



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.



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:

- | | |
|--|---|
| <input type="checkbox"/> Keyman | <input type="checkbox"/> Buy/Sell |
| <input type="checkbox"/> Creditor | <input type="checkbox"/> Split Dollar |
| <input type="checkbox"/> Deferred Compensation | <input type="checkbox"/> 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.: _____



TRANSMITTAL REPORT

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

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

PLEASE PRINT

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

Proposed Insured (1)	
Proposed Insured (2)	
Plan of Insurance	Face Amount
PREMIUM SUBMITTED \$ _____ Please attach a copy of Illustration	

<p>Please indicate by placing an O if ordered or A if attached next to the requirement.</p> <table border="0"> <thead> <tr> <th style="text-align: left;">Proposed Insured (1)</th> <th style="text-align: left;">Requirement</th> <th style="text-align: left;">Proposed Insured (2)</th> </tr> </thead> <tbody> <tr><td>_____</td><td>Paramedical Exam</td><td>_____</td></tr> <tr><td>_____</td><td>Date ordered _____</td><td>_____</td></tr> <tr><td>_____</td><td>Physical Measurements/Vitals</td><td>_____</td></tr> <tr><td>_____</td><td>MD Exam</td><td>_____</td></tr> <tr><td>_____</td><td>EKG</td><td>_____</td></tr> <tr><td>_____</td><td>Treadmill</td><td>_____</td></tr> <tr><td>_____</td><td>APS Dr. _____</td><td>_____</td></tr> <tr><td>_____</td><td>Date ordered _____</td><td>_____</td></tr> <tr><td>_____</td><td>Vendor Name _____</td><td>_____</td></tr> <tr><td>_____</td><td>APS Dr. _____</td><td>_____</td></tr> <tr><td>_____</td><td>Date ordered _____</td><td>_____</td></tr> <tr><td>_____</td><td>Vendor Name _____</td><td>_____</td></tr> <tr><td>_____</td><td>Confidential Financial Statement _____</td><td>_____</td></tr> <tr><td>_____</td><td>Urine/HIV</td><td>_____</td></tr> <tr><td>_____</td><td>Full Blood Profile</td><td>_____</td></tr> <tr><td>_____</td><td>Replacement Forms</td><td>_____</td></tr> <tr><td>_____</td><td>Illustration</td><td>_____</td></tr> <tr><td>_____</td><td>Cover Letter</td><td>_____</td></tr> <tr><td>_____</td><td>Underwriter Checklist</td><td>_____</td></tr> <tr><td>_____</td><td>Other (describe)</td><td>_____</td></tr> </tbody> </table>	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)	_____	<p>Please complete the following:</p> <p>POLICY NUMBER: _____ (if applicable)</p> <p>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.</p> <p>If mailing the application please mail to:</p> <p style="text-align: center;">New Business Team North American Company One Sammons Plaza Sioux Falls, SD 57193</p> <p>Special Requests/Remarks (i.e. Policy Date, Trust Date, 1035 Information etc. Include cover letter for financial justification or special circumstances) _____ _____ _____ _____</p> <p>Partner: _____</p> <p>Additional Policy: _____</p> <p>Special Policy Date: _____</p> <p>Hold Policy Issue for Special Instructions: <input type="checkbox"/> Yes <input type="checkbox"/> No</p>
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_____	Other (describe)	_____																																																														

Date submitted: _____ By: _____



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

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

I authorize any licensed physician, medical practitioner, health care professional, hospital, clinic, or other medically related facility, laboratory, pharmacy, pharmacy benefit manager, insurance or reinsuring company, viatical company, viatical broker or provider, the Medical Information Bureau, Inc., consumer reporting agency, insurance support organization, independent administrator, governmental agency, or group policyholder, or employer having information available as to diagnosis, prescription history, medications prescribed and that has provided payment, treatment or services to me or on my behalf within the past 10 years ("My Providers") to disclose my entire medical record and any other protected health information concerning me to The North American Company for Life and Health Insurance and its agents, employees, and representatives. This includes information on the diagnosis or treatment of Human Immunodeficiency Virus (HIV) infection and sexually transmitted diseases. This also includes information on the diagnosis, prognosis and treatment of mental illness and the use of alcohol, drugs, and tobacco, but excludes psychotherapy notes.

By my signature below, I acknowledge that any agreements I have made to restrict my protected health information do not apply to this Authorization and I instruct My Providers to release and disclose my entire medical record without restriction.

This protected health information is to be disclosed under this Authorization so that North American Company for Life and Health Insurance may: 1) underwrite my application for coverage, determine eligibility, risk rating, policy issuance and enrollment determinations; 2) obtain reinsurance; 3) administer claims and determine or fulfill responsibility for coverage and provision of benefits; 4) administer coverage; and 5) conduct other legally permissible activities that relate to any coverage I have or have applied for with North American Company for Life and Health Insurance.

