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®

L2270WA

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

The Tests:

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

Meaning of Test Results:

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

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

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

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

Potential Risks of HIV Testing:

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

AIDS:

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

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

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

Disclosure of Test Results:

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

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

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

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

_____

Address _____

Consent:

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

_____ _____
Name of Proposed Insured (Please Print) Date

_____ _____
Signature of Proposed Insured State of Residence

_____ _____
Signature of Person Obtaining Consent County of Residence

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

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

Adams County Health Department
108 West Main
Ritzville, Washington 99169-1408
(509) 659-3319

Asotin County Health District
431 Elm Street
Clarkston, Washington 99403
(509) 758-3344

Benton-Franklin Health District
1218 North 4th Street
Pasco, Washington 99301-3709
(509) 547-9737, ext. 225

Chelan-Douglas County Health District
200 Valley Mall Parkway
East Wenatchee, Washington 98802
(509) 886-6400

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

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

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

Garfield County Health District
121 South 10th, P.O. Box 130
Pomeroy, Washington 99347
(509) 843-3412

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

Grays Harbor County Health Department
2109 Sumner Avenue
Aberdeen, Washington 98520
(360) 532-8631

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

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

Kitsap County Health Department
345 6th Street, Suite 300
Bremerton, Washington 98337
(360) 337-5235

Kittitas County Health Department
507 Nanum Street
Ellensburg, Washington 98926-2898
(509) 962-7028

Klickitat County Health Department
501 NE Washington Street
White Salmon, WA 98672
(509) 493-1558

Lewis County Health District
360 NW North Street
Chehalis, Washington 98532-1900
(360) 740-2787

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

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

Northeast Tri-County Health District
240 East Dominion
Colville, Washington 99114
(509) 684-5048

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

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

San Juan County Health Department
145 Rhone Street
Friday Harbor, Washington 98250-0607
(360) 378-4474

Skagit County Health Department
700 S 2nd Street #301
Mount Vernon, Washington 98273-1071
(360) 336-9477, ext. 5291 or (360) 336-9380

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

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

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

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

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

Wahkiakum County Health Department
64 Main Street
Cathlamet, Washington 98612
(360) 795-6207

Walla Walla County-City Health Department
310 West Poplar
Walla Walla, Washington 99362-0336
(509) 524-2661

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

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

Whitman County Health Department
North 310 Main Street
Colfax, Washington 99111-1893
(509) 397-6280

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

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

NORTH AMERICAN®

L3190C

INDEXED UNIVERSAL LIFE INSURANCE

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

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

ALLOCATION CHOICES

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

1. The Standard & Poor's 500® Composite Stock Price Index (S&P 500®)
2. The S&P MidCap 400®
3. The Russell 2000®
4. The Fidelity Multifactor Yield Index℠ 5% ER

INDEX CREDITING METHODS

The interest credited to the Policy is calculated by one of the following methods: the Annual Point-to-Point method, the Annual Point-to-Point with Spread method, or the Monthly Point-to-Point method. No Index Credits will be applied until the end of the Index Period and money withdrawn or surrendered prior to this time will not receive Index Credits.

When the **Annual Point-to-Point** method is chosen, the Index credit is determined by calculating the change between the Index Value on the first day of the Index Period and last day of the Index Period. The Index change is subject to the Index Cap Rate, Index Participation Rate, and Index Floor Rate. The Index Credit, if any, is credited and locked in at the end of the 12-month Index Period. The Annual Point-to-Point crediting method is available for the S&P 500®, S&P MidCap 400®, Russell 2000®, and the Fidelity Multifactor Yield Index℠ 5% ER. The S&P 500® includes both a capped and an uncapped version of this crediting method.

When the **Annual Point-to-Point with Spread** method is chosen, the Index credit is determined by calculating the change between the Index Value on the first day of the Index Period and last day of the Index Period. The Index change is multiplied by the Index Participation Rate, and then the Index Spread Rate is deducted. The rate credited at the end of the Index Period will never be less than zero percent (the Index Floor Rate). The Index Credit, if any, is credited and locked in at the end of the 12-month Index Period. The Annual Point-to-Point with Spread crediting method is available for the S&P 500®.

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

OTHER ELEMENTS AFFECTING INDEX CREDITS

- **Index Participation Rate** – the portion of the Index change that is used in the calculation of the Index Credit. This rate can be changed by the Company but can never be less than the minimum shown in the Policy.
- **Index Cap Rate** – the maximum interest rate that can be used in the calculation of the Index Credit. This rate can be changed by the Company but can never be less than the minimum shown in the Policy.

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

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- **Index Floor Rate** – the minimum interest rate that can be used in the calculation of the Index Credit. This rate can be changed by the Company but can never be less than zero percent.
- **Index Spread Rate -** the interest rate that will be subtracted from the Index growth in the calculation of the Annual Point-to-Point with Spread Index Crediting Method. This rate can be changed by the Company but can never be more than the maximum shown in the Policy.
- **Minimum Account Value –** the rate credited to your Policy at the end of each Index Period will never be less than zero percent (the Index Floor Rate). However, we will also calculate a Minimum Account Value that usesthe Policy's Guaranteed Interest Rate in all Policy years for all premiums. If your Policy terminates (due to death, surrender, maturity, or lapse), we compare the Account Value using actual interest credits to the Minimum Account Value and use the greater value.
- **Surrender Charge –** the Surrender Charge is a charge made against the Policy Account Value in the event of a surrender of the Policy. The Surrender Charge may vary by Issue Age, Gender, Tobacco Status and Premium Class of the Insured and varies by Policy Year. Surrender Charges apply to the initial Specified Amount. Additional Surrender Charges will apply to any increase in Specified Amount and any decrease in Specified Amount or Withdrawal will reduce the Surrender Charge. Surrender Charges vary by product.
- **Transfers from an Index Selection –** transfers out of an Index Selection can only occur at the end of an Index Period.

