NORTH AMERICAN COMPANY FOR LIFE AND HEALTH INSURANCE

LEAVE WITH APPLICANT

ACCELERATED DEATH BENEFIT ENDORSEMENT SUMMARY AND DISCLOSURE STATEMENT

When used in this disclosure, "Death Benefit" applies to a permanent life insurance policy; "Face Amount" applies to a term or whole life insurance policy.

There is no additional charge for the Accelerated Death Benefit Endorsement. However, there is an administrative fee required each time an Election is made.

The accelerated death benefits may provide benefits to pay for long-term care services but are NOT part of a long-term care or nursing home insurance policy and the amount these products pay may not be enough to cover your medical, nursing home or other bills. Accelerated Death Benefit Payments used to pay for long-term care services are subject to limits imposed by the federal government and any amounts received in excess of these limits are includible in taxable income. You may use the money you receive as an accelerated death benefit for any purpose.

If you already have long-term care insurance, Medicaid, or similar coverage, you should consider whether the accelerated death benefits are suitable for your needs. Receipt of accelerated death benefits 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.

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 UNDER THIS ENDORSEMENT TO ASSESS THE TAX TREATMENT IN YOUR INDIVIDUAL CIRCUMSTANCES. THE COMPANY SHALL ACT AS IT DETERMINES IS REQUIRED BY THE INTERNAL REVENUE CODE AND THE REGULATIONS IN REPORTING ANY AMOUNTS PROVIDED PURSUANT TO AN ELECTION UNDER THIS ENDORSEMENT.

PAYMENT OF ACCELERATED DEATH BENEFITS WILL REDUCE THE POLICY'S DEATH BENEFIT OR FACE AMOUNT, MONTHLY DEDUCTIONS OR PREMIUMS, NONFORFEITURE VALUES OR POLICY VALUES, WHICH INCLUDE, BUT ARE NOT LIMITED TO, THE ACCOUNT VALUE, NET CASH SURRENDER VALUE, AND POLICY LOAN VALUE WILL BE REDUCED IN PROPORTION TO THE AMOUNT OF THE DEATH BENEFIT OR FACE AMOUNT THAT IS ACCELERATED.

ACCELERATED DEATH BENEFITS ARE REDUCED BY A NUMBER OF FACTORS, INCLUDING BUT NOT LIMITED TO, THE IMPACT AN ILLNESS HAS ON THE INSURED'S FUTURE MORTALITY EXPECTATIONS AND IN THE CASE OF TERM OR WHOLE LIFE INSURANCE THE AMOUNT OF PREMIUM REMAINING UNTIL THE POLICY EXPIRES OR MATURES. THIS MAY RESULT IN A SMALL BENEFIT OR NO BENEFIT BEING PAID.

THE IMPACT OF ACCELERATED DEATH BENEFIT PAYMENTS

Upon instructions received by the owner of the Policy, the company will pay an Accelerated Death Benefit as described below, subject to the limitations and requirements described in the Accelerated Death Benefit Endorsement. Any assignee or Irrevocable Beneficiary must consent before we make an Accelerated Death Benefit Payment. The Lifetime Maximum Accelerated Death Benefit that we will accelerate is described in the Endorsement.

The Accelerated Death Benefit Payment is discounted. The discount we apply reflects the early payment of the Policy's Death Benefit or Face Amount and includes, among other things:
(1) A mortality adjustment using our determination of the future expected lifetime of the Insured;
(2) A discount reflecting the time value of money using the Accelerated Death Benefit Interest Rate; and
(3) In the case of term insurance, an offset for the uncollected premiums otherwise payable over the life of the Policy.

The factors listed above may reduce the amount of the Accelerated Death Benefit payable. Chronic Illnesses or Critical Illnesses often have little or no impact on the Insured's life expectancy, such that the application of the factor for mortality

and reduced life expectancy could result in a small Accelerated Death Benefit Payment or no Accelerated Death Benefit Payment being paid even if a Qualifying Event has been established.

Proposed Insureds are subject to underwriting eligibility requirements to qualify for the Chronic Illness or Critical Illness Accelerated Death Benefit. Only the Terminal Illness Accelerated Death Benefit is available without underwriting eligibility requirements.

The minimum and maximum Accelerated Death Benefit amounts for Critical, Chronic or Terminal Illness on the Election Date are described in the Endorsement.

Accelerated Death Benefit for Terminal Illness: You may elect to receive advancement of the Death Benefit or Face Amount when the Insured has a Terminal Illness while the Endorsement is in effect.

An Insured qualifies as being Terminally Ill if the Insured has been certified through a certification by a Physician that the Insured has been diagnosed with a medical condition that results in a drastically limited life span. A drastically limited life span is a life span of 24 months or less.

The Accelerated Benefit Payment will be determined upon your Election and will be paid in a lump sum.

We will waive the Monthly Deductions or Premiums following the Election of Accelerated Death Benefits for Terminal Illness. Upon Election, all Endorsements and Riders attached to the Policy will continue to be effective subject to the terms and conditions of each Endorsement or Rider.

After you receive Accelerated Death Benefits for Terminal Illness, you may elect to take withdrawals; increase or decrease the Specified Amount or Face Amount, change the Death Benefit Option; and obtain Policy Loans as described in the Policy.

Only one Election can be made for Terminal Illness.

If the Insured dies after you elect to receive Accelerated Death Benefits, but before any Accelerated Death Benefit Payment is made, the Election will be cancelled and the Death Benefit or Face Amount will be paid as described in the Policy.

Accelerated Death Benefit for Chronic Illness (if available): You may elect to receive advancement of the Death Benefit or Face Amount when the Insured is Chronically Ill while the Endorsement is in effect.

An Insured qualifies as being Chronically Ill if the Insured has been certified through a certification by a Physician within the last 12 months as:

(a) Being unable to perform, for at least 90 days without Substantial Assistance from another person, at least two Activities of Daily Living; or
(b) Requiring 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;
2. orientation to people, places, or time;
3. deductive or abstract reasoning; or
4. judgment as it relates to safety awareness.

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 Lifetime Maximum Accelerated Death Benefit limitation, or if you are making a Final Election.

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 or Face Amount in the Policy, minus the Residual Death Benefit. A Final Election occurs when you accelerate all of the Death Benefit or Face Amount in the Policy, minus the Residual Death Benefit.

The Residual Death Benefit only applies to benefits for Chronic Illness.

We will waive the Monthly Deductions or Premiums while a Chronic Illness Election is in effect if the Death Benefit or Face Amount immediately prior to the Initial Election Date does not exceed the Lifetime Maximum Accelerated Death Benefit If

the Death Benefit or Face Amount immediately prior to the Initial Election Date exceeds the Lifetime Maximum Accelerated Death Benefit while an Election is in effect, the Monthly Deductions or Premiums will be multiplied by the specified ratio, as described in the Endorsement. Monthly Deductions or Premiums will stop being waived when an Election is no longer in effect.

While the Chronic Illness Election is in effect, you cannot take withdrawals; increase or decrease the Specified Amount or change the Death Benefit Option. After any Election, other than a Final Election, you may elect to obtain Policy Loans as described in the Policy.

After the Initial Election Date, no additional Endorsement and Riders may be added to the Policy. Upon any Election other than a Final Election, all Endorsements and Riders attached to the Policy will continue to be effective subject to the terms and conditions of each Endorsement or Rider. Upon a Final Election, all Endorsements and Riders, except the Accelerated Death Benefit Endorsement, the Guaranteed Insurability Rider, if any, or the Option to Purchase Additional Insurance Rider, if any, will terminate on the Final Election date.

The Chronic Illness Election Period begins on the Election Date of a Chronic Illness and ends immediately prior to the Monthly Anniversary or Monthly Policy Date, as applicable that occurs when the number of completed Policy Months as shown on the Policy Data Pages is completed.

If the 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 or Face Amount will be paid as described in the Policy. 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 Insured.

Accelerated Death Benefit for Critical Illness (if available): You may elect to receive advancement of the Death Benefit or Face Amount when the Insured is Critically Ill while the Endorsement is in effect.

An Insured qualifies as being Critically Ill if the Insured has been certified through certification by a Physician as having incurred a Specified Medical Condition within the past 12 months. A Specified Medical Condition is defined as one of the following five events:

(a) **Cancer** – means any malignant tumor positively diagnosed with histological confirmation and characterized by the uncontrolled growth of malignant cells and invasion of tissue. The term malignant tumor includes leukemia, lymphoma and sarcoma.

