



## LEAVE WITH APPLICANT

### ACCELERATED DEATH BENEFIT SUMMARY and DISCLOSURE STATEMENT

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

**PREMIUM** – There is no additional premium charge for the Accelerated Death Benefit Endorsement provided under this life insurance Policy or Certificate. 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 or Certificate may provide benefits to pay for long-term care services but are NOT part of a long-term care or nursing home insurance Policy or Certificate 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 or Certificate are suitable for your needs. Receipt of accelerated death benefits under this Policy or Certificate **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 OR CERTIFICATE PROVISIONS

Upon written request by the owner (“You”) of the Policy or Certificate, 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 or Certificate is \$1,000,000. Accelerated Death benefits paid under this Endorsement will reduce the Policy or Certificate’s Death Benefit and Policy or Certificate 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 or Certificate 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 or Certificate 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 or Certificate, 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 or

Certificate loan provision. A portion of the Accelerated Death Benefit Payment will be used to reduce any Policy or Certificate Debt.

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 or Certificate.

**Accelerated Death Benefit for Chronic Illness (if available)<sup>1</sup>:** You may elect to receive advancement of the Accelerated Death Benefits when the Survivor or Insured is Chronically Ill while this Endorsement is in effect.

A Survivor or Insured qualifies as being Chronically Ill if a Physician has certified within the last 12 months that the Survivor or Insured:

1. Is permanently unable to perform for at least 90 consecutive days, without Substantial Assistance from another person, at least two Activities of Daily Living; "90 consecutive days" includes consecutive days immediately prior to the Policy or Certificate being in effect; 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, continence, dressing, eating, toileting, or transferring.

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.

The minimum Accelerated Death Benefit for Chronic Illness, at each Election, except the Final Election, is the smaller of 5% of the Policy or Certificate Death Benefit on the Initial Election Date or \$50,000.

You can accelerate an amount less than the minimum Accelerated Death Benefit for Chronic Illness allowed if it is necessary to do so to comply with the \$1,000,000 maximum Accelerated Death Benefit limitation for this Endorsement.

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

The Accelerated Benefit Payment will be determined as of each Election Date. Each Payment will be paid in a lump sum, unless a Periodic Payment is chosen by You. We will pay the present value of the Policy or Certificate 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.

Under a Periodic Payment, We will divide the Accelerated Death Benefit Payment into equal Periodic Payments that will be paid in lieu of a lump sum payment. You may select to receive Periodic Payments as frequently as once each month.

A Final Election is available if the maximum Chronic Illness Accelerated Death Benefit at the time of Election is greater than the remaining Death Benefit in the Policy or Certificate, minus the Residual Death Benefit. A Final Election occurs when You accelerate all of the Death Benefit in Your Policy or Certificate, minus the Residual Death Benefit. The Payment must first be applied to pay off any Policy or Certificate Debt to Us.

Residual Death Benefit is the greater of 5% of the Policy or Certificate Death Benefit on the Initial Election Date or \$10,000. The Residual Death Benefit only applies to benefits for Chronic Illness.

We will waive the Monthly Deductions while a Chronic Illness Election is in effect (12 months following the Election Date) immediately prior to the Initial Election Date if the Death Benefit does not exceed \$1,000,000. If the Death Benefit immediately prior to the initial Election Date exceeds \$1,000,000, while an Election is in effect the Monthly Deductions will be multiplied by the specified ratio, as stated in the Endorsement. Monthly Deductions will stop being waived when an Election is no longer in effect.

In addition, while the Chronic Illness Election is in effect and as stated in Your Policy or Certificate, You cannot take Withdrawals; cannot elect to increase or decrease the Specified Amount or change the Death Benefit Option; and after any Election, other than a Final Election, You may obtain loans as described under the Policy or Certificate Loan provisions of the Policy or Certificate. On the Election Date, the Policy or Certificate Debt and the Accelerated Death

Benefit Payment will be reduced by the Debt Repayment Amount. Following a Final Election, Policy or Certificate Loans are not available.

Upon any Election other than a Final Election, all Riders and Endorsements attached to the Policy or Certificate will continue to be effective subject to the terms and conditions of each Rider or Endorsement. Upon a Final Election, all Riders and Endorsements, except this Endorsement, attached to the Policy or Certificate will terminate on the Final Election date. After the Initial Election Date, no additional Riders or Endorsements may be added to the Policy or Certificate to which this Endorsement is attached.