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.

Signature Proposed Insured or Personal Representative	Date
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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:



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

PROPOSED INSURED

Legal Last Name

Legal First Name M. I.

Social Security Number - - Date of Birth - -

Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	Age	Place of Birth – State / Country	Marital Status
1. In the past year, have you ever used a different name? <input type="checkbox"/> Yes <input type="checkbox"/> 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. E-mail Address: Check box if no email address <input type="checkbox"/> , otherwise list below. _____	
2e. Do you have a valid driver's license? (If no, also complete question 2f.) <input type="checkbox"/> Yes - Issue State / Country: _____ Driver's License #: _____ <input type="checkbox"/> No - Why do you not have a valid driver's license? _____			
2f. Government issued ID: <input type="checkbox"/> State ID <input type="checkbox"/> Passport <input type="checkbox"/> Military <input type="checkbox"/> Permanent Resident Issue State/Country: _____ Card #: _____			
2g. Employer Name and Address: _____		2h. Occupation: _____ If homemaker, complete the following: Family Income: \$ _____ Family Net Worth: \$ _____ Spouse's Total Life Insurance In Force and Applied For: \$ _____	
2i. Annual Income: _____		2j. Net Worth: _____	

PLAN INFORMATION

3a. Amount Applied For: \$ _____	4. Proposed Plan of Insurance: _____ For Universal Life: Death Benefit Option (Defaults to Level, if none selected): (Check One): <input type="checkbox"/> Level <input type="checkbox"/> Increasing <input type="checkbox"/> Return of Premium Death Benefit Qualification Test, if applicable. (Defaults to GPT, if available and none selected): (Check One): <input type="checkbox"/> Guideline Premium Test (GPT) <input type="checkbox"/> Cash Value Accumulation Test (CVAT)	
3b. Underwriting Type: <input type="checkbox"/> Traditional <input type="checkbox"/> Online		
5a. Term Riders <input type="checkbox"/> Children's Term Insurance \$ _____ <input type="checkbox"/> Waiver of Premium <input type="checkbox"/> Other _____ \$ _____ Plan Amount	5b. UL and IUL Riders <input type="checkbox"/> Premium Guarantee Rider <input type="checkbox"/> Accidental Death Benefit \$ _____ <input type="checkbox"/> Children's Term Insurance \$ _____ <input type="checkbox"/> Guaranteed Insurability \$ _____ <input type="checkbox"/> Waiver of Monthly Deductions <input type="checkbox"/> Waiver of Surrender Charge Option <input type="checkbox"/> Other _____ \$ _____ Plan Amount	

6. 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 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 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 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 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 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.

To be completed by Parent or Legal Guardian:

- 6a.** 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) Bone or muscle disorder, mental or psychiatric disorder, epilepsy, brain or neurological disorder, blood disorder, or tested positive for the HIV virus? Yes No
- 6b.** 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 6a. and 6b. If more space is needed, attach a completed and signed Application Overflow Page.

Question #	Dependent's Name	Details

OWNER INFORMATION

7. 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, including Trustee, is other than the Proposed Insured.

7a. NAME OF OWNER:

Owner Type:

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

Owner's E-mail Address: Check box if no email address , otherwise list below.

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 #	Marital Status	Relationship to Proposed Insured
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Citizenship and ID information is required for all Owners, including Trustees.

Are you a U.S. Citizen? Yes No

<input type="checkbox"/> Driver's License #:	Issue State/Country
<input type="checkbox"/> State ID <input type="checkbox"/> Passport <input type="checkbox"/> Military <input type="checkbox"/> Permanent Resident Card #:	

7b. NAME OF JOINT OWNER:

Joint Owner Type:

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

Joint Owner's E-mail Address: Check box if no email address , otherwise list below.

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 #	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

<input type="checkbox"/> Driver's License #:	Issue State/Country
<input type="checkbox"/> State ID <input type="checkbox"/> Passport <input type="checkbox"/> Military <input type="checkbox"/> Permanent Resident Card #:	

7c. NAME OF CONTINGENT OWNER:

Date of Birth:	Social Security/Tax ID #:
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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.