OWNER:

This is an indexed life insurance Policy, and even though the values of the Policy may be affected by an external Index, the Policy does not directly participate in any stock, bond or equity investments.

- **The values of the external Indices do not reflect the payment of dividends.**
- **The Policy applied for is not a registered security.**
- **Current illustrated values are based on past Index performance and are not intended to predict future performance.**
- **The Company has the right to change Index Spread Rates, Index Cap Rates, Index Floor Rates, Index Participation Rates and interest rates.**
- **Any values shown, other than guaranteed minimum values, are not guarantees, promises or warranties.**

I acknowledge that I have read this disclosure material and received a copy.

Signature(s) of **Owner / Joint Owner** (If Owner is Corporation, Trust or other Entity, include Title of Signee. For Corporation, signatures of two officers are needed.)	
X	DATE
X	DATE
X	DATE

AGENT:
I certify I have provided a copy to and reviewed this disclosure material with the Applicant. This application is being submitted after an examination of the interests of the Applicant and an assessment of the stated goals of the Applicant. I have discussed this product with the Applicant and have not made any statements which contradict the disclosure materials provided to the Applicant. I have not made any promises about the future performance or values of any non-guaranteed elements of any indexed life insurance Policy. I certify that I have completed the Company's Indexed Universal Life Certification Training and passed the Agent Certification Exam.

AGENT'S SIGNATURE **X**	DATE

S&P 500® COMPOSITE STOCK PRICE INDEX
S&P 400® COMPOSITE STOCK PRICE INDEX

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FIDELITY MULTIFACTOR YIELD INDEX℠ 5% ER - The Fidelity Multifactor Yield Index℠ 5% ER (the "Index") is a multi-asset index, offering exposure to companies with attractive valuations, high quality profiles, positive momentum signals, lower volatility and higher dividend yield than the broader market, as well as U.S. treasuries, which may reduce volatility over time. Fidelity and its related marks are service marks of FMR LLC.

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Neither FPS nor any other party involved in, or related to, making or compiling the Index has any obligation to continue to provide the Index to the Company with respect to the Product. Neither FPS nor any other party involved in, or related to, making or compiling the Index makes any representation regarding the Index, Index information, performance, annuities generally or the Product particularly.

Fidelity Product Services LLC disclaims all warranties, express or implied, including all warranties of merchantability or fitness for a particular purpose or use. Fidelity Product Services LLC shall have no responsibility or liability whatsoever with respect to the Product.

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ICC22SA101NAC

SUPPLEMENT TO INDIVIDUAL LIFE INSURANCE APPLICATION
Initial Premium Allocation -Indexed Universal Life Insurance

Life Insurance Qualification Test

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

Smart Builder 3

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

		PREMIUM ALLOCATION
Index Selection 1	S&P 500® – Annual Point to Point	%
Index Selection 2	High Par Fidelity Multifactor Yield Index℠ 5% ER – Annual Point to Point	%
Index Selection 3	Fidelity Multifactor Yield Index℠ 5% ER – Annual Point to Point	%
Index Selection 4	S&P 500® – Annual Point to Point with Spread	%
Index Selection 5	High Par S&P 500® – Annual Point to Point	%
Index Selection 6	Uncapped S&P 500® – Annual Point to Point	%
Index Selection 7	S&P 500® – Monthly Point to Point	%
Index Selection 8	S&P MidCap 400® – Annual Point to Point	%
Index Selection 9	Russell 2000® – Annual Point to Point	%
	Fixed Account	%
	Total	**%**

TELEPHONE AUTHORIZATION (READ CAREFULLY) ☐ **YES** ☐ **NO**
I hereby authorize and direct the Company to act on telephone instructions when proper identification has been furnished, to make transfers or change premium allocations of future premium payments. The Company will employ reasonable procedures to confirm that telephone instructions are genuine; nonetheless, I agree that the Company is not liable for any loss arising from any change in premium allocations of future premium payments or transfers by acting in accordance with these telephone instructions.

AUTHORIZATION FOR AGENT (READ CAREFULLY) ☐ **YES** ☐ **NO**
I hereby authorize and direct the company to act on instructions communicated by the Agent of Record to make transfers or change the premium allocations of future premium payments. This authorization does not grant the Agent discretion to communicate any transaction without my prior approval. The Company will employ reasonable procedures to confirm that instructions are genuine; nonetheless, I agree that the Company is not liable for any loss arising from any change in premium allocations of future premium payments or transfers by acting in accordance with these instructions. This authorization will remain in effect until the Company receives instructions of cancellation from the owner, or the named Agent is no longer contracted and appointed with the Company.

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

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AGENT: I certify that the equity indexed disclosure material has been presented to the Applicant. This application is being submitted after an examination of the interests of the Applicant and an assessment of the stated goals of the Applicant. I have discussed this product with the Applicant and have not made any statements which contradict the disclosure materials provided to the Applicant. I have not made any promises or guarantees about the future values of any non-guarantee elements.