A Chronic Illness Election is effective for 12 months starting from the Election Date and only one Election can be made in this 12-month period. If the Survivor or Insured dies after You elect to receive Accelerated Death Benefits, but before the payment is made, the Election will be cancelled and the Death Benefit will be paid as described in Your Policy or Certificate. If the Survivor or Insured dies before all Periodic Payments are paid, We will pay the Death Benefit in lieu of the remaining Accelerated Death Benefit Payments. If a Final Election has occurred, the Residual Death Benefit will be paid to the Beneficiary in a lump sum upon due proof of death of the Survivor or Insured.

<sup>1</sup> Proposed Insureds are subject to underwriting eligibility requirements to qualify for the Chronic Illness benefit of the Accelerated Death Benefit Endorsement. If a Proposed Insured does not meet the underwriting eligibility requirements, only the Accelerated Death Benefits Endorsement for Terminal Illness is available.

Sample Illustration of Impact of Accelerated Death Benefits on Policy or Certificate Provisions For Chronic Illness		Sample Illustration of Impact of Accelerated Death Benefits on Policy or Certificate Provisions For Terminal Illness	
<b>Immediately Prior to initial Election:</b>		<b>Immediately Prior to initial Election:</b>	
Death Benefit (DB)	\$100,000	Death Benefit (DB)	\$100,000
Account Value	\$30,000	Account Value	\$30,000
Policy or Certificate Debt	\$10,000	Policy or Certificate Debt	\$10,000
Net Cash Surrender Value	\$20,000	Net Cash Surrender Value	\$20,000
Monthly Deductions	\$300	Monthly Deductions	\$300
<b>Initial Election:</b>		<b>Election:</b>	
<u>Limitations on Benefits</u>		<u>Limitations on Benefits</u>	
Maximum Accelerated Death Benefit	\$24,000	Maximum Accelerated Death Benefit	\$75,000
24% of DB or \$240,000 if smaller		75% of DB or \$750,000 if smaller	
Residual Death Benefit \$10,000		<u>Requested on Application for Election:</u>	
5% of DB or \$10,000 if greater		Accelerated Death Benefit	\$20,000
<u>Requested on Application for Election:</u>			
Accelerated Death Benefit	\$20,000		
<b>Immediately After Initial Election:</b>		<b>Immediately After Election:</b>	
Death Benefit	\$80,000	Death Benefit	\$80,000
Reduced by Accelerated DB		Reduced by Accelerated DB	
\$100,000 - \$20,000		\$100,000 - \$20,000	
Account Value	\$24,000	Account Value	\$24,000
Reduced by Accelerated DB / DB		Reduced by Accelerated DB / DB	
Reduced by \$20,000 - \$100,000 = 20%		Reduced by \$20,000 - \$100,000 = 20%	
\$30,000 * (100% - 20%)		\$30,000 * (100% - 20%)	
Debt Repayment Amount	\$2,000	Debt Repayment Amount	\$2,000
Accelerated DB * Policy or Certificate Debt / DB		Accelerated DB * Policy or Certificate Debt / DB	
20,000 * 10,000 / \$100,000		\$20,000 * 10,000 / \$100,000	
Policy or Certificate Debt	\$8,000	Policy or Certificate Debt	\$8,000
Reduced by Debt Repayment Amount		Reduced by Debt Repayment Amount	
\$10,000 - \$2,000		\$10,000 - \$2,000	
Monthly Deductions	\$0 (Waived)	Monthly Deductions	\$0 (Waived)



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](http://www.mib.com).



## 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<sup>®</sup> Composite Stock Price Index (S&P 500<sup>®</sup>)
2. The Dow Jones Industrial Average<sup>SM</sup> (DJIA<sup>SM</sup>) Composite Stock Price Index
3. The Nasdaq-100<sup>®</sup> Stock Price Index
4. The S&P MidCap 400<sup>®</sup>
5. The Russell 2000<sup>®</sup>
6. The Dow Jones EURO STOXX 50<sup>®</sup>
7. Uncapped S&P 500<sup>®</sup>
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<sup>®</sup>, S&P MidCap 400<sup>®</sup>, Russell 2000<sup>®</sup> and DJIA<sup>SM</sup>.
- 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<sup>®</sup>, S&P MidCap 400<sup>®</sup>, Russell 2000<sup>®</sup>, DJIASM, Dow Jones EURO STOXX 50<sup>®</sup>, and NASDAQ-100<sup>®</sup>.
- 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<sup>®</sup>.

