

<i>SERFF Tracking Number:</i>	<i>EMCN-126301961</i>	<i>State:</i>	<i>Arkansas</i>
<i>Filing Company:</i>	<i>EMC National Life Company</i>	<i>State Tracking Number:</i>	<i>43535</i>
<i>Company Tracking Number:</i>			
<i>TOI:</i>	<i>L04I Individual Life - Term</i>	<i>Sub-TOI:</i>	<i>L04I.103 Renewable - Single Life - Fixed/Indeterminate Premium</i>
<i>Product Name:</i>	<i>STOLI Certification</i>		
<i>Project Name/Number:</i>	<i>/</i>		

Filing at a Glance

Company: EMC National Life Company

Product Name: STOLI Certification

TOI: L04I Individual Life - Term

Sub-TOI: L04I.103 Renewable - Single Life -
Fixed/Indeterminate Premium

Filing Type: Form

SERFF Tr Num: EMCN-126301961 State: Arkansas

SERFF Status: Closed-Approved-
Closed State Tr Num: 43535

Co Tr Num:

State Status: Approved-Closed

Author: Daryl Schoenfeld

Date Submitted: 09/21/2009

Reviewer(s): Linda Bird

Disposition Date: 09/25/2009

Disposition Status: Approved-
Closed

Implementation Date Requested: On Approval

State Filing Description:

Implementation Date:

General Information

Project Name:

Project Number:

Requested Filing Mode: Review & Approval

Explanation for Combination/Other:

Submission Type: New Submission

Overall Rate Impact:

Filing Status Changed: 09/25/2009

Deemer Date:

Submitted By: Daryl Schoenfeld

Filing Description:

Re: EMC National Life Company

NAIC #62928

FEIN #42-0868851

Certification Regarding Stranger Originated Life Insurance EUN012

Flesch Score 55

Status of Filing in Domicile: Authorized

Date Approved in Domicile: 09/14/2009

Domicile Status Comments: Filed and
approved.

Market Type: Individual

Group Market Size:

Group Market Type:

Explanation for Other Group Market Type:

State Status Changed: 09/25/2009

Created By: Daryl Schoenfeld

Corresponding Filing Tracking Number:

SERFF Tracking Number: EMCN-126301961 State: Arkansas
Filing Company: EMC National Life Company State Tracking Number: 43535
Company Tracking Number:
TOI: L04I Individual Life - Term Sub-TOI: L04I.103 Renewable - Single Life -
Fixed/Indeterminate Premium
Product Name: STOLI Certification
Project Name/Number: /

There is growing concern in the life insurance industry and with state and federal regulators regarding the practice called stranger originated life insurance (STOLI). EMC National Life Company is implementing a new procedure to prevent STOLI transactions with our Company.

Attached for your review and approval is our Certification Regarding Stranger Originated Life Insurance EUN012. It will be used by our licensed representatives in the individual life insurance application process with all applications where the insured is age 65 or older and the face amount of all currently pending life insurance applications is \$500,000.00 or more. The form will be used in the application process with our previously approved life applications LA100 (1-05) SCD or EAP006 (12-07) to detect and prevent STOLI transactions.

This is a new form and will not replace any previously approved forms. It will be filed for approval in all states we are admitted. This submission contains no unusual or possibly controversial items that may deviate from normal company or industry standards.

Please review this and inform us of your approval. Thank you.

Daryl Schoenfeld, FLMI, CLU, ChFC
Assistant Secretary
515-237-2032
E-mail: dschoenfeld@emcni.com

Company and Contact

Filing Contact Information

Daryl Schoenfeld, Assistant Secretary
4095 NW Urbandale Drive
Urbandale, IA 50322-7914

Dschoenfeld@emcni.com
515-237-2032 [Phone]

Filing Company Information

EMC National Life Company
4095 NW Urbandale Drive
Urbandale, IA 50322-7914
(515) 645-4000 ext. 4094[Phone]

CoCode: 62928
Group Code:
Group Name:
FEIN Number: 42-0868851

State of Domicile: Iowa
Company Type: L and Health
State ID Number:

SERFF Tracking Number: EMCN-126301961

State: Arkansas

Filing Company: EMC National Life Company

State Tracking Number: 43535

Company Tracking Number:

TOI: L04I Individual Life - Term

Sub-TOI: L04I.103 Renewable - Single Life -
Fixed/Indeterminate Premium

Product Name: STOLI Certification

Project Name/Number: /

Filing Fees

Fee Required? Yes
Fee Amount: \$50.00
Retaliatory? No
Fee Explanation:
Per Company: No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
EMC National Life Company	\$50.00	09/21/2009	30688679

SERFF Tracking Number: EMCN-126301961

State: Arkansas

Filing Company: EMC National Life Company

State Tracking Number: 43535

Company Tracking Number:

TOI: L041 Individual Life - Term

Sub-TOI: L041.103 Renewable - Single Life -
Fixed/Indeterminate Premium

Product Name: STOLI Certification

Project Name/Number: /

Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved- Closed	Linda Bird	09/25/2009	09/25/2009

SERFF Tracking Number: EMCN-126301961

State: Arkansas

Filing Company: EMC National Life Company

State Tracking Number: 43535

Company Tracking Number:

TOI: L04I Individual Life - Term

Sub-TOI: L04I.103 Renewable - Single Life -
Fixed/Indeterminate Premium

Product Name: STOLI Certification

Project Name/Number: /

Disposition

Disposition Date: 09/25/2009

Implementation Date:

Status: Approved-Closed

Comment:

Rate data does NOT apply to filing.

