

SERFF Tracking Number: NAWS-125958130 State: Arkansas  
Filing Company: National Western Life Insurance Company State Tracking Number: 41242  
Company Tracking Number: 01-S022-08  
TOI: L09I Individual Life - Flexible Premium Sub-TOI: L09I.101 External Indexed - Single Life  
Adjustable Life  
Product Name: EIUL Options Application Supplement  
Project Name/Number: EIUL Options Application Supplement/01-S022-08

## Filing at a Glance

Company: National Western Life Insurance Company

Product Name: EIUL Options Application Supplement SERFF Tr Num: NAWS-125958130 State: ArkansasLH

TOI: L09I Individual Life - Flexible Premium SERFF Status: Closed State Tr Num: 41242  
Adjustable Life

Sub-TOI: L09I.101 External Indexed - Single Life Co Tr Num: 01-S022-08 State Status: Approved-Closed

Filing Type: Form Co Status: Initial Reviewer(s): Linda Bird  
Author: Stephanie Foskitt Disposition Date: 01/12/2009  
Date Submitted: 01/05/2009 Disposition Status: Approved

Implementation Date Requested: On Approval Implementation Date:

State Filing Description:

## General Information

Project Name: EIUL Options Application Supplement  
Project Number: 01-S022-08  
Requested Filing Mode: Review & Approval

Status of Filing in Domicile: Authorized  
Date Approved in Domicile:  
Domicile Status Comments: This form is deemed exempt in our state of domicile, Colorado, under Bulletin 5-92

Explanation for Combination/Other:  
Submission Type: New Submission  
Overall Rate Impact:

Market Type: Individual  
Group Market Size:  
Group Market Type:

Filing Status Changed: 01/12/2009

State Status Changed: 01/12/2009

Deemer Date:

Corresponding Filing Tracking Number:

Filing Description:

RE: Equity Index UL Options Supplement, form 01-S022-08

National Western Life Insurance Company, NAIC 66850, FEIN 84-0467208

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To Whom It May Concern:

Please find attached form 01-S022-08. This form is new and will replace an existing, previously approved form. This form is deemed exempt in our State of Domicile, Colorado, under Bulletin 92-5. The above captioned forms meet Arkansas's readability requirements. A certificate is enclosed for the Flesch Reading Ease Test score. No part of this filing contains any unusual or possibly controversial items from normal company standards.

This form is used by an applicant to initially select the equity index interest credit options for allocation. It will replace form 01-S022(Rev.09/07) approved for use in Arkansas on November 19, 2007. This form is used with long form life application 01-9043AR(Rev.07/00) to issue equity index life policy form 01-1140-08.

If these forms are acceptable for use, please notify me. Please feel free to contact me by phone at 512-719-1563 or by email at SFoskitt@NationalWesternLife.com if you have questions or concerns. Thank you for your time and consideration in this matter.

Sincerely,  
Stephanie Foskitt  
Contract Compliance Analyst

We reserve the right to change the format of this form without changing any of the language. Printing standards will never be less than that required by your state.

## Company and Contact

### Filing Contact Information

Stephanie Foskitt, Contract Compliance Analyst SFoskitt@NationalWesternLife.com  
National Western Life Insurance Company (512) 719-1563 [Phone]  
Austin, TX 78752 (512) 719-8522[FAX]

### Filing Company Information

National Western Life Insurance Company CoCode: 66850 State of Domicile: Colorado  
850 East Anderson Lane Group Code: -99 Company Type:

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Austin, TX 78752-1602  
(512) 836-1010 ext. [Phone]

Group Name:  
FEIN Number: 84-0467208  
-----

State ID Number:

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## Filing Fees

Fee Required? Yes  
Fee Amount: \$20.00  
Retaliatory? No  
Fee Explanation: \$20 per form x 1 form = \$20 total  
Per Company: No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
National Western Life Insurance Company	\$20.00	01/05/2009	24830095

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## Correspondence Summary

### Dispositions

Status	Created By	Created On	Date Submitted
Approved	Linda Bird	01/12/2009	01/12/2009



SERFF Tracking Number: *NAWS-125958130* State: *Arkansas*  
 Filing Company: *National Western Life Insurance Company* State Tracking Number: *41242*  
 Company Tracking Number: *01-S022-08*  
 TOI: *L09I Individual Life - Flexible Premium* Sub-TOI: *L09I.101 External Indexed - Single Life*  
*Adjustable Life*  
 Product Name: *EIUL Options Application Supplement*  
 Project Name/Number: *EIUL Options Application Supplement/01-S022-08*