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

- 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<sup>®</sup>, Dow Jones EURO STOXX 50<sup>®</sup> and Russell 2000<sup>®</sup>. 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
X

DATE

**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
X

DATE

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

### The Tests:

To evaluate your eligibility for Insurance or Insurance benefits, you may be asked to provide a sample of your blood for testing and analysis. One of the tests to be performed on this sample would be a test to determine the presence of antibodies to the Human Immunodeficiency Virus (HIV), also known as the AIDS Virus. The HIV antibody test is actually a series of tests done by a medically accepted procedure, which is extremely reliable.

### Meaning of Test Results:

While positive HIV antibody test results do not mean that you have AIDS, they do mean that you are at seriously increased risk of developing AIDS or AIDS-related conditions. Federal authorities say that persons who are HIV antibody positive should be considered infected with the AIDS virus and capable of infecting others. Positive HIV antibody test results will adversely affect your insurance application.

An HIV test will be considered positive only after confirmation by a laboratory procedure, which is extremely reliable. Nonetheless, the HIV antibody test is not 100% accurate. Possible errors include:

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

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

### Potential Risks of HIV Testing:

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

### AIDS:

Acquired Immunodeficiency Syndrome (AIDS) is a life-threatening disorder of the Immune system, caused by a virus, HIV. The virus is transmitted by sexual contact with an infected person, from an infected mother to her newborn infant, or by exposure to infected blood (as in needle sharing during IV drug use). Persons at high risk of contacting AIDS include males who have had sexual contact with another man, intravenous drug users, hemophiliacs, and sexual contacts of any of these persons. AIDS does not typically develop until a person has been infected with HIV for several years. A person may remain free of symptoms for years after becoming infected.

Persons who have a history of high risk behavior should change these behaviors to prevent getting or giving AIDS, regardless of whether they are tested. Specific important changes in behavior include safe sex practices (including condom use for sexual contact with someone other than a long-term monogamous partner) and not sharing needles.

**Disclosure of Test Results:**

All test results will be treated confidentially. The results will be reported to the insurance company indicated above. They will also be reported to that insurance company's affiliates, reinsurers, or contractors. Access to test results within the insurance company, its affiliates, reinsurers, or contractors is restricted to persons involved in handling or determining applications for coverage or claims of the applicant or claimant. In addition, if your HIV antibody test is abnormal (positive), a generic code signifying a nonspecific blood abnormality may be made known to the Medical Information Bureau (MIB, Inc.) as described in the notice given you at the time of application. The fact that the test has been done and the results of the test will not be otherwise disclosed except as required by law or as authorized by you.

Under state law, individuals whose HIV test results are positive or indeterminate must be provided at least one post-test counseling session at the time they receive their test results. State law prohibits us from sending your HIV test results directly to you. Instead, you are asked to designate a test result recipient qualified to provide any necessary post-test counseling. Under your state's laws, that recipient must be either a health care provider (such as a physician) or a health care agency.

In the space below, please designate a recipient of your HIV test results. State law requires that we provide any positive or indeterminate test results to your state or local health officer.

Name of health care provider (such as a physician) or health care agency for reporting a possible positive or indeterminate test result:

\_\_\_\_\_

Address \_\_\_\_\_

**Consent:**

I have read and I understand this Notice of AIDS Virus (HIV) Antibody Testing and Consent for Testing. For my information, I have been given written material about AIDS. I voluntarily consent to the withdrawal of blood from me by needle or finger prick, the testing of my blood for HIV antibodies, and the disclosure of the test results as described above.

\_\_\_\_\_  
Name of Proposed Insured (Please Print)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Proposed Insured

\_\_\_\_\_  
State of Residence

\_\_\_\_\_  
Signature of Person Obtaining Consent

\_\_\_\_\_  
County of Residence

Copy 1 – Administrative Office

Copy 2 – Applicant

**WASHINGTON STATE  
HIV ANTIBODY TESTING/COUNSELING SERVICES  
HIV PRETEST COUNSELING SERVICES**

You may wish to obtain pretest counseling to become better informed about the implications of an AIDS related blood test. This list of counseling organizations is provided to you so that you may obtain such counseling prior to being tested.