SERFF Tracking Number: EMCN-126301961 State: Arkansas
 Filing Company: EMC National Life Company State Tracking Number: 43535
 Company Tracking Number:
 TOI: L041 Individual Life - Term Sub-TOI: L041.103 Renewable - Single Life -
 Fixed/Indeterminate Premium
 Product Name: STOLI Certification
 Project Name/Number: /

Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification		Yes
Supporting Document	Application		Yes
Supporting Document	Life & Annuity - Acturial Memo		No
Form	Certification Regarding Stranger Originated Life Insurance		Yes

SERFF Tracking Number: EMCN-126301961 State: Arkansas
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 TOI: L04I Individual Life - Term Sub-TOI: L04I.103 Renewable - Single Life -
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Form Schedule

Lead Form Number: EUN012

Schedule Item Status	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
	EUN012	Other	Certification Regarding Stranger Originated Life Insurance	Initial		55.000	EUN012-STOLI.pdf



P.O. Box 9202 ■ Des Moines, IA 50306-9202
 1.800.232.5818 ■ www.EMCNationalLife.com

Certification Regarding Stranger Originated Life Insurance

The following Policyowner's Certification is required with all life insurance applications where the insured is age 65 or older and the face amount of all currently pending life insurance applications is \$500,000 or more (including applications with other insurers.) Please complete this Certification after reviewing the accompanying information regarding stranger originated life insurance ("STOLI"):

Name of Insured	Date of Application	Life Insurance Face Amount

As the Policyowner:

- | | Yes | No |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------|--------------------------|
| 1. Do you intend to use or transfer the policy for any type of pre-death financial settlement, such as viatical settlement, senior settlement, life settlement or for any other secondary market? | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Did you have discussions with the agent about the possible sale or assignment of the Policy to a life settlement, viatical, or other secondary market provider? | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Have you, the insured or any other person been offered cash, premium financing, services, etc. as an inducement to enter into this transaction? | <input type="checkbox"/> | <input type="checkbox"/> |

Give complete details below to all Yes answers.

I/we, the undersigned, declare and certify to the following:

- A. All of the answers contained in the Certification are true, correct and complete to the best of my knowledge, information and belief.
- B. I agree that this Certification, the application and any policy amendments and riders shall constitute the entire contract.

Proposed Policyowner's Signature

Signed At City/State

Date

Joint Policyowner's Signature (if any)

Signed At City/State

Date

EMC NATIONAL LIFE COMPANY'S POLICY REGARDING STRANGER ORIGINATED LIFE INSURANCE

Over the last several years, there has been a growing concern in the life insurance industry and with state and federal regulators regarding a practice called stranger originated life insurance ("STOLI"). The following is to inform you about STOLI and the Company's position on STOLI transactions.

What is a STOLI transaction?

A person traditionally purchases life insurance to provide protection for someone who has an insurable interest in the life of the insured. In other words, the beneficiary would suffer a genuine economic loss if the insured would die.

But in a STOLI transaction, a promoter contacts a prospective insured, generally a senior citizen and offers inducements to purchase a life insurance policy. The policy is funded by investors, who hope for a financial profit from the death of the insured. The National Council of Life Insurance Legislators (NCOIL) defines STOLI as "a practice or plan to initiate a life insurance policy for the benefit of a third party investor who, at the time of policy origination, has no insurable interest in the insured." While these schemes are often advertized as 'free insurance,' there are hidden costs, potential tax consequences and legal issues which dishonest promoters fail to disclose. Life insurance is designed to protect an interest, rather than to become a wager on the life of the insured.

EMC National Life Company's Policy

EMC National Life Company's position is that STOLI business is unacceptable. We seek your assistance in identifying STOLI transactions by completing the Certification Regarding Stranger Originated Life Insurance as part of your application for insurance. If you have any questions regarding this certification, please discuss them with your agent, or you may contact us directly at 800-232-5818.

SERFF Tracking Number: EMCN-126301961

State: Arkansas

Filing Company: EMC National Life Company

State Tracking Number: 43535

Company Tracking Number:

TOI: L04I Individual Life - Term

Sub-TOI: L04I.103 Renewable - Single Life -
Fixed/Indeterminate Premium

Product Name: STOLI Certification

Project Name/Number: /

Supporting Document Schedules

Item Status:

Status

Date:

Satisfied - Item: Flesch Certification

Comments:

Compliance and readability certificates are attached.

Attachments:

AR Certificate of Compliance.pdf

AR Readability Certificate.pdf

Item Status:

Status

Date:

Satisfied - Item: Application

Comments:

Applications mentioned in the Filing Description are attached for your information.

Attachments:

LA100_0105_SCD.pdf

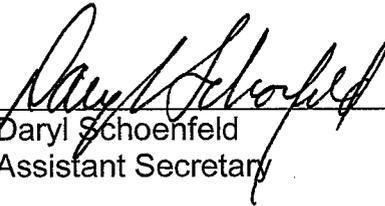
EAP006_1207_scd.indd.pdf

STATE OF ARKANSAS
CERTIFICATE OF COMPLIANCE

I hereby certify that this submission complies with the Arkansas Rule and Regulation 19 which relates to eliminating the act of denying benefits or coverage on the basis of sex or marital status in the terms and conditions of insurance contracts or underwriting criteria, as applicable.