8. Primary

Name: _____ Relationship to Proposed Insured: _____

Address: _____

Date of Birth: _____ Social Security / Tax ID: _____

Telephone # with Area Code: _____ Distribute Proceeds "Per Stirpes" % Share: _____

Name: _____ Relationship to Proposed Insured: _____

Address: _____

Date of Birth: _____ Social Security / Tax ID: _____

Telephone # with Area Code: _____ Distribute Proceeds "Per Stirpes" % Share: _____

Name: _____ Relationship to Proposed Insured: _____

Address: _____

Date of Birth: _____ Social Security / Tax ID: _____

Telephone # with Area Code: _____ Distribute Proceeds "Per Stirpes" % Share: _____

TOTAL _____%

9. Contingent

Name: _____ Relationship to Proposed Insured: _____

Address: _____

Date of Birth: _____ Social Security / Tax ID: _____

Telephone # with Area Code: _____ Distribute Proceeds "Per Stirpes" % Share: _____

Name: _____ Relationship to Proposed Insured: _____

Address: _____

Date of Birth: _____ Social Security / Tax ID: _____

Telephone # with Area Code: _____ Distribute Proceeds "Per Stirpes" % Share: _____

TOTAL _____%

PAYOR / BILLING INFORMATION

10. PAYOR: Proposed Insured Owner Joint Owner Other _____
(Print Full Name)

Other Payor Type:

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

Trust – Also complete Certification of Trust Agreement Form

Business (Check one of the following)

- Sole Proprietorship
- Partnership – Also complete Certification of Business Signing Authority Form
- Corporation – Also complete Certification of Business Signing Authority Form
- Other: _____ – Also complete Certification of Business Signing Authority Form

Other Payor Type Social Security/Tax ID #: _____

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.)

PAYOR / BILLING INFORMATION (Continued)

Citizenship and ID information is required for Payor, including Trustee.	
Are you a U.S. Citizen? <input type="checkbox"/> Yes <input type="checkbox"/> No	
<input type="checkbox"/> Driver's License #:	Issue State/Country
<input type="checkbox"/> State ID <input type="checkbox"/> Passport <input type="checkbox"/> Military <input type="checkbox"/> Permanent Resident Card #:	
11. Third Party Billing 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: <i>(If P.O. Box, street address, city, state, and zip code are required.)</i>	
Telephone Number with Area Code:	

PREMIUM INFORMATION

12. Premium Frequency:	<input type="checkbox"/> Annually <input type="checkbox"/> Semi-Annually <input type="checkbox"/> Quarterly <input type="checkbox"/> Monthly <input type="checkbox"/> Single Pay <input type="checkbox"/> Lump Sum \$ _____
13. Source of Premium:	<input type="checkbox"/> Salary <input type="checkbox"/> Savings <input type="checkbox"/> Investments <input type="checkbox"/> 1035 Exchange <input type="checkbox"/> Other: _____
14. I (Owner) certify that the funds used to satisfy the initial premium of the policy are not from a loan made by a third-party (secured or unsecured) to me nor through a reverse mortgage, or the use of any form of equity line of credit or similar credit facility on any property in which I may have an interest. I further certify that as the date of this application, I have no intention to secure any funds from any of the aforementioned sources of financing to pay any portion of the premium under the policy for which I am applying. <input type="checkbox"/> Yes <input type="checkbox"/> No	
15. Payment Type:	
<input type="checkbox"/> Electronic Fund Transfer (EFT) – Complete EFT Authorization <input type="checkbox"/> Direct Billing (Annual, Semi-Annual, Quarterly Only) <input type="checkbox"/> List Billing – List Bill Code / Business Name: _____ <input type="checkbox"/> Civil Service Allotment – Complete Direct Deposit Sign-Up Form <input type="checkbox"/> Military Government Allotment – Complete Military Allotment Form	
16. Amount of Modal Premium:	\$ <input style="width: 100px;" type="text"/>
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.	
17. Payment of Initial Premium – (Must check one):	
<input type="checkbox"/> 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.)	
<input type="checkbox"/> 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.

18. Does the Proposed Insured have any life insurance or annuities currently in force or pending?	<input type="checkbox"/> Yes <input type="checkbox"/> No
19. 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?	<input type="checkbox"/> Yes <input type="checkbox"/> No
20. Is the Proposed Insured or Owner considering using funds from existing policies or contracts to pay premiums due on the new policy?	<input type="checkbox"/> Yes <input type="checkbox"/> No
<ul style="list-style-type: none"> • 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	<input type="checkbox"/> Life Insurance <input type="checkbox"/> Annuity	<input type="checkbox"/> Life Insurance <input type="checkbox"/> Annuity	<input type="checkbox"/> Life Insurance <input type="checkbox"/> Annuity	<input type="checkbox"/> Life Insurance <input type="checkbox"/> Annuity	<input type="checkbox"/> Life Insurance <input type="checkbox"/> Annuity
In Force or Pending	<input type="checkbox"/> In Force <input type="checkbox"/> Pending	<input type="checkbox"/> In Force <input type="checkbox"/> Pending	<input type="checkbox"/> In Force <input type="checkbox"/> Pending	<input type="checkbox"/> In Force <input type="checkbox"/> Pending	<input type="checkbox"/> In Force <input type="checkbox"/> Pending
Will this Policy/Certificate be changed or replaced?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
1035 Exchange	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
<p>21. 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? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>22. 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.) <input type="checkbox"/> Yes <input type="checkbox"/> No</p>					

If the answer is "Yes" to either question 21 or 22, provide details here. If more space is needed, attach a completed and signed Application Overflow Page.