**Adams County Health Department**

108 West Main  
Ritzville, Washington 99169-1408  
(509) 659-3319

**Asotin County Health District**

431 Elm Street  
Clarkston, Washington 99403  
(509) 758-3344

**Benton-Franklin Health District**

1218 North 4<sup>th</sup> Street  
Pasco, Washington 99301-3709  
(509) 547-9737, ext. 225

**Chelan-Douglas County Health District**

200 Valley Mall Parkway  
East Wenatchee, Washington 98802  
(509) 886-6400

**Clallam County Health Department**

223 East 4th Street, Suite #14  
Port Angeles, Washington 98362-0149  
(360) 565-2612

**Clark County Health Department**

1601 E. Fourth Plain Blvd  
Vancouver, WA 98663  
(360) 397-8425

**Cowlitz Health District**

1952 Ninth Avenue  
Longview, Washington 98632-4045  
(360) 414-5584

**Garfield County Health District**

121 South 10<sup>th</sup>, P.O. Box 130  
Pomeroy, Washington 99347  
(509) 843-3412

**Grant County Health District**

1038 West Ivy, Suite 1  
Moses Lake, Washington, 98837  
(509) 766-7960

**Grays Harbor County Health Department**

2109 Sumner Avenue  
Aberdeen, Washington 98520  
(360) 532-8631

**Island County Health Department**

6th and Main Street  
Coupeville, Washington 98239-5000  
(360) 678-7932

**Jefferson County Health Department**

Castle Hill Center  
615 Sheridan  
Port Townsend, Washington 98368-2439  
(360) 385-9421

**Kitsap County Health Department**

345 6<sup>th</sup> Street, Suite 300  
Bremerton, Washington 98337  
(360) 337-5235

**Kittitas County Health Department**

507 Nanum Street  
Ellensburg, Washington 98926-2898  
(509) 962-7028

**Klickitat County Health Department**

501 NE Washington Street  
White Salmon, WA 98672  
(509) 493-1558

**Lewis County Health District**

360 NW North Street  
Chehalis, Washington 98532-1900  
(360) 740-2787

**Lincoln County Health District**

90 Nichols Street  
Davenport, Washington 99122  
(509) 725-9213, ext. 27

**Mason County Health Department**

303 N Fourth  
Shelton, Washington 98584  
(360) 427-9670, ext. 545

**Northeast Tri-County Health District**

240 East Dominion  
Colville, Washington 99114  
(509) 684-5048

**Okanogan County Health District**

1234 South Second Avenue  
Okanogan, Washington 98840  
(509) 422-7153

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

**Pacific County Health Department**

1216 West Robert Bush Dr.  
 South Bend, Washington 98586  
 (360) 642-9349

**San Juan County Health Department**

145 Rhone Street  
 Friday Harbor, Washington 98250-0607  
 (360) 378-4474

**Skagit County Health Department**

700 S 2<sup>nd</sup> Street #301  
 Mount Vernon, Washington 98273-1071  
 (360) 336-9477, ext. 5291 or (360) 336-9380

**Snohomish Health District**

3020 Rucker Avenue, #106  
 Everett, Washington 98201-3971  
 (425) 339-5275

**Spokane County Health District**

1101 W College Ave  
 Spokane, Washington 99201-2095  
 (509) 324-1547

**Spokane County Health District**

C/O 5107 North Jefferson  
 Spokane, WA 99205  
 (509) 236-2435

**Tacoma-Pierce County Health Department**

3629 South D Street MS 433  
 Tacoma, Washington 98418-6813  
 (253) 798-4785 or (253) 798-2939

**Thurston County Health Department**

412 Lilly Rd. NE  
 Olympia, WA 98506-5132  
 (360)-786-5277

**Wahkiakum County Health Department**

64 Main Street  
 Cathlamet, Washington 98612  
 (360) 795-6207

**Walla Walla County-City Health Department**

310 West Poplar  
 Walla Walla, Washington 99362-0336  
 (509) 524-2661

**Walla Walla – Heart to Heart**

2330 Eastgate Street, Suite 105  
 Walla Walla, Washington 99362-0346  
 (509) 529-4744

**Whatcom County Health District**

1500 N State Street  
 Bellingham, Washington 98225  
 (360) 676-4593, ext 32029 or ext. 50804

**Whitman County Health Department**

North 310 Main Street  
 Colfax, Washington 99111-1893  
 (509) 397-6280

**Whitman -WSU**

100 Dairy Road  
 Pullman, Washington 99164  
 (509) 335-6778

**Yakima County Health District**

104 North First Street  
 Yakima, Washington 98901  
 (509) 249-6518



**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%.

<u>INDEX SELECTION</u>			<u>PREMIUM ALLOCATION</u>
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 <sup>SM</sup> – Annual Point to Point	(DPn)	%
Index Selection 5	Dow Jones Industrial Average <sup>SM</sup> – 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)	%
	<b>Total</b>		<b>100 %</b>

