North American Company for Life and Health Insurance

Clear Form Clear Kit

L3212

SUPPLEMENT TO INDIVIDUAL LIFE INSURANCE APPLICATION

Eligibility for Chronic Illness

(Print and Use Black Ink)

PROPOSED INSURED

1. Last Name

First Name

Middle Initial

Social Security or Tax ID No. - -

Date of Birth M M - D D - Y Y Y Y

Replacement Information

1. Are the Accelerated Death Benefits for Chronic Illness being applied for intended to replace any long term care insurance presently in force? ☐ Yes ☐ No

   If "yes", provide information below.

Full Company Name:_____

Policy Number _____

Underwriting Questions

2. Has a licensed medical professional ever treated the Proposed Insured for or diagnosed the Proposed Insured with:
   - a. Amyotrophic lateral sclerosis (ALS, Lou Gehrig's Disease)? ☐Yes ☐No
   - b. Huntington's chorea? ☐Yes ☐No
   - c. Ataxia? ☐Yes ☐No
   - d. Transverse myelitis ? ☐Yes ☐No
   - e. Myasthenia gravis? ☐Yes ☐No
   - f. Chronic, recurrent or persistent memory loss or confusion? ☐Yes ☐No
   - g. Senility? ☐Yes ☐No
   - h. Cognitive impairment? ☐Yes ☐No
   - i. Dementia? ☐Yes ☐No
   - j. Organic brain disease? ☐Yes ☐No
   - k. Amputation of more than one limb? ☐Yes ☐No
   - l. A stroke? ☐Yes ☐No
   - m. More than one mini stroke (transient ischemic attack, TIA)? ☐Yes ☐No
   - n. Osteoporosis with compression fracture(s) or other related fracture(s)? ☐Yes ☐No
   - o. Post polio syndrome? ☐Yes ☐No
   - p. Chronic pain syndrome currently requiring treatment with narcotic medication(s)? ☐Yes ☐No

3. Within the past 2 years, has the Proposed Insured:
   - a. Been advised by a licensed medical professional to permanently discontinue the driving of an automobile? ☐Yes ☐No
   - b. Required care from a licensed medical professional for a fall? ☐Yes ☐No

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4. Does the Proposed Insured currently:
   a. Reside in a long term care facility or nursing home? ☐Yes ☐No
   b. Receive or require the services of a home health care provider? ☐Yes ☐No
   c. Attend adult day care? ☐Yes ☐No
   d. Receive, or applied to receive, any type of disability benefits, excluding maternity benefits? ☐Yes ☐No
   e. Use, or require the use of:
      i. Devices such as a wheelchair, motorized scooter, walker, quad cane or stairlift? ☐Yes ☐No
      ii. Oxygen or a respirator? ☐Yes ☐No
      iii. A catheter? ☐Yes ☐No
      iv. A dialysis machine?
   f. Need, or been advised by a licensed medical professional to receive help or supervision of another to:
      i. Perform personal care? ☐Yes ☐No
      ii. Perform household chores? ☐Yes ☐No
      iii. Get in or out of a bed or chair? ☐Yes ☐No
   g. Have, or applied for, a handicap placard or handicap license plate? ☐Yes ☐No

SIGNATURES

I hereby agree that all statements and answers to the above questions are true and complete to the best of my knowledge and belief. A copy of this form will be attached to and made a part of my application for insurance.

Caution: If your answers on this application are misstated or untrue, the insurer may have the right to deny benefits or rescind your accelerated death benefit coverage.

Signed at (Solicitation State)	Date
Signature of Proposed Insured (Parent/Legal Guardian Signature, if Proposed Insured is a Minor) X	

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

X

X

X

Signature of Soliciting Agent X	Print Agent's Last Name	Agent Code
Telephone Number ( )	Mobile Phone Number ( )	

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Since 1886

L3107A

Senior Notice — Your Rights Regarding In-home Meetings

California legislation requires that you _____ (the senior addressed) be provided with this notice no less than 24 hours prior or no more than 14 days prior to a meeting in your home.

I am a licensed insurance agent. My purpose for coming to your home is to sell, discuss, and/or deliver one of the following:
(Indicate all that will apply.)

- ❑ **Life Insurance, including annuities**
- ❑ **Other insurance products (specify)** _____
  List Type of Insurance Contract

You have the right to have other persons present at the meeting, including family members, financial advisors or attorneys. You have the right to end the meeting at any time. You have the right to contact the Department of Insurance for information or to file a complaint. You may contact the Department of Insurance at 1-800-927-HELP (4357).

The following individual(s) will be coming to your home:
(List all attendees, including license information, if applicable.)

	*Agent's full name	*Agent's License #	*Agent's mailing address & phone #
1.			
2.			
3.			
4.			
5.			
6.			