Question #	Details

23. 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
			\$	
			\$	
			\$	
			\$	
			\$	

24. 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.

25. Job Duties:
26. Are you currently drawing extra duty or hazard pay? <input type="checkbox"/> Yes <input type="checkbox"/> No
27. Military Information: <input type="checkbox"/> USA <input type="checkbox"/> USN <input type="checkbox"/> USAF <input type="checkbox"/> USMC <input type="checkbox"/> USCG <input type="checkbox"/> Other (Specify) _____ Military ID: _____ Pay Grade: _____ Rotation Date: _____ Expected Discharge or Retirement Date: _____
28. Has the Proposed Insured applied to be a member of or been a member of any special forces, special or hazardous duty organization? <input type="checkbox"/> Yes <input type="checkbox"/> No <i>If yes, provide specific details.</i>
29. Has the Proposed Insured been alerted to, volunteered for, or received formal orders to a hazardous area or overseas assignment? <input type="checkbox"/> Yes <input type="checkbox"/> No <i>If yes, provide specific details.</i>

LIFESTYLE INFORMATION

30a. Indicate the number of cigars used in the past 12 months: <input type="checkbox"/> None <input type="checkbox"/> 1 to 12 <input type="checkbox"/> 13 to 24 <input type="checkbox"/> 25 or more
30b. In the past 5 years, have you used any nicotine products including cigarettes, E-cigarettes, vapor products, pipe, snuff, chewing tobacco, or nicotine gum or patches? <i>(If yes, complete questions 1 and 2.)</i> <input type="checkbox"/> Yes <input type="checkbox"/> No
1) What product(s)? <input type="checkbox"/> Cigarettes <input type="checkbox"/> E-cigarettes <input type="checkbox"/> Vapor products <input type="checkbox"/> Pipe <input type="checkbox"/> Snuff <input type="checkbox"/> Chewing tobacco <input type="checkbox"/> Nicotine gum or patches
2) Last use of any of these products was within the: <input type="checkbox"/> last 12 months <input type="checkbox"/> last 2 years <input type="checkbox"/> last 3 years <input type="checkbox"/> last 5 years

UNDERWRITING QUESTIONS

Questions 31 through 39 only need to be completed if:

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

31a. Do you use alcoholic beverages? <i>(If yes, complete question 31b.)</i>	<input type="checkbox"/> Yes <input type="checkbox"/> No
31b. Amount: _____ Frequency: _____	
32. Are you actively employed? <i>(If no, provide reason in DETAILS section below.)</i>	<input type="checkbox"/> Yes <input type="checkbox"/> No
33. Are you a U.S. citizen or do you have a U.S. permanent resident card (green card)?	<input type="checkbox"/> Yes <input type="checkbox"/> No
<i>(If no, complete a Foreign Travel and Residence Questionnaire and attach a copy of your visa.)</i>	
34. In the next 12 months, do you plan to travel or reside outside the United States or Canada?	<input type="checkbox"/> Yes <input type="checkbox"/> No
<i>(If yes, complete a Foreign Travel and Residence Questionnaire.)</i>	
35. Are you an active member of the U.S. Armed Forces, Reserves, or National Guard?	<input type="checkbox"/> Yes <input type="checkbox"/> No
36. 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?	<input type="checkbox"/> Yes <input type="checkbox"/> No
<i>(If yes, complete an Aviation Questionnaire.)</i>	
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?	<input type="checkbox"/> Yes <input type="checkbox"/> No
<i>(If yes, complete the applicable Avocation Questionnaire.)</i>	
37. 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, or in the past 3 years, have you had 3 or more moving violations?	<input type="checkbox"/> Yes <input type="checkbox"/> No
b. Filed bankruptcy?	<input type="checkbox"/> Yes <input type="checkbox"/> No
<i>(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.)</i>	
c. Been declined, postponed, or charged an extra premium for life insurance?	<input type="checkbox"/> Yes <input type="checkbox"/> No

UNDERWRITING QUESTIONS (Continued)

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 seizures, 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

45a. (Females only) Are you currently pregnant? (If yes, complete question 45b.) Yes No

45b. What was your pre-pregnancy weight? _____

46. Other than tests related to the HIV virus, 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

47. 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

48. (Ages 70 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)		

49. (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 42 THROUGH 47 AND QUESTION 49.
If more space is needed, attach a completed and signed Application Overflow Page.

Question #	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 the 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 – Any insurance issued as a result of this application will either: (1) not take effect until the full first premium is paid and the contract is delivered to and accepted by the Owner during the lifetime of any person proposed for insurance and while such person is in the financial condition and state of health described in all parts of this application; or (2) take effect only as specified in the Temporary Insurance Agreement, if issued, provided the Proposed Insured(s) remains in the same state of health as described in this Application and the Temporary Life Insurance Agreement.