The following are **NOT** covered:

1. All cancers which are histologically classified as any of the following:
    i) Premalignant;
    ii) Non-invasive;
    iii) Cancer in situ;
    iv) Having borderline malignancy; or
    v) Having low malignancy potential.
2. All tumors of the prostate unless histologically classified as having a Gleason score of 7 or greater or having progressed to at least clinical TNM classification Stage 2b, T2N0M0.
3. Thyroid Cancer unless classified as T2N0M0 or greater.
4. Breast cancer unless classified as T2N0M0 or greater.
5. Any skin cancer unless classified as Malignant Melanoma Stage 2 or greater.

(b) Heart Attack – means the death of heart muscle due to inadequate blood supply that has resulted in evidence of myocardial infarction based on typical rise and gradual fall of Troponin and other biochemical markers of myocardial necrosis with at least one of the following:

1. Typical clinical symptoms (chest pain may or may not be present);
2. Characteristic electrocardiogram (ECG or EKG) changes; or
3. Coronary artery intervention.

The following are **NOT** included:

1. Angina;
2. Elevated biochemical cardiac markers as a result of intra-arterial cardiac procedures including, but not limited to, coronary angiography and coronary angioplasty, in the absence of new Q waves; or
3. ECG changes suggesting a prior myocardial infarction, which do not meet the definition of Heart Attack described above.

(c) **Kidney Failure** – means chronic and end stage renal failure (failure of both kidneys to function effectively) diagnosed and managed by a nephrologist, as a result of which regular dialysis is necessary.

(d) **Major Organ Transplant** – means the undergoing as a recipient of a transplant of bone marrow or a complete heart, kidney, liver, lung, small intestine, or pancreas, or inclusion on the United Network of Organ Sharing (UNOS) waiting list. Transplant of any other organs, parts of organs, tissues or cells is not covered.

(e) **Stroke** – (cerebrovascular accident) means a definite diagnosis of an acute cerebrovascular event caused by intra-cranial thrombosis, hemorrhage, or embolism with acute onset of new neurological symptoms and new objective neurological deficits on clinical examination, persisting for at least 96 hours following the date of diagnosis. These new symptoms and deficits must be corroborated by diagnostic imaging testing.

The following are **NOT** included:

1. Transient ischemic attacks;
2. Brain damage due to an accident or injury, infection, vasculitis, and inflammatory disease;
3. Vascular disease affecting the eye or optic nerve;
4. Ischemic disorders of the vestibular system; or
5. Chronic Cerebrovascular insufficiency.

The Accelerated Benefit Payment will be determined as of each Election Date and will be paid in a lump sum. On the Election Date, the Accelerated Death Benefit Payment and the Policy Debt will be reduced by the Debt Repayment Amount.

After each Election Date, Monthly Deductions or Premiums will remain the same as described in the Policy and be based on the reduced Specified Amount or Face Amount.

While the Critical Illness Election is in effect, you cannot take withdrawals; increase or decrease the Specified Amount or change the Death Benefit Option. After any Election you may elect to obtain Policy Loans as described in the Policy.

Upon any Election all Endorsements and Riders attached to the Policy will continue to be effective subject to the terms and conditions of each Endorsement or Rider. After the Initial Election Date, additional Endorsement and Riders may be added to the Policy.

Election of Accelerated Death Benefits for Critical Illness is required within 12 months of incurred date. Only one Election can be made for each occurrence of a Specified Medical Condition.

If the 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 or Face Amount will be paid as described in the Policy.

Sample Illustration of the impact of Accelerated Death Benefits

	Terminal Illness	Critical Illness	Chronic Illness
Accelerated Death Benefit	$375,000	$50,000	$120,000
Lump Sum Accelerated Death Benefit Payment	$338,374	$18,000	$82,498
Administrative Fee	$200	N/A	$200

Values Before Accelerated Death Benefit	Terminal Illness	Critical Illness	Chronic Illness
Death Benefit/Face Amount	$500,000	$500,000	$500,000
Death Benefit Proceeds	$480,000	$480,000	$480,000
Account Value/Cash Value	$100,000	$100,000	$100,000
Net Cash Surrender Value	$80,000	$80,000	$80,000
Cost of Insurance or Premium	$300	$300	$300
Outstanding Policy Debt	$20,000	$20,000	$20,000
Residual Death Benefit:	N/A	N/A	$25,000

Values After Accelerated Death Benefit	Terminal Illness	Critical Illness	Chronic Illness
Death Benefit/Face Amount	$125,000	$450,000	$380,000
Death Benefit Proceeds	$120,000	$432,000	$364,800
Account Value/Cash Value	$25,000	$90,000	$76,000
Net Cash Surrender Value	$20,000	$72,000	$60,800
Cost of Insurance or Premium	$0	$270	$0
Outstanding Policy Debt	$5,000	$18,000	$15,200
Residual Death Benefit	N/A	N/A	$25,000

For Conversions, please indicate new Policy #, if assigned: Policy Number _____

Consent to do business electronically and use of electronic records

Owner's Name:	Policy Number (if known):

This consent contains important information you are entitled to receive before you consent to receive and execute electronic records.

If you consent, North American Company for Life and Health Insurance®, herein after referred to as the "Company," will transmit documents related to your life insurance policy by electronic means, to the extent that electronic transmission is consistent with applicable state and federal law. Any document the Company sends by electronic means, which complies with applicable law, will have the same force and effect as if that document was sent in paper format.

This consent will only apply to the electronic transmission of your life insurance policy pages and any supplemental forms, including delivery notices, included in that transmission.

The Company will only send documents by electronic means if you consent by selecting 'I Consent' below. Your consent is voluntary. You are not required to consent to electronic transmissions if you prefer not to do so.

You have the right to receive the documents in paper form and you may be charged for the paper copies. You can request paper copies of documents you receive by electronic transmission by contacting the Company in one of the methods shown on this form.

You can withdraw your consent to receive document by electronic transmission at any time for no charge by contacting the Company in one of the methods shown on this form.

In order to successfully receive electronic transmissions it is recommended that your electronic device supports Windows 8® or above or Macintosh OSX; Adobe Acrobat Reader; has browser settings such as Internet Explorer 11.0® or above (Windows only), Google® Chrome® (Windows only), Apple Safari (for Mac and iPad), or Mozilla Firefox (Windows or Mac); a valid email address and security settings that allow per session cookies. It is recommended that you print and/or save all documents, including this Consent, you receive by electronic transmission for your records.

If your email address changes it is suggested that you notify your agent or North American Company.

North American Company
One Sammons Plaza
Sioux Falls, SD 57193
Phone: 1-877-872-0757
Fax: 1-877-208-6136
Email: NAnewbusiness@sfgmembers.com

Please make a selection below.

☐ ***I consent to the terms outlined above and want my policy documents delivered electronically via email.***

☐ ***I do not consent to the terms outlined above and do not want my policy documents delievered electronically via email.***

Please provide the email address of the Policyowner.

Email: _____

O-2000

North American Company for Life and Health Insurance

L2978

LEAVE WITH APPLICANT/PROPOSED INSURED

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.

MIB, Inc. 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., a not-for--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. 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.

North American Company • New Business Processing Center: P. O. Box 5089, Sioux Falls, SD 57117 • Principal Office: West Des Moines, IA
Phone: (800) 669-9100 • Fax: (800) 951-9430 • www.NorthAmericanCompany.com

Electronic funds transfer authorization for premium and/or loan repayments

Clear Form

Clear Kit

NORTH AMERICAN®

If your request is not in good order, how would you like us to notify you?

Call me at	or Email me at

If more than one policy will be placed on Electronic Funds Transfer (EFT), please submit additional EFT forms.

1. Owner Information

Policy Number or Application Date (for new applications):

Owner's Name:	Insured's Name:

2. Payment Information

- Select a date between the 1st and the 28th. If the date is not completed we will default to the day of the month equal to the issue date of the policy. If a date after the 28th is chosen, we will default to the 28th.
- If the draft date chosen is more than 10 days past the Policy Anniversary date, it may result in multiple drafts to pay premiums current.
- Premium is due by the monthly Policy Date, and all applicable grace periods are based on that date and not the withdrawal date.
- **If your policy is not paid current upon the Company's receipt of a completed form, premium for a prior month(s) may be withdrawn to bring your policy current. Please notify our office in advance of completing this form if your policy is not current and you do not want it brought current with an electronic funds transfer.**

Payment Option 1: (New applicants only)	☐ Deduct the first and future premium payments. (The first deduction will occur on or after the policy date and then at the intervals selected below.) Premium Amount: _____ Payment Frequency: ☐ Monthly ☐ Quarterly ☐ Semi-Annually ☐ Annually First Withdrawal Date (mm/dd/yyyy) _____ / _____ / _____
Payment Option 2:	☐ Deduct the future premium payments only. Premium is due on or before the due date (Policy Date). Premium Amount: _____ Loan Repayment Amount: _____ Total Withdrawal Amount: _____ Amount allocated to loan repayment will be applied as premium when loan is paid in full. Payment Frequency: ☐ Monthly ☐ Quarterly ☐ Semi-Annually ☐ Annually Withdrawal Date (mm/dd/yyyy) _____ / _____ / _____
Payment Option 3:	☐ Deduct a one-time premium payment only. One time only premium amount: _____

3. Account Type

For business accounts, complete the Certificate of Business Signing Authority (form O-2927).
For Trust Accounts, complete the Certification of Trust Agreement (form L-3172A).