***As it appears on California insurance license**

NORTH AMERICAN COMPANY FOR LIFE AND HEALTH INSURANCE®
Life Division: P.O. Box 5088, Sioux Falls, SD 57117-5088 • Phone: 877-872-0757 • Fax: 877-595-8254
Annuity Service Center: P.O. Box 79905, Des Moines, Iowa 50325-0905 • Phone: 866-322-7068 • Fax: 866-322-7072

North American Company for Life and Health Insurance

L2978

LEAVE WITH APPLICANT/PROPOSED INSURED

CONSUMER PROTECTION NOTICES FOR THE PROPOSED INSURED

Investigative Consumer Report Notice

In connection with your application for insurance, an investigative consumer report may be prepared, in which information is obtained from public records and through personal interviews with your neighbors, friends, employers, business associates, financial sources, or others with whom you are acquainted. This inquiry includes information as to your character, general reputation, personal characteristics and mode of living. You may make a written request to be interviewed in connection with the preparation of this report and receive a copy of the report. Either of these written requests should be directed to the Underwriting Department at the above address.

Insurance Information Practices

Personal information we obtain during the underwriting process is private and confidential. We will not disclose such information to other person or organizations without your written authorization, except to the extent necessary to conduct our business, or as permitted or required by law. You have the right to be told about and obtain access to certain items of personal information in our files. You also have the right to request correction of information you believe to be inaccurate. You have the right to receive the specific reason for an adverse underwriting decision in writing upon your written request. If you would like to receive more detailed explanation of our information practices, please write to us at the above address.

MIB, Inc. Notice

Information regarding your insurability will be treated as confidential. North American Company for Life and Health Insurance, or its reinsurers, may, however, make a brief report thereon to the MIB, Inc., a not-for--profit membership organization of life insurance companies, which operates an information exchange on behalf of its Members. If you apply to another MIB member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, MIB, upon request, will supply such company with the information in its file.

Upon receipt of a request from you, MIB will arrange disclosure of any information it may have in your file. Please contact MIB at 866 692-6901. If you question the accuracy of information in MIB's file, you may contact MIB and seek a correction in accordance with the procedures set forth in the federal Fair Credit Reporting Act. The address of MIB's information office is 50 Braintree Hill Park, Suite 400, Braintree, Massachusetts 02184-8734.

North American Company for Life and Health Insurance, or its reinsurers, may also release information in its file to other insurance companies to whom you may apply for life or health insurance, or to whom a claim for benefits may be submitted. Information for consumers about MIB may be obtained on its website at www.mib.com.

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

The Tests:

To evaluate your eligibility for insurance, the insurer named above has requested that you provide a sample of your blood, urine and/or other body fluid for testing and analysis to determine the presence of human Immunodeficiency virus (HIV) antibodies. By signing and dating this form you agree that this test may be done and that underwriting decisions will be based on the test result. A series of tests will be performed by a certified laboratory through medically accepted procedures.

Meaning of Test Results:

While positive HIV antibody test results do not mean that you have AIDS, they do mean that you are at seriously increased risk of developing AIDS or AIDS-related conditions. Federal authorities say that persons who are HIV antibody positive should be considered infected with the AIDS virus and capable of infecting others. Positive HIV antibody test results will adversely affect your insurance application. An HIV test will be considered positive only after confirmation by a laboratory procedure which is extremely reliable. Nonetheless, the HIV antibody test is not 100% accurate. Possible errors include:

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

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

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

AIDS:

Acquired Immunodeficiency Syndrome (AIDS) is a life-threatening disorder of the immune system, caused by a virus, HIV. The virus is transmitted by sexual contact with an infected person, from an infected mother to her newborn infant, or by exposure to infected blood (as in needle sharing during IV drug use). Persons at high risk of contacting AIDS include males who have had sexual contact with another man, intravenous drug users, hemophiliacs, and sexual contacts of any of these persons. AIDS does not typically develop until a person has been infected with HIV for several years. A person may remain free of symptoms for years after becoming infected. Infected persons have a 25-50% chance of developing AIDS over the next 10 years. Persons who have a history of high risk behavior should change these behaviors to prevent getting or giving AIDS, regardless of whether they are tested. Specific important changes in behavior include safe sex practices (including condom use for sexual contact with someone other than a long-term monogamous partner) and not sharing needles.

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Disclosure of Test Results:

All test results will be treated confidentially. The results will be reported to the insurance company indicated above. The results may also be reported to that insurance company's affiliates, agents, or reinsurers in connection with insurance you have or have applied for. In addition, if your HIV antibody test is abnormal (positive), a generic code signifying a non-specific blood abnormality may be made known to the Medical Information Bureau (MIB, Inc.) as described in the notice given you at the time of application. The fact that the test has been done and the results of the test will not be otherwise disclosed except as may be required by law or as authorized by you. If your HIV antibody test is negative, no routine notification will be sent to you. If your test results are reported by the laboratory to the Company as being positive, you are entitled to that information.