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, Inc. (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.

The undersigned applicant(s) acknowledges receipt of the Consumer Protection Notice that includes the Fair Credit Reporting Act Notice, MIB, Inc. 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)	Date	City	State
X			

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

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

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

TO BE COMPLETED BY SOLICITING AGENT	Commission Option (Defaults to A, if none selected): <input type="checkbox"/> A <input type="checkbox"/> B <input type="checkbox"/> C <input type="checkbox"/> D
<p>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? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>2. Does any person covered under this application have any existing life insurance or annuities? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>3. Is any insurance applied for in this application intended to replace any existing life insurance or annuity? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>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.) <input type="checkbox"/> Yes <input type="checkbox"/> No</p>	

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



**IMPORTANT NOTICE:
REPLACEMENT OF LIFE INSURANCE OR ANNUITIES**

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

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

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

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

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

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

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

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

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

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

The existing policy or contract is being replaced because _____.

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

Applicant's Signature and Printed Name

Date

Producer's Signature and Printed Name

Date

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

Producer's Statement

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

Producer's Signature and Printed Name

Date



L29682

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

PREMIUMS:

- Are they affordable?
- Could they change?
- You're older--are premiums higher for the proposed new policy?
- How long will you have to pay premiums on the new policy? On the old policy?

POLICY VALUES:

- New policies usually take longer to build cash values and to pay dividends.
- Acquisition costs for the old policy may have been paid; you will incur costs for the new one.
- What surrender charges do the policies have?
- What expense and sales charges will you pay on the new policy?
- Does the new policy provide more insurance coverage?

INSURABILITY:

- If your health has changed since you bought your old policy, the new one could cost you more, or you could be turned down.
- You may need a medical exam for a new policy.
- Claims on most new policies for up to the first two years can be denied based on inaccurate statements.
- Suicide limitations may begin anew on the new coverage.

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

- How are premiums for both policies being paid?
- How will the premiums on your existing policy be affected?
- Will a loan be deducted from death benefits?
- What values from the old policy are being used to pay premiums?

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

- Will you pay surrender charges on your old contract?
- What are the interest rate guarantees for the new contract?
- Have you compared the contract charges or other policy expenses?

OTHER ISSUES TO CONSIDER FOR ALL TRANSACTIONS:

- What are the tax consequences of buying the new policy?
- Is this a tax-free exchange? (See your tax advisor.)
- Is there a benefit from favorable "grandfathered" treatment of the old policy under the federal tax code?
- Will the existing insurer be willing to modify the old policy?
- How does the quality and financial stability of the new company compare with your existing company?

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



LEAVE WITH APPLICANT

**ACCELERATED DEATH BENEFIT SUMMARY AND DISCLOSURE STATEMENT
FOR TERM LIFE INSURANCE**

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

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

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. Unlike conventional life insurance proceeds, amounts payable as accelerated death benefits COULD BE TAXABLE UNDER SOME CIRCUMSTANCES. Benefit payments under this endorsement are intended to qualify for favorable tax treatment; however, We recommend that you consult your personal tax advisor prior to electing an accelerated death benefit.

If you already have long-term care insurance, Medicaid, or similar coverage, you should consider whether the accelerated death benefits 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.

THE BENEFIT AND ITS EFFECT ON POLICY PROVISIONS

Upon written request by the Owner (“You” or “Your”) of the Policy, the Company (“We”) 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.

For the Terminal Illness only Endorsement, the Maximum Accelerated Death Benefit that we will accelerate on the Policy is \$1,000,000. For the Terminal and Chronic Illnesses Endorsement or the Terminal, Chronic, and Critical Illnesses Endorsement, the Lifetime Maximum Accelerated Death Benefit for all qualified illnesses that We will accelerate on the Policy is \$2,000,000.

Payment of Accelerated Death Benefits will reduce the Face Amount of the Policy.

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

An Insured qualifies as being Terminally Ill if a Physician has certified that the Insured’s life expectancy is 24 months or less. The Terminal Illness benefit is not subject to underwriting eligibility requirements

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

The maximum Accelerated Death Benefit for Terminal Illness is the lesser of 90% of the Face Amount on the Election Date or \$1,000,000.

The Accelerated Benefit Payment will be determined upon Your Election and will be paid in a lump sum. We will pay the present value of the Accelerated Death Benefit. An actuarial discount based on mortality and interest will be applied to the Accelerated Death Benefit. This discount will be based on mortality rates determine by Us and reflects the early payment of the Face Amount that is being accelerated.

We will waive the premiums for the Policy 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.

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 Face Amount will be paid as described in the Policy.

Accelerated Death Benefit for Chronic Illness (if available)¹: You may elect to receive advancement of the Face Amount when the Insured is Chronically Ill while the Endorsement is in effect.