Signed At (City, State): _____

Signature(s) of **Owner / Joint Owner** (If Owner is Corporation, Trust or other Entity, include Title of Signee. For Corporation, signatures of two officers are needed.)	
X	Date
X	Date
X	Date

Signature of **Soliciting Agent**	Agent Code	Date
X		

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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 ____ Buy/Sell
____ Creditor ____ Split Dollar
____ Deferred Compensation ____ 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)

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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

A consumer's guide to:

Life Insurance

What you should know about shopping for life insurance

OFFICE of the INSURANCE COMMISSIONER
WASHINGTON STATE

BG-WA

Table of Contents

A consumer's guide to life insurance

You can obtain life insurance policies through agents or brokers, by mail, via the Internet, or through group plans offered by your employer or an association.

No matter how you buy your life insurance, you should only buy from a licensed company that offers policies approved in Washington state.

To protect you, the Office of the Insurance Commissioner (OIC) regulates all insurance transactions that take place in Washington state. To operate in our state, insurance companies must be licensed with our agency. Insurance companies must also file their policies with us.

In addition to our protections, state law created the Washington Life and Disability Guaranty Association. The association protects policyholders when insurance companies become unable to pay claims.

To find out if a company is licensed in our state, call our Insurance Consumer Hotline at 1-800-562-6900. You can also look the company up on our website at: www.insurance.wa.gov.

Deciding how much insurance to buy

You should decide how much life insurance you need. You need to look carefully at your individual circumstances. The real value of life insurance is to protect your loved ones after your death. Before you buy, ask yourself:

- What costs and hardships will my family have to deal with after I am gone?
- How will the loss of my salary affect my family?

These questions require careful thought and perhaps a candid talk with your beneficiaries.

Insurance shopping tips

First, set the goals you want. Then shop around. The cost of insurance varies from company to company—as do their services, standards, and policies.

Research the policy carefully to make sure it meets your needs. Once you decide to buy life insurance, don't delay! Make the purchase. Your beneficiaries will not benefit unless you buy a policy. Also, if you wait, you could develop a health problem, which could cause the rates to go up, or the company could reject your application.

The company must provide you with a buyer's guide and a policy summary before they give you the policy. If you do not receive these two items, ask for them.

The "free look" rule

- When you receive your new policy, read it carefully.
- Every new life insurance policy issued in Washington state comes with a 10-day "free look" period.
- If you are not satisfied for any reason, you may return the new policy within 10 days after you receive it.
- Mail it to the company's home office or give it back to the agent who sold it to you.
- Be sure to get a dated receipt from the post office or the agent.
- The company must return your premium within 30 days from the date you returned the policy. If they keep your money longer, legally they are responsible for a 10 percent penalty—payable to you.

How to buy life insurance

Mail order

A few insurance companies sell through the mail. You mail a completed application directly to the company. The company usually does not have an agent in your hometown.

The Internet

A growing number of insurance companies are expanding their marketing and are starting to sell policies on the Web. All state laws and regulations regarding selling insurance apply to the Internet and insurance-based Web sites. Do your research and make sure the company is authorized to do business in Washington state. If you have questions, call our Insurance Consumer Hotline at 1-800-562-6900.

Agents and brokers

Most people buy life insurance through an agent or broker. Agents and brokers operate differently.

Agents represent one or more companies. The agent's job, which is commission based, is to sell you the policies of the company he or she represents.

Brokers represent and work for you. Typically, you describe to the broker the type of coverage you want and the amount you want to spend. The broker surveys the market and brings back options for you to review. Brokers also receive a commission on the sales they arrange.

Choose your agent or broker carefully. It is wise to select someone who is an established business person in your community. You may wish to ask, "What makes you feel you are qualified to talk to me about my financial security?" Reliable salespeople should not mind verifying their credentials or listing their qualifications.

If you have concerns about an insurance provider or a sales offer, contact our Insurance Consumer Hotline at 1-800-562-6900.

What to do if a company turns you down

If a company turns you down for a policy, try another company. Companies use different methods and factors to decide whether or not to insure you. For example if you have high blood pressure that you control with medication, one company might reject you while another company may accept you.

If you have a medical problem, it's a good idea to talk it over with your doctor. Treatments may improve your condition enough to meet company standards, or the company may qualify you as a special risk at an adjusted premium. If the company uses your medical information to arrive at its rating, it must share that information with your doctor at your request.

You might also want to check on group life insurance. Some group plans do not require medical exams or health histories.

Insurance companies are part of the free enterprise system and can – within certain limits – select those individuals they want to insure. However, they are not free to turn down coverage without a valid reason. Under Washington state law, insurers cannot refuse insurance to anyone based on:

- Sex
- Marital status
- Race
- Creed
- Color
- National origin

It's also against the law to deny coverage to domestic violence victims. And it's illegal to refuse people with a sensory, mental, or physical problem – except when the company can prove statistically that someone is more likely to file a claim.

If you feel an insurance company is treating you unfairly, you can file a complaint with our agency by calling 1-800-562-6900. We will look into the issue on your behalf.

What you should know about your insurance company

Different companies offer different products. Some companies work with agents you can find in the phone book. Other companies prefer to deal directly with you.

One other key item you should think about before you buy is the financial security of the insurance company. As with most businesses, the security of a company depends on how it is managed, supervised, and controlled.

