

Documents Package Prepared for: **NBA**

Prepared Date: **2/28/2019 12:58 PM EST**

Document Name	Description	Expiration Date
L-3100 HIPAA REV. 5...	HIPAA Authorization	12/31/2199
ICC16L3208A (5-16) ...	Application	12/31/2199
L-1683 (6-18) Elect...	EFT Authorization	12/31/2199
L-1760 (IN) Replace...	Replacement-Internal and External	12/31/2199
L-2972 5-16 fillabl...	Agent Report	12/31/2199
L-2977C (6-14)	Temporary Life Insurance Agreement	11/17/2099



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

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: <input type="checkbox"/> Male <input type="checkbox"/> Female	Age	Place of Birth – State / Country	Height (FT. IN)	Weight (LBS.)	Marital Status
<input type="checkbox"/> Driver's License: # _____ <input type="checkbox"/> State ID <input type="checkbox"/> Passport <input type="checkbox"/> Military <input type="checkbox"/> Permanent Resident Card: # _____			Issue State / Country		

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: RESIDENCE (_____) _____
 BUSINESS (_____) _____
 MOBILE (_____) _____
 _____(CST) AM PM

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

OWNER INFORMATION

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.	Owner <input type="checkbox"/> Yes <input type="checkbox"/> No	Joint Owner <input type="checkbox"/> Yes <input type="checkbox"/> 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 <input type="checkbox"/> Individual <input type="checkbox"/> Trust—Also complete Certificate of Trust Agreement <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> No If no, provide information on your Government Issued identification below.				
* <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: #				
9b. NAME OF JOINT OWNER <input type="checkbox"/> Individual <input type="checkbox"/> Trust—Also complete Certificate of Trust Agreement <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> No If no, provide information on your Government Issued identification below.				
* <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: #				
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.

<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: # _____	

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	<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				
1035 Exchange	<input type="checkbox"/> Yes <input type="checkbox"/> 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.

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 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 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 medically related facility, 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 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. 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 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 <input type="checkbox"/> if Spouse's Signature WILL NOT be obtained.	Signature of Joint Owner's Spouse for Community Property States Check this box <input type="checkbox"/> if Spouse's Signature WILL NOT be obtained.
X	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



ELECTRONIC FUND TRANSFER AUTHORIZATION

Any incomplete forms will be returned unprocessed. If your request is not in good order, how would you like us to notify you?

Call me at _____ or Email me at _____

Insured's Name	Owner's Name	Policy Number or Application Date (If new application)	Premium Amount	Loan Repayment Amount	Total Withdrawal Amount

Select Payment Frequency and Timing

Monthly
 Quarterly
 Semi-annually
 Annually

Withdrawal Day of the Month (**1st – 28th** only): _____ Beginning: _____ (MM/YY)

Please note: If a specific day of the month is not indicated, the policy issue date will be used to determine timing. Selecting a withdrawal day of the month that is after the monthly Policy Date may initially result in deductions to pay both the current month and the next month premiums.

Payment Option 1: Deduct the **first and future** premium payments. (The first deduction will occur on or after the policy date and then at the intervals selected above.) (New Applicants Only)

Payment Option 2: Deduct the **future** premium payments only. (The initial premium payment is to be made by check. Premium is due on or before the due date (Policy Date).)

Premium is due by the monthly Policy Date, and all applicable grace periods are based on that date and not the withdrawal date. **In addition, if your policy is not paid current upon the Company's receipt of this form (including any required supplemental documentation) in good order as determined by the Company, premium for a prior month(s) may be withdrawn and this could result in multiple payment withdrawals from the account. Please contact our office to ensure your policy is paid current and/or if you have questions about the due date of your policy.**

Financial Institution Information

Account Type: (If the account is a business account, please complete our Certification of Business Signing Authority (form O-2927). For Trust Accounts, please complete our Certification of Trust Agreement (form L-3172A).

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

Savings - A letter from your financial institution, signed by a bank officer, listing the account holder name, account number, and routing number is required.

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.