☐ **Checking** – A voided check with a pre-printed name or printed EFT directions from your financial institution is recommended. Deposit slips are not accepted.

☐ **Savings** – Contact your financial institution for the routing number.

Bank Name:

Bank Account Holder(s) Name(s) (Include all applicable names):

Routing Number:	Account Number:

Please be sure to complete all pages and sign and date the form.

L-1683

Policy Number or Application Date (for new applications):

4. Fraud Statement

CA Residents: For your protection, California law requires the following to appear on this form: Any person who knowingly presents false or fraudulent information to obtain or amend insurance or to make a claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

5. Agreement, Authorization, and Signature(s)

PLEASE READ CAREFULLY

I (we) authorize the Company to make electronic fund transfers from my (our) account as designated on this form.

By signing below, I (we) understand and agree that:

- I (we) acknowledge that this form must be completed in full and signed, and that failure to complete any portion of this form may delay implementing this request and any premium payments due. I (we) understand it is our responsibility to confirm premium payments are processed.
- If this form is not in good order or lacks necessary supplemental documentation, or if the policy enters a contractual grace period, the Company will cancel any existing EFT authorization and place the policy on quarterly direct bill until a completed request is processed.
- A notification will not be sent prior to the withdrawal being made.
- If the date listed is not a business day, the EFT will occur on the first business day to follow.
- **If a withdrawal request is not honored by the financial institution, the Company will not consider the payment to be made.** The Company may, in its sole discretion, resubmit the withdrawal request to the financial institution. In cases such as insufficient funds, the Company may try to draft up to 3 times and the authorized account owner is responsible for any fees incurred.
- I (we) may cancel the authorization at any time by giving the Company prior verbal or written notification at least three business days preceding the scheduled date of the withdrawal.
- Under this agreement, I (we) have 60 days from the date of any withdrawal to notify the Company of any errors related to any such withdrawal.
- Except as required by the Electronic Funds Transfer Act and Regulation E, the Company will not be liable for any exemplary, special, consequential, punitive, indirect, or incidental damages arising from an electronic funds transfer, regardless of whether any claim is based on contract or whether any such damages were foreseeable.
- The Company, in its sole discretion, reserves the right to remove any policy from electronic funds transfer premium payment arrangement at any time.
- I (we) hereby terminate any prior Authorization of the Company to charge this account, effective the date on which the completed form is received by the Company.
- I (we) request and authorize the Company to obtain payment of amounts becoming due it or amounts as scheduled and requested by the policy owner / payer by initiating charges to my (our) account in the form of checks, drafts, share drafts, or electronic debit entries, and I (we) request and authorize the financial institution named above to honor the same and charge the same to my (our) account.

Please be sure to complete all pages and sign and date the form.

Bank Account Owner Signature:	Date (mm/dd/yyyy):
Joint Bank Account Owner Signature:	Date (mm/dd/yyyy):

NORTH AMERICAN®

L2412AZ1

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

To evaluate your eligibility for insurance coverage, it is requested that you consent to be tested to determine the presence of antibodies or antigens to the Human Immunodeficiency Virus (HIV). By signing and dating this form, you agree that these tests may be performed and that underwriting decisions (for example, the decision to accept or reject your application) will be based on the test results. You may have ten (10) days to decide whether you wish to sign this form. You may refuse to be tested. However, such refusal may be used by the insurer as a reason to deny coverage. Please see below for additional counseling information.

Information on HIV - HIV, the virus that causes AIDS, is transmitted from one person to another through blood, semen, and vaginal fluids. The disease is spread primarily during anal, vaginal or oral intercourse, the sharing of needles and syringes used for shooting drugs, or from a mother to her unborn child. *HIV is not spread through casual contact, such as eating with or touching a person infected with the virus. There is no medical evidence that HIV is spread by kissing.*

Persons most at risk of contracting HIV are men who have sex with other men; intravenous ("IV") drug users; prostitutes (male or female); persons who have had many sexual partners since 1977; persons who received transfusions of blood or blood products prior to March, 1985; the sexual partners of persons in any of these groups; and infants born to infected mothers.

Pre-test Counseling Considerations - Many public health organizations have recommended that before taking an HIV antibody/antigen test a person seek counseling to become fully informed about the implications of such tests. You may wish to consider obtaining such counseling at your own expense prior to being tested. Free confidential counseling is available in most Arizona communities. If you need information about the availability of counseling in your area contact your county health department or:

Phoenix metropolitan area: 234-2752
(Arizona AIDS Information Line)

Outside the Phoenix area: 1-800-334-1540
(Arizona Department of Health Services)

Disclosure of Test Results - All test results will be treated confidentially. The results of the tests will be reported to the insurer identified on this form. Results of the tests will not be otherwise disclosed without your written consent except as required or allowed by law. Disclosure of HIV test results pertaining to your application for insurance is governed by A.R.S. §20-448.01.

Meaning of Positive Test Results - The most commonly used test for HIV is designed to detect the presence of antibodies to the virus. Antibodies are made by the body's immune system to fight infection. While positive HIV antibody test results do not mean that you have AIDS, they do indicate that you have been infected with HIV, the virus that causes AIDS. About 50% of infected individuals have developed AIDS within 10 years after being infected with the virus.

Positive HIV antibody/antigen test results will adversely affect your application for insurance. This means that your application will probably be declined.

Consent - I have read and I understand this Notice and Consent Form. I voluntarily consent to testing and disclosure as described above. I understand that I have a right to request and receive a copy of this form. A photocopy of this form will be as valid as the original. I understand that release of information provisions are valid for 180 days from the date this consent form is signed. No HIV-related information will be released to any person after that time without my written consent.

X _____ _____

Signature of Proposed Insured or Parent/Guardian — Date

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Optional Release of Information to Personal Physician

In addition to the release of information as described above, I hereby authorize the release of my HIV test results to my personal physician named below:

_____

Physician's Name

_____

Address

_____

City State Zip

X _____ _____

Signature of Proposed Insured or Parent/Guardian — Date

North American Company | **New Business Processing Center:** P.O. Box 5089, Sioux Falls, SD 57117 | **Principal Office:** West Des Moines, IA
Phone: 800-669-9100 | **Fax:** 800-951-9430 | NorthAmericanCompany.com

Agent Instructions: Provide the Applicant a copy of this form; submit one copy to the Administrative Office and keep a copy for your records

Clear Form Clear Kit

North American Company for Life and Health Insurance

L29721

AGENT REPORT

Name of proposed insured and/or applicant _____

Do the proposed insured and/or applicant want to save age? ____ Yes ____ No

Are you related to the proposed insured and/or applicant? ____ Yes ____ No

If yes, please provide details _____

If the proposed insured and/or applicant is married, give spouse's name and amount of spouse's insurance (in-force and applied for)

_____

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

_____

What is the purpose of insurance? ____ Personal ____ Business

If business coverage indicate what type:

____ Keyman
____ Creditor
____ Deferred Compensation
____ Buy/Sell
____ Split Dollar
____ Other (give details) _____

Do the proposed insured and/or applicant have ownership in the company? If so, what percentage? _____%

What is the net worth of the company? _____ What is the market value of the company? _____

Is the company purchasing insurance on other partners or associates? ____ Yes ____ No

If yes, please provide details _____

Writing Agent No.: _____ Other Agent No.: _____

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ICC23A101NAC

GENERAL PURPOSE INDIVIDUAL LIFE INSURANCE APPLICATION (Print and Use Black Ink)

PROPOSED INSURED

Legal Last Name

Legal First Name Middle Initial

Social Security/ Tax ID Number Date of Birth (M M - D D - Y Y Y Y)

Gender ☐ Male ☐ Female	Age	Place of Birth – State/Country	Marital Status

1. In the past 12 months, have you used a different name (including maiden name)? ☐ Yes ☐ No
If yes, give name used and date it was changed. _____

2a. Residence Address *(If P.O. Box, street address, city, state, and zip code are required.)*

2b. Previous Residence Address if there was an address change within the past 3 months
(If P.O. Box, street address, city, state and zip code are required.)