Rating your insurance company

One way to find out about your insurance company is to check its security rating. Several independent rating organizations monitor the financial strength of insurance companies. They also offer free rating information by phone and on the Web. These rating organizations include:

- A.M. Best Co., publisher of "Best Insurance Reports"
  908-439-2200, www.ambest.com
- Moody's Investor Service, Inc.
  212-553-0377, www.moodys.com
- Standard & Poor's
  1-800-523-4534, www.standardandpoor.com
- Fitch Ratings, Inc.
  1-800-893-4824, www.fitchratings.com
- Weiss Research
  1-800-289-9222. www.weissratings.com

Be aware that each organization uses its own criteria to determine financial ratings. Even though all use some form of "A," "B," or "C" grading system, what is "AAA" for one might be "A+" or "A-" for another.

What you should know about life insurance premiums

Premiums are the dollar amount you pay into a life insurance policy. Depending on your arrangement with the insurance company, you can pay premiums on a monthly basis or less often. All policies must contain a 31-day grace period for late payments. This means if you are late paying your premium, your policy still stays in effect for 31 days, until you pay your premium.

For group life insurance, employers can deduct your premiums with your permission from your paycheck.

Insurers base your life insurance premium on several factors:

- Gender
- Health problems
- Occupation
- Hobbies
- Habits
- Other circumstances that may reduce your life span, such as a bad driving record or participating in dangerous activities
- Expenses the company expects to pay regarding your coverage, such as sales charges, and underwriting and administration costs
- Interest the company expects to earn from investing your premiums

What you should know about life insurance policies

A life insurance policy is a legal contract between you and the insurance company. This contract spells out:

- The rights and duties of you and the company
- How much and how often you pay
- The benefits you are entitled to receive
- The circumstances under which the policy will pay benefits

The best insurance policy is the one that best fits your needs. However, what is best for you right now, may not suit your situation 10 years from now. This means you should review your coverage regularly, even on an annual basis to make sure your coverage is current.

Term life and cash value life insurance

Term and cash value insurance are the two basic types of life insurance that companies offer in various forms.

Term insurance

Term insurance gets its name because it protects you for a specific "term"—usually a year or a limited number of years. You have to pay more for it as you get older because your risk of dying increases with age. Term insurance does not have a cash value and you cannot cash it in. Once the term ends, the policy no longer covers you. If the policy is renewable, you may buy it for another term at a rate guaranteed in the policy, without providing health information and some other proof of insurability, such as a driving record. However, the renewed policy will usually cost more. Over time, it may be too costly to renew.

Term insurance is well suited to fill a temporary need for increased insurance. If you leave one job for another, you may not have group life insurance coverage through your employer for a short time. Term insurance offers an easy purchase to bridge such a gap. It is also provides you with an option to quickly supplement an existing whole life policy with additional coverage.

Cash value life

For this type of insurance, you pay higher premiums at the beginning of the policy. The company uses part of your premium to set up an account under your policy with a cash value that you may use in a variety of ways. For example:

- You may borrow against a policy's cash value by taking out a loan. If you don't pay back the loan and the interest on it, the company will subtract the amount you owe from the benefits when you die. If you cancel the policy, the company will also subtract the loan balance from the cash value you receive
- You can use the cash value to pay an overdue premium on the policy
- You can use the cash value to increase your income in retirement or to provide for other financial needs. However, to build up this cash value, you must pay higher premiums in the early years of the policy

Whole life, universal life and variable life

These are all considered types of cash value insurance. For whole life and universal life, the life insurance company invests your cash value as a general asset of the company. The interest the company credits to your cash value is based on its earnings.

Whole life

This is the traditional form of cash value life insurance. Also referred to as "ordinary life" or "straight life," whole life insurance provides coverage for your entire lifetime. The premium depends on your age at the time you buy and stays the same as you grow older. The lowest premiums go to those who buy it when they are young, because they will pay into it the longest. Your cash value grows based on a fixed interest rate set each year in your policy by the company.

Some whole life policies let you pay premiums for a shorter time, such as 15 years, or until you reach age 65. Premiums for these policies are higher because you make premium payments during a short time frame.

Universal life

This is a type of flexible cash value policy that lets you vary your premium payments. You can also make limited adjustments in the death benefit amount of your policy. The company credits the premium you pay to a policy account that earns interest. The company then deducts the expense charges from the account. If your yearly premiums plus the interest the company credits to your account is greater than the cost of the insurance, your account will grow. However, if your premiums and interest earnings are less than the cost of insurance, your account will decrease. If your account keeps dropping, your coverage will end. To prevent this, you can increase your premium payments or lower the death benefits.

Variable life

As with universal life, the death benefit and cash values of variable life insurance vary. With variable life, the company invests your cash values into separate investment accounts, such as portfolios of stocks, bonds, and other investments. These separate accounts are like mutual funds. The company should provide you with information (also called a prospectus) that describes each separate account. Study the information carefully. As the policy owner, you choose the separate account to invest the cash value. The cash values and death benefit vary due to increases or decreases in the value of the separate accounts. You take the investment risk as the policyholder in return for possible improved benefits.

Life insurance illustrations

For most individual policies, cash values, death benefits, or premiums vary based on factors the company cannot guarantee (such as interest rates). Companies use computer-generated illustrations, such as a table to show how policies perform over the years under given assumptions. The illustrations show how benefits that are not guaranteed will change each year as interest rates and other factors change. The

illustrations also show what the company actually guarantees and what could happen in the future. Remember, no one knows what will happen in the future. If the policy does not perform well, be prepared to adjust your financial plans.