You are asked to name a private physician so that the Company can have him or her tell you the test result and explain its meaning.

Name of physician for reporting a possible positive test result:

_____

Address: _____

Consent:

I have read and I understand this Notice of AIDS Virus (HIV) Antibody Testing and Consent for Testing. For my information, I have been given written material about AIDS. I voluntarily consent to provide a sample of my blood, urine and/or other body fluid testing, and the disclosure of the test results as described above.

Name of Proposed Insured	Date
Signature of Proposed Insured	State of Residence

AIDS COUNSELING SERVICES

AIDS Project - East Bay
400 - 40th Street, Suite 20
Oakland, CA 94609 (415) 420-8181

AIDS Project Los Angeles
3670 Wilshire Boulevard, Suite 300
Los Angeles, CA 90010 (213) 380-2000

AIDS Services Foundation of Orange County
1685-A Babcock Street
Costa Mesa, CA 92627 (714) 646-0411

ARIS Project
595 Millich Drive, Suite 104
Campbell, CA 95008 (408) 370-3272

Central Valley AIDS Team
P.O. Box 4640
Fresno, CA 93744 (209) 264-2436

Sacramento AIDS Foundation
1900 "K" Street, Suite 201
Sacramento, CA 95814 (916) 448-2437

San Diego AIDS Project
3777 Fourth Avenue
San Diego, CA 92103 (619) 543-0300

San Francisco AIDS Foundation
25 Van Ness Avenue, Suite 660
San Francisco, CA 94102 (415) 864-5855

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North American Company for Life and Health Insurance

L29721

AGENT REPORT

Name of proposed insured and/or applicant _____

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

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

If yes, please provide details _____

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

_____

Is the proposed insured and/or applicant fluent in the English language? _____ Yes _____ No

If no, please explain how the application was completed, including the name and relationship of any translator involved in the application process

_____

What is the purpose of insurance? _____ Personal _____ Business

If business coverage indicate what type:

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

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

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

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

If yes, please provide details _____

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

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North American Company
for Life and Health Insurance

L3208ACA

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

PROPOSED INSURED

1. Last Name

First Name | Middle Initial

Social Security or Tax ID No. ___ - __ - ____ | Date of Birth M M - D D - Y Y Y Y

1a. Are you a U.S. Citizen or do you have a permanent Visa? ☐ Yes ☐ No (If no, complete Foreign Travel and Residence Questionnaire)

1b. Have you ever used a different name? ☐ Yes ☐ No

If Yes, give name used and time period. _____

Sex: ☐Male ☐Female	Age	Place of Birth – State / Country	Height (FT. IN)	Weight (LBS.)	Marital Status

☐ Driver's License: # | Issue State / Country

☐ State ID ☐ Passport ☐Military ☐Permanent Resident Card: #

2. Residence Address (If P.O. Box, include Street Address) Street | City | State | Zip Code

3. Employer (Company Name and Address) | Are you actively employed? ☐ Yes ☐ No

Occupation (Title and Duties) | Annual Income $ | Net Worth $

4. CONTACT THE PROPOSED INSURED AT: _____(CST) ☐AM ☐PM

☐ RESIDENCE (_____) _____

☐ BUSINESS (_____) _____

☐ MOBILE (_____) _____

PLAN INFORMATION

5. Amount Applied For
$

6. Proposed Plan of Insurance: _____

Death Benefit Options For UL: (check one): ☐ Level ☐ Increasing ☐ Return of Premium

Death Benefit Qualification Test, if applicable. Defaults to GPT, if none selected:

☐ Guideline Premium Test (GPT) ☐ Cash Value Accumulation Test (CVAT)

7. RIDERS

a. Term Products

☐ Children's Term Insurance $_____

☐ Waiver of Term Premium for Disability

☐ Other _____ $_____
Plan Amount

b. UL and IUL Products

☐ Waiver of Monthly Deductions

☐ Accidental Death Benefit $_____

☐ Children's Term Insurance $_____

☐ Guaranteed Insurability $_____

☐ Waiver of Surrender Charge Option

☐ Estate Preservation – Survivorship Only

☐ Other _____ $_____
Plan Amount

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8. DEPENDENT CHILDREN PROPOSED FOR INSURANCE - Complete ONLY if Children's Term Insurance is applied for

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

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

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

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

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

To be completed by Parent or Legal Guardian

8a. Has any child proposed for insurance ever been diagnosed or treated by a licensed medical professional for: heart disease; cancer; tumor; diabetes; jaundice; mental disease, bone or muscle disorder; respiratory disease; liver disorder, neurological disease, or alcohol or drug abuse? .... ☐ Yes ☐ No

8b. In the past 5 years, has any child proposed for insurance pled guilty or been convicted of: (1) a moving violation; (2) driving under the influence of alcohol or drugs; or (3) had his/her driver's license suspended or revoked? .... ☐ Yes ☐ No

Provide details below to "Yes" answers for the above questions. If more space is needed, attach additional sheet, identify question, sign and date.