<b>Item Type</b>	<b>Item Name</b>	<b>Item Status</b>	<b>Public Access</b>
<b>Supporting Document</b>	Certification/Notice		No
<b>Supporting Document</b>	Application		Yes
<b>Supporting Document</b>	Health - Actuarial Justification		No
<b>Supporting Document</b>	Outline of Coverage		No
<b>Supporting Document</b>	Cover Letter		Yes
<b>Supporting Document</b>	Previously Approved Form -- Marked Up		Yes
<b>Form</b>	Equity Index Universal Life Application Supplement		Yes

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## Form Schedule

Lead Form Number: 01-S022-08

Review Status	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
	01-S022-08	Application/Equity Index Enrollment Form	Universal Life Application Supplement	Initial		0	01-S022-08.pdf



**EQUITY INDEX UNIVERSAL LIFE  
APPLICATION SUPPLEMENT**

For use with Life Application form 01-9043 and State-Variations

Proposed Insured \_\_\_\_\_ Date of Birth \_\_\_\_\_

**Select the interest credit options and Allocation Percentages (whole numbers only) for the first Index Date.**

First Index Date

Index Interest Credit Option A	_____	%
Fixed Interest Amount	_____	%
Index Interest Credit Option D	_____	%
Index Interest Credit Option J	_____	%
<hr/>		
Total	100	%

**Select the Additional Riders to be issued with the policy. If Term Insurance Rider, Other Insured Rider, Spouse Term Life Insurance Rider, or Children’s Term Life Insurance Rider are desired, complete information in full on the Life Application.**

<u>RIDER</u>	<u>YES</u>	<u>NUMBER OF UNITS</u>
Accidental Death Benefit Rider	_____	_____
Total Disability Premium Payment Rider	_____	_____
Lifetime No Lapse Premium Rider	_____	<u>Units Not Applicable</u>
Paid Up Rider	_____	<u>Units Not Applicable</u>
Living Benefit Rider	_____	<u>Units Not Applicable</u>
Waiver of Monthly Deduction Disability Benefit Rider	_____	<u>Units Not Applicable</u>

Dated at \_\_\_\_\_ this \_\_\_\_\_ day of \_\_\_\_\_, 20 \_\_\_\_\_ .

Proposed Insured Signature \_\_\_\_\_ Date \_\_\_\_\_

Agent Signature as Witness \_\_\_\_\_ Date \_\_\_\_\_



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## Supporting Document Schedules

### Review Status:

**Satisfied -Name:** Application 12/19/2008

**Comments:**

Attached is form 01-9043AR(Rev.07/00) to be used in conjunction with the submitted supplement to issue life policy form 01-1140-08.

**Attachment:**

01-9043AR(Rev.07~00).pdf

### Review Status:

**Satisfied -Name:** Cover Letter 01/05/2009

**Comments:**

**Attachment:**

AR 01-S022-08 Cover Letter.pdf

### Review Status:

**Satisfied -Name:** Previously Approved Form -- Marked Up 01/05/2009

**Comments:**

**Attachment:**

EIUL App Supp 01-S022(Rev.09~07) MARKED UP.pdf

**PRIMARY INSURED:**

**PART I**

Full Name \_\_\_\_\_ Sex \_\_\_\_\_ Date of Birth \_\_\_\_\_ Age \_\_\_\_\_ State of Birth \_\_\_\_\_  Tobacco Use  
 Tobacco Free  
 Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
 Height \_\_\_\_\_ Weight \_\_\_\_\_ Driver's Lic. No. & State of Issue \_\_\_\_\_ Home Phone \_\_\_\_\_ Best Time  am  
 pm  
 Annual Income \$ \_\_\_\_\_ Work Phone \_\_\_\_\_ Best Time  am  
 pm  
 Employer \_\_\_\_\_ Annual Income \$ \_\_\_\_\_ Home Phone \_\_\_\_\_ Best Time  am  
 pm  
 Occupational Duties \_\_\_\_\_ Soc. Sec. Number \_\_\_\_\_ Amt. of Life Ins. In Force \$ \_\_\_\_\_ Amt. of ADB In Force \$ \_\_\_\_\_  
 Plan of Insurance \_\_\_\_\_ Death  Option I Face  WP  GIR  PD&D  
 Option II Amount \$ \_\_\_\_\_  ADB \$ \_\_\_\_\_  Other \_\_\_\_\_  
 Children's Rider\* \_\_\_\_\_ Units  Spouse Rider\* \_\_\_\_\_ Units  OIR  TIR \$ \_\_\_\_\_  Other \_\_\_\_\_  
 \*For children's and spouse riders, complete only the first two lines of each "Other Insured" block.