I hereby certify that this submission complies with the Arkansas Rule and Regulation 49 which relates to providing Life and Health Guaranty Association notices, as applicable.

I hereby certify that this submission complies with the Arkansas Statutes – Insurance Laws 23-79-138 which relates to required policy information on every policy of life insurance, accident and health insurance issued, as applicable.



Daryl Schoenfeld
Assistant Secretary

September 21, 2009

Date

READABILITY

CERTIFICATION

I certify to the best of my knowledge that form EUN012 is readable based on the factors specified in Sections 66-3251 to 66-3258 of the Arkansas Statutes. The Flesch Scores are as follows:

<u>Form Number</u>	<u>Flesch Score</u>
EUN012	55



Daryl Schoenfeld
Assistant Secretary

September 21, 2009
Date



National Life Company

A STOCK LIFE INSURANCE COMPANY

P.O. Box 9202 ■ Des Moines, IA 50306-9202

1.800.232.5818 ■ www.EMCNationalLife.com

Application
for
Individual Life
Insurance

**Use for all fully
underwritten life products**

Do not use for Worksite products

EMC, flag design and *Count on EMC* are registered trademarks of Employers Mutual Casualty Company.

— ALWAYS DETACH AND GIVE TO APPLICANT —

FAIR CREDIT REPORTING ACT

In Compliance with 15 USC 1681 et. seq., this notice is to inform you that:

In making this application for insurance it is understood that an investigative consumer report may be made whereby information is obtained through personal interviews with third parties, such as family members, business associates, financial sources, friends, neighbors, or others with whom you are acquainted. This inquiry includes information as to your character, general reputation, personal characteristics, and mode of living, whichever may be applicable. You have the right to make a written request to EMC National Life Company, P.O. Box 9144, Des Moines, IA 50306-9144 within a reasonable period of time for a complete and accurate disclosure of additional information concerning the nature and scope of the investigation.

NOTIFICATION REGARDING THE MEDICAL INFORMATION BUREAU

Information regarding your insurability will be treated as confidential. EMC National Life Company or its Reinsurer(s) may, however, make a brief report thereon to the MIB, Inc., formerly known as Medical Information Bureau, a not-for-profit membership organization of insurance companies, which operates an information exchange on behalf of its Members. If you apply to another MIB Member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, MIB, upon request, will supply such company with the information about you in its file.

Upon receipt of a request from you, MIB will arrange disclosure of any information in your file. Please contact MIB at 866-692-6901 (TTY 866-346-3642). If you question the accuracy of the information in MIB's file, you may contact MIB and seek a correction in accordance with the procedures set forth in the federal Fair Credit Reporting Act. The address of MIB's information office is [50 Braintree Hill Park, Suite 400, Braintree, Massachusetts 02184-8734].

EMC National Life Company, or its Reinsurer(s) may also release information from its file to other insurance companies to whom you may apply for life or health insurance, or to whom a claim for benefits may be submitted. Information for consumers about MIB may be obtained on its website at www.mib.com.

— COMPLETE, DETACH AND GIVE TO APPLICANT ONLY WHEN FULL FIRST PREMIUM IS PAID WITH APPLICATION —

CONDITIONAL COVERAGE RECEIPT

RECEIVED FROM _____, this _____ day of _____ the sum of \$ _____, subject to the terms and conditions of the policy, as full (check one) annual semi-annual quarterly monthly check plan premium, along with the application bearing the date of this Receipt, for coverage on _____, the Proposed Insured(s).

TERMS AND CONDITIONS

“Effective Date” as used herein means the later of a) the date the application is signed; b) the date of completion of all medical examinations, if required; or c) the requested Effective Date shown on the application.

Coverage may become effective prior to the policy delivery if and when all of the following conditions are met:

1. The amount of the payment is equal to the first full premium selected and the payment is taken with the application;
2. The Proposed Insured(s) must be, on the Effective Date as defined above, a risk acceptable to EMC National Life Company under its rules, standards and practices for the exact contract of insurance and premium applied for, without any modifications; and
3. The contract is issued exactly as applied for within 60 days from the date of the application. If the application is declined or disapproved or if the contract is not issued within 60 days from the date of application, then this condition has not been fulfilled, no coverage is or has been provided under the terms of this Conditional Receipt, and any premium paid will be returned.
4. The maximum amount of coverage which may become effective under this Conditional Receipt, including any Riders applied for, cannot exceed \$250,000.

If any of the above conditions is not met, there shall be no liability on the part of EMC National Life Company except to return the premiums collected with the application.

This Receipt shall be rendered void if it is modified or altered, or if a check or draft given in payment is not honored. No agent or broker of EMC National Life Company, P.O. Box 9144, Des Moines, IA 50306-9144 is authorized to waive or alter any of the above conditions.

