$75,000
75% of DB or $750,000 if smaller	
Requested on Application for Election:	
Accelerated Death Benefit	$20,000
Immediately After Election:	
Death Benefit	$80,000
Reduced by Accelerated DB	
$100,000 - $20,000	
Account Value	$24,000
Reduced by Accelerated DB / DB	
Reduced by $20,000 - $100,000 = 20%	
$30,000 * (100% - 20%)	
Debt Repayment Amount	$2,000
Accelerated DB * Policy Debt / DB	
$20,000 * 10,000 / $100,000	
Policy Debt	$8,000
Reduced by Debt Repayment Amount	
$10,000 - $2,000	
Monthly Deductions	$0 (Waived)

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CONSUMER PROTECTION NOTICES FOR THE PROPOSED INSURED

Investigative Consumer Report Notice

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

Insurance Information Practices

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

Medical Information Bureau Notice

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

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

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

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INDEXED UNIVERSAL LIFE INSURANCE

As a valued customer of North American Company of Life and Health Insurance, We want to make sure You understand the unique features of the indexed life insurance policy for which You have applied. The policy may earn interest based on the movement of the selected Index(es), but will never credit less than zero percent. While earnings are based on the Index(es) You select, premiums are not invested in stocks, bonds or equity investments, and the Index growth does not include dividends.

The policy for which you have applied is not registered as a security. Therefore, purchasing this indexed life insurance policy is not the same as making an investment directly in the stock market. This summary is not intended to be a full description of the policy. Please refer to your policy when issued for complete details and definitions.

ALLOCATION CHOICES

You may direct Your money among the Fixed Account and/or any combination of the following Indices:

1. The Standard & Poor's 500® Composite Stock Price Index (S&P 500®)
2. The Dow Jones Industrial Average℠ (DJIA℠) Composite Stock Price Index
3. The Nasdaq-100® Stock Price Index
4. The S&P MidCap 400®
5. The Russell 2000®
6. The Dow Jones EURO STOXX 50®
7. Uncapped S&P 500®
8. Multi-Index Group

INDEX CREDITING METHODS

The earnings credited to the selected Index(es) are calculated through the use of either the Daily Averaging method, the Annual Point-to-Point method, the Monthly Point-to-Point method. No Index Credits will be applied until the end of the Index Period and money withdrawn or surrendered prior to this time will not receive Index Credits.

- When the **Daily Averaging** method is chosen, the Index change is determined by calculating the difference between the Index Value on the first day of the Index Period and the average Index Value throughout the Index Period. The Index change is subject to the Index Participation Rate, Index Cap Rate, and Index Floor Rate. The Index Credit, if any, is credited and locked in at the end of the Index Period. The Daily Averaging crediting method is available for the S&P 500®, S&P MidCap 400®, Russell 2000® and DJIA℠.

- When the **Annual Point-to-Point** method is chosen, the Index credit is determined by calculating the change between the Index Value on the first day of the Index Period and last day of the Index Period. The Index growth is subject to the Index Cap Rate and any earnings are credited and locked in at the end of the 12 month Index Period. The rate credited will never be less than zero percent. The Annual Point-to-Point crediting method is available for the S&P 500®, S&P MidCap 400®, Russell 2000®, DJIASM, Dow Jones EURO STOXX 50®, and NASDAQ-100®.

- When the **Monthly Point-to-Point** method is chosen, the Index credit is determined by calculating the 12 Monthly Index Returns which are determined by the change in the Index during the month. The Monthly Index Return can not be greater than the Monthly Cap Rate and it can be a negative number. At the end of the 12 month Index Period, the 12 preceding Monthly Index Returns are added together to determine the Index Credit which is credited and locked in. The rate credited at the end of the Index Segment will never be less than zero percent, and will never be greater than 12 times the Monthly Cap Rate. The Monthly Point to Point crediting method is available for the S&P 500®.

Copy 1 - Administrative Office, Copy 2 - Applicant, Copy 3 – Agent

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- When the **Multi-Index Annual Point-to-Point** method is chosen, the Index credit is determined by calculating a Multi-Index change between the first day of the Index Period and the last day of the Index Period. The Multi-Index change uses the following three indices – S&P 500®, Dow Jones EURO STOXX 50®and Russell 2000®**.** The annual point-to-point Index growth from each of the three individual indices derives the Multi-Index change. 50% of the best performing Index growth plus 30% of the second best performing Index growth plus 20% of the third best performing Index growth equals the Multi-Index change. The Multi-Index change is subject to the Index Cap Rate and any earning are credited and locked in at the end of the 12 month Index Period. The rate credited will never be less than zero percent.