**OWNER:**

Full Name (If other than primary insured) \_\_\_\_\_ Relationship to Insured \_\_\_\_\_  
 Address \_\_\_\_\_ Soc. Sec. Number \_\_\_\_\_

**BENEFICIARY:**

Primary Beneficiary Name \_\_\_\_\_ Relationship \_\_\_\_\_ Age \_\_\_\_\_  
 Contingent Beneficiary Name \_\_\_\_\_ Relationship \_\_\_\_\_ Age \_\_\_\_\_

**PREMIUMS:**

Annual Premium \$ \_\_\_\_\_ One-time Deposit \$ \_\_\_\_\_ Planned Mode Premium \$ \_\_\_\_\_ CWA \$ \_\_\_\_\_  
**Mode:**  Monthly  Quarterly  Semiannual  Annual  \_\_\_\_\_  
**Method:**  Bank Draft  Direct  Allotment  Salary Deduction  \_\_\_\_\_

**SPECIAL REQUESTS:**

**OTHER INSURED:**

1. Full Name \_\_\_\_\_ Sex \_\_\_\_\_ Date of Birth \_\_\_\_\_ Age \_\_\_\_\_ State of Birth \_\_\_\_\_  Tobacco Use  
 Tobacco Free  
 Plan of Insurance \_\_\_\_\_ Face Amount \$ \_\_\_\_\_ Height \_\_\_\_\_ Weight \_\_\_\_\_ Relationship To Primary Insured \_\_\_\_\_  
 Occupational Duties \_\_\_\_\_ Annual Income \$ \_\_\_\_\_ Soc. Sec. Number \_\_\_\_\_ Amt. of Life Ins. In Force \$ \_\_\_\_\_  
 Beneficiary \_\_\_\_\_ Relationship To Other Insured \_\_\_\_\_ Age \_\_\_\_\_

2. Full Name \_\_\_\_\_ Sex \_\_\_\_\_ Date of Birth \_\_\_\_\_ Age \_\_\_\_\_ State of Birth \_\_\_\_\_  Tobacco Use  
 Tobacco Free  
 Plan of Insurance \_\_\_\_\_ Face Amount \$ \_\_\_\_\_ Height \_\_\_\_\_ Weight \_\_\_\_\_ Relationship To Primary Insured \_\_\_\_\_  
 Occupational Duties \_\_\_\_\_ Annual Income \$ \_\_\_\_\_ Soc. Sec. Number \_\_\_\_\_ Amt. of Life Ins. In Force \$ \_\_\_\_\_  
 Beneficiary \_\_\_\_\_ Relationship To Other Insured \_\_\_\_\_ Age \_\_\_\_\_

3. Full Name \_\_\_\_\_ Sex \_\_\_\_\_ Date of Birth \_\_\_\_\_ Age \_\_\_\_\_ State of Birth \_\_\_\_\_  Tobacco Use  
 Tobacco Free  
 Plan of Insurance \_\_\_\_\_ Face Amount \$ \_\_\_\_\_ Height \_\_\_\_\_ Weight \_\_\_\_\_ Relationship To Primary Insured \_\_\_\_\_  
 Occupational Duties \_\_\_\_\_ Annual Income \$ \_\_\_\_\_ Soc. Sec. Number \_\_\_\_\_ Amt. of Life Ins. In Force \$ \_\_\_\_\_  
 Beneficiary \_\_\_\_\_ Relationship To Other Insured \_\_\_\_\_ Age \_\_\_\_\_

4. Full Name \_\_\_\_\_ Sex \_\_\_\_\_ Date of Birth \_\_\_\_\_ Age \_\_\_\_\_ State of Birth \_\_\_\_\_  Tobacco Use  
 Tobacco Free  
 Plan of Insurance \_\_\_\_\_ Face Amount \$ \_\_\_\_\_ Height \_\_\_\_\_ Weight \_\_\_\_\_ Relationship To Primary Insured \_\_\_\_\_  
 Occupational Duties \_\_\_\_\_ Annual Income \$ \_\_\_\_\_ Soc. Sec. Number \_\_\_\_\_ Amt. of Life Ins. In Force \$ \_\_\_\_\_  
 Beneficiary \_\_\_\_\_ Relationship To Other Insured \_\_\_\_\_ Age \_\_\_\_\_

**NON-MEDICAL QUESTIONS:**

Apply to each proposed insured. For "yes" answers, give details below (Part I: Details) or complete the appropriate questionnaire required by the Company.

