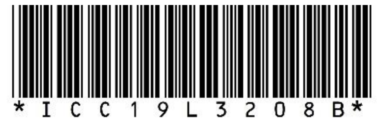
North American Company
for Life and Health Insurance



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

PROPOSED INSURED

Legal Last Name

Legal First Name M. I.

Social Security Number - -

Date of Birth MM - DD - YYYY

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

1. In the past year, have you ever used a different name? ☐ Yes ☐ No
If yes, give name used and date it was changed. ____________________

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

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

2c. Best Telephone Number with Area Code:

2d. E-mail Address: Check box if no email address ☐, otherwise list below.

2e. Do you have a valid driver's license? *(If no, also complete question 2f.)*
☐ Yes - Issue State / Country: ____________________ Driver's License #: ____________________
☐ No - Why do you not have a valid driver's license? ____________________

2f. Government issued ID: ☐ State ID ☐ Passport ☐ Military ☐ Permanent Resident
Issue State/Country: ____________________ Card #: ____________________

2g. Employer Name and Address:

2h. Occupation: ____________________
If homemaker, complete the following:
Family Income: $ ____________ Family Net Worth: $ ____________
Spouse's Total Life Insurance In Force and Applied For: $ ____________

2i. Annual Income:

2j. Net Worth:

PLAN INFORMATION

3a. Amount Applied For:
$____________

3b. Underwriting Type:
☐ Traditional ☐ Online

4. Proposed Plan of Insurance: ____________________
For Universal Life: Death Benefit Option (Defaults to Level, if none selected):
(Check One): ☐ Level ☐ Increasing ☐ Return of Premium
Death Benefit Qualification Test, if applicable. (Defaults to GPT, if available and none selected):
(Check One): ☐ Guideline Premium Test (GPT) ☐ Cash Value Accumulation Test (CVAT)

5a. Term Riders
☐ Children's Term Insurance $____________
☐ Waiver of Premium
☐ Other ____________ (Plan) $____________ (Amount)

5b. UL and IUL Riders
☐ Premium Guarantee Rider
☐ Accidental Death Benefit $____________
☐ Children's Term Insurance $____________
☐ Guaranteed Insurability $____________
☐ Waiver of Monthly Deductions
☐ Waiver of Surrender Charge Option
☐ Other ____________ (Plan) $____________ (Amount)

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

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

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

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

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

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

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

To be completed by Parent or Legal Guardian:

6a. Has any child proposed for insurance ever been diagnosed or treated by a licensed medical professional for:

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

2) Bone or muscle disorder, mental or psychiatric disorder, epilepsy, brain or neurological disorder, blood disorder, or tested positive for the HIV virus? .... ☐ Yes ☐ No

6b. In the past 5 years, has any child proposed for insurance been treated or advised to be treated by a licensed medical professional for alcohol or drug abuse or been convicted of driving under the influence of alcohol or drugs or had a suspended or revoked driver's license? .... ☐ Yes ☐ No

Provide details below to "Yes" answers to Questions 6a. and 6b. If more space is needed, attach a completed and signed Application Overflow Page.

Question #	Dependent's Name	Details

OWNER INFORMATION

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

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

7a. NAME OF OWNER:

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

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

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

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

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

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

7b. NAME OF JOINT OWNER:

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

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

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

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

Citizenship and ID information is required for all Joint Owners, including Trustees.
Are you a U.S. Citizen? ☐ Yes ☐ No

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

7c. NAME OF CONTINGENT OWNER:

Date of Birth: Social Security/Tax ID #:

BENEFICIARY

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

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

8. Primary

Name:______________________ Relationship to Proposed Insured: ______________

Address:______________________

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

Telephone # with Area Code: ______________ ☐ Distribute Proceeds "Per Stirpes" % Share: ________

Name:______________________ Relationship to Proposed Insured: ______________

Address:______________________

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

Telephone # with Area Code: ______________ ☐ Distribute Proceeds "Per Stirpes" % Share: ________

Name:______________________ Relationship to Proposed Insured: ______________

Address:______________________

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

Telephone # with Area Code: ______________ ☐ Distribute Proceeds "Per Stirpes" % Share: ________

TOTAL ________%

9. Contingent

Name:______________________ Relationship to Proposed Insured: ______________

Address:______________________

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

Telephone # with Area Code: ______________ ☐ Distribute Proceeds "Per Stirpes" % Share: ________

Name:______________________ Relationship to Proposed Insured: ______________

Address:______________________

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

Telephone # with Area Code: ______________ ☐ Distribute Proceeds "Per Stirpes" % Share: ________

TOTAL ________%

PAYOR / BILLING INFORMATION

10. PAYOR: ☐ Proposed Insured ☐ Owner ☐ Joint Owner ☐ Other ______________________

(Print Full Name)

Other Payor Type:

☐ Individual – Provide Date of Birth: ______________ Relationship to Proposed Insured: ______________

☐ Trust – Also complete Certification of Trust Agreement Form

☐ Business (Check one of the following)

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

Other Payor Type Social Security/Tax ID #: ______________

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

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

PAYOR / BILLING INFORMATION (Continued)

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

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

11. Third Party Billing Notification – Optional – Complete this section to designate an additional person, excluding the Agent, to receive Grace Period notices for insufficient premium and lapse notices.