Policy Number or Application Date (if new application)

AGREEMENT, AUTHORIZATION, AND SIGNATURE(S):

PLEASE READ CAREFULLY

As a convenience to me (us), 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 the processing of the request and any required premium payment.
- If I (we) submit a request to change my (our) EFT information, including but not limited to my (our) banking information or premium contribution amount, and the form is not in good order or lacks supplemental documentation the Company requires to process, the Company will cancel any previous existing EFT authorization and place the policy on a quarterly direct bill until the new request has been submitted complete and in good order and the updates have been processed by us.
- A pre-notification will not be sent prior to the withdrawal being made.
- If a policy on EFT enters a contractual grace period (whether due to insufficient premium or non-payment of loan interest), the Company will cancel any EFT authorization in effect, place this policy on quarterly direct bill and send this bill to the owner's last known address of record, along with an applicable grace period notice specifying the required premium to be paid.
- For automatic recurring premiums, the Company reserves the right to allocate premiums to this policy on a consistent day of the month even if that day is not a business day.
- 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.
- 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.
- I (we) may modify this Agreement by authorizing the Company to make preauthorized electronic funds transfers from any other bank account that I so designate, in writing. A new Electronic Funds Transfer Authorization, along with any necessary supplemental documentation, will be required.
- Under this agreement, I 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, 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 the electronic funds transfer premium payment arrangement at any time. The payment frequency on a direct bill basis may be changed to quarterly or another less frequent mode.
- This Authorization will remain in effect until I (we) notify the Company or financial institution to terminate and the Company or the financial institution has a reasonable time to act on the termination.
- 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 / payor 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 accept and honor the same and charge the same to my (our) account.
- This Authorization will become effective only upon acceptance by the Company at the address shown below. The Company reserves the right to discontinue this program at any time.

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

X _____
Bank Account Owner Signature Date (month/day/year)

X _____
Joint Bank Account Owner Signature Date (month/day/year)

**Please include a voided check
rather than a deposit form as the
routing numbers may be different.**

Please do not staple.



IMPORTANT NOTICE REGARDING REPLACEMENT OF LIFE INSURANCE

If you are thinking out DISCONTINUING or CHANGING an existing life insurance policy or annuity contract and BUYING a replacement, your decision could be a good one -- or possibly a mistake. Make sure that you understand the facts. You should:

- Make a careful comparison of your existing policy and the proposed policy.
- Ask the company or agent that sold you your existing policy to provide you with complete information about it.
- Consider both sides before you decide.
- Determine what you want your insurance program to do.
- Consider your present health. You may have had a change which could affect your insurability, so make sure to continue your present policy until a new policy is delivered to you and accepted by you.

This form **MUST** be completed in triplicate and the original given to you by the agent proposing replacement no later than at the time you apply for the new policy. (This form must be completed and given to you even though the proposed replacement policy is with the same company that sold you your existing policy.)

EXISTING POLICY INFORMATION on _____
(Name of Insured)

COMPANY	TYPE OF POLICY*	POLICY NO.	DATE OF ISSUE	FACE AMOUNT OF BASIC POLICY	TYPE OF OPTIONAL BENEFITS

(If more policies are involved, use additional sets of forms)

PROPOSED POLICY INFORMATION on _____
(Name of Insured)

COMPANY	TYPE OF POLICY*	FACE AMOUNT OF BASIC POLICY	TYPE OF OPTIONAL BENEFITS

Indiana Department of Insurance Regulation 760 IAC 1-16.1 requires that the company making the replacement notify your existing insurance company that you may be replacing your existing policy. (You have the right, within twenty days after delivery of a replacement policy, to return it to the company and to claim an unconditional refund of all premiums paid on it.)

Applicant's/Insured's Signature

Replacing Agent's Signature

Date

Address

Telephone Number: _____

Indiana License Number: _____

* As shown on face of policy

L-1760(IN)



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.: _____



TEMPORARY LIFE INSURANCE AGREEMENT

Proposed Insured

Premium or Authorization for Initial EFT draft or Credit Card has been received from _____ in the amount of \$_____ in payment of one full monthly premium for an insurance policy applied for on the life (lives) of the above named Proposed Insured, for whom an application (the "Application") dated _____ has been made to North American Company for Life and Health Insurance (the "Company"). **This Temporary Life Insurance Agreement does not provide any coverage, except as provided herein. If any of the below representations are answered YES or LEFT BLANK, the agent is not authorized to accept any premium or authorization for initial EFT draft or Credit Card, and there will be NO COVERAGE. There will also be no coverage under this Agreement if Section 1035 exchange paperwork is received without premium payment. Premium may be paid by check, authorized withdrawal, or credit card.**