X _____	X _____	X _____
Applicant's Signature	Agent's Signature	Date

**ALL PREMIUM CHECKS OR DRAFTS MUST BE MADE PAYABLE TO EMC NATIONAL LIFE COMPANY.
DO NOT MAKE CHECKS PAYABLE TO THE AGENT. DO NOT LEAVE THE PAYEE BLANK.**

7. **Life Plan:** _____ **Amount of Coverage:** \$ _____

Please use Marketing name. See agent website or product guide for product options and rider specifications

Term Life Options and Riders

- Level Term for _____ Years
- Spouse/Other Insured Term Rider Amt. \$ _____
- Disability Income Rider (must complete Section 11)
- Waiver of Premium
- Children's Term # Units _____ or \$ _____
- Accidental Death Benefit \$ _____
- Other _____

Critical Illness Options and Riders

- Acceleration Option: 50% 100%
(must complete Acceleration Benefit Disclosure form)
- Disability Income Rider (must complete Section 11)
 - Waiver of Premium
 - Children's Term # Units _____ or \$ _____
 - Accidental Death Benefit \$ _____
 - Other _____

Universal Life Options and Riders

- Option 1 / B - Level Death Benefit
- Option 2 / A - Increasing Death Benefit
- Waiver: (specify one) Monthly Deductions
- Stipulated Amt. \$ _____
- Minimum Premium
- Primary Insured Term Rider Amt. \$ _____
- Spouse/Other Insured Term Rider Amt. \$ _____
- Children's Term # Units _____ or \$ _____
- Disability Income Rider (must complete Section 11)
- Accidental Death Benefit \$ _____
- GPO/GIO \$ _____
- Other _____

Participating Whole Life Options and Riders

- Waiver of Premium
- Children's Term # Units _____ or \$ _____
- Family Plan # Units _____
- Accidental Death Benefit \$ _____
- Automatic Premium Loan (if available)
- GPO/GIO \$ _____
- Value Plus
- Paid-Up Additions: Modal Prem. \$ _____
- Single Prem. \$ _____
- Dividends: Purchase Paid-Up Additions Cash
- Reduce Premiums Accumulate at Interest
- Other _____

Premium Options

Mode: Annual Semiannual Quarterly Monthly Check Plan List Bill Other _____
 Premium: Planned Periodic \$ _____ Extra Single / Lump Sum \$ _____ Estimated 1035 / Lump Sum \$ _____
Amount Paid with Application \$ _____

8. Has any person proposed for coverage:

- | | | |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------|--------------------------|
| | Yes | No |
| A. Have any other application for personal insurance pending? | <input type="checkbox"/> | <input type="checkbox"/> |
| B. Applied for life, health, or disability insurance or reinstatement which was declined, postponed, rated, restricted or modified? | <input type="checkbox"/> | <input type="checkbox"/> |
| C. Engaged in aviation activity other than as a passenger? (If yes, complete 1,2, 3, 4 and 5) | <input type="checkbox"/> | <input type="checkbox"/> |
| (1) Number of hours flown last 12 months _____ (2) Number of hours contemplated over next 12 months _____ | | |
| (3) Total number of hours flown _____ (4) License type _____ (5) Type of flying _____ | | |
| D. Engaged in ballooning, sky diving, racing, mountain climbing, rodeo competition, SCUBA diving (max depth _____) or any hazardous sport or activity? Intentions to engage in such activities over next 12 months: activity _____ frequency _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| E. Within the past three years, had a driver's license suspended or revoked for any reason, or been charged with or convicted of driving while intoxicated or under the influence of a controlled substance, or with any moving violation involving a motor vehicle? If yes, list below the name(s), date(s) and details including the driver's license number(s) | <input type="checkbox"/> | <input type="checkbox"/> |
| F. Been convicted of a felony? | <input type="checkbox"/> | <input type="checkbox"/> |
| G. Within the past five years, been a member of the Armed Forces? If yes, list below name, branch, rank and duties | <input type="checkbox"/> | <input type="checkbox"/> |
| H. (1) Now use tobacco? | <input type="checkbox"/> | <input type="checkbox"/> |
| (2) Ever used tobacco? If yes, provide date when stopped _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| If yes to H(1) or (2), indicate below name of person and type of tobacco used (cigarettes, pipe, cigar, chew, other) | | |

Specify person's name and give details to all Yes answers. Also, use this area to provide any other information.

9. Family History (on any person proposed for coverage)

	Proposed Insured		Spouse/Other Insured	
	Age if Living	Age at Death/Cause	Age if Living	Age at Death/Cause
Father				
Mother				
Siblings				

10. IMPORTANT! GIVE COMPLETE DETAILS BELOW FOR EACH "YES" ANSWER SPECIFYING TO WHOM MEDICAL HISTORY APPLIES, DATES AND RESULTS OF TREATMENT, DOCTORS AND COMPLETE ADDRESSES.

- A. Has any person proposed for coverage: **Yes No**
- (1) Had any diagnosis or treatment for: high blood pressure, chest pain or angina, heart attack, stroke, or disease or disorder of the heart, heart valves, blood, or blood vessels?
 - (2) Had any diagnosis or treatment for: cancer, tumor, leukemia, epilepsy, nervous or mental disorder, diabetes, hepatitis, disease or disorder of the pancreas, stomach or intestines, lungs including asthma or emphysema, brain or nervous system, kidney or liver?
 - (3) Been diagnosed as having or been treated for Human Immunodeficiency Virus (HIV), Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC) by a member of the medical profession?
 - (4) Been diagnosed as having or been treated for any immune deficiency disorder or autoimmune or connective tissue disease or disorder (not HIV related)?
 - (5) Except as prescribed by a physician, ever used marijuana, heroin, cocaine, barbiturates or other illegal drugs, joined any organization, received or had treatment or counseling for drug or alcohol abuse?
 - (6) Within the past five years, seen a physician or received treatment for any disease or condition not stated above?
- B. Is any person proposed for coverage taking prescription medication?
- C. Is any person proposed for coverage currently awaiting surgery, diagnostic testing, results of diagnostic testing or been advised to have diagnostic testing or consultation with a medical practitioner?