**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.

**Any person who knowingly presents a false statement in an application for insurance may be guilty of a criminal offense and subject to penalties under state law.**





# AGENT'S REPORT

Proposed Insured's Name	Social Security Number
-------------------------	------------------------

1. Do the Proposed Insured and/or Applicant want to save age?  Yes  No
2. How well do you know the Proposed Insured? (Check all that apply)  Self  Relative (state relationship) \_\_\_\_\_  Met very recently  
 Know slightly  Known well for \_\_\_\_\_ years Known through:  Business  Home  Church  Other \_\_\_\_\_
3. Was this insurance suggested by someone other than you? (If "yes," who and what prompted request?)  Yes  No

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

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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.

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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

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

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

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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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\*L-3182WA\*

**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  
(Insurance Producer 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**

<p><b>a. Term Products</b></p> <p><input type="checkbox"/> Additional Insured Rider \$ _____</p> <p><input type="checkbox"/> Children's Term Insurance Rider (CTR) _____ units</p> <p><input type="checkbox"/> Guaranteed Insurability Rider _____ units</p> <p><input type="checkbox"/> Monthly Income Endorsement: Initial Lump Sum \$ _____ \$ _____ Monthly for _____ years; Final Lump Sum \$ _____</p> <p><input type="checkbox"/> Waiver of Premium Rider</p> <p><input type="checkbox"/> Other _____ \$ _____</p>	<p><b>b. Permanent Products</b></p> <p><input type="checkbox"/> Accidental Death Benefit \$ _____</p> <p><input type="checkbox"/> Additional Insured Rider \$ _____</p> <p><input type="checkbox"/> Automatic Distribution Option</p> <p><input type="checkbox"/> Children's Term Insurance Rider (CTR) _____ units</p> <p><input type="checkbox"/> Estate Preservation Rider</p> <p><input type="checkbox"/> Guaranteed Insurability Rider _____ units</p> <p><input type="checkbox"/> Premium Guarantee Rider</p> <p><input type="checkbox"/> Waiver of Monthly Deductions Rider</p> <p><input type="checkbox"/> Waiver of Surrender Charge Option</p> <p><input type="checkbox"/> Other _____ \$ _____</p>
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<b>ADDITIONAL INSURED PROPOSED for INSURANCE (Complete Separate Application for Business Associates and Additional Insureds)</b>									
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 \$	
<b>10. DEPENDENT CHILDREN PROPOSED for INSURANCE</b>									
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	
<b>11. OWNER INFORMATION (Complete only if other than Proposed Primary Insured)</b>									
Name of Owner(s): If Trust, list all Trustees as well as Name and Date of Trust and complete <b>Trust Form</b> . If Owner is a business, complete <b>Company/Corporate Owned Life Insurance (COLI) Form</b> .									
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 #				
<b>12. PRIMARY BENEFICIARY</b>									
<b>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)</b>									
Name		Percent	Relationship to Proposed Primary Insured			Social Security Number/Tax ID#			
<b>Total</b>		<b>100</b>	Beneficiary designations do not apply to others covered under Children's Insurance Riders.						
<b>13. CONTINGENT BENEFICIARY</b>									
<b>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)</b>									
Name		Percent	Relationship to Proposed Primary Insured			Social Security Number/Tax ID#			
<b>Total</b>		<b>100</b>							
<b>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:</b>									
14a. <b>Proposed Primary Insured:</b> <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. <b>Additional Insured Rider:</b> <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 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 _____ (1 <sup>st</sup> - 28 <sup>th</sup> ) 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) <b>X</b>
16a. Initial Draft <input type="checkbox"/> Yes <input type="checkbox"/> No		<b>X</b>
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.			<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 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 INSURANCE PRODUCER**

- 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 Insurance Producer 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.



**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.....
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:				
<b>A. Owner #1</b>				
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>B. Owner #2</b>				
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 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:**

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

**Accelerated Death Benefit:** If the policy being applied for includes an accelerated death benefit(s), the Proposed Primary Insured understands and acknowledges: (1) Receipt of such benefits may affect eligibility for public assistance programs and benefits may be taxable; (2) Payment of this benefit will reduce the Insured's death benefit; (3) There is no additional premium for this benefit; and (4) The Insurance Producer 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 Insurance Producer	Print Insurance Producer's Last Name	Insurance Producer Code	Telephone Number ( )	
X			Cell Phone Number ( )	
Other Insurance Producer (Print)		% Credit	Insurance Producer Code	
Other Insurance Producer (Print)		% Credit	Insurance Producer Code	

# LIFE INSURANCE BUYER'S GUIDE

This guide can help you when you shop for life insurance. It discusses how to:

- Find a Policy That Meets Your Needs and Fits Your Budget
- Decide How Much Insurance You Need
- Make Informed Decisions When You Buy a Policy

*Prepared by the National Association of Insurance Commissioners*

The National Association of Insurance Commissioners is an association of state insurance regulatory officials. This association helps the various insurance departments to coordinate insurance laws for the benefit of all consumers.