IMPORTANT POLICY TERMS YOU SHOULD KNOW

- **Index Participation Rate** – the portion of the Index change that is used in the calculation of the Index Credit. This rate can be changed by North American Company for Life and Health Insurance but can never be less than the minimum shown in the policy.
- **Index Cap Rate** – the maximum interest rate that can be used in the calculation of the Index Credit. This rate can be changed by North American Company for Life and Health Insurance but can never be less than the minimum shown in the policy.
- **Index Floor Rate** – the minimum interest rate that can be used in the calculation of the Index Credit. This rate can be changed by North American Company for Life and Health Insurance but can never be less than zero.

PROPOSED OWNER/APPLICANT:

I acknowledge that I have read this disclosure material, received a copy and understand the following:

- **Any values shown, other than guaranteed minimum values, are not guarantees, promises or warranties.**
- **I am applying for an indexed life insurance policy, and even though the values of the policy may be affected by an external Index, the policy does not directly participate in any stock, bond or equity investments.**
- **The values of the external Indices do not reflect the payment of dividends.**
- **The policy applied for is not a registered security.**
- **Current illustrated values are based on past Index performance and are not intended to predict future performance.**
- **I understand that North American Company for Life and Health Insurance has the right to change Index Cap Rates, Index Floor Rates, Index Participation Rates and interest rates.**

PROPOSED OWNER'S SIGNATURE	DATE
X	

AGENT:
I certify I have provided a copy to and reviewed this disclosure material with the applicant. I have not made statements that differ from this material, nor have I made any promises about the future performance or values of any non-guaranteed elements of any indexed life insurance policy. I certify that I have completed the North American Company for Life and Health Insurance Indexed Universal Life Certification Training and passed the Agent Certification Exam.

AGENT'S SIGNATURE	DATE
X	

The term S&P 500® refers to **The Standard & Poor's 500® Composite Stock Price Index**. This Index does not include dividends paid by the underlying companies. S&P 500® and Standard & Poor's 500® are trademarks of The McGraw-Hill Companies, Inc. and have been licensed for use by North American Company for Life and Health Insurance. This product is not sponsored, endorsed, sold or promoted by Standard & Poor's® and Standard & Poor's® makes no representation regarding the advisability of purchasing this contract.

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THE STANDARD & POOR'S 400® COMPOSITE STOCK PRICE INDEX
This Index does not include dividends paid by the underlying companies.

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THE RUSSELL 2000® COMPOSITE STOCK PRICE INDEX
This Index does not include dividends paid by the underlying companies.

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L2412CT1

NOTICE AND CONSENT FORM FOR AIDS VIRUS (HIV) ANTIBODY/ANTIGEN TESTING

Insurer: NORTH AMERICAN COMPANY
FOR LIFE AND HEALTH INSURANCE
4601 Westown Parkway, Suite #300
Des Moines, IA 50266

Examiner: (Name and Address) ______________________________

Acquired Immunodeficiency Syndrome (AIDS) is a life-threatening disorder of the immune system. It is caused by a virus called Human Immunodeficiency Virus (HIV). The virus is spread by sexual contact with an infected person, by exposure to infected blood (as in needle sharing during intravenous drug use or, rarely, as a result of a blood transfusion), or from an infected mother to her newborn infant.

To determine your insurability, the insurer named above (the Insurer) has requested that you provide a sample of your blood, urine, and/or oral fluid for testing and analysis. All tests will be performed by a licensed laboratory.

Unless precluded by law, tests will be performed to determine the presence of HIV antibodies or antigens. The HIV antibody test that we perform is actually a series of tests done by a medically accepted procedure. The HIV antigen test directly identifies AIDS viral particles. These tests are extremely reliable. Should you desire more information about the test of HIV infection before providing a blood sample, you may wish to consult with your physician or your local health department. If you are at high risk of HIV infection, you may want to be counseled and tested by your physician or at a free/low cost local test site. Your local health department can provide you with information as to the location of these sites.

All test results will be treated confidentially. They will be reported by the laboratory to the insurer. When necessary for business reasons in connection with insurance you have or have applied for with the Insurer, the Insurer may disclose test results to others such as its affiliates, reinsurers, employees or contractors, but not to agents and brokers.

If the Insurer is a member of the Medical Information Bureau (MIB, Inc.), and if the test results for HIV antibodies/antigens are other than normal, the Insurer will report to the MIB, Inc. a generic code which signified only a non-specific blood test abnormality. If your HIV test is normal, no report will be made about it to the MIB, Inc.

The organizations described in the last two paragraphs may maintain the test results in a file or data bank. There will be no other disclosure of test results or even that the tests have been done except as may be required or permitted by law or as authorized by you.

