

AN IMPORTANT NOTICE ABOUT FORMS FOR PA -- READ FIRST

Form requirements in PA vary based on product. We strongly recommend that you use the "Forms Kit" option to select forms in PA. The following chart designates applicable forms in PA by product.

Product	Advantage Term Series	Custom GrowthCV
	Custom Accumulator	Custom TermGUL
	Survivor GIUL	Guarantee Builder IUL
	Builder IUL Gen 6	Rapid Builder IUL
		Custom Guarantee
<u>New Business Forms</u>		
ABE Form	L-2966A37NS	L-2966ANS
Consumer Protection Notice	L-2978	L-2978
HIV	L-2412PA	L-2412PA
Life Insurance Application	L-3182PA	L-3182CRT
Surrender Comparison Index Disclosure***	L-1893(37)	L-1893(37)
Chronic Condition Accelerated Benefit Disclosure*	L-3178PANS	
CIABR Disclosure		L-3178CRTNS
Replacement Form	L-2038(37)	L-2038(37)
Supplement to Application Guar Builder IUL and Rapid Builder IUL	N/A	L-3170BCRT
Disclosure – Guar Builder IUL and Rapid Builder IUL	N/A	L-3171BCRT
IUL Application Supplement**	ICC09L-3189	
Disclosure for IUL**	L-3190	
Accelerated Benefit Disclosure**	L-3191NS	
Term Disclosure****	L-2259(B)	
<u>POS Forms</u>		
Policy Change/Conversion/Reinstatement Application	L-3187APA	L-3187A
Application for AIO****	L-2876(37)	N/A
<u>Miscellaneous Forms</u>		
Election App of Chronic Illness Benefits	L-3180PA	L-3180CRT

* Custom Accumulator only

** Survivorship GIUL & Builder IUL Gen only

*** UL/IUL Plan only

**** ADDvantage Term only



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.



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

INSURER NAME AND ADDRESS:

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

As part of your application for insurance, and to evaluate your acceptability for coverage, it is requested that you consent to be tested to determine the presence of antibodies or antigens to the Human Immunodeficiency Virus (HIV). The HIV antibody test is a series of tests performed on your blood or other body fluid sample for analysis. The testing will be performed by a licensed laboratory through medically accepted procedures. By signing and dating this form, you agree that these tests may be performed and that the results will be considered in deciding whether to accept or decline applications for coverage.

INFORMATION ON HIV

The HIV virus causes a life-threatening disorder of the immune system called Acquired Immune Deficiency Syndrome (AIDS). The virus is transmitted from one person to another through blood, semen, and vaginal fluids. The virus is most commonly spread through sexual contact (vaginal, anal, or oral intercourse) and by sharing of needles and syringes to shoot injectable drugs. An infected mother may infect her baby during pregnancy, at the time of birth, or while breast feeding. HIV is not spread through casual contact, such as eating with or touching a person infected with the virus. There is no medical evidence that HIV is spread by kissing.

PRE-TEST CONSIDERATIONS

Many public health organizations have recommended that before taking an AIDS virus (HIV) antibody/antigen test, a person seek counseling to become informed concerning the implications of such tests. You may wish to consider counseling at your own expense, prior to being tested.

Alternative AIDS-related testing and counseling are also provided by the Pennsylvania Department of Health and local health departments. To obtain additional information on such testing and counseling services call the Pennsylvania Department of Health at (717) 783-0479.

CONFIDENTIALITY OF TEST RESULTS

All test results will be treated confidentially. They will be reported by the laboratory to the insurer identified on this form. The test results may be disclosed as required by law. The results may be disclosed to those responsible for making underwriting decisions on behalf of the Insurer, such as its affiliated companies, reinsurers or contractors, and third party administrators. The test results may be released to an insurance medical information exchange under procedures that are designed to assure confidentiality, including the use of general codes that also cover results of tests for other diseases or conditions not related to AIDS, or for the preparation of statistical reports that do not disclose the identity of any particular person.

MEANING OF POSITIVE TEST RESULTS

While a positive HIV antibody test result does not mean that you have AIDS, it does mean that you may be at increased risk of developing AIDS or AIDS-related conditions. The tests are tests for antibodies to the HIV virus, the causative agent for AIDS, and show whether you have been exposed to the virus.

Positive HIV antibody/antigen test results 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.