Question #	Dependent's Name	Details

OWNER INFORMATION

	Owner	Joint Owner
9. 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? ..... If yes, also complete Military Sales Disclosure form.	☐ Yes ☐ No	☐ Yes ☐ No

Complete the following section(s) ONLY if Owner or Joint Owner, including a Trustee *, is other than the Proposed Insured.

9a. NAME OF OWNER ☐Individual ☐Trust–Also complete Certificate of Trust Agreement ☐Business/Corporate–Also complete COLI Consent Form

Owner's Address (If P.O. Box, include Street Address)	Street	City	State	Zip Code

Date of Birth	Social Security/Tax ID #:	Relationship to Proposed Insured

Are you a U.S. Citizen? ☐ Yes ☐ No If no, provide information on your Government Issued identification below.

	Issue State / Country
* ☐Driver's License: #	
* ☐State ID ☐Passport ☐Military ☐Permanent Resident Card: #	

9b. NAME OF JOINT OWNER ☐Individual ☐Trust–Also complete Certificate of Trust Agreement ☐Business/Corporate–Also complete COLI Consent Form

Joint Owner's Address (If P.O. Box, include Street Address)	Street	City	State	Zip Code

Date of Birth	Social Security/Tax ID #:	Relationship to Proposed Insured

Are you a U.S. Citizen? ☐ Yes ☐ No If no, provide information on your Government Issued identification below.

	Issue State / Country
* ☐Driver's License: #	
* ☐State ID ☐Passport ☐Military ☐Permanent Resident Card: #	

9c. NAME OF CONTINGENT OWNER:

Date of Birth	Social Security/Tax ID #

BENEFICIARY

Share percentages 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. Beneficiary designations do not apply to others covered under Children's Term Insurance Rider. If more space is needed, attach additional sheet, identify question(s), sign and date.

10. Primary

Name:_____ Relationship to Proposed Insured:_____

Address: _____

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

Telephone # with Area Code: _____ % Share: _____

Name:_____ Relationship to Proposed Insured:_____

Address: _____

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

Telephone # with Area Code: _____ % Share: _____

Name:_____ Relationship to Proposed Insured:_____

Address: _____

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

Telephone # with Area Code: _____ % Share: _____

BENEFICIARY INFORMATION - Continued

Name:_____ Relationship to Proposed Insured:_____

Address: _____

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

Telephone # with Area Code: _____ % Share: _____

TOTAL _____%

10a. Contingent

Name:_____ Relationship to Proposed Insured:_____

Address: _____

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

Telephone # with Area Code: _____ % Share: _____

Name:_____ Relationship to Proposed Insured:_____

Address: _____

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

Telephone # with Area Code: _____ % Share: _____

TOTAL _____%

LIFESTYLE INFORMATION

11. Has the Proposed Insured ever used cigarettes, nicotine patches, nicotine gum, or other nicotine substitutes? ☐ Yes ☐ No

If yes, what product? ☐ Cigarettes ☐ Nicotine patches ☐ Nicotine gum ☐ Other: _____

If yes, was use of the product within: ☐ last 12 months ☐ last 24 months ☐ last 36 months ☐ last 60 months ☐ 60+ months

11a. Has the Proposed Insured used tobacco in pipe or cigar form in the last 12 months? ☐ Yes ☐ No

If yes, how often: ☐ Daily ☐ Weekly ☐ Monthly ☐ Less than monthly

PAYOR / BILLING INFORMATION

12. PAYOR: ☐ Proposed Insured ☐ Owner ☐ Joint Owner ☐ Other _____

If Other, provide Date of Birth: _____ (Print Full Name)

Billing Address: ☐ Check this box if billing address is same as residence previously provided, otherwise list below.

(If P.O. Box, include Street Address) Street City State Zip Code

Social Security/Tax ID#: | Relationship to Proposed Insured:

Are you a U.S. Citizen? ☐ Yes ☐ No If No, provide information on your Government Issued identification below.

☐ Driver's License: # | Issue State / Country

☐ State ID ☐ Passport ☐ Military ☐ Permanent Resident Card: #

PREMIUM INFORMATION

Distributions from a qualified plan or individual retirement account (IRA) cannot be used as premium for this policy. Will funds from a qualified plan or IRA, other than required minimum distributions (RMDs), be used to pay all or a portion of the premiums for this policy? ☐ Yes ☐ No

13. Premium Frequency: ☐ Annual ☐ Semi-Annual ☐ Quarterly ☐ Monthly ☐ Single Pay

☐ Lump Sum $_____ Source of Lump Sum: _____

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

For term and whole life policies, if you elect to pay premium on a basis other than annual, you will pay more premium than would be required if you paid on an annual basis. Make all checks payable to: NORTH AMERICAN COMPANY FOR LIFE AND HEALTH INSURANCE.