2c. Best Telephone Number with Area Code

2d. Email Address

2e. Provide your current valid driver's license number and issue state or country. (*If you do not have a current valid driver's license, complete 2f and 2g.)*
Driver's License Number _____ Issue State/Country _____

2f. Provide reason and additional details why you do not have a current valid driver's license.
☐ License was revoked or suspended ☐ Has never had a license
☐ Unable to drive due to a diagnosed medical condition ☐ Other reason
Provide additional details _____

2g. Government issued ID ☐ State ID ☐ Passport ☐ Military ☐ Permanent Resident (green card)
Card Number _____ Issue State/Country _____

2h. Employer Name and Address

2i. Occupation _____
(If homemaker, complete the following)
Family Income $ _____ Family Net Worth $ _____
Spouse's Total Life Insurance In Force and Applied For $ _____

2j. Annual Income

2k. Net Worth

PLAN INFORMATION

3a. Amount Applied For
$_____

3b. Underwriting Type
☐ Traditional ☐ Online

4. Specific Product Applied For _____
For Universal Life Death Benefit Option (Defaults to Level, if none selected)
(Check One) ☐ Level ☐ Increasing ☐ Return of Premium
Death Benefit Qualification Test, if applicable.
(Check One) ☐ Guideline Premium Test (GPT) ☐ Cash Value Accumulation Test (CVAT)

North American Company for Life and Health Insurance®
Administrative Office: P.O. Box 5088, Sioux Falls, SD 57117 | **Principal Office**: West Des Moines, IA
Phone: 877-872-0757 | **Fax:** 877-208-6136 | NorthAmericanCompany.com

PLAN INFORMATION (Continued)

5. What is the purpose of coverage? *(select all that apply)*

- ☐ Personal
- ☐ Income Replacement
- ☐ Estate Preservation
- ☐ Business *(If yes, complete 5a.)*
- ☐ Other ______________________________

5a. If business policy, what is the purpose of coverage?

- ☐ Key Person
- ☐ Buy Sell
- ☐ Split Dollar
- ☐ Other ______________________________

6a. Term Riders

- ☐ Children's Term Insurance $______________
- ☐ Waiver of Premium
- ☐ Other ____________ (Plan) $______________ (Amount)

6b. UL and IUL Riders

- ☐ Premium Guarantee (PGR)
- ☐ Accidental Death Benefit $______________
- ☐ Children's Term Insurance $______________
- ☐ Guaranteed Insurability $______________
- ☐ Waiver of Monthly Deductions
- ☐ Waiver of Surrender Charge Option
- ☐ Other ____________ (Plan) $______________ (Amount)

7. DEPENDENT CHILDREN PROPOSED FOR INSURANCE (Complete ONLY if Children's Term Insurance is applied for)

Name ______________________ Gender ☐ Male ☐ Female Height (FT. IN.) ________ Weight (LBS.) ________
Social Security/Tax ID Number ______________ Date of Birth ______________ State/Country of Birth ______________
Relationship to Proposed Insured ______________________
Address: Check box if address is same as ☐ Proposed Insured, ☐ Owner or ☐ Joint Owner, otherwise list below.

Name ______________________ Gender ☐ Male ☐ Female Height (FT. IN.) ________ Weight (LBS.) ________
Social Security/Tax ID Number ______________ Date of Birth ______________ State/Country of Birth ______________
Relationship to Proposed Insured ______________________
Address: Check box if address is same as ☐ Proposed Insured, ☐ Owner or ☐ Joint Owner, otherwise list below.

Name ______________________ Gender ☐ Male ☐ Female Height (FT. IN.) ________ Weight (LBS.) ________
Social Security/Tax ID Number ______________ Date of Birth ______________ State/Country of Birth ______________
Relationship to Proposed Insured ______________________
Address: Check box if address is same as ☐ Proposed Insured, ☐ Owner or ☐ Joint Owner, otherwise list below.

Name ______________________ Gender ☐ Male ☐ Female Height (FT. IN.) ________ Weight (LBS.) ________
Social Security/Tax ID Number ______________ Date of Birth ______________ State/Country of Birth ______________
Relationship to Proposed Insured ______________________
Address: Check box if address is same as ☐ Proposed Insured, ☐ Owner or ☐ Joint Owner, otherwise list below.

Name ______________________ Gender ☐ Male ☐ Female Height (FT. IN.) ________ Weight (LBS.) ________
Social Security/Tax ID Number ______________ Date of Birth ______________ State/Country of Birth ______________
Relationship to Proposed Insured ______________________
Address: Check box if address is same as ☐ Proposed Insured, ☐ Owner or ☐ Joint Owner, otherwise list below.

7. DEPENDENT CHILDREN PROPOSED FOR INSURANCE (Continued)

To be completed by Parent or Legal Guardian

7a. Has any child proposed for insurance ever been diagnosed or treated by a licensed medical professional for

1) Heart disorder, heart murmur, cancer, tumor, diabetes, kidney disorder, asthma requiring hospitalization, cystic fibrosis, or any disorder of the digestive system or liver? ☐ Yes ☐ No

2) Mental or psychiatric disorder, epilepsy or seizure(s), brain or neurological disorder, blood disorder, bone or muscle disorder, or tested positive for HIV infection? ☐ Yes ☐ No

7b. In the past 5 years, has any child proposed for insurance been treated or advised to be treated by a licensed medical professional for alcohol or drug abuse or been convicted of driving under the influence of alcohol or drugs, or had a suspended or revoked driver's license? ☐ Yes ☐ No

Provide details below to "Yes" answers to Questions 7a. and 7b. If more space is needed, attach a completed and signed Application Overflow Page.

Question Number	Dependent's Name	Details

OWNER INFORMATION

8. Is the Owner or Joint Owner of this policy a full-time active duty Service Member of the United States Armed Forces (Army, Navy, Air Force, Marine Corps, Coast Guard, National Guard), or dependent thereof? ..... **Owner** ☐ **Yes** ☐ **No** **Joint Owner** ☐ **Yes** ☐ **No**
(*If yes, also complete Military Sales Disclosure Form.)*

Complete the following sections ONLY if the Owner or Joint Owner, <u>including Trustee</u>, is other than the Proposed Insured.

8a. Owner Name

Owner Type

- ☐ Individual
- ☐ Trust – Complete Certification of Trust Agreement Form
- ☐ Business (Check one of the following and complete COLI Consent Form)
  - ☐ Sole Proprietorship
  - ☐ Partnership – Complete Certification of Business Signing Authority Form
  - ☐ Corporation – Complete Certification of Business Signing Authority Form
  - ☐ Other _____ – Complete Certification of Business Signing Authority Form

Owner's Email Address

Owner's Address ☐ Check this box if same as Proposed Insured, otherwise list below. *(If P.O. Box, street address, city, state, and zip code are required.)*

Date of Birth	Social Security/Tax ID Number	Marital Status	Relationship to Proposed Insured

Citizenship and ID information is required for all Owners, including Trustees.

Are you a U.S. Citizen? ☐ Yes ☐ No

☐ Driver's License Number	Issue State/Country
☐ State ID ☐ Passport ☐ Military ☐ Permanent Resident (green card) Card Number _____	

OWNER INFORMATION (Continued)

8b. Joint Owner Name

Joint Owner Type

- ☐ Individual
- ☐ Trust – Complete Certification of Trust Agreement Form
- ☐ Business (Check one of the following and complete COLI Consent Form)
  - ☐ Sole Proprietorship
  - ☐ Partnership – Complete Certification of Business Signing Authority Form
  - ☐ Corporation – Complete Certification of Business Signing Authority Form
  - ☐ Other _____ – Complete Certification of Business Signing Authority Form

Joint Owner's Email Address

Joint Owner's Address ☐ Check this box if same as Owner, otherwise list below. *(If P.O. Box, street address, city, state, and zip code are required.)*

Date of Birth	Social Security/Tax ID Number	Marital Status	Relationship to Proposed Insured

Citizenship and ID information is required for all Joint Owners, including Trustees.

Are you a U.S. Citizen? ☐ Yes ☐ No

☐ Driver's License Number	Issue State/Country
☐ State ID ☐ Passport ☐ Military ☐ Permanent Resident (green card) Card Number _____	

8c. Contingent Owner Name

Contingent Owner's Email Address

Contingent Owner's Address ☐ Check this box if same as Owner, otherwise list below. *(If P.O. Box, street address, city, state, and zip code are required.)*

Date of Birth	Social Security/Tax ID Number

BENEFICIARY

Share percentage totals must equal 100%. Please use percentages in your designation for each beneficiary listed below. Fractions and dollar amounts are not accepted. Provide Beneficiary(ies) Full Name(s). If Trust, list Name and Date of Trust and complete Certification of Trust Agreement. If Business, complete COLI Consent Form. Beneficiary designations do not apply to others covered under the Children's Term Insurance Rider. If more space is needed, attach a completed and signed Application Overflow Page.