If your HIV test results are normal, no routine notification will be sent to you. If the HIV test results are other than normal, the Insurer will contact you. The Insurer may ask you for the name of a physician or other health care provider to whom you may authorize disclosure and with whom you may wish to discuss the results.

Positive HIV antibody/antigen test results do not mean that you have AIDS, but that you are at significantly increased risk of developing AIDS or AIDS-related conditions. Federal authorities say that persons who are HIV antibody/antigen positive should be considered infected with the AIDS virus and capable of infecting others.

Positive HIV antibody or antigen test results or other significant blood abnormalities will 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.

You are urged, at this time, to designate the physician or other health care provider to whom the HIV test results may be disclosed by the Insurer in the event the results are other than normal.

I authorize the disclosure of any HIV test results which are other than normal to the following physician or health care provider:

Name ______________________________

Address ______________________________ Zip Code ______________

I have read and understand this Notice of Consent for AIDS Virus (HIV) Antibody/Antigen Testing. I voluntarily consent to the withdrawal of blood from me by needle, urine, and/or oral fluid, the testing of that blood, urine, and/or oral fluid, and the disclosure of the test results as described above.

I understand that I have the right to request and receive a copy of this authorization. A photocopy of this form will be as valid as the original.

______________________________ ______________________________
Proposed Insured Date of Birth

____
State of Residence

______________________________ ______________________________
Signature of Proposed Insured or Parent/Guardian Date

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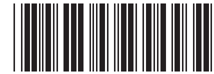

SUPPLEMENT TO LIFE INSURANCE APPLICATION

Life Insurance Qualification Test

Please indicate your election for the Life Insurance Qualification Test: [ ] Guideline Premium Test [ ] Cash Value Accumulation Test
(If not indicated, the Guideline Premium Test will be used.)

Initial Premium Allocation - Indexed Universal Life Insurance

Please indicate the percentage of premium you want allocated to each Selection. Percentages must be in whole numbers and total 100%.

INDEX SELECTION			PREMIUM ALLOCATION
Index Selection 1	S&P 500® – Annual Point to Point	(SPn)	%
Index Selection 2	S&P 500® – Monthly Point to Point	(SMn)	%
Index Selection 3	S&P 500® – Daily Averaging	(SDn)	%
Index Selection 4	Dow Jones Industrial Average℠ – Annual Point to Point	(DPn)	%
Index Selection 5	Dow Jones Industrial Average℠ – Daily Averaging	(DDn)	%
Index Selection 6	Dow Jones EURO STOXX 50® – Annual Point to Point	(EPn)	%
Index Selection 7	Uncapped S&P 500 – Annual Point to Point	(UPn)	%
Index Selection 8	Multi Index	(MPn)	%
Index Selection 9	NASDAQ -100 ® Annual Point to Point	(NPn)	%
Index Selection 10	S&P MidCap 400® - Annual Point to Point	(4Pn)	%
Index Selection 11	S&P MidCap 400® Daily Averaging	(4Dn)	%
Index Selection 12	Russell 2000® - Annual Point to Point	(RPn)	%
Index Selection 13	Russell 2000® - Daily Averaging	(RDn)	%
Fixed Selection	Fixed Account	(FAn)	%
	Total		**100 %**

TELEPHONE AUTHORIZATION (READ CAREFULLY) ☐ **YES** ☐ **NO**

I hereby authorize and direct North American Company for Life and Health Insurance (NA) to act on telephone instructions when proper identification has been furnished, to make transfers or change premium allocations of future premium payments. NA will employ reasonable procedures to confirm that telephone instructions are genuine; nonetheless, I agree that NA is not liable for any loss arising from any change in premium allocations of future premium payments or transfers by acting in accordance with these telephone instructions that NA believes to be genuine.

AUTHORIZATION FOR AGENT (READ CAREFULLY) ☐ **YES** ☐ **NO**

I hereby authorize and direct North American Company for Life and Health Insurance (NA) to act on telephone, written, or facsimile instructions communicated by the Agent of Record to make transfers or change the premium allocations of future premium payments. This authorization does not grant the Agent discretion to communicate any transaction without my prior approval. NA will employ reasonable procedures to confirm that instructions are genuine; nonetheless, I agree that NA is not liable for any loss arising from any change in premium allocations of future premium payments or transfers by acting in accordance with these instructions that NA believes to be genuine. This authorization will remain in effect until NA receives written notification of cancellation from the policyowner, or the named Agent is no longer contracted and appointed with NA.