Name of Designated Person:

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

Telephone Number with Area Code:

PREMIUM INFORMATION

12. Premium Frequency: ☐ Annually ☐ Semi-Annually ☐ Quarterly ☐ Monthly ☐ Single Pay ☐ Lump Sum $____________________

13. Source of Premium: ☐ Salary ☐ Savings ☐ Investments ☐ 1035 Exchange ☐ Other: ____________________

14. I (Owner) certify that the funds used to satisfy the initial premium of the policy are not from a loan made by a third-party (secured or unsecured) to me nor through a reverse mortgage, or the use of any form of equity line of credit or similar credit facility on any property in which I may have an interest. I further certify that as the date of this application, I have no intention to secure any funds from any of the aforementioned sources of financing to pay any portion of the premium under the policy for which I am applying. .... ☐ Yes ☐ No

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

16. Amount of Modal Premium: $

For term policies, if you elect to pay premium on a basis other than annual, you may pay more premium than would be required if you paid premium on an annual basis.

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

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

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

REPLACEMENT AND EXISTING COVERAGE INFORMATION

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

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

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

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

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

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

REPLACEMENT AND EXISTING COVERAGE INFORMATION (Continued)

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

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

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

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

Question #	Details

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

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

24. SPECIAL REQUESTS OR DETAILS

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

25. Job Duties:

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

27. Military Information: ☐ USA ☐ USN ☐ USAF ☐ USMC ☐ USCG ☐ Other (Specify) ______________________________
Military ID:____
Pay Grade: Rotation Date: Expected Discharge or Retirement Date:

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

29. 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.*

LIFESTYLE INFORMATION

30a. Indicate the number of cigars used in the past 12 months:
☐ None ☐ 1 to 12 ☐ 13 to 24 ☐ 25 or more

30b. In the past 5 years, have you used any nicotine products including cigarettes, E-cigarettes, vapor products, pipe, snuff, chewing tobacco, or nicotine gum or patches? *(If yes, complete questions 1 and 2.)*.. ☐ Yes ☐ No

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

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

UNDERWRITING QUESTIONS

Questions 31 through 39 only need to be completed if:

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

31a. Do you use alcoholic beverages? *(If yes, complete question 31b.)* .... ☐ Yes ☐ No

31b. Amount: ____________________ Frequency: ____________________

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

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

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

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

36. In the past 24 months, have you:

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

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

37. In the past 5 years, have you:

a. Been convicted of or pleaded guilty to reckless driving, driving under the influence of alcohol or any drug, or had your driver's license suspended or revoked, or in the past 3 years, have you had 3 or more moving violations? .... ☐ Yes ☐ No

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

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

UNDERWRITING QUESTIONS (Continued)

38. In the past 10 years, have you:

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

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

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

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

DETAILS TO "NO" ANSWER FOR QUESTION 32 AND "YES" ANSWER FOR QUESTION 37.
If more space is needed, attach a completed and signed Application Overflow Page.

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

Questions 40-49 only need to be completed if a paramedical exam is not required.

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

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

41a. Height: ____________ feet _________ inches Weight: ____________ pounds

41b. In the past 12 months, have you lost more than 10 pounds? *(If yes, complete questions 1 and 2.)* ☐ Yes ☐ No

1) How many pounds? ___________________

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

42. In the past 5 years, have you had weight loss surgery? ☐ Yes ☐ No
(If yes, provide date and type of surgery in DETAILS section below.)

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

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

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

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

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

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

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

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

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

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

UNDERWRITING QUESTIONS (Continued)

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

f. Mental or memory impairment, dementia, epilepsy or seizures, brain tumor, or other brain injury or disorder? .... ☐ Yes ☐ No

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

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

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

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

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

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

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

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

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

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

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

48. **(Ages 70 and under only)** Have you had a biological parent or sibling die before age 60 from heart disease or cancer? .... ☐ Yes ☐ No
(If yes, provide details in the family history chart below and list the specific location of the cancer, such as breast, colon, etc.)