To distribute proceeds "per stirpes" please check the box. Per stirpes is a common way of distributing proceeds where if one or more of your beneficiaries has died, his or her children share equally in his or her share of the proceeds (also known as Right of Representation). If per stirpes is selected it is required to attach a completed and signed Application Overflow Page listing the names, Social Security numbers, date of births, address and phone numbers for all children of the beneficiary.

9. Primary

Legal Name _____ Relationship to Proposed Insured _____

Address _____

Date of Birth _____ Social Security/Tax ID Number _____

Telephone Number with Area Code _____ Email Address _____

☐ Distribute Proceeds "Per Stirpes" % Share _____

Legal Name _____ Relationship to Proposed Insured _____

Address _____

Date of Birth _____ Social Security/Tax ID Number _____

Telephone Number with Area Code _____ Email Address _____

☐ Distribute Proceeds "Per Stirpes" % Share _____

BENEFICIARY (Continued)

9. Primary (Continued)

Legal Name _____ Relationship to Proposed Insured _____

Address _____

Date of Birth _____ Social Security/Tax ID Number _____

Telephone Number with Area Code _____ Email Address _____

☐ Distribute Proceeds "Per Stirpes" % Share _____

TOTAL _____%

10. Contingent

Legal Name _____ Relationship to Proposed Insured _____

Address _____

Date of Birth _____ Social Security/Tax ID Number _____

Telephone Number with Area Code _____ Email Address _____

☐ Distribute Proceeds "Per Stirpes" % Share _____

Legal Name _____ Relationship to Proposed Insured _____

Address _____

Date of Birth _____ Social Security/Tax ID Number _____

Telephone Number with Area Code _____ Email Address _____

☐ Distribute Proceeds "Per Stirpes" % Share _____

TOTAL _____%

PAYOR/BILLING INFORMATION

11. Payor ☐ Proposed Insured ☐ Owner ☐ Joint Owner ☐ Other _____

(Print Full Name)

Other Payor Type

☐ Individual – Provide Date of Birth _____ Relationship to Proposed Insured _____

☐ Trust – Complete Certification of Trust Agreement Form

☐ Business (Check one of the following)

☐ Sole Proprietorship

☐ Partnership – If payment type is EFT, complete Certification of Business Signing Authority Form

☐ Corporation – If payment type is EFT, complete Certification of Business Signing Authority Form

☐ Other _____ – If payment type is EFT, complete Certification of Business Signing Authority Form

Other Payor Type Social Security/Tax ID Number _____

Payor's Email Address

Billing Address ☐ Check this box if billing address is same as address previously provided, otherwise list below.
(If P.O. Box, street address, city, state, and zip code are required.)

Citizenship and ID information is required for Payor, including Trustee.
Are you a U.S. Citizen? ☐ Yes ☐ No

☐ Driver's License Number	Issue State/Country
☐ State ID ☐ Passport ☐ Military ☐ Permanent Resident (green card) Card Number _____	

12. Secondary Addressee Notification – Optional – Complete this section to designate an additional person, excluding the Agent, to receive Grace Period notices for insufficient premium and lapse notices.

Name of Designated Person

Address *(If P.O. Box, street address, city, state, and zip code are required.)*

Telephone Number with Area Code

Designated Person's Email Address

PREMIUM INFORMATION

13. Premium Frequency ☐ Annually ☐ Semi-Annually ☐ Quarterly ☐ Monthly ☐ Single Pay
☐ Lump Sum $_____ Source of Lump Sum _____

14. Source of Premium ☐ Salary ☐ Savings ☐ Investments ☐ 1035 Exchange ☐ Lending Institution
☐ Other _____

15. Will the funds used to pay the initial premium of the policy come from a loan made by a third-party (secured or unsecured) to the owner, a reverse mortgage, or from any form of equity line of credit or similar credit facility on any property in which the owner has interest? ☐ Yes ☐ No
If yes, please provide details _____

16. As of the date of this application, is there an intention by the owner or beneficiary to secure funds from any of the aforementioned sources of financing to pay any portion of the premium for the policy being applied for? ☐ Yes ☐ No
If yes, please provide details _____

17. Payment Type
☐ Electronic Fund Transfer (EFT) – Complete EFT Authorization
☐ Direct Billing (Annual, Semi-Annual, Quarterly Only)
☐ List Billing – List Bill Code/Business Name _____
☐ Civil Service Allotment – Complete Direct Deposit Sign-Up Form
☐ Military Government Allotment – Complete Military Allotment Form

18. Amount of Modal Premium $

For term 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.

19. Payment of Initial Premium – (Must check one)

☐ I have elected Temporary Life Insurance Agreement (TIA) with this Application and have completed the TIA form. The Owner(s) has/have elected payment of the initial premium by one of the acceptable payment methods as outlined in the TIA form and has read, understands, and agrees to the terms of such Agreement. (When submitting premium, the TIA form is required.)

☐ No money was collected with this application and Temporary Insurance Coverage is not intended. TIA form was not completed.

REPLACEMENT AND EXISTING COVERAGE INFORMATION

A *replacement* occurs when a new policy or contract is purchased and, in connection with the sale, you discontinue making premium payments on the existing policy or contract, or an existing policy/certificate or contract is surrendered, forfeited, assigned to the replacing insurer, or otherwise terminated or used in a financed purchase. This includes policies or contracts that have or will be sold, assigned or otherwise placed via life settlement, viatical or other agreements, or that will be replaced, canceled, or sold.

NOTE: If your current policy is replaced, you may pay a surrender charge. When a new policy is purchased, the surrender charge and other applicable provisions will start anew.

20. Does the Proposed Insured have any life insurance or annuities currently in force or pending? ☐ Yes ☐ No

21. Is the Proposed Insured or Owner considering discontinuing making premium payments, surrendering, forfeiting, assigning to the insurer, or otherwise terminating his/her existing life insurance or annuity contract? ☐ Yes ☐ No

22. Is the Proposed Insured or Owner considering using funds from existing policies or contracts to pay premiums due on the new policy? ☐ Yes ☐ No

- If the answer is "Yes" to any of the above questions, provide information on existing insurance and annuities below.
- Complete Replacement Notice form, if applicable, and submit with this application.
- If this is a 1035 Exchange, complete 1035 Exchange paperwork and submit with this application.
- If more space is needed, attach a completed and signed Application Overflow Page.

REPLACEMENT AND EXISTING COVERAGE INFORMATION (Continued)

	Existing Policy/Certificate 1	Existing Policy/Certificate 2	Existing Policy/Certificate 3	Existing Policy/Certificate 4	Existing Policy/Certificate 5
Company Name					
Policy/Certificate Number					
Year Issued					
Death Benefit	$	$	$	$	$
Policy/Certificate Type	☐ Life Insurance ☐ Annuity	☐ Life Insurance ☐ Annuity	☐ Life Insurance ☐ Annuity	☐ Life Insurance ☐ Annuity	☐ Life Insurance ☐ Annuity
In Force or Pending	☐ In Force ☐ Pending	☐ In Force ☐ Pending	☐ In Force ☐ Pending	☐ In Force ☐ Pending	☐ In Force ☐ Pending
Will this Policy/Certificate be changed or replaced?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
1035 Exchange	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

23. Has or will the Proposed Insured or Owner of this policy receive any compensation, including, but not limited to cash or property in connection with the issuance of this or any other policy? ☐ Yes ☐ No

24. Has the Proposed Insured, Owner, or any Beneficiary been involved in any discussion about selling, transferring, or assigning this policy or any rights under it? (Selling or assigning means the rights of the life insurance policy are transferred to another party.) ☐ Yes ☐ No

If the answer is "Yes" to either question 23 or 24, provide details here. If more space is needed, attach a completed and signed Application Overflow Page.

Question Number	Details

25. Individual Juvenile Coverage – Answer only for proposed insureds under the age of 18. This section should not be completed for any child applying under a Children's Term Insurance Rider. Please complete the chart below for all parents and siblings of the proposed insured. If there is no coverage, state "NONE" under Total Life Coverage and explain the reason under Details. If more space is needed, attach a completed and signed Application Overflow Page.

Name of Family Member	Relationship	Age	Total Life Coverage In Force and Pending with ALL Companies	Details
			$	
			$	
			$	
			$	
			$	

26. SPECIAL REQUESTS OR DETAILS

TO BE COMPLETED FOR MILITARY PERSONNEL (Including National Guard and Reserves)
If the Proposed Insured is the Owner, also complete Military Sales Disclosure Form.