**PART I (cont)**

- |  |                          |     |                          |
|--|--------------------------|-----|--------------------------|
|  |                          | Yes | No                       |
| 1. During the last 12 months, has any proposed insured used any tobacco or nicotine product?.....  | <input type="checkbox"/> |     | <input type="checkbox"/> |
| 2. Is any application for life insurance or application for reinstatement pending with any company?.....   | <input type="checkbox"/> |     | <input type="checkbox"/> |
| 3. Has any proposed insured been declined, postponed, or charged an extra premium for life insurance? .....  | <input type="checkbox"/> |     | <input type="checkbox"/> |
| 4. Is this policy intended to replace any existing life insurance or annuity policy in any company? .....  | <input type="checkbox"/> |     | <input type="checkbox"/> |
| If "yes", list company and policy number _____   |                          |     |                          |
| 5. Do you intend to travel as a civilian (non-military) to any foreign country within the next two years? .....                                    | <input type="checkbox"/> |     | <input type="checkbox"/> |
| 6. In the past 5 years, has any proposed insured:  |                          |     |                          |
| A. Been a pilot or crew member of an airplane, or been on a balloon, hanglider or like device, or jumped therefrom? .....                          | <input type="checkbox"/> |     | <input type="checkbox"/> |
| B. Been a vehicle racer, diver, parachutist, mountain climber, bungee jumper or participant in a hazardous sport or hobby? .....                   | <input type="checkbox"/> |     | <input type="checkbox"/> |
| C. Been convicted of driving under the influence of alcohol or drugs, of a criminal offense, or is now incarcerated, on parole or probation? ..... | <input type="checkbox"/> |     | <input type="checkbox"/> |
| D. Been convicted of four or more driving violations or had driver's license suspended or revoked? .....   | <input type="checkbox"/> |     | <input type="checkbox"/> |
| E. Been treated or counseled by a health care provider for alcohol use, or attended a support group for help to stop alcohol use?..                | <input type="checkbox"/> |     | <input type="checkbox"/> |
| F. Used cocaine, marijuana, heroin, amphetamines, narcotics, stimulants, or other illegal drugs or controlled substances?.....                     | <input type="checkbox"/> |     | <input type="checkbox"/> |

**PART I DETAILS:** \_\_\_\_\_

**MEDICAL QUESTIONS:**

Apply to each proposed insured. Give full details below. (Part II: Details).

**PART II**

- |  |                          |     |                          |
|--|--------------------------|-----|--------------------------|
|  |                          | Yes | No                       |
| 1. Has any proposed insured, within the last ten years, ever had, or received medical advice or treatment for:   |                          |     |                          |
| A. High blood pressure, stroke, anemia, chest pain, heart attack, disease or disorder of the blood, heart, arteries or veins? .....  | <input type="checkbox"/> |     | <input type="checkbox"/> |
| B. Ulcers, or disease or disorder of the stomach, intestines, liver, gallbladder or rectum? .....  | <input type="checkbox"/> |     | <input type="checkbox"/> |
| C. Diabetes, cancer, tumors, cysts, leukemia, or disorder of the pancreas, thyroid, adrenal, lymph or other glands? .....  | <input type="checkbox"/> |     | <input type="checkbox"/> |
| D. Epilepsy convulsions, nervous or mental disorder, paralysis, or disorder of the brain or nervous system? .....  | <input type="checkbox"/> |     | <input type="checkbox"/> |
| E. Disease of the kidney, bladder, genital organs, or had sugar, albumin, or blood in the urine, or had gonorrhoea or syphilis? .....  | <input type="checkbox"/> |     | <input type="checkbox"/> |
| F. Asthma, emphysema, tuberculosis, chronic bronchitis, or disease of the lung, chest, or throat? .....  | <input type="checkbox"/> |     | <input type="checkbox"/> |
| 2. Has any proposed insured lost or gained more than 10 lbs. during the past 12 months?.....   | <input type="checkbox"/> |     | <input type="checkbox"/> |
| 3. Has a family member of a proposed insured died of an illness before reaching age 60? .....  | <input type="checkbox"/> |     | <input type="checkbox"/> |
| 4. Other than as answered above, has any proposed insured within the past 5 years:   |                          |     |                          |
| A. Consulted a health care provider, or been admitted to a hospital, treatment center, or other facility? .....  | <input type="checkbox"/> |     | <input type="checkbox"/> |
| B. Been treated for or been diagnosed by a medical professional as having infection with the Human Immunodeficiency Virus (HIV), AIDS-related Complex (ARC), or Acquired Immune Deficiency Syndrome (AIDS)?..... | <input type="checkbox"/> |     | <input type="checkbox"/> |
| C. Had an x-ray, ECG, blood or urine test, or other diagnostic medical test? .....   | <input type="checkbox"/> |     | <input type="checkbox"/> |
| D. Requested or received payments or reimbursements for a mental or physical disability?.....  | <input type="checkbox"/> |     | <input type="checkbox"/> |
| E. Been advised to have surgery, hospitalization, treatment, or diagnostic test that has not been completed? .....   | <input type="checkbox"/> |     | <input type="checkbox"/> |
| 5. Does any proposed insured now have, or take medication for, any disease, disorder or condition not indicated above?.....  | <input type="checkbox"/> |     | <input type="checkbox"/> |