You should be aware that due to past sales abuse, companies cannot use the term "vanishing premium" in life insurance illustrations. Vanishing premiums imply that you start out making large premium payments for the first several years of your policy with the possibility of no payments later on. There is NO guarantee this will occur.

Other life insurance policy options

The following are other popular types of life insurance:

Group life insurance

Typically purchased one year at a time, group life insurance gives you very little control over the conditions of the coverage. You buy group life through an association of individuals. For example, an association of individuals affiliated with an employer, labor union or credit union. In Washington state, if you leave a group life plan or your employer drops the plan, the law requires group life insurance to allow you to convert to permanent whole life insurance coverage.

The advantages to group life include:

- Group life insurance may cost less than individually purchased life policies
- Employers may choose to subsidize part of the cost as a fringe benefit for their employees
- It usually doesn't require a medical exam or health history

The disadvantages to group life include:

- It does not typically guarantee premiums
- It does not typically guarantee a renewable policy
- Group life coverage only applies to members of the group
- If you leave the group or drop your association membership, your coverage ends — unless you convert the policy to private insurance at a higher cost

Convertible policies

This type of policy starts out as term life insurance and then converts to a cash value life insurance policy. Young people who want financial security for their new families, but cannot afford cash value life insurance, may choose a convertible term insurance policy. These policies give you the option to convert your coverage to cash value life

insurance for a limited time—without providing health information and some other proof of insurability and at the insurer's current premium rates. Premium rates start fairly low and then rise after you convert. When you shop for term insurance, look for policies that are both renewable and convertible.

Joint life insurance

When a husband and wife or business associates need life insurance, it is often cheaper to buy a joint life insurance policy instead of two or more separate policies. While this type of insurance saves on administrative costs, the policy usually only pays the death benefit on the first to die. However, some companies issue "second or last to die" policies for estate planning.

Family insurance

This is basically a whole life insurance policy on a parent with smaller amounts of additional term insurance on other family members.

Final expense insurance

Also known as "burial policies" or "senior life insurance packages," these small policies cover or pre-pay a person's funeral costs. Historically, some of these policies had a very high price compared to the death benefit. In response to consumer complaints, Washington created the high-priced life insurance regulation.

This regulation includes a special formula that bans companies from marketing certain high-priced life insurance policies with small death benefits. Companies cannot sell life insurance polices in Washington when the amount paid into them quickly exceeds the possible benefit. For example, during the first 10 years of the policy, the death benefit must be greater than the sum of the premiums compounded at the average interest rate on five-year government bonds. Otherwise, you would be better off with your money in a savings account.

Please note: This rule does not apply to policies with a death benefit of $5,000 or more.

Optional policy benefits

Waiver of premium

If you become seriously ill or injured and cannot work, you may not be able to pay your premium. A waiver of premium benefit lets you waive paying your premiums as long as you remain disabled (according the definition in your policy). You must remain disabled at least six months to collect this modest disability income benefit. You can usually add this life insurance extra to your policy for only a few cents more per month per thousand dollars of insurance coverage.

Accidental death benefit

The industry also refers to this life insurance extra, as "double, triple, or additional" indemnity. If an accident causes your death, this life insurance extra allows your beneficiaries to receive double, triple, or even more of your policy's death benefit value.

Accelerated life insurance benefit

This permits life insurance companies to include policy language that allows for an early, discounted benefit payment to terminally ill policyholders. A doctor must certify that policyholders have less than 24 months to live.

What you should know about trading in policies

It's become more common for policyholders to use their life insurance cash values in various financial actions. Some people borrow the base value of their policy to take advantage of the low interest rate. Some cash their policies in and put the cash in higher interest accounts while making other plans for their insurance needs. Others may look into new developments in the life insurance market, such as policies that include investments or variable interest options.

Be careful if you are tempted to use your life insurance coverage as described in these examples. Your individual and family situation will help you decide if any of these options will work for you.

If you decide to change your coverage, you should never drop your old policy until the new one takes effect, and you have reviewed it. Ask your agent or broker for complete disclosure on any new policy you are thinking about buying.

If an agent or broker suggests you exchange a policy for a new one, ask for a comparison of the new offering and the old policy. Be sure to get it in writing before you agree to the transaction.

Be aware that any replacement policy may contain new restrictions such as a new two-year suicide clause, and may allow the company to revoke your policy for false statements on your application. Replacement policies may also include important new surrender penalties if you wish to cash them in. A surrender penalty is a financial penalty you pay for canceling a policy or contract early. Older people should be wary of trading in current policies for new ones that require a substantial new surrender penalty.

If you trade in policies, by law you must receive a "Notice Regarding Replacement of Insurance." This will help you make the best decision when you're thinking about replacing an existing life insurance policy. The agent or broker should give you a completed replacement notice at the time he or she takes your applications for the new insurance policy.

The "free-look" rule also applies to consumers who exchange one policy for another. (For an explanation of the free-look rule, see page 2).

What you should know about death claims

The company's home office usually handles life insurance claims. Your beneficiary will need to notify the company and request a claim form. Your beneficiary should expect to provide the company's claim department with:

- A completed claim form
- A certified copy of the death certificate
- The life insurance policy or a lost policy affidavit

Your beneficiary should keep copies of the documents he or she sends to the company.