27. Job Duties

28. Are you currently drawing extra duty or hazard pay? ☐ Yes ☐ No

29. Military Information ☐ USA ☐ USN ☐ USAF ☐ USMC ☐ USCG ☐ Other (Specify) _____
Expected Discharge or Retirement Date _____

30. Has the Proposed Insured applied to be a member of or been a member of any special forces, special or hazardous duty organization?
☐ Yes ☐ No (*If yes, provide specific details.)*

31. Has the Proposed Insured been alerted to, volunteered for, or received formal orders for an overseas assignment?
☐ Yes ☐ No (*If yes, provide specific details.)*

LIFESTYLE INFORMATION

32a. Indicate the number of cigars used in the past 12 months
☐ None ☐ 1 to 12 ☐ 13 to 24 ☐ 25 or more

32b. Have you ever used cigarettes, E-cigarettes, vapor products, chewing tobacco, snuff, pipe, nicotine gum or patches, or any other nicotine product(s) (excluding cigars)? *(If yes, complete questions 1 and 2.)* ☐ Yes ☐ No

1) What product(s)? ☐ Cigarettes ☐ E-cigarettes ☐ Vapor products ☐ Pipe ☐ Snuff ☐ Chewing tobacco ☐ Nicotine gum or patches ☐ Other nicotine product(s)

2) Last use of any of these products was within the ☐ last 12 months ☐ last 2 years ☐ last 3 years ☐ last 5 years ☐ over 5 years

UNDERWRITING QUESTIONS

Questions 33 through 42 only need to be completed if:

- **A paramedical exam is NOT required or**
- **Another company's paramedical exam is being submitted**

33a. Do you use alcoholic beverages? *(If yes, complete question 33b.)* ☐ Yes ☐ No

33b. Amount: _____ Frequency: _____

34. Are you actively employed? *(If no, provide reason in DETAILS section below.)* ☐ Yes ☐ No

35. Are you a U.S. citizen or do you have a U.S. permanent resident card (green card)? ☐ Yes ☐ No
(*If no, complete a Foreign Travel and Residence Questionnaire.)*

36. In the next 12 months, do you plan to travel or reside outside the United States or Canada? ☐ Yes ☐ No
(If yes, complete a Foreign Travel and Residence Questionnaire.)

37. Are you an active member of the U.S. Armed Forces, Reserves, or National Guard? ☐ Yes ☐ No

38. In the past 24 months, have you:

a. Flown as a pilot or crew member, except on a regularly scheduled commercial airline, or intend to do this in the next 24 months? ☐ Yes ☐ No
(If yes, complete an Aviation Questionnaire.)

b. Engaged in scuba diving, mountain or rock climbing, hang gliding, skydiving, or motorcycle, automobile or boat racing or intend to do any of these in the next 24 months? ☐ Yes ☐ No
(If yes, complete the applicable Avocation Questionnaire.)

39. In the past 3 years, have you been convicted of or pleaded guilty to 3 or more moving violations? ☐ Yes ☐ No

40. In the past 5 years, have you:

a. Been convicted of or pleaded guilty to reckless driving, driving under the influence of alcohol or any drug, or had your driver's license suspended or revoked? ☐ Yes ☐ No

b. Filed bankruptcy? ☐ Yes ☐ No
(If yes, provide details below of all chapters filed, discharge date or expected discharge date, and if applicable, the monthly payments and total amount still owed.)

c. Been declined, postponed, or charged an extra premium for life insurance? ☐ Yes ☐ No

UNDERWRITING QUESTIONS (Continued)

41. In the past 10 years, have you:

a. Ever used prescription medications such as sedatives, amphetamines, opioids, or narcotics that were not prescribed to you by your licensed medical professional? ☐ Yes ☐ No
(If yes, complete a Drug Questionnaire.)

b. Ever used any form of marijuana (whether legal or illegal) or cocaine, ecstasy, heroin, hallucinogens, or other drugs of abuse? ☐ Yes ☐ No
(If yes for marijuana only, complete a Marijuana Questionnaire; otherwise complete a Drug Questionnaire.)

c. Been medically diagnosed or medically treated for alcohol abuse or dependence, or been told by a licensed medical professional to limit your alcohol use? ☐ Yes ☐ No
(If yes, complete an Alcohol Questionnaire.)

42. Have you ever been on parole or probation, or been convicted of or have charges pending for a felony or misdemeanor? ☐ Yes ☐ No
(If yes, complete a Criminal History Questionnaire.)

DETAILS TO "NO" ANSWER FOR QUESTION 34 AND "YES" ANSWERS FOR QUESTIONS 39 AND 40.
If more space is needed, attach a completed and signed Application Overflow Page.

Question Number	Date and Details (If applicable, include Name, Address and Telephone Number of Physician, Health Care Provider, or Medical Facility.)

Questions 43-51 only need to be completed if a paramedical exam is not required.

43. In the past 5 years, have you consulted with or been seen for primary care by a licensed medical professional or at a medical facility? *(If yes, provide details below.)* ☐ Yes ☐ No

Physician, Health Care Provider, or Medical Facility Name/Address/Telephone Number	Date Last Seen	Reason Seen	Results

44a. Height: _____ feet _____ inches Weight: _____ pounds

44b. In the past 12 months, have you lost more than 10 pounds? *(If yes, complete questions 1 and 2.)* ☐ Yes ☐ No

1) How many pounds? _____

2) Reason for weight loss: ☐ Diet/Exercise ☐ Surgery ☐ Childbirth ☐ Diagnosed medical condition ☐ Medication ☐ Unknown

45. Have you ever consulted with or been medically diagnosed, medically treated, or prescribed medication by a licensed medical professional for:

a. Acquired Immune Deficiency Syndrome (AIDS) or tested positive for HIV infection? ☐ Yes ☐ No

b. Cancer (excluding basal and squamous cell skin cancer), malignant melanoma, lymphoma, or leukemia? ☐ Yes ☐ No

c. Heart disease including angina, heart attack, angioplasty, balloon, stent, or bypass? ☐ Yes ☐ No

d. Cardiomyopathy, heart failure, valve disorder or heart murmur? ☐ Yes ☐ No

46. In the past 10 years, have you consulted with or been medically diagnosed, medically treated, or prescribed medication by a licensed medical professional for:

a. High blood pressure, high cholesterol, arrhythmia, abnormal electrocardiogram (EKG), other heart disorder, or do you have a pacemaker or defibrillator? ☐ Yes ☐ No

b. High blood sugar or diabetes, thyroid disorder, or disorder of the adrenal, pituitary or parathyroid gland? ☐ Yes ☐ No

c. Bipolar disorder, depression, anxiety, attention deficit disorder, eating disorder, schizophrenia, suicide attempt, or other emotional disorder? ☐ Yes ☐ No

UNDERWRITING QUESTIONS (Continued)

d. Asthma, Chronic Obstructive Pulmonary Disease (COPD), emphysema, chronic bronchitis, sarcoidosis, sleep apnea, or other respiratory disorder? ☐ Yes ☐ No

e. Aneurysm, stroke, mini-stroke (TIA), blood clot of the leg or lung, peripheral arterial disease, or other disease or disorder of the blood vessels? ☐ Yes ☐ No

f. Mental or memory impairment, dementia, epilepsy or seizure(s), brain tumor, or other brain injury or disorder? ☐ Yes ☐ No

g. Rheumatoid arthritis, chronic pain, systemic lupus, or other connective tissue disorder? ☐ Yes ☐ No

h. Pancreatitis, ulcerative colitis, Crohn's disease, liver cirrhosis, hepatitis, or other gastrointestinal disorder including the liver, gallbladder, esophagus, stomach, or intestines? ☐ Yes ☐ No

i. Anemia, immune deficiency, spleen disorder, or other blood disorder? ☐ Yes ☐ No

j. Bladder disorder, kidney or renal insufficiency or failure, recurring protein or blood in the urine, or other kidney disorder (except for one episode of kidney stones)? ☐ Yes ☐ No

k. Muscular dystrophy, multiple sclerosis, Parkinson's disease, myasthenia gravis, paralysis, or other neurological disorder? ☐ Yes ☐ No

l. **(Males only)** Elevated PSA, or disorder of the prostate or testicle? ☐ Yes ☐ No

m. **(Females only)** Disorder of the breast, ovary, or uterus? ☐ Yes ☐ No

47a. (Females only) Are you currently pregnant? *(If yes, complete question 47b.)* ☐ Yes ☐ No

47b. What was your pre-pregnancy weight? _____

48. Other than tests related to HIV, in the past 24 months, have you had an abnormal diagnostic test, or been advised by a licensed medical professional to see a medical specialist, have surgery, or a diagnostic test or procedure, which has not been completed or results are unknown? ☐ Yes ☐ No

49. In the past 24 months, have you been medically diagnosed, medically treated, or prescribed medication by a licensed medical professional for any other medical condition that you have not already mentioned? ☐ Yes ☐ No

50. (Ages 59 and under only) Have you had a biological parent or sibling die before age 60 from heart disease or cancer? ☐ Yes ☐ No
(If yes, provide details in the family history chart below and list the specific location of the cancer, such as breast, colon, etc.)