15. Amount of Modal Premium: $ **16.** Amount Paid with Application: $

17. Payment of Initial Premium – (check one):

☐ I have elected Temporary Life Insurance Agreement (TIA) with this Application and have completed the TIA form. The Owner(s) has/have elected payment of the initial premium by EFT, Credit Card, or Check and has read, understands, and agrees to the terms of such Agreement. (When submitting premium, the TIA form is required.

☐ This application is C.O.D. with No Temporary Insurance Coverage. (TIA not intended).

18. Third Party Billing Notification – Optional - Complete this section to designate an additional person to receive Grace Period notices for insufficient premium and lapse notices.

Name of Designated Person: _____

_____

Street Address City State Zip Code

Telephone # with Area Code: _____

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 or contract is surrendered, forfeited, assigned to the replacing insurer, or otherwise terminated or used in a financed purchase. This includes policies or certificates 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.

19. Does any person proposed for coverage, including Dependents, have any life insurance or annuities currently in force or pending?
☐ **Yes** ☐ **No**

1) If the response to the above questions is "Yes", provide information on existing insurance below.
2) Complete applicable Replacement Notice form and submit with this application.

If more space is needed, attach additional sheet, identify question(s), sign and date.

	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	$	$	$	$	$
ADB Amount	$	$	$	$	$
In force or Pending	☐ In Force ☐ Pending	☐ In Force ☐ Pending	☐ In Force ☐ Pending	☐ In Force ☐ Pending	☐ In Force ☐ Pending
Will this Policy/Certificate be changed or replaced?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
1035 Exchange	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

20.	Has, or will, the Proposed Insured or Owner of this policy been, or be, compensated in any way to purchase this policy?	☐ Yes ☐ No
21.	Is the Proposed Insured or Owner of this policy, paying for this policy with his/her own funds?	☐ Yes ☐ No
22.	Will the proceeds of a home equity loan or reverse mortgage transaction be used to pay the premiums on this policy?	☐ Yes ☐ No
23.	Has the Proposed Insured or Owner of this policy financed, or intend to finance, all or a portion of the premiums for this policy?	☐ Yes ☐ No
24.	Has the Proposed Insured, Owner, or Beneficiary entered into, or considering entering into, any other agreement with a third party, trust, or other entity, in regard to this policy, including, but not limited to, an agreement to sell, transfer or assign the policy or any policy rights or beneficial interests?	☐ Yes ☐ No

If the answer is 'Yes' to questions 20, 22, 23, or 24 provide details below. If answer is 'No' to question 21, provide details below. If more space is needed, attach additional sheet, identify question(s), sign and date.

25. 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.

26. Job Duties

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

28. Military Information ☐ USA ☐ USN ☐ USAF ☐ USMC ☐ USCG ☐ Other (Specify) _____
Military ID_____
Pay Grade: Rotation Date: Expected Discharge Date:

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

30. Has the Proposed Insured been alerted to, volunteered for, or received formal orders to a hazardous area or overseas assignment?
☐ Yes ☐ No If yes, provide specific details.

UNDERWRITING QUESTIONS
Details to "Yes" answers are to be provided in the Details Section below.