Typically, beneficiaries will get a death-claim settlement from the company once he or she provides due proof of the policyholder's death, and turns in the policy. Due proof is what the company normally requires to establish that death occurred. Your beneficiary can provide due proof with one of the following:

- Death certificate from the Office of Vital Statistics
- Coroner's report
- Attending doctor's statement
- Hospital certificate of death

Individual policies

To ensure prompt settlements, insurers must pay your beneficiary no less than 8 percent interest starting from the date of death. An additional 3 percent is payable on those claims not settled within 90 days of when the beneficiary provided proof of death.

What your beneficiary can expect

In most instances, your beneficiary will receive the death benefit amount of the policy. Although, the insurer may adjust the amount depending on the specifics of your coverage. For example, any loan against the cash value of the policy and any interest due on such a loan may reduce the face amount. Also, adding any premium payments made in advance, or subtracting premiums due may adjust the face value. For a dividend paying policy, the insurer adds accrued dividends to the death benefit amount of the policy.

Settlement options

Beneficiaries normally have several options. They may choose to:

- Receive the policy proceeds in cash as soon as the claim is settled
- Leave the proceeds with the company, while it earns interest, until they decide what to do
- Convert the proceeds into monthly income

For example, companies usually offer beneficiaries several options to receive payment. One method draws the amount down in equal monthly payments over a fixed time, such as 10 years. Another method places the proceeds in a life annuity, which will pay a monthly amount for as long as your beneficiary lives. Yet another method provides a joint annuity—one that pays as long as your two beneficiaries live.

Your policy must include a section explaining these settlement options.

Options for seriously ill people

Life Settlements

Many people who suffer serious, terminal illnesses realize one of their most valuable assets is a life insurance policy. However, only the beneficiary has access to this asset after the policyholder passes away. Life settlement contracts give the policyholder access to this asset prior to his or her death. Life settlement companies arrange the "sale" of life insurance benefits as an investment. Typically, a life settlement company agrees to buy the life insurance policy of a seriously ill person by paying the person

an amount less than the benefit. The seriously ill person receives much needed cash, and the buyer receives the full amount of the benefit. This benefit is payable once the former policyholder dies.

Other options

If you own a cash value policy, you could take a loan from the policy to help pay expenses. Also, if your policy contains an accelerated benefits option for catastrophic illness, you may qualify for a discounted payment from the face amount of the policy.

Top 10 life insurance cautions

1. Beware if it sounds too good to be true. It probably is NOT true.

2. Never sign a form that leaves blank spaces—even if the agent or broker assures you it is merely a formality.

3. If someone offers you a chance to turn in a small policy for a larger one without paying substantially more, WATCH OUT!

4. Don't drop your old policy until your new policy takes effect.

5. Save every piece of paper explaining your coverage and your policy. Keep them on file with your policy. (If the agent used a laptop computer, insist on a hard copy version of what he or she showed you.)

6. Never buy coverage you don't understand. It is the responsibility of the agent, broker or company to explain your coverage in terms you can understand.

7. Don't let someone pressure you. You do NOT face any deadlines.

8. Don't buy life insurance portrayed as a "pension plan" or a "retirement fund." Life insurance is NOT a pension plan.

9. Be careful of any life insurance plan that promises "vanishing premiums" or guarantees you a premium-free policy over a specific period.

10. Never ignore notices from the insurance company even though your agent tells you it's a "mistake" and nothing to worry about.

Need more help?

Call our Insurance Consumer Hotline!

1-800-562-6900

Our professional consumer advocates provide counseling on insurance options, enforce insurance law and can investigate complaints against insurance companies and agents on your behalf.

We also offer individual counseling and group education on health care issues in your communities. Our highly trained Statewide Health Insurance Benefits Advisors (SHIBA) volunteers can help you understand your rights and options about Medicare, health care coverage, prescription drugs, government programs, and more.

Visit us at:

www.insurance.wa.gov

2069-OIC-Guide-Life insurance-rev. 02/16

Clear Form Clear Kit

Authorization for Release of Health-Related Information

This Authorization complies with the HIPAA Privacy Rules

NORTH AMERICAN®

Personal information

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.

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, 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.

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.

Signatures

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:

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

L-3100

North American Company
for Life and Health Insurance

Clear Form Clear Kit

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TRANSMITTAL REPORT

Emerald Team:	F:800-951-9430	Amber Team:	F:855-714-4507
Ruby Team:	F:800-978-7959	Amethyst Team:	F:855-714-4503
Sapphire Team:	F:855-288-8150		

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

Assignment and Surrender for §1035 Exchange

Clear Form | Clear Kit

NORTH AMERICAN®

ALL FIELDS MUST BE COMPLETE

Existing Policy Number(s)

Policy Information

Insured's Name	Owner's Name **(Must be completed. Do not mark as "same")**
Net Cash Surrender Value (Estimated):	Does the policy have loan(s)? ☐ Yes ☐ No See items 6. and 7. below for more information.

Existing Policy Type: ☐ Life ☐ Variable ☐ Annuity ☐ Endowment Policy

North American Policy Type Applied For: ☐ Universal Life ☐ Variable ☐ Annuity

The following must be completed:
The contract(s) referenced above are ☐ attached ☐ lost.
If "attached" is marked, please mail the original policy to North American Company.

Full Name and Address of company that issued existing policy(ies):

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.