	Cause of Death List the specific location of the cancer, if applicable	Age at Death
Father		
Mother		
Brother(s)		
Sister(s)		

51. (Ages 71 and over only) In the past 12 months, have you:

a. Been advised by a licensed medical professional to be admitted to a nursing home, assisted living facility, long-term care facility, or are you currently receiving home healthcare? ☐ Yes ☐ No

b. Received assistance or supervision with eating, bathing, dressing, bowel or bladder function, toileting, or getting up out of a chair? ☐ Yes ☐ No

DETAILS TO "YES" ANSWERS FOR QUESTIONS 45 THROUGH 49 AND QUESTION 51.
If more space is needed, attach a completed and signed Application Overflow Page.

Question Number	Date, Diagnosis, Treatment, Results, and Duration	Name, Address, and Telephone Number of Physician, Health Care Provider, or Medical Facility

IT IS DECLARED that statements and answers in this application, including statements by the Proposed Insured 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; (2) the acceptance of any policy or policy change issued on this application shall constitute a ratification of any correction or amendment made by North American Company for Life and Health Insurance (the Company); and (3) No change in amount, risk 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 arise or is discovered after completing this application, but before the policy or policy change is effective, as defined herein.

Effective Date – Based on the disclosures and representations in this application(s) and any Statement of Health and Insurability form, any insurance issued as a result of this application(s) and any amendments to this application will 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 financial condition and state of health described in all parts of this application(s), any amendment(s) to this application, and any Statement of Health and Insurability form. For Reinstatements, the reinstatement is effective as of the date approved by the Company, all required premium is paid and while the Proposed Insured is living and in the same state of health as stated in all parts of this application(s), any amendment(s) to this application, and any Statement of Health and Insurability form. If any insurance is provided under a Temporary Insurance Agreement ("TIA"), such insurance will be subject to any restrictions or limitations in the TIA and only take effect as specified in the TIA.

IRS SUBSTITUTE W-9 TAX PAYER IDENTIFICATION NUMBER CERTIFICATION – To be completed by Owner. (If Joint Owners, to be completed by owner who assumes tax liability.) Under penalties of perjury, as Owner of this policy, I certify that:

1. The taxpayer identification number shown on this application is my correct taxpayer identification number;
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. Check this box ☐ if you ARE subject to backup withholding;
3. I am a U.S. citizen or other U.S. person as defined by the IRS for federal tax purposes.
4. I am exempt from Foreign Account Tax Compliance Act (FATCA) reporting.

AUTHORIZATION: To determine eligibility for insurance, I, the undersigned applicant(s) authorize any licensed physician, licensed medical practitioner, health care professional, hospital, clinic, or other medically related facility, laboratory, pharmacy or pharmacy benefit manager, insurance or reinsuring company, MIB, LLC. (MIB), consumer reporting agency, insurance support organization, independent administrator, or governmental agency or group policyholder, 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 proposed for insurance and any other nonmedical information of the Proposed Insured or minor children proposed for insurance to give to North American Company for Life and Health Insurance (the Company) or its legal representative, any and all such information. The release of the above listed information can be made in paper form or by Electronic Health Records to the Company or their authorized representatives. I authorize the Company or its reinsurers to make a brief report of my personal health information to MIB. I also authorize the Company to conduct a personal telephone interview in connection with my application. I further authorize the Company to collect information about me from public and non-public sources, including my Social Security number, financial and credit history, employment, general character and reputation, personal characteristics and mode of living. I authorize the Company to release any information obtained to its reinsurers, MIB, or other persons or organizations performing business or legal services in connection with my application or to persons or organizations performing services on behalf of the Company for other business or marketing purposes, 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 from the date signed for the length of time permitted by applicable law in the state where the policy is delivered or issued for delivery. 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.

With respect to any investigative or consumer report prepared by a third-party consumer reporting agency on the Proposed Insured and used in connection with underwriting, regardless of whether a policy is ultimately issued or remains in force, the Proposed Insured authorizes the Company, and/or the applicable third-party consumer reporting agency providing such information:

(1) to provide the investigative or consumer report in its possession, or the possession of its duly authorized agent or third-party administrator, to the Company, its regulators, reinsurers, or any other governmental entity upon request; or

(2) to recreate, make, or provide the investigative report or consumer report, either as it existed at the time originally provided for underwriting of the Proposed Insured or as it would be provided if underwriting were currently performed, to the Company, its regulators, reinsurers, or any other governmental entity upon request.

The undersigned applicant(s) acknowledges receipt of the Consumer Protection Notice that includes the Fair Credit Reporting Act Notice, MIB, LLC. Notice, and Notice of Insurance Information Practices.

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

The Internal Revenue Service does not require your consent to any provision of this document other than the certifications required to avoid backup withholding.

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.

SIGNATURES

Signature of **Proposed Insured** (Signature of Parent/Legal Guardian if Proposed Insured is a Minor) **X**	Date	City	State

Owner – If Owner is a Corporation, Trust or other Entity, include Title of Signee. For a Corporation or Partnership, signatures of two officers and their titles are required.

Signature/Title of **Owner** (If other than Proposed Insured) **X**	Date	City	State
Signature/Title of **Owner** (If other than Proposed Insured) **X**	Date	City	State

Joint Owner – If Joint Owner is a Corporation, Trust or other Entity, include Title of Signee. For a Corporation or Partnership, signatures of two officers and their titles are required.

Signature/Title of **Joint Owner** (If other than Proposed Insured) **X**	Date	City	State
Signature/Title of **Joint Owner** (If other than Proposed Insured) **X**	Date	City	State

Community Property: If this transaction is subject to a community property or civil union interest, we strongly recommend the Owner/Joint Owner obtain his/her spouse's signature to document his/her consent to this transaction. The Owner/Joint Owner understands and agrees the Company may presume that no such interest exists if the Owner/Joint Owner has not obtained his/her spouse's signature. Further, the Owner/Joint Owner understands and agrees the Company has no duty to inquire further about any such interest. As a result, the Owner/Joint Owner agrees to indemnify and hold the Company harmless from any consequences relating to community property or civil union interests and this transaction.

Please note that the term "Spouse" includes domestic partner or other partner as permitted by civil union, domestic partnership or similar law. Likewise, the term "civil union" is intended to mean civil union, domestic partnership or other marriage-like arrangement permitted by law.

Signature of **Owner's Spouse** for Community Property States **X**	Signature of **Joint Owner's Spouse** for Community Property States **X**

TO BE COMPLETED BY SOLICITING AGENT **Commission Option (Defaults to A, if none selected):** ☐ **A** ☐ **B** ☐ **C** ☐ **D**

1. If the policy being applied for includes an accelerated death benefit(s) endorsement, was the Owner provided the Accelerated Benefit Summary and Disclosure Statement(s) prior to or concurrent with this application? ..... ☐ Yes ☐ No

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

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

4. I used Company-created sales materials and received Company approval for all other sales materials, which require approval under the Life Insurance Compliance Guide for Producers. A copy of all such sales materials that were used was left with the applicant(s), including a printed copy of all such sales material presented electronically. (If unapproved sales materials were used, the Company will request a copy for review and approval.) ..... ☐ Yes ☐ No

Signature of **Soliciting Agent** **X**	Print Agent's Last Name	Date	Agent Code
Business Telephone Number with Area Code	Mobile Phone Number with Area Code		
Name of MGA (Print)			MGA Code
Other Agent (Print)		% Credit	Agent Code
Other Agent (Print)		% Credit	Agent Code
Other Agent (Print)		% Credit	Agent Code

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Authorization for Release of Health-Related Information
This Authorization complies with the HIPAA Privacy Rules

Name of Proposed Insured (Please print)	Birth Date Month / Day / Year

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, governmental agency, or group policyholder, or employer having information available as to diagnosis, prescription history, medications prescribed and 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, prognosis 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.

North American Company | **New Business Processing Center:** P.O. Box 5089, Sioux Falls, SD 57117 | **Principal Office:** West Des Moines, IA
Phone: 800-669-9100 | **Fax:** 800-951-9430 | NorthAmericanCompany.com

Agent Instructions: Provide the Applicant a copy of this form; submit one copy to the Administrative Office and keep a copy for your records.

This Authorization shall remain in force for 30 months (24 months in AK, AR, CA, CO, FL, IA, IN, KS, KY, MD, MS, MT, NE, NH, ND, NE, OK, OR, PA, PR, RI, SC, SD, TX, UT, VT, WV & WY) 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, 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 re-disclosed 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 or my Personal Representative has a right to receive, and have in fact received, a copy of this authorization.