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NOTIFICATION OF TEST RESULTS

If your test results are negative, no routine notification will be sent to you, unless specifically requested by you. In the event your HIV test results are positive, Pennsylvania state law requires that disclosure to you be provided by the physician or health department you designate below.

CONSENT

I have read and I understand this Notice and Consent Form. I voluntarily consent to testing and disclosure as described above. I understand that I have the right to request and receive a copy of this form. This consent shall remain in effect unless revoked by me in writing and received by the Insurance Company. A photocopy of this form will be as valid as the original.

I also understand that at any time I may revoke my consent to the disclosure of test results as described in the sections entitled Disclosure of Test Results and Notification of Test Results. However, such revocation will not be effective to the extent that the person who is to make the disclosure has already acted in reliance on my consent.

I designate the following entity to receive positive HIV test results:

(Check One)

My physician named below
(Please provide Name and Address)

Local Health Department

Pennsylvania Department of Health

Name of Proposed Insured

Signature of Proposed Insured or Parent/Guardian

Address

Date



AGENT'S REPORT

Proposed Insured's Name	Social Security Number
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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
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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:



LEAVE WITH APPLICANT ACCELERATED BENEFIT SUMMARY AND DISCLOSURE STATEMENT

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

PREMIUM – There is no cost for this Endorsement.

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

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

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

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

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

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

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

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

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

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

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

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

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



LEAVE WITH APPLICANT

ACCELERATED BENEFIT SUMMARY AND DISCLOSURE STATEMENT For Chronic Illness Accelerated Benefit Rider

EFFECTIVE DATE – The Chronic Illness Accelerated Benefit Rider takes effect on the Certificate Date.

PREMIUM – There is no additional cost for the Chronic Illness Accelerated Benefit Rider provided under this life insurance Certificate. However, an administrative fee is required when an Accelerated Benefit Payment is made.

The Accelerated Benefits provided under the Rider of this life insurance Certificate may provide benefits to pay for long-term care services but are NOT part of a long-term care or nursing home insurance Certificate and the amount these products pay may not be enough to cover Your medical, nursing home or other bills. Accelerated 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 Benefit for any purpose. Unlike conventional life insurance proceeds, amounts payable as Accelerated Benefits **COULD BE TAXABLE UNDER SOME CIRCUMSTANCES**. We recommend that You consult Your personal tax advisor prior to electing an Accelerated Benefit.

If You already have long-term care insurance, Medicaid, or similar coverage, You should consider whether the Accelerated Benefits provided under this Rider are suitable for Your needs. Receipt of Accelerated Benefits under this Rider **MAY AFFECT YOUR ELIGIBILITY FOR MEDICAID, SUPPLEMENTAL SECURITY INCOME (“SSI”), OR OTHER GOVERNMENT BENEFITS OR ENTITLEMENTS**. Contact the Medicaid Unit of Your local Department of Public Welfare and the Social Security Administration Office for more information.

BENEFIT

Upon written request by the owner (“You”) of the Certificate, the company will pay an Accelerated Benefit described below, subject to the limitations and requirements outlined in this Rider. Any assignee or Irrevocable Beneficiary must consent before We make an Accelerated Benefit Payment. The maximum Death Benefit that We will accelerate on the Certificate is \$1,000,000 under this Rider and any other Accelerated Benefit Rider or Endorsement attached to the Certificate.

Under this Rider and while this Rider is in effect, You may elect to receive advancement of the Death Benefit, if the Insured has been Chronically Ill for at least 90 consecutive days.

An Insured qualifies as being Chronically Ill if the Chronic Illness First Manifests itself after the Effective Date and a Physician has certified within the last 12 months that the Insured:

1. Is permanently unable to perform, without Substantial Assistance from another person, at least two Activities of Daily Living; or
2. Requires Substantial Supervision by another person to protect oneself from threats to health and safety due to Severe Cognitive Impairment.

Activities of Daily Living are: Bathing, Contenance, Dressing, Eating, Toileting, or Transferring.

Substantial Assistance means stand-by or hands-on assistance from another person without which the Insured receiving such assistance would be unable to perform Activities of Daily Living.

Stand-by assistance means the presence of another person within arm's reach of the Insured that is necessary to prevent, by physical intervention, injury to the Insured while he/she is performing Activities of Daily Living. Hands-on assistance means the direct physical assistance of another person.