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

1. Is unable to perform for at least 90 days, without Substantial Assistance from another person, at least two Activities of Daily Living; or
2. Requires Substantial Supervision by another person to protect oneself from threats to health and safety due to Severe Cognitive Impairment.

Activities of Daily Living are: bathing, continence, dressing, eating, toileting, or transferring.

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

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

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

You can accelerate an amount less than the minimum Accelerated Death Benefit for Chronic Illness allowed if it is necessary to do so to comply with the \$2,000,000 Lifetime Maximum Accelerated Death Benefit limitation for this Endorsement, or if you're making a Final Election.

The maximum Accelerated Death Benefit for Chronic Illness, at each Election, is the lesser of 24% of the Policy Death Benefit on the initial Election Date, or \$480,000. This amount may be smaller for 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 Face Amount in the Policy, minus the Residual Death Benefit. A Final Election occurs when You accelerate all of the Face Amount in the Policy, minus the Residual Death Benefit.

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

Premiums will not be waived during the Chronic Illness Election Period. After each Election Date, premiums for the Policy and any Waiver of Premium Rider attached to the Policy will continue to be payable, but will be calculated at the reduced Face Amount.

Premiums for riders, other than a Waiver of Premium rider, and any policy fee will not be reduced.

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, attached to the Policy will terminate on the Final Election date. After the Initial Election Date, no additional Endorsement and Riders may be added to the Policy.

A Chronic Illness Election is effective for 12 months starting from the Election Date and only one Election can be made in this 12-month period. If the Insured dies after You elect to receive Accelerated Death Benefits, but before the payment is made, the Election will be cancelled and the 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)¹: You may elect to receive advancement of the Face Amount when the Insured is Critically Ill while the Endorsement is in effect.

An Insured qualifies as being Critically Ill if a Physician has certified within the last 12 months that the Insured has incurred a Specified Medical Condition listed below:

1. **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:

- a) 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.
- b) All tumors of the prostate unless histologically classified as having a Gleason score greater than 6 or having progressed to at least clinical TNM classification T2N0M0.
- c) Any skin cancer, (other than malignant melanoma), that has been histologically classified as having caused invasion beyond the epidermis (outer skin layer).
- d) Thyroid Cancer classified as T1NOMO.

2. **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:

- a) Typical clinical symptoms (chest pain may or may not be present);
- b) Characteristic electrocardiogram (ECG or EKG) changes; or
- c) Coronary artery intervention.

This does NOT include:

- a) Angina;
- b) 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
- c) ECG changes suggesting a prior myocardial infarction, which do not meet the definition of Heart Attack described above.

3. **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.
4. **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.
5. **Stroke** – (cerebrovascular accident) means a definite diagnosis of an acute cerebrovascular event caused by intracranial 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:

- a) Transient ischemic attacks;
- b) Brain damage due to an accident or injury, infection, vasculitis, and inflammatory disease;
- c) Vascular disease affecting the eye or optic nerve;
- d) Ischemic disorders of the vestibular system; or
- e) Chronic Cerebrovascular insufficiency.

A Specified Medical Condition – means that, in the absence of extensive or extraordinary medical treatment, it would result in a drastically limited life span.

The minimum Accelerated Death Benefit for Critical Illness at each Election is the lesser of 10% of the Policy Face Amount of \$100,000.

The maximum Accelerated Death Benefit for Critical Illness, at each Election, is the lesser of 90% of the Policy Face Amount on the initial Election Date, or \$1,000,000.

The Accelerated Benefit Payment will be determined as of each Election Date and will be paid in a lump sum.

Premiums will not be waived during the Critical Illness Election Period. After each Election Date, premiums for the policy and any Waiver of Premium rider will continue to be payable, but will be calculated at the reduced Face Amount.

Premium for riders, other than a Waiver of Premium rider, and any policy fee, will not be reduced.

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, no 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 Face Amount will be paid as described in the Policy.

¹ 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.

Sample Illustrations of the Impact of Accelerated Death Benefits on Policy Provisions.

	Terminal Illness	Chronic Illness	Critical Illness
Accelerated Death Benefit	\$375,000	\$120,000	\$50,000
Lump Sum Accelerated Death Benefit Payment	\$338,374	\$82,498	\$18,000
Administrative Fee	\$200	\$500	\$500

Values Before Accelerated Death Benefit	Terminal Illness	Chronic Illness	Critical Illness
Face Amount	\$500,000	\$500,000	\$500,000
Premium	\$300	\$300	\$300
Residual Death Benefit:	N/A	\$25,000	N/A

Values After Accelerated Death Benefit	Terminal Illness	Chronic Illness	Critical Illness
Face Amount	\$125,000	\$380,000	\$450,000
Premium	\$0	\$242.40	\$276
Residual Death Benefit	N/A	\$25,000	N/A

Consent to do business electronically and use of electronic records



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, 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. At no additional charge, 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: 1-800-843-3316

Fax: 1-877-208-6136

Email: NorthAmericanSelectNewBusiness@sfgmembers.com

If you consent to the terms outlined above for electronic transmissions, please indicate in the option marked '**I Consent.**' below.