**PART II DETAILS:**

Ques No.	1st Name of Person Treated	Reason For Treatment	Date	Name of Doctor or Hospital And Address

If more space is needed, use an additional sheet of paper dated and signed by the proposed insured(s).

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Each of the undersigned: Declares that all answers in this application are true to the best of their knowledge and belief, and understands that: (a) all answers in this application will be relied upon to determine insurability and issue the policy; and (b) a material misrepresentation voids the policy as of its issue date. This policy will take effect when: (1) the application is approved at National Western's Office in Austin, Texas; (2) National Western delivers the policy; (3) the initial premium has been paid; and (4) each of the prior three conditions is satisfied while the applicant is alive and the applicant's health and insurability is as described herein.

Each of the undersigned: Authorizes any licensed physician, medical practitioner, hospital, clinic, other health care provider, insurance company or the Medical Information Bureau (MIB) or other organization or person to give any information about me or my mental or physical health to the Company and/or its authorized agents to determine my eligibility for life insurance coverage. The Company may disclose such information to its reinsurers and the MIB. National Western or its reinsurers may also release such information to other life or health insurance companies to whom an application for insurance or to whom a claim for benefits is submitted. This authorization also applies to any member of my family proposed for coverage in the application and is valid for 2 years after the date shown below. A photo of this form is as valid as the original. I may have a copy of this form upon request.

Each of the undersigned acknowledges receipt of the Consumer Report Notice, MIB Disclosure Notice, and Information Practices (if applicable).

The automatic premium loan provision (when available) is elected, unless otherwise indicated in this application.

✓  
\_\_\_\_\_  
**Signature of Owner** if other than Proposed Primary Insured  
(If business insurance, show the title of officer and name of firm)

✓  
\_\_\_\_\_  
**Signature of Proposed Primary Insured**  
(Parent if age 17 or less)

**Signatures of other proposed insureds age 18 or older:**

Other Insured #1 ✓ \_\_\_\_\_

Other Insured #2 ✓ \_\_\_\_\_

Other Insured #3 ✓ \_\_\_\_\_

Other Insured #4 ✓ \_\_\_\_\_

Signed in \_\_\_\_\_ Date \_\_\_\_\_  
City State

X  
\_\_\_\_\_  
**Agent/Witness** as to all signatures

**AGENTS' REPORT:**

- GENERAL QUESTIONS:** Always complete. Yes No
- A. How long have you known applicants? \_\_\_\_\_ How well? \_\_\_\_\_ Relationship? \_\_\_\_\_
  - B. If an adult, annual income? \$ \_\_\_\_\_ Approximate net worth? \$ \_\_\_\_\_
  - C. Proposed insured(s) is citizen of \_\_\_\_\_ . Length of time in current country of residence? \_\_\_\_\_
  - D. List prior NWL policy numbers and face amount \_\_\_\_\_
  - E. Do any of the proposed insureds appear to be unhealthy in any way?.....
  - F. Are you aware of anything about the proposed insureds that might affect their insurability? .....
  - G. Will the policy applied for replace or change any existing insurance or annuity? .....
  - H. Is the owner or beneficiary someone other than the proposed insured's parent, spouse or child?.....