Signature Proposed Insured or Personal Representative	Date

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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IMPORTANT NOTICE:
REPLACEMENT OF LIFE INSURANCE OR ANNUITIES

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

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

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

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

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

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

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

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

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

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

The existing policy or contract is being replaced because _____

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

_____ _____

Applicant's Signature and Printed Name Date

_____ _____

Producer's Signature and Printed Name Date

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

Producer's Statement

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

_____ _____

Producer's Signature and Printed Name Date

North American Company | **New Business Processing Center:** P.O. Box 5089, Sioux Falls, SD 57117 | **Principal Office:** West Des Moines, IA
Phone: 800-669-9100 | **Fax:** 800-951-9430 | NorthAmericanCompany.

Agent Instructions: Provide the Applicant a copy of this form; submit one copy to the Administrative Office and keep a copy for your records.

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

PREMIUMS:

Are they affordable?

Could they change?

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

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

POLICY VALUES:

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

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

What surrender charges do the policies have?

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

Does the new policy provide more insurance coverage?

INSURABILITY:

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

You may need a medical exam for a new policy.

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

Suicide limitations may begin anew on the new coverage.

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

How are premiums for both policies being paid?

How will the premiums on your existing policy be affected?

Will a loan be deducted from death benefits?

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

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

Will you pay surrender charges on your old contract?

What are the interest rate guarantees for the new contract?

Have you compared the contract charges or other policy expenses?

OTHER ISSUES TO CONSIDER FOR ALL TRANSACTIONS:

What are the tax consequences of buying the new policy?

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

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

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

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

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

North American Company
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TRANSMITTAL REPORT

Emerald Team: F:800-951-9430
Ruby Team: F:800-978-7959
Sapphire Team: F:855-288-8150

Amber Team: F:855-714-4507
Amethyst Team: F:855-714-4503

PLEASE PRINT

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

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

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

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

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

Please complete the following:

POLICY NUMBER: _____
(if applicable)

Applications may be mailed, faxed, sent via secure email, or uploaded through the NA website. Please send to your assigned New Business Team listed above.

If mailing the application please mail to:

New Business Team
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)

Partner: _____

Additional Policy: _____

Special Policy Date:_____

Hold Policy Issue for Special Instructions: ☐ Yes ☐ No

Date submitted:_____ By::_____

North American Company • New Business Processing Center • P. O. Box 5089, Sioux Falls, SD 57117 • Principal Office: West Des Moines, IA
Phone: (877) 872-0757 Fax: (877) 208-6136 • www.NorthAmericanCompany.com

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North American Company for Life and Health Insurance

ICC19L2977D

TEMPORARY LIFE INSURANCE AGREEMENT

Person Proposed for Life Insurance

Printed Name of Proposed Insured			
Legal First Name	Middle Initial	Legal Last Name	Suffix

A Premium, Authorization for Initial EFT draft, Government Allotment Authorization, or 1035 Exchange paperwork, as applicable, has been received in good order from _____ in the amount of $_____ in payment of one full monthly premium for an insurance policy applied for on the life of the above named Proposed Insured for whom an application (the "Application") dated _____ has been made to North American Company for Life and Health Insurance (the "Company"). Premium may be paid by check, authorized EFT draft, Government Allotment Authorization, or 1035 Exchange paperwork, as applicable; each of which will be considered acceptable premium to bind Temporary Insurance coverage when submitted along with the Temporary Life Insurance Agreement and all are completed in good order.

This Temporary Life Insurance Agreement does not provide any coverage, except as provided herein. There is NO TEMPORARY INSURANCE if:

- **Any of the below representations are answered YES or LEFT BLANK. The agent is not authorized to accept a premium check if any of the below representations are answered YES or left blank. EFT Authorization, Government Allotment Authorization, or 1035 Exchange paperwork may be completed; however, if any of the below representations are answered YES or LEFT BLANK, Temporary Insurance is not available.**
- **There is fraud or material misrepresentation in any answer to the representations below or to any question or statement in the Application. The Company's only liability is to refund any advance premium payment made.**
- **The Proposed Insured dies by suicide. The Company's only liability is to refund any advance premium payment made.**
- **No premium is paid with this Agreement, or if the premium check, authorized EFT draft, Government Allotment, or 1035 Exchange is not honored on the first presentation to the financial institution, government, or Company.**

I. REPRESENTATIONS

		Yes	No
1.	Has the Proposed Insured:		
a.	In the past five years, been medically diagnosed or medically treated for heart disorder or disease, stroke, cancer (other than basal and squamous cell skin cancer), leukemia, malignant melanoma, lymphoma, alcohol or drug dependence or abuse, insulin dependent diabetes, dementia, or have you ever tested positive for HIV infection?	☐	☐
b.	In the past 12 months, unintentionally lost more than 10 pounds?	☐	☐
c.	In the past 90 days, been admitted or advised by a medical professional to be admitted to a hospital or other licensed health care facility (other than for a normal childbirth), or been advised by a medical professional to have surgery or a diagnostic test or procedure (other than a test related to the HIV virus) which has not been completed or results are unknown?	☐	☐
2.	Is the Proposed Insured under 15 days of age or over 70 years of age?	☐	☐

II. TERMS AND CONDITIONS

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

If one full monthly premium, as described above, for the insurance applied for in the application for life insurance has been received as consideration by the Company from the Proposed Owner(s) as advance payment for the life insurance and a Proposed Insured 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.

In no event will the Company pay more than $1,000,000 in total Temporary Life Insurance coverage. 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 fully completed and signed by the Proposed Insured and the Proposed Owner(s) bearing the same date as this Temporary Life Insurance Agreement; one full monthly premium, as described above, is collected; and all of the questions in the above Section of this Temporary Life Insurance Agreement are truthfully and completely answered "NO".

North American Company | **Administrative Office:** P.O. Box 5088, Sioux Falls, SD 57117 | **Principal Office:** West Des Moines, IA
Phone: 877-872-0757 | **Fax:** 877-208-6136 | NorthAmericanCompany.com

Agent Instructions: Provide the Proposed Owner a copy of this form; submit one copy to the Administrative Office and keep a copy for your records.

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 (as defined in the Application) under the insurance contract(s) as applied for in the Application;
(c) the date on which the Proposed Insured is no longer in the state of health described in the Application and this Agreement, but is still alive;
(d) the date an insurance contract(s) other than as applied for in the Application, is offered to the Proposed Owner(s); or
(e) the date the Company mails notice of termination of coverage and refunds the advance premium payment to the Proposed Owner(s) at the address shown in the Application. The Company may cancel the coverage at any time.

4. SPECIAL LIMITATIONS

(a) No coverage is available under this Agreement for a child rider.
(b) No agent is authorized to modify any of the provisions of this Agreement. Any change or alteration to this Agreement renders the Agreement null and void.
(c) 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(S)/INSURED, 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 to the best of my knowledge and belief. I, the Proposed Owner(s), 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 this Agreement, provided the Proposed Insured(s) remain in the same state of health as described in the Application and this Agreement. I agree to be bound by all the answers, statements, and representations made in the Application and this Agreement.

I FURTHER AGREE to immediately advise the Company of any change to any of the responses contained in the Application and this Agreement, including any change in the health or habits of the Proposed Insured, that arise or is discovered after completing the Application and this Agreement.

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.

SIGNATURES

Proposed Owner Name (Print)	Date
Proposed Owner Signature	Signed At (City/State)
Proposed Joint Owner Name (Print)	Date
Proposed Joint Owner Signature	Signed At (City/State)
Proposed Insured Name (if other than Owner) (Print)	Date
Proposed Insured Signature	Signed At (City/State)

Agent Instructions: Provide the Proposed Owner a copy of this form; submit one copy to the Administrative Office and keep a copy for your records.

SIGNATURES (Continued)

Community Property: If this transaction is subject to a community property or civil union interest, we strongly recommend the Owner/Joint Owner obtain his/her spouse's signature to document his/her consent to this transaction. The Owner/Joint Owner understands and agrees the Company may presume that no such interest exists if the Owner/Joint Owner has not obtained his/her spouse's signature. Further, the Owner/Joint Owner understands and agrees the Company has no duty to inquire further about any such interest. As a result, the Owner/Joint Owner agrees to indemnify and hold the Company harmless from any consequences relating to community property or civil union interests and this transaction.

Please note that the term "Spouse" includes domestic partner or other partner as permitted by civil union, domestic partnership or similar law. Likewise, the term "civil union" is intended to mean civil union, domestic partnership or other marriage-like arrangement permitted by law.

Signature of **Owner's Spouse** for Community Property States	Signature of **Joint Owner's Spouse** for Community Property States
X	**X**

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 applied for under this and any other application to the Company with a combined face amount in excess of $2,000,000.

Agent Instructions: Provide the Proposed Owner a copy of this form; submit one copy to the Administrative Office and keep a copy for your records.