Substantial Supervision means requiring continual supervision by another person to protect the Insured from threats to health or safety due to Severe Cognitive Impairment and may include cueing by verbal prompting, gestures, or other similar demonstrations.

Severe Cognitive Impairment means deterioration or loss of intellectual capacity that is measured by clinical evidence and standardized tests, which reliably measure impairment in:

1. Short-term or long-term memory; or
2. Orientation to people, places, or time; or
3. Deductive or abstract reasoning; or
4. Judgment as it relates to safety awareness.

The minimum Accelerated Death Benefit at each Election, except the Final Election, is the smaller of 5% of the Death Benefit on the Initial Election Date or \$75,000.

The maximum Accelerated Death Benefit at each Election is the smaller of 24% of the Death Benefit on the Initial Election Date, or \$240,000. This amount may be smaller for a Final Election.

The Accelerated Benefit Payment (Payment) will be determined as of each Election Date. Each Payment will be paid in a lump sum, unless a Periodic Payment is chosen.

Under a Periodic Payment, We will divide the Payment into equal Periodic Payments that will be paid in lieu of a lump sum Payment. The Periodic Payments offered by this Rider are semi-annual payments.

Since the Accelerated Death Benefit is paid prior to death, the Payment received will be reduced by a discount factor and will be less than the amount accelerated.

A Final Election is available if the maximum Accelerated Death Benefit at the time of the Election is greater than the remaining Death Benefit in the Certificate, minus the Residual Death Benefit. To make a Final Election, You must choose to accelerate all remaining Death Benefit in Your Certificate minus the Residual Death Benefit. The Payment must first be applied to repay any Certificate Debt.

Residual Death Benefit – Upon the death of the Insured, We will pay the Beneficiary any remaining portion of the Death Benefit that We have not accelerated to the Owner under this Rider. If a Final Election has occurred, the Residual Death Benefit will be paid to the Beneficiary in a lump sum upon due proof of the death of the Insured. The Residual Death Benefit will be the greater of 5% of the Death Benefit on the Initial Election Date or \$10,000.

EFFECT OF THE BENEFIT

Accelerated Benefits paid under this Rider will reduce the Certificate's Death Benefit, Specified Amount and Certificate values, if any, which include but are not limited to the Account Value, Surrender Value, and amount available for loan.

You may obtain Certificate loans as described under the loan provisions of the Certificate. A portion of the Accelerated Benefit Payment will be used to repay any Certificate Debt. Following a Final Election, Certificate loans are not available.

After the Initial Election Date, no additional Riders or Endorsements may be added to the Certificate to which this Rider is attached.

An Election is effective for 12 months starting from the Election Date. While an Election is in effect, the Certificate to which this Rider is attached will not enter the Grace Period. If the total Accelerated Death Benefits received under this Rider are equal to or greater than the Cumulative Accelerated Benefit Percentage, shown in

the Schedule of Certificate Benefits for this Rider, multiplied by the Death Benefit on the Initial Election Date, the Certificate will not enter the Grace Period for the remaining life of the Certificate.

While an Election is in effect, Partial Surrenders are not available. If the total Accelerated Death Benefits received under this Rider are equal to or greater than the Cumulative Accelerated Benefits Percentage, shown in the Schedule of Certificate Benefits for this Rider, multiplied by the Death Benefit on the Initial Election Date, Partial Surrenders are not available for the remaining life of this Certificate.

While an Election is in effect, You cannot elect to increase or decrease the Specified Amount or change the Death Benefit Option on the Certificate. If the total Accelerated Death Benefits received under this Rider are equal to or greater than the Cumulative Accelerated Benefit Percentage, shown in the Schedule of Certificate Benefits for this Rider, multiplied by the Death Benefit on the Initial Election Date, You cannot elect to increase or decrease the Specified Amount or change the Death Benefit Option for the remaining life of this Certificate.

If You elect to increase the Specified Amount or change from a Level Death Benefit Option to an Increasing Death Benefit Option while this Rider is in effect, but the evidence of insurability is not satisfactory to meet the requirements for this Rider, the total Death Benefit that We will accelerate on the Certificate under this Rider will be limited to the Death Benefit immediately prior to the increase or change in the Death Benefit Option.