	Yes	No
31. In the past 10 years, has the Proposed Insured:		
a. Used barbiturates, hallucinatory drugs, narcotics, including crack, ecstasy, opium derivatives, marijuana, LSD, PCP, or any derivatives of these drugs not prescribed by a licensed medical practitioner, or been advised by a licensed medical professional to get medical treatment or undergone any medical treatment, counseling or hospitalization for drug abuse? If yes, complete Drug Questionnaire	☐	☐
b. Been advised by a licensed medical professional to limit your alcohol use or been advised to get medical treatment, or undergone any medical treatment or counseling or hospitalization for alcoholism, excessive alcohol use or abuse? Or, have you subsequently consumed alcohol after receiving counseling or medical treatment for alcohol use? Or, drink on average more than 3 alcoholic drinks per day? If yes, complete Alcohol Questionnaire.	☐	☐
c. Had your driver's license revoked or suspended or been convicted of reckless driving, driving without a valid license, or for driving while under the influence of alcohol or drugs (DWI, DUI)?	☐	☐
d. Pled guilty to or been convicted of a felony or misdemeanor? If yes, provide details on the nature of the plea or conviction, the date and state where the plea or conviction occurred, and whether time was served in prison.	☐	☐
e. Been refused for life insurance or charged an extra premium for life insurance?	☐	☐
32. Has the Proposed Insured:		
a. Within the past five years, had his/her driver's license revoked or suspended or been convicted of reckless driving, driving without a valid license, or for driving while under the influence of alcohol and/or drugs (DWI, DUI)?	☐	☐
b. Within the past five years, had more than one speeding violation or, motor vehicle moving violation, been involved in any accident in which he/she was found to be at fault, or pled guilty or been convicted for driving under the influence of alcohol?	☐	☐
c. Flown a plane in the past 24 months or plan to fly in the next 12 months as a pilot, copilot, student pilot, military pilot, engineer or in any other capacity except as a regularly scheduled commercial airline pilot or fare-paying passenger? If yes, complete Aviation Questionnaire.	☐	☐
d. In the past 12 months or in the next 12 months, engaged in or plan to engage in the following recreational activities: hang gliding, skydiving, motor vehicle/cycle racing, rock climbing, ballooning, bungee jumping, mountain climbing, motor boat racing, snowmobile racing, ultra light aircraft flying, scuba diving to more than 50 feet in depth, or in caves, ship wrecks or deep seas? If yes, complete applicable Underwriting Questionnaire.	☐	☐
e. Traveled to or resided for more than 30 days outside of the U.S., U.S. territories, Canada, or Japan within the past 12 months or plan to travel to or reside outside of the U.S., U.S. territories, Canada, or Japan in the next 12 months? If yes, complete Foreign Travel and Residence Questionnaire.	☐	☐
f. Had or have any bankruptcy pending or expect to file bankruptcy in the next 12 months?	☐	☐

DETAILS TO 'YES' ANSWERS FOR QUESTIONS 31 THROUGH 32.
If more space is needed, attach additional sheet, identify question(s), sign and date.

Question #	Dates and Details

Questions 33 through 36 must be completed for Proposed Insureds NOT subject to a full paramedical exam. Details to "Yes" answers are to be provided in the Details Section below.

	Yes	No
33. In the past 10 years, has any person proposed for insurance been diagnosed by a licensed medical professional, treated or recommended to get medical treatment from a licensed medical professional, hospitalized, or presently taking prescription(s) or medication(s) for any of the following disease(s) or disorder(s):		
a. Angina, chest pain, heart attack, heart failure, heart surgery, arrhythmia, abnormal EKG, coronary artery bypass, angioplasty, stents, peripheral vascular disease, circulatory disorder, valvular heart disease, cardiomyopathy or heart murmur?	☐	☐
b. High blood pressure, hypertension or abnormal cholesterol levels?	☐	☐
c. Stroke, seizures, epilepsy, dizziness, fainting, or dementia?	☐	☐
d. Multiple Sclerosis, neuritis, neuropathy, paralysis, muscular dystrophy, Parkinson's disease or any other disorder of the muscles?	☐	☐
e. Arthritis, chronic pain, fibromyalgia, connective tissue disease, lupus or scleroderma?	☐	☐
f. Cancer, malignancy, tumor, melanoma, lymphoma, Hodgkin's disease or leukemia?	☐	☐
g. Chronic obstructive pulmonary or lung disease, chronic bronchitis, emphysema, sarcoidosis, asthma, shortness of breath, tuberculosis or sleep apnea?	☐	☐
h. Diabetes, pre-diabetes or impaired glucose tolerance, sugar in the urine, disease or disorders of the adrenal, parathyroid, pituitary or thyroid glands?	☐	☐
i. Disorder of the kidney, bladder or urinary system, abnormal PSA, abnormal PAP smear without subsequent normal PAP smear or protein or blood in the urine?	☐	☐
j. Anemia, hemophilia, or clotting disorder excluding HIV (Human Immunodeficiency syndrome)?	☐	☐
k. AIDS (Acquired Immunodeficiency Syndrome), any other disease or disorder of the immune system, or had positive test results to an ELISA test for HIV (Human Immunodeficiency syndrome) followed by positive results to a Western Blot Assay performed by or at the direction of the insurer for the purposes of obtaining insurance?	☐	☐
l. Colitis, ulcerative colitis, Crohn's, esophageal varices, peptic or gastric ulcer, intestinal or rectal bleeding, diverticulitis, colon polyps, cirrhosis, hepatitis, liver failure, liver impairment, loss of bowel function or other disease or disorder of the liver or pancreas?	☐	☐
34. Other than indicated above, has the Proposed Insured:		
a. In the past 5 years, been diagnosed, treated or advised to get medical treatment from a licensed medical professional for any mental or physical disorder or medically or surgically treated condition not listed above?	☐	☐
b. Had a parent or sibling who before age 60 was diagnosed with or died from cardiovascular disease, stroke, cancer (except basal or squamous cell cancer of the skin), Huntington's Chorea, familial polyposis or polycystic kidney disease? If yes, provide age at onset and current age if living. If deceased, provide age at death.	☐	☐
c. Had a weight gain or loss of 10 or more pounds within the past 12 months for any reason other than pregnancy?	☐	☐
d. Except for tests related to Human Immunodeficiency Virus (AIDS virus), in the past 12 months been advised by a licensed medical professional to have a check up, EKG, X-ray, blood or urine test that has not been performed or any other diagnostic test, or sought medical advice or treatment for any reason?	☐	☐
e. In the past 12 months been advised by a licensed medical professional to be admitted to a hospital, medical facility, nursing home or assisted living facility?	☐	☐
35. Is the Proposed Insured currently taking any prescription medications, herbal remedies or non-prescription medications for any disease or disorder not listed above? If yes, list the medications and remedies and the reasons for which they are taken.	☐	☐
36. Is the Proposed Insured currently receiving or have an application pending for any illness or disability benefits or compensation?	☐	☐