- DEPENDENT CHILD QUESTIONS:** Complete if any proposed insured is a dependent child.
- I. Number of brothers? \_\_\_\_\_ Sisters? \_\_\_\_\_ Amount of insurance on each child? \_\_\_\_\_
  - J. Amount in force on Father? \_\_\_\_\_ Mother? \_\_\_\_\_ Parent's annual income? \_\_\_\_\_ Net worth? \_\_\_\_\_
  - K. Is child insured for more than the parents or insured for more than the other children in the family?.....

**DETAILS:** \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

I personally solicited and completed this application. All medical and non-medical questions were asked of each proposed insured and their answers were recorded exactly as given. The consumer notices were delivered to either the proposed primary insured or the proposed owner. The temporary insurance agreement was explained fully and (if applicable), the receipt was given.

Date \_\_\_\_\_ **Agent Signature** X \_\_\_\_\_ Agent No. \_\_\_\_\_ Percent of Case \_\_\_\_\_ %

Date \_\_\_\_\_ **Agent Signature** X \_\_\_\_\_ Agent No. \_\_\_\_\_ Percent of Case \_\_\_\_\_ %

**DRAFT AUTHORIZATION INFORMATION**


Names of other insureds on this draft

Policy Number(s)

Type or print bank name and address in window

**Attach void check or deposit slip to this authorization form.**

Bank Account No. \_\_\_\_\_ Bank Transit No. \_\_\_\_\_

**AUTHORIZATION TO HONOR WITHDRAWALS MADE BY NATIONAL WESTERN LIFE**

TO: BANK NAMED ABOVE. I hereby request the named bank to accept and honor drafts or transfers from my account made by National Western Life. I agree that your rights regarding each draft or transfer shall be same as if it was signed personally by me. This Authorization shall remain in effect until I give you, my financial institution, 3 days written notice to revoke it, or if verbal notice is given, you may require me to provide written notice within 14 days after the oral notice was given. I have retained a copy of this authorization.

Date \_\_\_\_\_ Print Name of Depositor(s) \_\_\_\_\_ Signature of Depositor(s) ✓

Date \_\_\_\_\_ Print Name of Depositor(s) \_\_\_\_\_ Signature of Depositor(s) ✓

**TEMPORARY INSURANCE AGREEMENT & RECEIPT**

This agreement shall be void if altered or modified. • Premium checks must be made payable to National Western Life.

Proposed Insured \_\_\_\_\_ Amount Paid \$ \_\_\_\_\_ Application Date \_\_\_\_\_

Subject to all terms and conditions of the insurance policy applied for in this application, this Temporary Insurance Agreement & Receipt (TIA) provides Temporary Insurance in the amount of the lesser of: (a) the amount of insurance applied for; or (b) \$50,000 on each proposed insured; or (c) \$250,000 in the aggregate for all insureds listed on the application. This Temporary Insurance will take effect on the effective date and end as defined on the reverse side of this TIA.

I have read this Temporary Insurance Agreement & Receipt and it has been explained to me by the agent. I understand and agree to all conditions and limitations. Proposed owner's signature \_\_\_\_\_ Date \_\_\_\_\_

I explained and witnessed the signing of this Agreement.

Agent's signature \_\_\_\_\_ Date \_\_\_\_\_

Temporary Insurance will take effect on the date that the following four requirements are met: (1) the application is fully completed, including any amendments required by National Western; (2) the initial premium has been paid; and (3) all medical exams or tests required by National Western are completed; and (4) as of the date of this Agreement, the proposed insured must be insurable at standard rates for the type and amount of insurance applied for.

Temporary Insurance will end on the earliest of the following dates: (1) the date insurance begins under the policy applied for; (2) the date this application is cancelled or declined; or (3) 60 days have passed since the date of this application.

**DETACH AND KEEP THIS NOTICE**

DATE \_\_\_\_\_

**NOTICE UNDER THE FAIR CREDIT REPORTING ACT.** This is to inform you that, as part of our procedure for processing your application for insurance, an investigative consumer report may be prepared whereby information is obtained through personal interviews with your neighbors, friends, or others with whom you are acquainted. This inquiry includes information as to your character, general reputation, personal characteristics and mode of living. You have the right to make a written request within a reasonable period of time to receive additional, detailed information about the nature and scope of this investigation.