Give complete details below to all Yes answers. Use box near bottom of page 2 if additional space is needed.

Ques. No.	Person's Name	Dates	Symptom(s),Condition(s) Diagnosis	Treatment / Medication	Name(s) & Address(es) of Doctors, Hospitals or Clinics

11. Disability Income Rider (Complete for each person applying for the Disability Income Rider)

- A. Name of each person proposed for Rider coverage: _____
Primary Other
- B. Has any person proposed for coverage: **Yes No**
- (1) Have any reason for not being physically capable of full time employment?
 - (2) Have any other Disability Income policies inforce? If yes, amount \$ _____
 - (3) Within the past 5 years, received Disability, Worker's Comp. or Pension Benefits?
 - (4) Within the past 5 years, received medical care for the muscles, bones, joints, including back, spine or feet or any other nerve disorder or treatment of any muscular or neuromuscular disorder?
- C. Annual Income: Primary Insd.: Earned: \$ _____ Unearned: \$ _____ Other Insd.: Earned: \$ _____ Unearned: \$ _____
- D. Elimination Period (select 30 or 90 days) Primary Insd.: 30 days 90 days Other Insd.: 30 days 90 days
- E. Monthly Benefit Amount applied for: Primary Insd. \$ _____ Other Insd. \$ _____
- F. Describe employment duties below for each person proposed for Rider coverage (what you do, types of machines used)

Specify person's name and give details to all Yes answers. Specify employment duties.

12. Taxpayer Identification Certification. Per Internal Revenue Service guidelines, use this area to report and certify the taxpayer identification number (typically this is your social security number or an employer identification number) of the owner of the policy.

Under penalties of perjury, by my signature on this form on page 4, I certify that:

1. The number shown on this form on page 1 is my correct taxpayer identification number, **and**
2. I am not subject to backup withholding either because: **(a)** I am exempt from backup withholding, or **(b)** I have not been notified by the Internal Revenue Service (IRS) 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, **and**
3. I am a U.S. person (including a U.S. resident alien).

Note: You must cross out item 2 above if you have been notified by the IRS that you are currently subject to backup withholding because you have failed to report all interest and dividends on your tax return.

AUTHORIZATION TO OBTAIN AND DISCLOSE INFORMATION

I (person(s) signed below) understand EMC National Life Company (EMCNL), its reinsurers, insurance support organizations, and their authorized representative, may obtain medical and other information in order to evaluate my application for insurance. I authorize any Medical Providers, as described below, to disclose or release Protected Health Information, as described below, to EMC National Life Company, P.O. Box 9144, Des Moines, Iowa 50306-9144 or its authorized representative.

- Medical Providers: All physicians, medical or dental practitioners, hospitals, clinics, pharmacies, pharmacy benefit managers, other medical care facilities and all other providers of medical or dental services who have provided treatment or other health care services to me or on my behalf.
- Protected Health Information: Any and all records and health information within such Medical Person's possession such as medical history, entire medical records, mental, psychiatric (excluding psychotherapy notes) and physical condition, prescription drug records, tobacco, drug and alcohol use and any other protected health information concerning me. This includes information which may be considered to be a communicable or a sexually transmitted disease, which may include, but are not limited to diseases such as Hepatitis, Syphilis, Gonorrhea, the Human Immunodeficiency Virus (HIV) and the Acquired Immune Deficiency Syndrome (AIDS).

In addition, I authorize the Veterans Administration, the MIB, Inc., my employer, consumer reporting agency, insurance company or other organization who possesses information, records or knowledge of me including information about drugs, alcoholism or mental illness, to furnish such information to EMCNL, its reinsurers and their authorized representative upon presenting this authorization.

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 any Medical Provider to release and disclose my entire medical record without restriction.

The purpose of the release of the above information is for EMCNL to evaluate and underwrite an application for insurance coverage, to determine the rates and terms that apply to such insurance coverage, and/or to resolve any issues of incomplete, incorrect or misrepresented information on the application which may arise during the processing of the application.

This authorization will remain in effect from the date signed below for a period of two years, and a copy of this authorization is as valid as the original. I understand that this authorization may be revoked at any time by sending written notice of such to EMCNL at the address above. The right to revoke this authorization is limited to the extent that EMCNL has taken action in reliance on the authorization or the law provides the Company with the right to contest a claim under the policy for which I have applied or to contest the policy itself. I understand that any information that is disclosed pursuant to this authorization may no longer be covered by federal rules governing privacy and confidentiality of health information, but it will not be redisclosed by the recipient except as authorized by me or as allowed by law. EMCNL or its reinsurers may make a brief report regarding me or my children to other insurance companies to whom I have applied or may apply.

I understand that my Medical Providers may not refuse to provide treatment or payment for health care services if I refuse to sign this authorization. I further understand that if I refuse to sign this authorization, EMCNL may not issue the insurance coverage for which I am applying or if coverage has been issued may not be able to make any benefit payments. I understand that any Personal Representative or I will receive a copy of this authorization upon request.

I authorize EMC National Life Company to obtain an investigative consumer report on me, if required.