DETAILS TO 'YES' ANSWERS FOR QUESTIONS 33 THROUGH 36.
If more space is needed, attach additional sheet, identify question(s), sign and date.

Question #	Date, Diagnosis, Treatment, Results and Duration	Name, Address and Phone # of Attending Physician and Hospital

DETAILS TO 'YES' ANSWERS FOR QUESTIONS 33 THROUGH 36 - Continued

Question #	Date, Diagnosis, Treatment, Results and Duration	Name, Address and Phone # of Attending Physician and Hospital

37. If not listed above, please provide full name, address and phone numbers of licensed medical professional(s) consulted in the past five years.

a. Date and findings of last visit:

b. Tests performed and treatment received:

c. Do you have medical records under any other name? ☐ Yes ☐ No If yes, please provide details here.

IT IS AFFIRMED 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 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, that arises or is discovered after completing this application, but before the policy is effective, as defined herein.

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

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, the undersigned applicant(s) (I) authorizes any licensed physician, licensed medical practitioner, health care professional, hospital, clinic, or other medical care provider, laboratory, pharmacy or pharmacy benefit manager, insurance or reinsuring company, viatical company, viatical broker or provider, MIB, Inc. (MIB), consumer reporting agency, insurance support organization, independent administrator, 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 (excluding HIV) 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. 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. Such revocation will not be effective until received by the Company. I understand any information that is disclosed pursuant to this Authorization may be redisclosed and no longer covered by federal rules governing privacy and confidentiality of health information. I understand that 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 of Information Practices.

ACCELERATED DEATH BENEFIT(S): If the policy being applied for includes an accelerated death benefit(s) endorsement or rider, 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

Signed at (Solicitation City and State):	Date:
Signature of **Proposed Insured** (Parent/Legal Guardian Signature, if Proposed Insured is a Minor) **X**	

Signature(s) of **Owner / Joint Owner** (If other than Proposed Insured) (If Owner is a Corporation, Trust or other Entity, include Title of Signee. For a Corporation, a Corporate Resolution is needed including signatures of two officers and their titles.) **X**
X
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 Check this box ☐ if Spouse's Signature WILL NOT be obtained. **X**	Signature of **Joint Owner's Spouse** for Community Property States Check this box ☐ if Spouse's Signature WILL NOT be obtained. **X**

TO BE COMPLETED BY SOLICITING AGENT

1. If the policy being applied for includes an accelerated death benefit(s) endorsement or rider, was the Owner provided the Accelerated Death Benefit Summary and Disclosure Statement(s) prior to or concurrent with this application? ..... ☐ Yes ☐ No
2. Does any person covered under this application have any existing life insurance or annuities? ..... ☐ Yes ☐ No
3. Is any insurance applied for in this application intended to replace any existing life insurance or annuity? ..... ☐ Yes ☐ No
4. The Company approved all sales material that I used with respect to the solicitation of the application for the policy. A copy of all sales material was left with the applicant(s), including a printed copy of all such sales material presented electronically. ..... ☐ Yes ☐ No

Signature of **Soliciting Agent** **X**	Print Agent's Last Name	Agent Code
Telephone Number ( )	Mobile Phone Number ( )	
Name of MGA (Print):		MGA Code:

Other Agent (Print)	% Credit	Agent Code
Other Agent (Print)	% Credit	Agent Code
Other Agent (Print)	% Credit	Agent Code
Other Agent (Print)	% Credit	Agent Code
Other Agent (Print)	% Credit	Agent Code

Clear Form Clear Kit

North American Company
for Life and Health Insurance

L3100

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

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

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

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

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

North American Company for Life and Health Insurance® • Principal Office: West Des Moines, IA • www.NorthAmericanCompany.com
New Business Processing Center: P. O. Box 5089, Sioux Falls, SD 57117 • Phone: (800) 669-9100 • Fax: (800) 951-9430
Policy Change: P. O. Box 5088, Sioux Falls, SD 57117 • Phone: (877) 872-0757 • Fax: (855) 704-4779

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

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

If you are the Personal Representative of the Proposed Insured, describe the scope and/or basis of your authority to act on the Insured's behalf:

_____

_____

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

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North American Company
for Life and Health Insurance
Since 1886

O2309261

NOTICE REGARDING REPLACEMENT

REPLACING YOUR LIFE INSURANCE POLICY OR ANNUITY?