This Guide Does Not Endorse Any Company or Policy.

Reprinted by North American Company for Life and Health Insurance • Executive Office: Chicago, IL

## IMPORTANT THINGS TO CONSIDER

1. Review your own insurance needs and circumstances. Choose the kind of policy that has benefits that most closely fit your needs. Ask an agent or company to help you.
2. Be sure that you can handle premium payments. Can you afford the initial premium? If the premium increases later and you still need insurance, can you still afford it?
3. Don't sign an insurance application until you review it carefully to be sure all the answers are complete and accurate.
4. Don't buy life insurance unless you intend to stick with your plan. It may be very costly if you quit during the early years of the policy.
5. Don't drop one policy and buy another without a thorough study of the new policy and the one you have now. Replacing your insurance **may be costly**.
6. Read your policy carefully. Ask your agent or company about anything that is not clear to you.
7. Review your life insurance program with your agent or company every few years to keep up with changes in your income and your needs.

### Buying Life Insurance

When you buy life insurance, you want coverage that fits your needs.

**FIRST**, decide how much you need—and for how long—and what you can afford to pay. Keep in mind the major reason you buy life insurance is to cover the financial effects of unexpected or untimely death. Life insurance also can be one of many ways you plan for the future.

**NEXT**, learn what kinds of policies will meet your needs and pick the one that best suits you.

**THEN**, choose the combination of policy premium and benefits that emphasizes protection in case of early death, or benefits in case of long life, or a combination of both.

It makes good sense to ask a life insurance agent or company to help you. An agent can help you review your insurance needs and give you information about the available policies. If one kind of policy doesn't seem to fit your needs, ask about others.

This guide provides only basic information. You can get more facts from a life insurance agent or company or from your public library.

### What About the Policy You Have Now?

If you are thinking about dropping a life insurance policy, here are some things you should consider:

- If you decide to replace your policy, don't cancel your old policy until you have received the new one. You then have a minimum period to review your new policy and decide if it is what you wanted.
- It may be costly to replace a policy. Much of what you paid in the early years of the policy you have now, paid for the company's cost of selling and issuing the policy. You may pay this type of cost again if you buy a new policy.
- Ask your tax advisor if dropping your policy could affect your income taxes.

- If you are older or your health has changed, premiums for the new policy will often be higher. You will not be able to buy a new policy if you are not insurable.
- You may have valuable rights and benefits in the policy you now have that are not in the new one.
- If the policy you have now no longer meets your needs, you may not have to replace it. You might be able to change your policy or add to it to get the coverage or benefits you now want.
- At least in the beginning, a policy may pay no benefits for some causes of death covered in the policy you have now.

In all cases, if you are thinking of buying a new policy, check with the agent or company that issued you the one you have now. When you bought your old policy, you may have seen an illustration of the benefits of your policy. Before replacing your policy, ask your agent or company for an updated illustration. Check to see how the policy has performed and what you might expect in the future, based on the amounts the company is paying now.

### How Much Do You Need?

Here are some questions to ask yourself:

- How much of the family income do I provide? If I were to die early, how would my survivors, especially my children, get by? Does anyone else depend on me financially, such as a parent, grandparent, brother or sister?
- Do I have children for whom I'd like to set aside money to finish their education in the event of my death?
- How will my family pay final expenses and repay debts after my death?
- Do I have family members or organizations to whom I would like to leave money?
- Will there be estate taxes to pay after my death?
- How will inflation affect future needs?

As you figure out what you have to meet these needs, count the life insurance you have now, including any group insurance where you work or veteran's insurance. Don't forget Social Security and pension plan survivor's benefits. Add other assets you have: savings, investments, real estate and personal property. Which assets would your family sell or cash in to pay expenses after your death?

### What is the Right Kind of Life Insurance?

All policies are not the same. Some give coverage for your lifetime and others cover you for specific number of years. Some build up cash values and others do not. Some policies combine different kinds of insurance, and others let you change from one kind of insurance to another. Some policies may offer other benefits while you are still living. Your choice should be based on your needs and what you can afford.