I. REPRESENTATIONS

- | Has the Proposed Insured: | Yes | No |
|---|--------------------------|--------------------------|
| 1. In the past five years, been diagnosed, treated for, or been advised to be treated for: heart disease; vascular disease; stroke; cancer; leukemia; malignant tumor; alcohol or drug dependence or abuse; insulin dependent diabetes; or disorder of the brain or immune system? | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. In the past five years, had any unintentional weight loss or any symptoms of a disease or an impairment for which a physician has not been consulted?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. In the past 90 days, been admitted, or medically advised by a member of the medical profession to be admitted, to a hospital or other licensed health care facility, had surgery performed or recommended, or been medically advised to have any diagnostic test that has not been completed?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. In the past ten years, pled guilty or been convicted of any criminal activity, or been held or served time in any type of incarceration, jail, penitentiary, prison, probation, or parole program?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Is any person proposed for insurance under 15 days of age or over 70 years of age? | <input type="checkbox"/> | <input type="checkbox"/> |

II. TERMS AND CONDITIONS

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

If one full monthly premium for the insurance applied for in the application for life insurance has been received as consideration by the Company from the Proposed Owner as advance payment for the life insurance and a Proposed Insured(s) dies while this Agreement is in effect, upon receipt of due proof of death, the Company will pay to the designated beneficiary the LESSER of (a) the amount of all death benefits applied for in the Application; or (b) \$1,000,000.

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 completed and signed by the Proposed Insured and the Proposed Owner bearing the same date as this Temporary Life Insurance Agreement; one full monthly premium is collected; and all of the questions in the above Section of this Temporary Life Insurance Agreement are truthfully and completely answered "NO".

3. DATE TEMPORARY COVERAGE TERMINATES

The Temporary Life Insurance under this Agreement will terminate automatically on the earliest of:

- (a) 90 days from the date the Application was signed;
- (b) the date that insurance takes effect (as defined in the Application) under the insurance contract(s) as applied for in the Application;
- (c) the date an insurance contract(s) other than as applied for in the Application, is offered to the Proposed Owner; or
- (d) the date the Company mails notice of termination of coverage and refunds the advance premium payment to the proposed Owner at the address shown in the Application. The Company may cancel the coverage at any time.

4. SPECIAL LIMITATIONS

- (a) Fraud or material misrepresentation in the Application or in this Agreement shall invalidate this Agreement and the Company's only liability is to refund any advance premium payment made.
- (b) There is no insurance under this Agreement if the check, initial EFT draft or Credit Card is not honored when presented.
- (c) If the Proposed Insured dies by suicide, the Company's liability under this Agreement is limited to a refund of any advance premium payment made.

- (d) No agent or other person is authorized to accept money on a Proposed Insured under 15 days of age or over 70 years of age from the date of this Agreement, nor will any insurance take effect for such person.
- (e) No agent is authorized to modify any of the provisions of this Agreement.
- (f) The total of the amount payable under this and any other Temporary Life Insurance Agreement or application with the Company will not exceed \$1,000,000 for each life proposed for insurance.

5. GENERAL

Premium(s) will be returned if a policy is not delivered and no benefit is paid under this Agreement. If a policy is delivered, premium(s) will be applied to the first policy premium. Premiums are billed from the Policy Date. If the Policy Date is prior to the delivery date, premiums will be based on the Policy Date.

I, the PROPOSED OWNER/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. I, the Proposed Owner, agree that they are to be relied on for this coverage and declare that I have received a copy of this Agreement and that I have read and understand this Agreement. I agree to all the provisions, terms and limitations of this Agreement and acknowledge that I do not expect any insurance to become effective based on the Application or under this Agreement, other than as stated in the Application and in this Agreement. I agree to be bound by all the answers, statements, and representations made in the Application and this Agreement.

Proposed Owner Name (Print)		Date
Proposed Owner Signature	Signed At (City/State)	
Proposed 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)	
<p>Community Property: If this transaction is subject to a community property or civil union interest, we <u>strongly recommend</u> the Owner obtain his/her spouse's signature to document his/her consent to this transaction. The Owner understands and agrees the Company may presume that no such interest exists if the Owner has not obtained his/her spouse's signature. Further, the Owner understands and agrees the Company has no duty to inquire further about any such interest. As a result, the Owner agrees to indemnify and hold the Company harmless from any consequences relating to community property or civil union interests and this transaction.</p> <p>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.</p>		
Signature of Owner's Spouse for Community Property States Check this box <input type="checkbox"/> if Spouse's Signature WILL NOT be obtained.	Signature of Joint Owner's Spouse for Community Property States Check this box <input type="checkbox"/> if Spouse's Signature WILL NOT be obtained.	
X	X	
Agent Name (Print)	Agent Phone Number	
Agent Signature	Date	

All premium checks must be made payable to North American Company for Life and Health Insurance. Do not make checks payable to the agent or leave the payee space blank.

No agent or other person is authorized to accept money on any application in excess of \$1,000,000. A temporary life insurance agreement cannot be accepted on any application in excess of \$1,000,000.

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