I elect to be interviewed if any investigative consumer report is prepared in connection with this application.

X		
Signature of Proposed Insured or Personal Representative	Printed Name	Date

X		
Signature of Spouse (if applying) or Personal Representative	Printed Name	Date

X		
Signature of Other Applicant (other than Proposed Insured or Spouse - if applying) or Personal Representative	Printed Name	Date

Note: If the authorization is signed by a Personal Representative of an individual, a description of the Representative's authority and relationship must be provided below.

Description of Personal Representative's Authority and Relationship to the Individual



A STOCK LIFE INSURANCE COMPANY

P.O. Box 9202 ■ Des Moines, IA 50306-9202
1.800.232.5818 ■ www.EMCNationalLife.com

Tele-Underwriting Application

for

Life Insurance

for Medically Underwritten Amounts of Coverage

Fax Application to MAAS at 1-866-679-3961

and

Mail Original Application to Home Office
or fax to Home Office at 1-800-439-9526

- ALWAYS DETACH AND GIVE TO APPLICANT -

FAIR CREDIT REPORTING ACT

In Compliance with 15 USC 1681 et. seq., this notice is to inform you that:

In making this application for insurance it is understood that an investigative consumer report may be made whereby information is obtained through personal interviews with third parties, such as family members, business associates, financial sources, friends, neighbors, or others with whom you are acquainted. This inquiry includes information as to your character, general reputation, personal characteristics, and mode of living, whichever may be applicable. You have the right to make a written request to EMC National Life Company, P.O. Box 9144, Des Moines, IA 50306-9144 within a reasonable period of time for a complete and accurate disclosure of additional information concerning the nature and scope of the investigation.

NOTIFICATION REGARDING THE MEDICAL INFORMATION BUREAU

Information regarding your insurability will be treated as confidential. EMC National Life Company or its Reinsurer(s) may, however, make a brief report thereon to the MIB, Inc., formerly known as Medical Information Bureau, a not-for-profit membership organization of insurance companies, which operates an information exchange on behalf of its Members. If you apply to another MIB Member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, MIB, upon request, will supply such company with the information about you in its file.

Upon receipt of a request from you, MIB will arrange disclosure of any information in your file. Please contact MIB at 866-692-6901 (TTY 866-346-3642). If you question the accuracy of the information in MIB's file, you may contact MIB and seek a correction in accordance with the procedures set forth in the federal Fair Credit Reporting Act. The address of MIB's information office is [50 Braintree Hill Park, Suite 400, Braintree, Massachusetts 02184-8734].

EMC National Life Company, or its Reinsurer(s) may also release information from its file to other insurance companies to whom you may apply for life or health insurance, or to whom a claim for benefits may be submitted. Information for consumers about MIB may be obtained on its website at www.mib.com.

**- COMPLETE, DETACH AND GIVE TO APPLICANT
ONLY WHEN FULL FIRST PREMIUM IS PAID WITH APPLICATION -**

CONDITIONAL COVERAGE RECEIPT

RECEIVED FROM _____, this _____ day of _____ the sum of \$ _____, subject to the terms and conditions of the policy, as full (check one) annual semi-annual quarterly monthly check plan premium, along with the application bearing the date of this Receipt, for coverage on _____, the Proposed Insured(s).

TERMS AND CONDITIONS

“Effective Date” as used herein means the later of a) the date the application is signed; b) the date of completion of all medical examinations, if required; or c) the requested Effective Date shown on the application.

Coverage may become effective prior to the policy delivery if and when all of the following conditions are met:

1. The amount of the payment is equal to the first full premium selected and the payment is taken with the application;
2. The Proposed Insured(s) must be, on the Effective Date as defined above, a risk acceptable to EMC National Life Company under its rules, standards and practices for the exact contract of insurance and premium applied for, without any modifications; and
3. The contract is issued exactly as applied for within 60 days from the date of the application. If the application is declined or disapproved or if the contract is not issued within 60 days from the date of application, then this condition has not been fulfilled, no coverage is or has been provided under the terms of this Conditional Receipt, and any premium paid will be returned.
4. The maximum amount of coverage which may become effective under this Conditional Receipt, including any Riders applied for, cannot exceed \$250,000.

If any of the above conditions is not met, there shall be no liability on the part of EMC National Life Company except to return the premiums collected with the application.

This Receipt shall be rendered void if it is modified or altered, or if a check or draft given in payment is not honored. No agent or broker of EMC National Life Company, P.O. Box 9202, Des Moines, IA 50306-9202 is authorized to waive or alter any of the above conditions.

Applicant's Signature

Agent's Signature

Date

**ALL PREMIUM CHECKS OR DRAFTS MUST BE MADE PAYABLE TO EMC NATIONAL LIFE COMPANY.
DO NOT MAKE CHECKS PAYABLE TO THE AGENT. DO NOT LEAVE THE PAYEE BLANK.**

1. PRIMARY APPLICANT (Please print all entries)

FIRST NAME	MIDDLE NAME	LAST NAME	SOCIAL SECURITY NUMBER	
ADDRESS		<input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	HEIGHT	WEIGHT
CITY	STATE	ZIP + 4 DIGIT	DATE OF BIRTH	BIRTH PLACE
TELEPHONE NUMBER HOME () WORK ()		OCCUPATION	DATE OF EMPLOYMENT	ANNUAL EARNED INCOME

2. FAMILY COVERAGE (Complete only if applying for policies or riders on family members - please print)

SPOUSE'S FULL NAME	SOCIAL SECURITY #	DATE OF BIRTH	BIRTH PLACE	SEX	HT.	WT.
CHILDREN(S) (if applying for Children's Term Rider - please print)						
FULL NAME(S)	SOCIAL SECURITY #	DATE OF BIRTH	BIRTH PLACE	SEX	HT.	WT.