There are two basic types of life insurance: **term insurance** and **cash value insurance**. Term insurance generally has lower premiums in the early years, but does not build up cash values that you can use in the future. You may combine cash value life insurance with term insurance for the period of your greatest need for life insurance to replace income.

**Term Insurance** covers you for a term of one or more years. It pays a death benefit only if you die in that term. Term insurance

generally offers the largest insurance protection for your premium dollar. It generally does not build up cash value.

You can renew most term insurance policies for one or more terms even if your health has changed. Each time you renew the policy for a new term, premiums may be higher. Ask what the premiums will be if you continue to renew the policy. Also ask if you will lose the right to renew the policy at some age. For a higher premium, some companies will give you the right to keep the policy in force for a guaranteed period at the same price each year. At the end of that time you may need to pass a physical examination to continue coverage, and premiums may increase.

You may be able to trade many term insurance policies for a cash value policy during a conversion period—even if you are not in good health. Premiums for the new policy will be higher than you have been paying for the term insurance.

**Cash Value Life Insurance** is a type of insurance where the premiums charged are higher at the beginning than they would be for the same amount of term insurance. The part of the premium that is not used for the cost of insurance is invested by the company and builds up a cash value that may be used in a variety of ways. You may borrow against a policy's cash value by taking a policy loan. If you don't pay back the loan and the interest on it, the amount you owe will be subtracted from the benefits when you die, or from the cash value if you stop paying premiums and take out the remaining cash value. You can also use your cash value to keep insurance protection for a limited time or to buy a reduced amount without having to pay more premiums. You also can use the cash value to increase your income in retirement or to help pay for needs such as a child's tuition without canceling the policy. However, to build up this cash value, you must pay higher premiums in the earlier years of the policy. Cash value life insurance may be one of several types: whole life, universal life and variable life are all types of cash value insurance.

**Whole Life Insurance** covers you for as long as you live if your premiums are paid. You generally pay the same amount in premiums for as long as you live. When you first take out the policy, premiums can be several times higher than you would pay initially for the same amount of term insurance. But they are smaller than the premiums you would eventually pay if you were to keep renewing a term policy until your later years.

Some whole life policies let you pay premiums for a shorter period such as 20 years, or until age 65. Premiums for these policies are higher since the premium payments are made during a shorter period.

**Universal Life Insurance** is a kind of flexible policy that lets you vary your premium payments. You can also adjust the face amount of your coverage. Increases may require proof that you qualify for the new death benefit. The premiums you pay (less expense charges) go into a policy account that earns interest. Charges are deducted from the account. If your yearly premium payment plus the interest your account earns is less than the charges, your account value will become lower. If it keeps dropping, eventually your coverage will end. To prevent that, you may need to start making premium payments, or increase your premium payments, or lower your death benefits. Even if there is enough in your account to pay the premiums, continuing to pay premiums yourself means that you build up more cash value.

**Variable Life Insurance** is a kind of insurance where the death benefits and cash values depend on the investment performance of one or more separate accounts, which may be invested in mutual funds or other investments allowed under the policy. Be sure to get the prospectus from the company when buying this kind of policy and **STUDY IT CAREFULLY**. You will have higher death benefits and cash value if the underlying investments do well. Your benefits and cash value will be lower or may disappear if the investments you chose didn't do as well as you expected. You may pay an extra premium for a guaranteed death benefit.

## Life Insurance Illustrations

You may be thinking of buying a policy where cash values, death benefits, dividends or premiums may vary based on events or situations the company does not guarantee (such as interest rates). If so, you may get an illustration from the agent or company that helps explain how the policy works. The illustration will show how the benefits that are not guaranteed will change as interest rates and other factors change. The illustration will show you what the company guarantees. It will also show you what *could* happen in the future. Remember that nobody knows what will happen in the future. You should be ready to adjust your financial plans if the cash value doesn't increase as quickly as shown in the illustration. You will be asked to sign a statement that says you understand that some of the numbers in the illustration are not guaranteed.

### Finding a Good Value in Life Insurance

After you have decided which kind of life insurance is best for you, compare similar policies from different companies to find which one is likely to give you the best value for your money. A simple comparison of the premiums is not enough. There are other things to consider. For example:

- Do premiums or benefits vary from year to year?
- How much do the benefits build up in the policy?
- What part of the premiums or benefits is not guaranteed?
- What is the effect of interest on money paid and received at different times on the policy?