Are you thinking about buying a new life insurance policy or annuity and discontinuing or changing an existing one? If you are, your decision could be a good one — or a mistake. You will not know for sure unless you make a careful comparison of your existing benefits and the proposed benefits.

Make sure you understand the facts. You should ask the company or agent that sold you your existing policy to give you information about it.

Hear both sides before you decide. This way you can be sure you are making a decision that is in **your** best interest.

We are required by law to notify your existing company that you may be replacing their policy.

Applicant's Signature	Date
Agent's Signature	Date

COPY 1 - Applicant COPY 2 - Company COPY 3 - Agent

O-2309(26) Rev. 11/99

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NORTH AMERICAN℠

L3242CA

ACCELERATED DEATH BENEFIT SUMMARY AND DISCLOSURE STATEMENT FOR TERM LIFE INSURANCE

IMPORTANT NOTICE TO APPLICANT/BUYER REGARDING ACCELERATED DEATH BENEFITS

The benefits provided by this Accelerated Death Benefit are not intended to provide, and will never provide, long-term care insurance, nursing home insurance, or home care insurance. If You are interested in long-term care insurance or nursing home or home care insurance, You should consult with an insurance agent licensed to sell that insurance, inquire with the insurance company offering the accelerated death benefits, or visit the California Department of Insurance internet web site (www.insurance.ca.gov) section regarding long-term care insurance.

If You choose to accelerate a portion of Your Death Benefit, doing so will reduce the amount that Your beneficiary will receipt upon Your death.

Receipt of Accelerated Death Benefits may be taxable. Prior to electing to buy the Accelerated Death Benefit, You should consult with the appropriate social services agency concerning how receipt of Accelerated Death Benefits may affect that eligibility.

Payment of Accelerated Death Benefits paid under this Endorsement are intended for favorable tax treatment under Section 101(g) of the Internal Revenue Code. Accelerated Death Benefit payments are subject to limits imposed by the federal government and any amounts received in excess of these limits are includible in gross income. You should seek assistance from a qualified tax advisor with any questions You may have.

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.

THE BENEFIT AND ITS EFFECT ON POLICY PROVISIONS

Proposed Insureds are subject to underwriting eligibility requirements to qualify for Accelerated Death Benefits for Chronic Illness.

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, 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.

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

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

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. The Accelerated Death Benefit Payment will be reduced by the administrative fee.

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 Licensed Health Care Practitioner has certified within the last 12 months that the Insured:

1. Is expected to be 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 (a) comparable to (and includes) Alzheimer's disease and similar forms of irreversible dementia, and (b) measured by clinical evidence and standardized tests, which reliably measure impairment in the individual's:

1. Short-term or long-term memory; or
2. Orientation to people, places, or time; and
3. Deductive or abstract reasoning.

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. 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.

[1] **Proposed Insureds are subject to underwriting eligibility requirements to qualify for the Chronic Illness Accelerated Death Benefit. Only the Terminal Illness Accelerated Death Benefit is available without underwriting eligibility requirements.**

This disclosure form is a summary only. We recommend that you consult Your Policy for further details.

Signature of Proposed Owner One X	Date
Signature of Proposed Owner Two X	Date
Signature of Agent X	Date

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

_____

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

	Terminal Illness	**Chronic Illness**
Accelerated Death Benefit	$375,000	$120,000
Lump Sum Accelerated Death Benefit Payment	$338,374	$82,498
Administrative Fee	$200	$500
Values Before Accelerated Death Benefit	**Terminal Illness**	**Chronic Illness**
Face Amount	$500,000	$500,000
Premium	$300	$300
Residual Death Benefit:	N/A	$25,000
Values After Accelerated Death Benefit	**Terminal Illness**	**Chronic Illness**
Face Amount	$125,000	$380,000
Premium	$0	$242.40
Residual Death Benefit	N/A	$25,000

North American Company
for Life and Health Insurance

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O922

TRANSMITTAL REPORT

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

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

PLEASE PRINT

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

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

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

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

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

Please complete the following:

POLICY NUMBER: _____
(if applicable)

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

If mailing the application please mail to:

New Business Team
North American Company
One Sammons Plaza
Sioux Falls, SD 57193

Special Requests/Remarks (i.e. Policy Date, Trust Date, 1035 Information etc. Include cover letter for financial justification or special circumstances)

Partner: _____

Additional Policy: _____

Special Policy Date:_____

Hold Policy Issue for Special Instructions: ☐ Yes ☐ No

Date submitted:_____ By::_____

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