If You have enacted a Certificate provision or Rider or Endorsement, which restricts You from making any changes to Your Death Benefit, You may not elect Accelerated Benefits under this Rider. This includes any restrictions specified by a Certificate provision or Rider or Endorsement, which provide over-loan protection.

Upon a Final Election, all Riders and Endorsements attached to the Certificate, except this Rider, will terminate on the final Election Date. A sample illustration of the Impact of Accelerated Benefits on a Certificate is given on the following page.

**Sample Illustration of Impact of Accelerated Benefits on Certificate Provisions For Chronic Illness
Accelerated Benefit Rider**

Immediately prior to Initial Election:

Death Benefit (DB)	\$100,000
Specified Amount	\$100,000
Account Value	\$30,000
Certificate Debt	\$10,000
Surrender Value	\$20,000
Account Value – Certificate Debt	\$30,000 – \$10,000

Initial Election:

Minimum Accelerated DB	\$5,000
5% of DB or \$75,000 if smaller	
Maximum Accelerated DB	\$24,000
24% of DB or \$240,000 if smaller	
Residual DB	\$10,000
5% of DB or \$10,000 if greater	
Requested Accelerated DB	\$20,000

Immediately after Initial Election:

Death Benefit	\$80,000
Reduced by Accelerated DB	
\$100,000 – \$20,000	
Specified Amount	\$80,000
Reduced by Accelerated DB / DB	
Reduced by \$20,000 / \$100,000 = 20%	
$\$100,000 * (100\% - 20\%)$	
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
Certificate Debt * Accelerated DB / DB	
$\$10,000 * \$20,000 / \$100,000$	
Certificate Debt	\$8,000
Reduced by Debt Repayment Amount	
\$10,000 – \$2,000	
Surrender Value	\$16,000
Account Value – Certificate Debt	
\$24,000 – \$8,000	



L3182CRT

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

PRIMARY INSURED PROPOSED FOR INSURANCE

1. Last Name	First Name	M.I.
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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: <input type="checkbox"/> Male <input type="checkbox"/> Female	Date of Birth	Age	Place of Birth - State / Country	Height (FT. IN.)	Weight (LBS.)	Marital Status
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Social Security Number/Tax ID#	Driver's License Number	Expiration Date	State
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2. Residence Address (If P. O. Box include Street Address)	Street	City	State	Zip Code
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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
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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 \$
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4. Contact The Proposed Insured At: <input type="checkbox"/> Residence _____ (CST) <input type="checkbox"/> A.M. <input type="checkbox"/> P.M. <input type="checkbox"/> Business	Residence Telephone Number: Primary Insured () Additional Insured () Cell Phone ()	Business Telephone Number: Primary Insured () Additional Insured () Cell Phone ()
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PLAN INFORMATION

5. Amount Applied For \$	Proposed Plan of Insurance	6. For UL: (check if applicable) <input type="checkbox"/> Level <input type="checkbox"/> Increasing <input type="checkbox"/> Return of Premium
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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? <input type="checkbox"/> Yes <input type="checkbox"/> No (If no, complete Foreign Travel and Residence Questionnaire)									
Sex: <input type="checkbox"/> Male <input type="checkbox"/> 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 #			<input type="checkbox"/> U.S. Citizen <input type="checkbox"/> Resident Alien - Country _____ <input type="checkbox"/> 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: <input type="checkbox"/> Yes <input type="checkbox"/> 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: <input type="checkbox"/> Yes <input type="checkbox"/> 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 certificates, if you elect to pay premium on a basis other than annual, you may pay more premium than would be required if you paid premium on an annual basis.

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

Make all checks payable to: NORTH AMERICAN COMPANY FOR LIFE & HEALTH INSURANCE

16. For EFT Only: Draw Day _____ (1 st - 28 th) Month Day	Account Type <input type="checkbox"/> Checking (attach voided check) <input type="checkbox"/> Savings (must complete 16b)	Authorized Signature(s) of Account Holder(s) X
16a. Initial Draft <input type="checkbox"/> Yes <input type="checkbox"/> No		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 certificates 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	Certificate #	Pending	Issue Yr.	Basic Amount	ADB Amount	WP Amount	Intention of Replacement or Change*
17a.			<input type="checkbox"/>					18a. <input type="checkbox"/> Yes <input type="checkbox"/> No
17b.			<input type="checkbox"/>					18b. <input type="checkbox"/> Yes <input type="checkbox"/> No
17c.			<input type="checkbox"/>					18c. <input type="checkbox"/> Yes <input type="checkbox"/> No
17d.			<input type="checkbox"/>					18d. <input type="checkbox"/> Yes <input type="checkbox"/> No