Are all proposed insureds U.S. citizens? YES NO
 If no, provide details on a separate sheet and send copy of permanent resident visa.

3. PLAN OF INSURANCE _____ Amount: \$ _____
Please use Marketing name. See agent website or product guide for product options and rider specifications

SPOUSE/OTHER INSURED PLAN OF INSURANCE _____ Amount: \$ _____

CHILDREN TERM INSURANCE Units/Face Amount: _____

UL DEATH BENEFIT OPTION Level Benefit Increasing Benefit **WAIVER OF PREMIUM** Y N

ACCIDENTAL DEATH BENEFIT Y N Amount \$ _____ **DISABILITY INCOME RIDER** Y N

PREMIUM MODE: Annual Semi-Annual Quarterly Monthly Check Plan List Bill (Co. #) _____

4. OWNER (if owner is other than insured)

FIRST NAME	MIDDLE NAME	LAST NAME	DATE OF BIRTH	SOCIAL SECURITY #
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5. BENEFICIARY: PRIMARY APPLICANT

	NAME (First, M.I., Last)	DATE OF BIRTH	SOCIAL SECURITY #	RELATIONSHIP	%
PRIMARY					
CONTINGENT					

BENEFICIARY: SPOUSE / OTHER INSURED

	NAME (First, M.I., Last)	DATE OF BIRTH	SOCIAL SECURITY #	RELATIONSHIP	%
PRIMARY					
CONTINGENT					

6. EXISTING INSURANCE REPLACEMENT

- A. Do any of the applicants have any life insurance or annuity contracts in force? YES NO
- B. Is this policy being purchased to replace any existing life insurance policy or annuity contract? YES NO

Complete replacement form applicable to your state and send with the application.



7. ANSWER QUESTIONS A THRU G

	Primary		Spouse		Child	
	Yes	No	Yes	No	Yes	No
A. 1. Primary Applicant Only. Are you actively at work now and have you worked at least 30 hours a week for the last 3 months except for minor illnesses of one week or less or pregnancy?.....	<input type="checkbox"/>	<input type="checkbox"/>				
2. Spouse/Children Only. Has any illness, injury or other health problem prevented any proposed Insured from working full-time at a regular occupation or performing the normal activities of a person of the same age?			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
B. Have you engaged in ballooning, sky diving, racing, mountain climbing, rodeo competition, SCUBA diving (max depth _____) or any hazardous sport or activity?	<input type="checkbox"/>					
Activity _____ Frequency _____ Do you have intentions to engage in such activities over the next 12 months?	<input type="checkbox"/>					
C. Have you ever flown as a pilot or crew member or intend to do so? (if yes, provide details) ... Details: _____	<input type="checkbox"/>					
D. Have you been convicted of a driving violation in the last three years? (if yes, provide DL# and details). DL#: _____ Details: _____	<input type="checkbox"/>					
E. Do you currently use tobacco in any form or have used tobacco in any form within the past 5 years? ..	<input type="checkbox"/>					
F. If yes, indicate the type of tobacco used _____						
G. If you quit, how long has it been since you quit? _____						

8. CHILD RIDER SUPPLEMENT (answer questions A-E if applying for a Children's Term Rider)

Have any of the Children listed in section 2 now or in the past 10 years been treated by a Medical Practitioner as having had: (if yes, give details below and which child)

	Yes	No
A. Cancer in any form?	<input type="checkbox"/>	<input type="checkbox"/>
B. Heart or coronary disease?	<input type="checkbox"/>	<input type="checkbox"/>
C. Diabetes, disorder of the lung, kidney, stomach, liver, intestine or rheumatic fever, or mental condition or disorder? ..	<input type="checkbox"/>	<input type="checkbox"/>
D. Acquired Immune Deficiency Syndrome (AIDS)?	<input type="checkbox"/>	<input type="checkbox"/>
E. Other than above, has any child proposed for coverage seen a physician for any health or physical condition not listed? You do not need to mention diagnostic tests such as blood tests or X rays performed more than (5) years ago. (You need not reveal any AIDS/HIV (Human Immunodeficiency Virus) consultation or testing done at anonymous counseling and testing sites and AIDS/HIV testing is limited to FDA licensed blood tests)	<input type="checkbox"/>	<input type="checkbox"/>