Remember that no one company offers the lowest cost at **all** ages for **all** kinds and amounts of insurance. You should also consider other factors:

- How quickly does the cash value grow? Some policies have low cash values in the early years that build quickly later on. Other policies have a more level cash value build-up. A year-by-year display of values and benefits can be very helpful. (The agent or company will give you a policy summary or an illustration that will show benefits and premiums for selected years.)
- Are there special policy features that particularly suit your needs?
- How are nonguaranteed values calculated? For example, interest rates are important in determining policy returns. In some companies increases reflect the average interest earnings on all of that company's policies regardless of when issued. In others, the return for policies issued in a recent year, or a group of years, reflects the interest earnings on that group of policies; in this case, amounts paid are likely to change more rapidly when interest rates change.



## 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:

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## TRANSMITTAL REPORT

Gold Team Phone: 800-669-9100 Fax: 800-951-9430 email: [nbgold@nacolah.com](mailto:nbgold@nacolah.com)  
Purple Team Phone: 866-606-2943 Fax: 800-978-7959 email: [nbpurple@nacolah.com](mailto: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 \$ _____ <b>Please attach a copy of Illustration</b>		

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**

<b>Step 1. Applicant/Insured</b> (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.

<b>FOR OFFICE USE ONLY</b>
Processed by: _____ Date: _____ Control #: _____



**IMPORTANT NOTICE REGARDING REPLACEMENT OF LIFE INSURANCE**

**(Save this notice! It may be important in the future.)**

The decision to buy a new life insurance policy or annuity and discontinue or change an existing one is very important. Your decision could be a good one – or a mistake. It should be carefully considered. The Washington State Insurance Commissioner requires us to give you this notice to help you make a wise decision.

STATEMENT TO APPLICANT BY AGENT OR BROKER: (Use additional sheets, as necessary.)

I believe the replacement of insurance involved in this transaction materially improves your position. My conclusion has taken into account the following factors, which I call to your attention.

1. Can there be reduced benefits or increased premiums in later years?  No  Yes, explain:
2. Are there penalties, set up or surrender charges for the new policy?  No  Yes, explain, emphasizing any extra cost for early withdrawal:
3. Will there be penalties or surrender charges under the existing insurance as a result of the proposed transaction?  
 No  Yes, explain:
4. Are there adverse tax consequences from the replacement under current tax law?  No  Yes, explain:
5. a) Are interest earnings a consideration in this replacement?  No  Yes.  
 b) If “yes,” explain what portions of premiums or contributions will produce limited or no earnings. As pertinent, include in your explanation the need for minimum deposits to enhance earnings, and the reduction of earnings that may result from set up charges, policy fees and other factors.
6. Are minimum amounts required to be on deposit before excess interest will be paid?  No  Yes, explain:
7. If the new program is based on a variable or universal life insurance policy or a single-premium policy or annuity:
  - a) Are the interest rates quoted before  or after  fees and mortality charges have been deducted?
  - b) Interest rates are guaranteed for how long? \_\_\_\_\_
  - c) The minimum interest rate to be paid is how much? \_\_\_\_\_
  - d) If applicable, the rate you pay to borrow is \_\_\_\_\_ %, and the limit on the amount that can be borrowed is \_\_\_\_\_
  - e) The surrender charges are \_\_\_\_\_
  - f) The death benefit is \_\_\_\_\_
- 8) Are there other short or long term effects from the replacement that might be materially adverse?  
 No  Yes, explain:

\_\_\_\_\_  
 Signature of Agent or Broker \_\_\_\_\_ Date

\_\_\_\_\_  
 Name of Agent or Broker (Print or Type)

\_\_\_\_\_  
 Address



**LIST OF POLICIES OR CONTRACTS TO BE REPLACED:**

Company	Insured	Contract No.
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

CAUTION: The insurance commissioner suggests you consider these points:

- Usually, contestable and suicide periods start again under a new policy. Benefits might be excluded under a new policy that would be paid under existing insurance.
- Terminating or altering existing coverage, before new insurance has been issued, might leave you unable to purchase other life insurance or let you buy it only at substantially higher rates.
- You are entitled to advice from the existing agent or company. Such advice might be helpful.
- Study the comments made above by the agent or broker. They apply to you and this proposal. They are important to you and your future.

Completed Copy Received: \_\_\_\_\_  
Date Applicant's Signature

THIS COMPLETED FORM SHOULD BE FILED PERMANENTLY WITH YOUR NEW INSURANCE POLICY



## 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? .....              | <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.**