***Replacement means that the insurance applied for may replace, change or use any value of an existing or pending life insurance certificate 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 certificates being used to fund this certificate? Yes No

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

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

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

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

24. Has the certificate 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 certificate, including, but not limited to, an agreement to sell, transfer or assign the certificate or any certificate rights or beneficial interests? Yes No

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

TO BE COMPLETED BY SOLICITING AGENT

Does any person covered under this application have any existing life insurance or annuities?..... Yes No

Is any insurance applied for in this application intended to replace any existing life insurance or annuity?..... Yes No

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

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

25. SPECIAL REQUESTS or DETAILS

--

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

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

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

28. Job Duties	29. Are you currently drawing extra duty or hazard pay? <input type="checkbox"/> Yes <input type="checkbox"/> No
----------------	--

30. Military Information <input type="checkbox"/> USA <input type="checkbox"/> USN <input type="checkbox"/> USAF <input type="checkbox"/> 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.

		Yes	No
33. Has any person proposed for insurance:			
(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	<input type="checkbox"/>		<input type="checkbox"/>
(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	<input type="checkbox"/>		<input type="checkbox"/>
(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)?	<input type="checkbox"/>		<input type="checkbox"/>
(d) Had more than one speeding violation, or any motor vehicle moving violations or accidents or been arrested for driving under the influence of alcohol within the past five years?	<input type="checkbox"/>		<input type="checkbox"/>
(e) In the past 10 years been convicted of any criminal activity, or been held or served time in any type of incarceration, jail, penitentiary, prison, probation, or parole program? Or, have any criminal charges pending against them at this time?	<input type="checkbox"/>		<input type="checkbox"/>
(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.	<input type="checkbox"/>		<input type="checkbox"/>
(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.	<input type="checkbox"/>		<input type="checkbox"/>
(h) In the past 10 years been refused for life insurance or charged an extra premium for life insurance?	<input type="checkbox"/>		<input type="checkbox"/>
(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.	<input type="checkbox"/>		<input type="checkbox"/>
(j) Have any bankruptcy pending or expect to file bankruptcy in the next 12 months?	<input type="checkbox"/>		<input type="checkbox"/>

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? | <input type="checkbox"/> | <input type="checkbox"/> |
| (b) High blood pressure, hypertension or abnormal cholesterol levels? | <input type="checkbox"/> | <input type="checkbox"/> |
| (c) Stroke, seizures, epilepsy, dizziness, fainting, memory disorder or any other neurological or brain disorder? | <input type="checkbox"/> | <input type="checkbox"/> |
| (d) Multiple Sclerosis, neuritis, neuropathy, paralysis, muscular dystrophy, Parkinson's disease or any other disorder of the muscles? | <input type="checkbox"/> | <input type="checkbox"/> |
| (e) Arthritis, chronic pain, fibromyalgia, connective tissue disease, lupus or scleroderma? | <input type="checkbox"/> | <input type="checkbox"/> |
| (f) Cancer, malignancy, tumor, melanoma, lymphoma, Hodgkin's disease or leukemia? | <input type="checkbox"/> | <input type="checkbox"/> |
| (g) Chronic obstructive pulmonary or lung disease, chronic bronchitis, emphysema, sarcoidosis, asthma, shortness of breath, tuberculosis or sleep apnea? | <input type="checkbox"/> | <input type="checkbox"/> |
| (h) Diabetes, abnormal blood sugar, sugar in the urine, disease or disorders of the adrenal, parathyroid, pituitary or thyroid glands? | <input type="checkbox"/> | <input type="checkbox"/> |
| (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? | <input type="checkbox"/> | <input type="checkbox"/> |
| (j) Anemia, hemophilia, clotting disorder or any other disorder of the blood? | <input type="checkbox"/> | <input type="checkbox"/> |
| (k) Immune Deficiency disorder (Acquired Immune Deficiency Syndrome (AIDS)), AIDS related complex (ARC) or been told test results indicate exposure to the AIDS virus? | <input type="checkbox"/> | <input type="checkbox"/> |
| (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? | <input type="checkbox"/> | <input type="checkbox"/> |
| (m) Depression, anxiety, stress, eating disorder or any other nervous, mental or emotional condition? | <input type="checkbox"/> | <input type="checkbox"/> |
| (n) Any mental or physical disorder or medically or surgically treated condition not listed above? | <input type="checkbox"/> | <input type="checkbox"/> |
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. | <input type="checkbox"/> | <input type="checkbox"/> |
| (b) Had a weight gain or loss of 10 or more pounds within the past 12 months for any reason other than pregnancy? | <input type="checkbox"/> | <input type="checkbox"/> |
| (c) In the past 12 months been advised by a licensed medical professional to have a check up, EKG, X-ray, blood or urine test or any other diagnostic test or are you now planning to seek medical advice or treatment for any reason? | <input type="checkbox"/> | <input type="checkbox"/> |
| (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? | <input type="checkbox"/> | <input type="checkbox"/> |
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..... Yes No
37. Is any person proposed for insurance currently receiving or have an application pending for any illness or disability benefits or compensation?
- | | | |
|--|--------------------------|--------------------------|
| | <input type="checkbox"/> | <input type="checkbox"/> |
|--|--------------------------|--------------------------|