Specify person's name and give details to all Yes answers. _____

9. DISABILITY INCOME RIDER (complete for each person applying for the Disability Income Rider)

A. Name of each person proposed for Rider coverage: _____

	Primary		Other	
	Yes	No	Yes	No
B. Has any person proposed for coverage:				
(1) Have any reason for not being physically capable for full time employment?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(2) Have any other Disability Income policies inforce? If yes, amount \$ _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(3) Within the past 5 years, received Disability, Worker's Comp. or Pension Benefits?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(4) Within the past 5 years, received medical care for the muscles, bones, joints, including back, spine or feet or any other nerve disorder or treatment of any muscular or neuromuscular disorder?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
C. Annual Income: Primary Insd.: Earned: \$ _____ Unearned \$ _____ Other Insd.: Earned: \$ _____ Unearned \$ _____				
D. Elimination Period (select 30 or 90 days) Primary Insd.: <input type="checkbox"/> 30 days <input type="checkbox"/> 90 days Other Insd.: <input type="checkbox"/> 30 days <input type="checkbox"/> 90 days				
E. Monthly Benefit Amount applied for: Primary Insd. \$ _____ Other Insd. \$ _____				
F. Describe employment duties below for each person proposed for Rider coverage (what you do, types of machines used)				
Specify person's name and give details to all Yes answers. Specify employment duties. _____				

AUTHORIZATION I authorize: (1) any physician, hospital, medical practitioner or other facility, insurance company, and MIB, Inc. to release to EMC National Life and its legal representatives any and all information they have regarding my physical or mental condition. (2) any employer, business associate, government unit, financial institution, consumer reporting agency, and MIB, Inc. to release to EMC National Life and its legal representative any information they have regarding my occupation, avocations, finances, driving record, and character, including information about HIV, communicable diseases, drugs, alcoholism or mental illness. (3) EMC National Life to obtain investigative consumer reports, as appropriate. (4) EMC National Life or its reinsurers may make a brief report regarding me or my children to other companies to whom I have applied or may apply. I have read this authorization and understand that I may receive a copy. I have received copies of the Fair Credit Reporting Act and MIB, Inc. Notice.

I represent that the foregoing statements are complete and true to the best of my knowledge and belief. I agree that the insurance applied for shall take effect on the date of the application or last medical examination, whichever is later, provided I am acceptable in every respect under the Company's standard rate of premium and practices for the amount and plan of insurance applied for and the first premium is paid.

I acknowledge that I have read the applicable fraud warning and other provisions on page 4.

This authorization will be valid from the date signed for a period of 26 months except for the confidential HIV-related information which shall not exceed 180 days from the date signed.

Proposed Insured's Signature Signed at City/State Date

Owner (if other than Insured) Spouse/Other Insured's Signature (if coverage applied for) Joint Owner's Signature (if any)

I certify that I have personally asked the questions on this application of the Proposed Insured(s), and have truly and accurately recorded the information supplied, and that the Notice regarding MIB, Inc. was given.

Agent's Printed Name Agent Signature Date

Agent Contract # Agent License Number (if required) Commission %

Commission Split if applicable:

Agent's Printed Name Agent Contract # Commission %

AGENT REPORT

- | | Yes | No |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------|--------------------------|
| 1. Is the purchase of this insurance suitable for the applicant? | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. To the best of your knowledge, will the insurance applied for replace any existing annuity/life policy in any company(s)? ... | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. If a replacement(s) and state regulations require it, have you given the applicant a Notice to Applicant regarding replacement of life insurance and completed replacement forms, if required in your state? | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Have you complied with state regulations on disclosure? | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Was Notice of the Fair Credit Reporting Act given to the applicant? | <input type="checkbox"/> | <input type="checkbox"/> |

Soliciting Agent _____ Date _____ Agent No. _____

INSTRUCTIONS FOR USE OF THIS APPLICATION

- This application is only to be used when Teleunderwriting is desired.
- This application is to be used only for amounts of insurance that require a medical examination based on the EMCNL Underwriting Guide (LB138).**
- All non medical amounts applied for based on the EMCNL Underwriting Guide (LB138) require state approved Application for Life Insurance.
- All state required replacement forms, blood consent forms, proposal illustrations, delivery receipts, and supplementary questionnaires will not be obtained by the paramedical representative, but are still required.
- The Part II medical questionnaire portion of this application will be completed by requiring a telephone interview with the applicant. Verification of this information and the applicants signature must be obtained by a paramedical representative.
- For quicker service, FAX a copy of this application to the fax number on the front of the application. Please indicate if application has been faxed.**
- Or forward completed application to the Home Office for Teleunderwriting order.

TAXPAYER IDENTIFICATION CERTIFICATION: Per Internal Revenue Service guidelines, use this area to report and certify the taxpayer identification number (typically this is your social security number or an employer identification number) of the owner of the policy.

Under penalties of perjury, by my signature on this form on page 3, I certify that:

1. The number shown on this form on page 1 is my correct taxpayer identification number, **and**
2. I am not subject to backup withholding either because: **(a)** I am exempt from backup withholding, or **(b)** I have not been notified by the Internal Revenue Service (IRS) 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, **and**
3. I am a U.S. person (including a U.S. resident alien).

Note: You must cross out item 2 above if you have been notified by the IRS that you are currently subject to backup withholding because you have failed to report all interest and dividends on your tax return.

FRAUD INFORMATION: The Company is relying on the information in this application to qualify all persons proposed for coverage under this insurance policy. Any false statement or misrepresentation may result in loss of coverage under this policy. 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. Caution: Read your state's specific fraud warning (as applicable).

COLORADO – It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

FLORIDA – Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

KANSAS – 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 may be guilty of a crime as determined by a court of law.

KENTUCKY – Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime.

MAINE – It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance benefits.

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

NEW MEXICO – 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 civil fines and criminal penalties.

OHIO – Any person who, with the intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

OKLAHOMA – WARNING: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

PENNSYLVANIA – Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

TENNESSEE – It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