Florida Residents: Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

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PROPOSED OWNER/APPLICANT: I have received a copy of the equity indexed disclosure material for the policy applied for. The undersigned hereby agree(s) that the statements made above shall be a part of the life insurance application as fully as though made in said application. **I understand I am applying for an indexed life insurance policy, and although any external index may affect the values of the policy, the policy does not directly participate in any stock, bond or equity investments and the values of the external Indices do not reflect the payment of dividends. North American Company for Life and Health Insurance has the right to change Index Caps, Index Participation Rates and interest rates as long as they do not go below the minimums shown in the policy. I understand that any values shown, other than guaranteed minimum values, are not guarantees, promises or warranties.**

AGENT: I certify that the equity indexed disclosure material has been presented to the Applicant. A copy was provided to the Applicant. I have not made statements which differ in any significant manner from this material. I have not made any promises or guarantees about the future values of any non-guarantee elements.

X ______________________________ X ______________________________ ______________

Signature of Proposed Owner
(If Owner is corporation, trust, or other entity, include title of signee.)

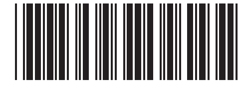
Signature of Agent

Agent Number

______________________________ ______________________________

Signed at (City) (State)

Date



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

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North American Company
for Life and Health Insurance
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L3182CT

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 ☐ Business ________ (CST) ☐ A.M. ☐ P.M.	Residence Telephone Number: Primary Insured ( ) Additional Insured ( ) Cell Phone ( )	Business Telephone Number: 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: Draw Day (1st - 28th) _______ Month _______ Day 16a. Initial Draft ☐ Yes ☐ No	Account Type ☐ Checking (attach voided check) ☐ Savings (must complete 16b)	Authorized Signature(s) of Account Holder(s) X 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 any at-fault motor vehicle accidents, or been convicted of driving under the influence, driving while intoxicated, more than one speeding ticket, or any other motor vehicle moving violations 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 convictions 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.

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): **Yes No**
   (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)? ☐ ☐
   (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 (excluding HIV and AIDS testing) 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 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 - Any person who knowingly and willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly and willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Accelerated Death Benefit: If the policy 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

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

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:

____

____

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

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
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)

(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

L27931

IMPORTANT NOTICE REGARDING REPLACEMENT OF LIFE INSURANCE OR ANNUITIES

Completion of this disclosure form is required when replacement of an existing policy or contract is anticipated.

Generally replacement occurs when you terminate an existing contract and purchase a new contract. Other transactions involving the values of your existing contract may also constitute a replacement such as:

1. lapse, surrender or forfeiture,
2. withdrawing the values or taking a loan from your contract,
3. assignment or conversion
4. placing your contract on extended term or reducing the face amount.

A replacement is **external** if a policy or contract is replaced by another insurer; or **internal** if an existing policy or contract is exchanged for or replaced by a policy or contract from the **same** insurer.

Replacement of an existing policy without comparing the differences in policy provisions is not in your best interest. It is important that you understand the essential features of both your existing contract and the proposed contract before you decide. To assist you in this decision, you should discuss some or all of the following items with your agent. **(Check all items that are discussed.)**

- ☐ annual premium
- ☐ credited interest rate on existing policy
- ☐ tax treatment
- ☐ duration of guaranteed premium rates
- ☐ guaranteed cash value
- ☐ eligibility for exchange treatment under S1035
- ☐ guaranteed maximum premium rates
- ☐ loan provision and loan interest rates
- ☐ underwriting class
- ☐ face amount
- ☐ withdrawal provisions
- ☐ contestability provision
- ☐ guaranteed death benefit
- ☐ expense charges
- ☐ suicide limitation
- ☐ guaranteed interest rate
- ☐ surrender charges
- ☐ other(s) ________________________________
  ____

Since each replacement transaction involves a different set of facts and issues, no listing of policy provisions will pertain to all situations. The policy provisions listed above are intended to assist in identification of pertinent factors. Only you can decide if replacing your contract is the right thing to do.

AGENT'S STATEMENT

The policy(ies) to be replaced is # ____________________________ With ____________________________

\# ____________________________ With ____________________________

My reasons for recommending the replacement of the existing policy(ies) are:

____

____

Name of Agent *(Please Print)* ______________________________________ **Agent #** ____________________

Signature of Agent ____ **Date** ______________________

APPLICANT'S STATEMENT

I hereby certify that I have considered the above information, and understand the results of replacing my life insurance policy(ies) or annuity contracts.

Name of Applicant *(Please Print)* ________________________________

Signature of Applicant ____ **Date** ____________________

Copy 1 - Insured   Copy 2 - Company   Copy 3 - Agent

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

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

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.

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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

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.**

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