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:
<i>Non-Natural/Business or Corporation</i>				
	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:
<i>Non-Natural/Business or Corporation</i>				
	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 certificate 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 Certificate is effective, as defined herein.

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

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

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

TAX PAYER IDENTIFICATION NUMBER CERTIFICATION - Under penalties of perjury, the undersigned applicant(s) (I) certify that:

1. The number shown on this form is my correct taxpayer identification number (or I am waiting for a number to be issued to me), **and**
2. I am not subject to backup withholding because: **(a)** I am exempt from backup withholding, or **(b)** I have not been notified by the Internal Revenue Service that I am subject to backup withholding as a result of a failure to report all interest or dividends, or **(c)** the IRS has notified me that I am no longer subject to backup withholding. **(Please check appropriate response.)**

FINANCIAL INSTITUTION DISCLOSURE - Insurance products and annuities are not a deposit or other obligation of, or guaranteed by a bank, any affiliate of a bank, or savings association and are not insured by the Federal Deposit Insurance Corporation (FDIC) or any other agency of the United States, a bank, any affiliate of a bank, or savings association, and involve investment risk, including possible loss of value. The approval or disapproval of any extension of credit by the bank or an affiliate is not based on whether or not this insurance is purchased through the bank or through any particular source.

AUTHORIZATION: To determine eligibility for insurance, the undersigned applicant(s) (I) authorize any licensed physician, medical practitioner, health care professional, hospital, clinic, or other medically related facility, laboratory, pharmacy or pharmacy benefit manager, insurance or reinsuring company, viatical company, viatical broker or provider, the Medical Information Bureau, Inc., consumer reporting agency, insurance support organization, independent administrator, or other organization, institution, or person, or employer having information available as to diagnosis, prescription history, medications prescribed, treatment and prognosis with respect to information regarding alcoholism, drug abuse, and psychiatric care or any physical or mental condition and/or treatment of me or my minor children and any other nonmedical information of me or my minor children to give to 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 - AR, KY, NM, OH and PA Residents: Any person who knowingly, and with intent to defraud any insurance company or other person, files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

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

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

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

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

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

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



L1893371

SURRENDER COMPARISON INDEX DISCLOSURE

Per \$ 1000 of Specified Amount of Basic Insurance

Name of Insured _____ Age _____ Sex _____

Specified Amount of Policy \$ _____

Death Benefit Option:

Option A - Your death benefit is the greater of:

- (1) the accumulation value plus the specified amount; or
- (2) the accumulation value plus any corridor amount.

Option B - Your death benefit is the greater of:

- (1) the specified amount; or
- (2) the accumulation value plus any corridor amount

The corridor amount is added so that there is no change in the tax status of the death proceeds.