I Consent

Please provide your email address so we may confirm your consent electronically upon receipt of this form.

Email: _____



O-2000

Electronic funds transfer authorization for premium and/or loan repayments



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

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: _____

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 27096).

For Trust Accounts, complete the Certification of Trust Agreement (form 7519).

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

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

4. 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 Owners Signature:	Date (mm/dd/yyyy):

Life application completion tips

Application for reinstatement or change to existing policy
(with underwriting)

Life



Oversights can delay an application turnaround time and the paying of commissions. Follow these steps to improve your application turnaround times.

1. Application form

- Complete all sections, including your policy number on page 1.
- Indicate the type of change being requested.

2. Information on additional insureds

- If there is/are additional insured(s), complete the “Additional Insured Proposed for Insurance” section in full. The “Authorization for Release of Health – Related Information (HIPPA)” will be required for each additional insured age 18 and older.

3. Ownership

- If the current policy owner(s) is/are someone other than the primary insured, complete the owner section in full.
- An ownership change cannot be processed on this application.

4. Payor information

- Complete payor/billing section if different from previous payor.

5. Premium information

- Indicate the billing preference.
- If the plan is a flexible premium policy, indicate the requested modal premium amount.

6. Replacement and existing coverage

- Complete this section only when an increase in the face amount is being requested.

7. Military personnel

- Complete section in full, if applicable.

8. Lifestyle information

- Complete this section in full for each insured covered on the policy.

9. Underwriting Questions

- Answer all questions providing details to questions answered yes for each insured covered on the policy.
- If more than one insured is covered, indicate to whom the “Yes” question pertains to.

10. Signatures

- Provide appropriate signatures of the insured and owner(s) of the policy, along with the date, city and state for each signature.
- If there is a joint owner listed on the policy, their signature is also required.

Sammons FinancialSM is the marketing name for Sammons[®] Financial Group, Inc.'s member companies, including North American Company for Life and Health Insurance[®]. Annuities and life insurance are issued by, and product guarantees are solely the responsibility of, North American Company for Life and Health Insurance.



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".

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)	

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

X

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

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.



Together, we can save a life

TESTING FOR HIV INFECTION



Deciding to be tested for HIV, the *human immunodeficiency virus*, may not be easy. If you or someone you know has questions about being tested for HIV, here are some facts that may help.

What tests are most commonly used to detect HIV infection?

There are three types of HIV tests commonly used.

1. The **ELISA** is the standard screening test used to detect HIV antibodies in a sample of blood, urine or saliva. If HIV antibodies are detected by an ELISA, the test is repeated. If the second test reacts to the presence of HIV antibodies, the sample is tested using the Western blot and IFA to confirm. Results from this type of HIV test are usually available within one to two weeks.
2. The **rapid** HIV test detects antibodies to HIV-1. A small sample of blood is taken using a “fingerstick” or small pin prick to the finger. A positive test result suggests that antibodies to HIV are present. If HIV antibodies are not present in the blood, the test result is interpreted as negative. These preliminary results may be available in less than 30 minutes, after which a confirmatory test must be conducted. The confirmatory results are available within one to two weeks.
3. **Oral** HIV testing is an alternative to blood testing. The oral HIV test uses a sample of mouth tissue taken from the cheek and gum. This tissue contains high levels of antibodies and is free of most of the contaminants found in saliva. If a test result is positive, another test on the same sample is conducted automatically to confirm HIV infection. No needle or blood is involved in this type of HIV test. Test results are usually available within three days.

How long should I wait before being tested?

Before getting tested, it is important to wait three months from the time you think that HIV exposure may have occurred. This is enough time for most people to develop antibodies to HIV. The average time for HIV antibodies to appear is 25 days. Otherwise, a person may test negative even though they have HIV. This is called the “window period.” During the “window period” and prior to HIV testing, you should avoid behavior that puts others at risk for HIV, including unprotected vaginal, anal or oral sexual intercourse and blood-to-blood contact, as in sharing needles.

Should I be tested?

If you think you might have been exposed to HIV, you are encouraged to seek individual counseling and testing. It is possible for people to be infected for years and to look and feel healthy, not knowing they are infected with HIV.

You may be at risk for HIV infection if you have—

- Shared needles and syringes.
- Had sex with anyone who injects drugs.
- Had sex with men who have had sex with other men.
- Had sex with multiple partners.

What is the difference between anonymous and confidential testing?

Anonymous testing ensures the privacy of the person being tested. This means that neither names nor any other identifying information that could link a person to their results is recorded. Instead, code names or numbers are used so that only the person who gets the HIV test can find out their test result.