Signatures

The undersigned understands and agrees to the following:

1. The owner hereby assigns and transfers all rights, title, and interest in the above policy to North American Company for Life and Health Insurance (hereinafter "the Company"). The above company shall be relieved from any and all liability under these original contract(s) upon their cash surrender.
2. The undersigned represent and warrant that no person, firm, or corporation has a legal or equitable interest in the policy, except the undersigned, and that no proceedings of either a legal or equitable nature have been instituted or are pending against the undersigned.
3. The undersigned intend that this assignment be part of an exchange of insurance policies or annuities under Internal Revenue Code Section 1035. The undersigned are aware that the Company intends to surrender this policy for its net cash surrender value and specifically authorize and approve of the Company surrendering the policy for its net cash surrender value, without in any way limiting the rights transferred under this assignment. **The undersigned represent and agree that the Company is furnishing this form and is participating in this transaction at the undersigned's request and as an accommodation to the undersigned. The undersigned represent and agree that the Company makes no representation, and that the Company has no responsibility or liability for the validity of this agreement or the undersigned's tax treatment under Internal Revenue Code Section 1035, or otherwise.**
4. The current insurer is authorized to recognize the Company's claim to rights under this assignment without investigation. An authorized signature on behalf of the Company shall be sufficient for the exercise of the Company's right of surrender. Any check for the surrender value of this policy shall be drawn to the exclusive order of the Company if, when, and in such amounts as may be requested by the Company.

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

L-2008

5. In addition to, but without limitation of all rights, title and interests assigned under this assignment, the undersigned specifically assigns the above policy as collateral security for the amount of the policy's cash surrender value with the right of the Company to collect either the proceeds at death or at maturity, or the cash surrender value of the policy paying the balance, if any, after payment of such cash surrender value, to the persons entitled thereto under the policy. If this transaction is subject to a community property interest, we strongly recommend that You obtain Your spouse's signature on this application to document his/her consent to this transaction. States that recognize community property interests in property held by married persons include Alaska, Arizona, California, Idaho, Louisiana, Nevada, New Mexico, Texas, Washington and Wisconsin. You understand and agree that the Company may presume that no community property exists if You have not obtained your spouse's signature below. Further, you understand and agree that the Company has no duty to inquire further about any such community property interest. As a result, You agree to indemnify and hold the Company harmless from any consequences relating to community property 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.
6. The owner will continue to pay the premiums necessary to keep the existing policy(ies) in force until the 1035 proceeds are released from the current insurer. The Company bears no responsibility for the payment of any premiums. Failure to pay premiums on the existing policy(ies) may create a loan, or reduce or eliminate surrender proceeds or cause the policy(ies) to lapse. The Company will not carry over to the new policy an outstanding loan on the old policy.
7. Any policy loan that exists prior to the exchange and is discharged may constitute the receipt of income which is taxable gain to the extent of the loan (reg. 1.1031 (b)-1(c)). We recommend you consult with and rely on your own qualified legal or tax advisor.
8. If the new application for insurance is canceled, declined, or postponed by the Company for any reason, the Company will release the owner from the assignment executed as part of this transaction.
9. The cash value of the existing assigned policy shall not be considered part of the premium consideration for the new policy until the Company actually receives the policy's net surrender value. The existing insurer may defer payment of the surrender proceeds of the existing policy(ies) in accordance with applicable policy provisions. Accordingly, the undersigned understand and agree that the Company has no control over, and assumes no responsibility for, the surrender processing of another company and the timeliness of the receipt of the 1035 exchange values.
10. The Company's maximum liability prior to the actual issuance and delivery of the new contract shall not exceed$1,000,000 ($100,000 in Kansas), as documented in the Temporary Insurance Agreement (TIA). If coverage is in effect under the TIA, the company's maximum liability shall not exceed $1,000,000 ($100,000 in Kansas).

Dated at (City, State)	Date (mm/dd/yyyy):
Owner Signature:	Owner Social Security Number / Tax I. D. Number:
Irrevocable Beneficiary Signature: (if any, or Spouse in Community Property States)*	Co-Owner Signature: (if any)

*Please note that the term "Spouse" includes domestic partner or other partner as permitted by civil union, domestic partnership or similar law.

CASH SURRENDER (This section to be completed by North American Company for Life and Health Insurance)

In consideration of and in exchange for the net cash value of the above existing policy(ies), North American Company, having been granted and having accepted the absolute assignment of the policy(ies) listed above, hereby surrenders said policy(ies) for cancellation. In accordance with the terms of the policy(ies), it is hereby agreed that any indebtedness thereon to the company whose policy(ies) is being surrendered will be deducted from the cash value. It is understood and agreed that upon execution of this request by the company whose policy(ies) is being surrendered, the entire liability of said company under this policy(ies) is hereby discharged and terminated, except for payment of the net cash surrender value. It is expressly represented and warranted that no other person, firm or corporation has any interest in said policy(ies) except North American Company and that there are no tax liens or proceedings in insolvency or bankruptcy instituted or pending against North American Company.

North American Company Policy Number:	Date Form Mailed to Existing Company: (mm/dd/yyyy)
North American Company Officer Signature and Title:	Dated at: (City, State)

Existing insurance company, please make your surrender check payable to North American Company for Life and Health Insurance and mail to:

☐ ATTN: New Business or ☐ ATTN: Policy Change
North American Company for Life and Health Insurance
One Sammons Plaza
Sioux Falls, SD 57193

Please include the Insured's name and our policy number on the surrender check and cost basis statement.

North American Company's Tax I.D. number is 36-2428931.