Planned Periodic Premium \$ _____, payable _____

Description Title of Policy - Flexible Premium Adjustable Life

Policy Number _____

Index numbers based on surrender values and death benefits produced with the Planned Periodic Premium shown and using GUARANTEED cost of insurance rates and the GUARANTEED interest rate of _____%:

10 Year Surrender Index _____

20 Year Surrender Index _____

Index numbers based on surrender values and death benefits produced with the Planned Periodic Premium shown and using CURRENT, NON-GUARANTEED cost of insurance rates and a NON-GUARANTEED interest rate of _____%*:

10 Year Surrender Index _____*

20 Year Surrender Index _____*

*The non-guaranteed interest rate shown is credited to the cash value. (If a policy loan exists, the guaranteed rate only, and not the non-guaranteed rates, applies to that portion of the cash value borrowed.) If the interest rate used is higher than that shown, or if the cost of insurance rates are lowered, within the 10 or 20 year period, the Index will be lower. If not, the Index will be the same or higher.

(Continued on Reverse Side)

(Please Detach And Attach Certification To Application)

CERTIFICATION

I certify that the written disclosure statement required by Chapter 83 has been given to _____
at the time that the applicant signed the application. (Proposed Insured)

Date

Signature of Agent

Name of Agent (Please Print)



L1893372

The Surrender Comparison Index was designed to measure the relative cost of life insurance protection and may be useful for comparison of similar policies offered by other companies. Technically, the Index shows the relationship between the amounts paid by the owner (the average annual premiums minus any average annual dividend) and the amounts paid by the insurer (the surrender value of the policy) over periods of 10 and 20 years, all adjusted for compound interest at the rate of five percent per annum to reflect the timing of the payments.

When comparing similar policies, if all things are equal, the policy with the lower Index is generally the lower cost policy and the better buy in the event that the policy is surrendered at the end of the designated period. If death would occur during the designated period, the policy with the lower Index would not necessarily be the lower cost policy. The Index does not take into account, among other things: (1) the value of the services of an agent or company; (2) the relative strength and reputation of the company; and (3) small differences in policy provisions. The index assumes that annual premiums are paid and that no additional benefit provisions are included.



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: _____



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 OF LIFE INSURANCE AND ANNUITIES

You have indicated that you intend to replace existing life insurance or annuity coverage in connection with the purchase of our life insurance or annuity policy. As a result, we are required to send you this notice. Please read it carefully.

Whether it is to your advantage to replace your existing insurance or annuity coverage, only you can decide. It is in your best interest; however, to have adequate information before a decision to replace your present coverage becomes final so that you may understand the essential features of the proposed policy and your existing insurance or annuity coverage.

You may want to contact your existing life insurance or annuity company or its agent for additional information and advice or discuss your purchase with other advisors. Your existing company will provide this information to you. The information you receive should be of value to you in reaching a final decision.

If either the proposed coverage or the existing coverage you intend to replace is participating, you should be aware that dividends may materially reduce the cost of insurance and are an important factor to consider. Dividends, however, are not guaranteed.

You should recognize that a policy which has been in existence for a period of time may have certain advantages to you over a new policy. If the policy coverages are basically similar, the premiums for a new policy may be higher because rates increase as your age increases. Under your existing policy, the period of time during which the issuing company could contest the policy because of a material misrepresentation or omission concerning the medical information requested in your application, or deny coverage for death caused by suicide, may have expired or may expire earlier than it will under the proposed policy. Your existing policy may have options which are not available under the policy being proposed to you or may not come into effect under the proposed policy until a later time during your life. Also, your proposed policy's cash values and dividends, if any, may grow slower initially because the company will incur the cost of issuing your new policy. On the other hand, the proposed policy may offer advantages which are more important to you.

If you are considering borrowing against your existing policy to pay the premiums on the proposed policy, you should understand that in the event of your death, the amount of any unpaid loan, including unpaid interest, will be deducted from the benefits of your existing policy thereby reducing your total insurance coverage.

After we have issued your policy, you will have twenty days from the date the new policy is received by you to notify us you are canceling the policy issued on your application and you will receive back all payments you made to us.

You are urged not to take action to terminate or alter your existing life insurance or annuity coverage until you have been issued the new policy, examined it and have found it acceptable to you.

(Signed) _____
(Agent's signature)

Date _____

I have received and read a copy of this Replacement Notice and the agent has provided me with copies of all materials used in this sale.

(Signed) _____
(Applicant's signature)

Date _____



TEMPORARY LIFE INSURANCE AGREEMENT

Proposed Primary Insured	Proposed Additional Insured(s)
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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? | <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.

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.**