Confidential testing ensures that no one can be given the results of an HIV test without the test taker’s written permission, except as required by state law. Test results become part of a person’s medical files at the facility where the test was administered. States that require HIV-positive test results to be reported are required by law to keep the information confidential.

Why is counseling recommended both before and after taking an HIV test?

Deciding whether or not to get an HIV test is not easy. Fear and worry about the test are very common feelings, both before the test and while waiting for the results. Many people fear the reactions of family, friends, employers and others if test results are positive. Counseling may help you decide what to do and how to respond to the results of the test.

Pretest counseling is important for a clear understanding of what the test is and what the test can and cannot tell you. It will help you understand if you are at risk for HIV infection and how to prevent the spread of HIV. Pretest counseling may vary from one test site to another.

Post-test counseling can help you understand what your test results mean. It can give you information about how to protect yourself and others from HIV, no matter what the test result is. If your result is positive for HIV infection, a counselor can also refer you for medical, legal and emotional support services, as needed, and can tell you about the kinds of services that are available in your area for people living with HIV infection.

What does a negative test result mean?

A negative test result shows that no HIV antibodies were found in your blood at the time the test was taken. A negative test result can mean either that you are not infected with HIV or that you are infected, but your body has not yet produced enough antibodies to show up on the test.

If you are advised to have the test repeated, avoid behaviors that put you and others at risk of HIV infection. Then, if you test negative six months later, you probably do not have HIV. To stay uninfected, you can take steps to protect yourself by not having sex without using a latex (or polyurethane) condom and by not sharing needles and syringes.

What does a positive test result mean?

A positive antibody test result means that you have HIV antibodies in your blood and you are infected with HIV. However, it does not mean that you have developed AIDS. The test cannot tell if or when you will develop AIDS.

A positive test result means that you can infect other people with HIV through sex (vaginal, anal or oral) or by sharing needles and syringes. Also, a pregnant woman who has HIV can infect her baby during pregnancy or birth or through breast feeding.

Your health care provider or HIV/AIDS counselor will talk to you in detail about your test results. He or she can also advise you about taking care of your health and about living with HIV infection. Several types of treatments are available that have helped people living with HIV stay healthy for many years. The goal of most treatments is to extend and improve the quality of life for people with HIV and AIDS by suppressing enough of the virus over time to avoid damage to the immune system. Although not a cure, many treatments have brought hope and new strength to people living with HIV and AIDS.

People living with HIV can get help in notifying sex or needle-sharing partners of their possible exposure to HIV through partner notification programs, which provide prevention counseling, HIV testing and referrals to other services. To learn about partner notification services in your area, contact your state or local public health department.

What else do I need to know?

- **Costs**—The cost for HIV testing varies. Some clinics offer free testing or request a small donation. Fees for tests given by private health care providers may be higher.
- **Laws**—Laws and regulations for reporting test results vary from state to state. Anonymous testing is not available everywhere. In some states, positive HIV test results must be reported to the local public health department, where they are kept confidential.

What about donating blood to get tested?

Do **not** donate blood to find out your HIV status. The Red Cross tests blood to safeguard the blood supply, not to provide a testing service for people who want to know their HIV status. Because these tests may not detect HIV infection in its earliest stages, people who think they may be infected could be putting other people at risk by donating blood. To find out where HIV testing services are available, call your local Red Cross chapter or station, health department or AIDS service organization.

How is HIV spread?

HIV is spread by—

- Having vaginal, oral or anal sex with someone who has HIV.
- Sharing needles or syringes with someone who has HIV.
- Pregnancy, birth or breast feeding, if the mother has HIV.

For more information, contact—

- Your local American Red Cross chapter or station. To locate the one closest to you, go to www.redcross.org.
- The CDC National AIDS Hotline (toll free): 1-800-342-AIDS. For Spanish-speaking persons, Línea Nacional del SIDA: 1-800-344-7432. For deaf and hearing-impaired persons, TTY-TDD Hotline: 1-800-243-7889.
- The CDC National Prevention Information Network (toll free): 1-800-458-5231, or at www.cdcnpin.org.
- The CDC Web site for recently revised guidelines on HIV counseling and testing. These guidelines are available at www.cdc.gov/hiv/pubs/rt-counseling.htm.
- Your doctor or your health care provider.
- Your state or local public health department.
- Your local AIDS service organization.

American Red Cross HIV/AIDS Programs

The American Red Cross has Basic, African American, Hispanic and Workplace HIV/AIDS programs. Youth materials, including *Act SMART*, "The Party" and "Don't Forget Sherrie," are also available. Contact your local American Red Cross chapter or station for additional information.

**All people share the responsibility
to protect themselves and others
from HIV infection.**



American Red Cross

Together, we can save a life

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