Clear Form Clear Kit

Granting Authorization to an Agent for Indexed Life

NORTH AMERICAN®

Policy Information

Insured	Policy/Certificate Number
Policy Owner (Complete if other than Insured.)	Social Security/Tax ID Number/Owner
Owner's Address (Street Address, City, State, Zip)	

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.

Authorization

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

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

I understand that a letter to confirm all transactions will be mailed to me at the address of record provided to North American Company for Life and Health Insurance (North American). I acknowledge that I am responsible for promptly reviewing all confirmation letters. I agree to notify North American of any erroneous or unauthorized transaction within five days of my receipt of such confirmation letter. This authorization will be no longer be in effect as of the date the ownership of the policy changes.

Signature of Policy Owner		Date
Signature of Agent	Agent Code	Date

Copy 1 - Company Copy 2 - Leave with Applicant Copy 3 - Agent

O-2758

Clear Form Clear Kit

NORTH AMERICAN®

L207546

IMPORTANT NOTICE REGARDING REPLACEMENT OF LIFE INSURANCE

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

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

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

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

1. Can there be reduced benefits or increased premiums in later years? ☐ No ☐ Yes, explain:

   _____

2. Are there penalties, set up or surrender charges for the new policy? ☐ No ☐ Yes, explain, emphasizing any extra cost for early withdrawal: _____
3. Will there be penalties or surrender charges under the existing insurance as a result of the proposed transaction?
   ☐ No ☐ Yes, explain: _____
4. Are there adverse tax consequences from the replacement under current tax law? ☐ No ☐ Yes, explain:

   _____

5. a) Are interest earnings a consideration in this replacement? ☐ No ☐ Yes
   b) If "yes," explain what portions of premiums or contributions will produce limited or no earnings. As pertinent, include in your explanation the need for minimum deposits to enhance earnings, and the reduction of earnings that may result from set up charges, policy fees and other factors.

   _____

6. Are minimum amounts required to be on deposit before excess interest will be paid? ☐ No ☐ Yes, explain:

   _____

7. If the new program is based on a variable or universal life insurance policy or a single-premium policy or annuity:
   a) Are the interest rates quoted before ☐ or after ☐ fees and mortality charges have been deducted?
   b) Interest rates are guaranteed for how long? _____
   c) The minimum interest rate to be paid is how much? _____
   d) If applicable, the rate you pay to borrow is _____ %, and the limit on the amount that can be borrowed is _____.
   e) The surrender charges are _____
   f) The death benefit is _____
8) Are there other short or long term effects from the replacement that might be materially adverse?
   ☐ No ☐ Yes, explain: _____

Signature of Agent or Broker	Date
Name of Agent or Broker (Print or Type)	
Address	

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.

LIST OF POLICIES OR CONTRACTS TO BE REPLACED:

Company	Insured	Contract No.

CAUTION: The insurance commissioner suggests you consider these points:

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

Completed Copy Received: _____ _____

Applicant's Signature Date

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

North American Company
for Life and Health Insurance
Since 1886

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L27661

STATEMENTS ABOUT LIFE INSURANCE ILLUSTRATIONS

Complete **ONLY ONE** of the following Sections as it pertains to the use of illustrations in the sale of a life insurance policy.

☐ Section A – NO ILLUSTRATION USED

I certify no illustration of non-guaranteed policy premiums or values was used in the sale of the life insurance.

Agent	Agent Code	Date

I acknowledge no life insurance illustration was provided. I understand an illustration conforming to the policy as issued will be provided to me, to be signed and returned to North American Company no later than at the time the policy is delivered.

Policyowner/Applicant	Date

☐ Section B – APPLICATION DIFFERS FROM ILLUSTRATION

I certify the life insurance policy applied for differs from the illustration used in the sale of the life insurance policy.

Agent	Agent Code	Date

I acknowledge that I have been shown no illustration conforming to the policy I applied for. I understand an illustration conforming to the policy as issued will be provided to me, to be signed and returned to North American Company no later than at the time the policy is delivered.

Policyowner/Applicant	Date

☐ Section C – ILLUSTRATION PROVIDED ON COMPUTER SCREEN

I certify that I displayed a computer screen illustration for (applicant's name) _____ that complies with state requirements and for which no paper copy was furnished. The life insurance illustration was based on the following personal and policy information:

Sex: Male☐ Female☐	Age	Plan of Insurance (Generic Name)
Riders (Generic Name)	Underwriting or Rating Class: ☐ Non-Smoker ☐ Smoker ☐ Preferred	Rating
Initial Death Benefit	Premium Number of Years_____	Frequency: ☐Annual ☐Semi-Annual ☐Quarterly ☐COM
Interest Rate: ☐ Guaranteed ☐ Current	Number of Years Illustrated _____	

Agent	Agent Code	Date

I acknowledge I viewed a computer screen illustration based on the information as stated above. No paper copy of the life insurance illustration was furnished. I understand a life insurance illustration conforming to the life insurance policy as issued will be provided to me no later than at the time the life insurance policy is delivered.

Policyowner/Applicant	Date

NORTH AMERICAN COMPANY • NEW BUSINESS OFFICE: P. O. BOX 5089, SIOUX FALLS, SD 57117 • PRINCIPAL OFFICE: WEST DES MOINES, IA
Emerald Team: (800) 669-9100 Fax: (800) 951-9430 • Ruby Team: (866) 606-2943 Fax (800) 978-7959 • Sapphire Team (855) 288-8149 Fax (855) 288-8150 www.nacolah.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.