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

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

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

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

DETAILS TO "YES" ANSWERS FOR QUESTIONS 42 THROUGH 47 AND QUESTION 49.
If more space is needed, attach a completed and signed Application Overflow Page.

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

IT IS DECLARED that statements and answers in this application, including statements by the Proposed Insured in any medical questionnaire or supplement that become part of this application, are complete and true to the best knowledge and belief of the undersigned. IT IS AGREED THAT: (1) any waiver or modification of this application will not be effective unless in writing and signed by the President or the Secretary; (2) the acceptance of any policy or policy change issued on this application shall constitute a ratification of any correction or amendment made by the North American Company for Life and Health Insurance (the Company); and (3) No change in amount, risk classification, plan of insurance, or benefits shall be effective unless agreed to in writing by the applicant(s).

The undersigned FURTHER AGREES to immediately advise the Company of any change to any of the responses contained in the application, including any change in the health or habits of any Proposed Insured(s), that arise or is discovered after completing this application, but before the policy or policy change is effective, as defined herein.

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

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

1. The taxpayer identification number shown on this application is my correct taxpayer identification number;
2. I am not subject to backup withholding because: (a) I am exempt from backup withholding, or (b) I have not been notified by the Internal Revenue Service that I am subject to backup withholding as a result of a failure to report all interest or dividends, or (c) the IRS has notified me that I am no longer subject to backup withholding. Check this box ☐ if you ARE subject to backup withholding;
3. I am a U.S. citizen or other U.S. person as defined by the IRS for federal tax purposes.
4. I am exempt from Foreign Account Tax Compliance Act (FATCA) reporting.

AUTHORIZATION: To determine eligibility for insurance, I, the undersigned applicant(s) authorize any licensed physician, licensed medical practitioner, health care professional, hospital, clinic, or other medically related facility, laboratory, pharmacy or pharmacy benefit manager, insurance or reinsuring company, MIB, Inc. (MIB), consumer reporting agency, insurance support organization, independent administrator, or governmental agency or group policyholder, or person, or employer having information available as to diagnosis, prescription history, medications prescribed, treatment and prognosis with respect to information regarding alcoholism, drug abuse, and psychiatric care or any physical or mental condition and/or treatment of me or my minor children proposed for insurance and any other nonmedical information of the Proposed Insured or minor children proposed for insurance to give to North American Company for Life and Health Insurance (the Company) or its legal representative, any and all such information. The release of the above listed information can be made in paper form or by Electronic Health Records to the Company or their authorized representatives. I authorize the Company or its reinsurers to make a brief report of my personal health information to MIB. I also authorize the Company to conduct a personal telephone interview in connection with my application. I further authorize the Company to collect information about me from public and non-public sources, including my Social Security number, financial and credit history, employment, general character and reputation, personal characteristics and mode of living. I authorize the Company to release any information obtained to its reinsurers, MIB, or other persons or organizations performing business or legal services in connection with my application or to persons or organizations performing services on behalf of the Company for other business or marketing purposes, or as required by law when given a copy of this authorization. I understand that I may request to be interviewed in connection with the preparation of an investigative consumer report. I understand that I am entitled to receive a copy of the investigative consumer report upon request. This authorization is valid from the date signed for the length of time permitted by applicable law in the state where the policy is delivered or issued for delivery. I may revoke this authorization for information not then obtained by notifying the Company in writing. Such revocation will not be effective until received by the Company. I understand that I or any authorized representative will receive a copy of this authorization upon request.

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

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

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

Any person who knowingly presents a false statement in an application for insurance may be guilty of a criminal offense and subject to penalties under state law.

SIGNATURES

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

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

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

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

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

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

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

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

TO BE COMPLETED BY SOLICITING AGENT	Commission Option (Defaults to A, if none selected): ☐ A ☐ B ☐ C ☐ D
1. If the policy being applied for includes an accelerated death benefit(s) endorsement, was the Owner provided the Accelerated Benefit Summary and Disclosure Statement(s) prior to or concurrent with this application?	☐ Yes ☐ No
2. Does any person covered under this application have any existing life insurance or annuities?	☐ Yes ☐ No
3. Is any insurance applied for in this application intended to replace any existing life insurance or annuity?	☐ Yes ☐ No
4. I used Company-created sales materials and received Company approval for all other sales materials, which require approval under the Life Insurance Compliance Guide for Producers. A copy of all such sales materials that were used was left with the applicant(s), including a printed copy of all such sales material presented electronically. (If unapproved sales materials were used, the Company will request a copy for review and approval.)	☐ Yes ☐ No

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