**MIB DISCLOSURE NOTICE.** Information regarding your insurability will be treated as confidential; however, we or our reinsurers may make a brief report thereon to the Medical Information Bureau (MIB), a non-profit organization of life insurance companies which operates an informational exchange for its members. If you apply for life or health insurance, or submit a claim for benefits to any MIB member, the MIB will, upon request, supply such member with the information in its file.

Upon your request, the MIB will disclose any information in your file. If you feel that any information in your MIB file is inaccurate, you may contact the MIB at P.O. Box 105, Essex Sta., Boston, Mass. 02112, Tel. (617) 426-3660, and seek correction in accordance with the procedures set out in the federal Fair Credit Reporting Act.

We or our reinsurers may also release information to other life insurance companies to whom you may (1) apply for life or health insurance, or (2) submit a claim for benefits.

**NOTICE OF INFORMATION PRACTICES.** Residents of Arizona, California, Georgia, Illinois, Maine, Minnesota, Montana, Nevada, North Carolina, Ohio, Oregon and Virginia must be given and sign an Authorization to Obtain and Disclose Information and Notice of Information Practices [SU-6412(Rev.1/95)].

**NATIONAL WESTERN LIFE INSURANCE COMPANY**  
850 East Anderson Lane, Austin, Texas 78752



January 5, 2009

Arkansas Department of Insurance  
Life and Health Compliance  
1200 West Third Street  
Little Rock, Arkansas 72201-1904

RE: Equity Index UL Options Supplement, form 01-S022-08  
National Western Life Insurance Company, NAIC 66850, FEIN 84-0467208

To Whom It May Concern:

Please find attached form 01-S022-08. This form is new and will replace an existing, previously approved form. This form is deemed exempt in our State of Domicile, Colorado, under Bulletin 92-5. The above captioned forms meet Arkansas's readability requirements. A certificate is enclosed for the Flesch Reading Ease Test score. No part of this filing contains any unusual or possibly controversial items from normal company standards.

This form is used by an applicant to initially select the equity index interest credit options for allocation. It will replace form 01-S022(Rev.09/07) approved for use in Arkansas on November 19, 2007. This form is used with long form life application 01-9043AR(Rev.07/00) to issue equity index life policy form 01-1140-08.

If these forms are acceptable for use, please notify me. Please feel free to contact me by phone at 512-719-1563 or by email at [SFoskitt@NationalWesternLife.com](mailto:SFoskitt@NationalWesternLife.com) if you have questions or concerns. Thank you for your time and consideration in this matter.

Sincerely,

A handwritten signature in black ink that reads "SFoskitt". The signature is written in a cursive, flowing style.

Stephanie Foskitt  
Contract Compliance Analyst

We reserve the right to change the format of this form without changing any of the language. Printing standards will never be less than that required by your state.



**EQUITY INDEX UNIVERSAL LIFE  
APPLICATION SUPPLEMENT**

For use with Life Application form 01-9043 and State-Variations

Proposed Insured \_\_\_\_\_ Date of Birth \_\_\_\_\_

**Select the interest credit options and Allocation Percentages (whole numbers only) for the first Index Date.**

First Index Date

Index Interest Credit Option A \_\_\_\_\_ %

Fixed Interest Amount \_\_\_\_\_ %

Index Interest Credit Option D \_\_\_\_\_ %

Total 100 %

Here we added Index Interest Credit Option J and we added a blank line for any additional options in the future.

**Select the Additional Riders to be issued with the policy. If Term Insurance Rider, Other Insured Rider, Spouse Term Life Insurance Rider, or Children's Term Life Insurance Rider are desired, complete information in full on application.**

<u>RIDER</u>	<u>YES</u>	<u>NUMBER OF UNITS</u>
Accidental Death Benefit Rider	_____	_____
Total Disability Premium Payment Rider	_____	_____
Lifetime No Lapse Premium Rider	_____	<u>Units Not Applicable</u>
Waiver of Monthly Deduction Disability Benefit Rider	_____	<u>Units Not Applicable</u>

Dated at \_\_\_\_\_ this \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_\_.

Proposed Insured Signature \_\_\_\_\_ Date \_\_\_\_\_

Agent Signature as Witness \_\_\_\_\_ Date \_\_\_\_\_