

SERFF Tracking Number: NALH-126296100 State: Arkansas
 Filing Company: North American Company for Life and Health Insurance State Tracking Number: 43481
 Company Tracking Number: L-3182, L-3186, L-3188, L-3187, L-3185, L-2991C, L-2992B, L-3116B
 TOI: L08 Life - Other Sub-TOI: L08.000 Life - Other
 Product Name: L-3182, L-3186, L-3188, L-3187, L-3185, L-2991C, L-2992B, L-3116B
 Project Name/Number: L-3182, L-3186, L-3188, L-3187, L-3185, L-2991C, L-2992B, L-3116B /L-3182, L-3186, L-3188, L-3187, L-3185, L-2991C, L-2992B, L-3116B

Filing at a Glance

Company: North American Company for Life and Health Insurance

Product Name: L-3182, L-3186, L-3188, L-3187, L-3185, L-2991C, L-2992B, L-3116B SERFF Tr Num: NALH-126296100 State: Arkansas

TOI: L08 Life - Other SERFF Status: Closed-Approved- Closed State Tr Num: 43481

Sub-TOI: L08.000 Life - Other Co Tr Num: L-3182, L-3186, L-3188, L-3187, L-3185, L-2991C, L-2992B, L-3116B State Status: Approved-Closed

Filing Type: Form Reviewer(s): Linda Bird
 Authors: Laurie Gruba, Paula Kunkel-White, Gayle Lovorn, Gail Velen Disposition Date: 09/16/2009
 Date Submitted: 09/11/2009 Disposition Status: Approved-Closed

Implementation Date Requested: On Approval Implementation Date:
 State Filing Description:

General Information

Project Name: L-3182, L-3186, L-3188, L-3187, L-3185, L-2991C, L-2992B, L-3116B Status of Filing in Domicile: Authorized

Project Number: L-3182, L-3186, L-3188, L-3187, L-3185, L-2991C, L-2992B, L-3116B Date Approved in Domicile: 09/02/2009

Requested Filing Mode: Review & Approval

Explanation for Combination/Other:

Submission Type: New Submission

Overall Rate Impact:

Filing Status Changed: 09/16/2009

Deemer Date:

Submitted By: Paula Kunkel-White

Domicile Status Comments:

Market Type: Individual

Group Market Size:

Group Market Type:

Explanation for Other Group Market Type:

State Status Changed: 09/16/2009

Created By: Paula Kunkel-White

Corresponding Filing Tracking Number:

SERFF Tracking Number: NALH-126296100 State: Arkansas
Filing Company: North American Company for Life and Health State Tracking Number: 43481
Insurance
Company Tracking Number: L-3182, L-3186, L-3188, L-3187, L-3185, L-2991C, L-2992B, L-3116B
TOI: L08 Life - Other Sub-TOI: L08.000 Life - Other
Product Name: L-3182, L-3186, L-3188, L-3187, L-3185, L-2991C, L-2992B, L-3116B
Project Name/Number: L-3182, L-3186, L-3188, L-3187, L-3185, L-2991C, L-2992B, L-3116B /L-3182, L-3186, L-3188, L-3187, L-3185, L-2991C, L-2992B, L-3116B

Filing Description:

North American Company for Life and Health Insurance

NAIC No.: 431-66974 / FEIN No.: 36-2428931

General Purpose Life Insurance Application, L-3182
Application – Part II, L-3186
Health Statement form, L-3188
Policy Change, Conversion and Reinstatement Application, L-3187
Convulsive Underwriting Questionnaire, L-3185
Civilian Aviation Underwriting Questionnaire, L-2991C
Scuba and Skin Diving Underwriting Questionnaire, L-3116B
Foreign Travel and Residence Underwriting Questionnaire, L-2992B

We are filing the above forms for your review and approval. These forms are laser printed and we reserve the right to change fonts and layouts. We certify the font size will never be less than 10 point type.

No part of the filing contains unusual or possibly controversial items from normal Company or industry standards.

The Application Part II form, Health Statement form, Policy Change, Conversion and Reinstatement Application and the Convulsive Underwriting Questionnaire are new forms.

The Application Part II form will be used in conjunction with the General Purpose Life application, or any future General Purpose Life applications approved by your department, when a paramedical exam is required for the full underwriting process. The Health Statement form is required by the underwriting department when 90 days or more have passed since the date of the Application Part II form or the date the paramedical exam completed. The Underwriting Questionnaire forms will be used in conjunction with the application forms, currently approved by your Department as well as future life application forms that may be approved by your Department, to evaluate an applicant's underwriting classification.

The General Purpose Life Insurance Application, Civilian Aviation, Scuba & Skin Diving and Foreign Travel and Residence Underwriting Questionnaires are new forms and are intended to replace the current forms previously approved by your Department on the dates noted below:

L-3159A: 11/13/06 under 34126

L-2991B: 6/3/04 under 26549

L-3116A: 6/3/04 under 26549

SERFF Tracking Number: NALH-126296100 State: Arkansas
Filing Company: North American Company for Life and Health State Tracking Number: 43481
Insurance
Company Tracking Number: L-3182, L-3186, L-3188, L-3187, L-3185, L-2991C, L-2992B, L-3116B
TOI: L08 Life - Other Sub-TOI: L08.000 Life - Other
Product Name: L-3182, L-3186, L-3188, L-3187, L-3185, L-2991C, L-2992B, L-3116B
Project Name/Number: L-3182, L-3186, L-3188, L-3187, L-3185, L-2991C, L-2992B, L-3116B /L-3182, L-3186, L-3188, L-3187, L-3185, L-2991C, L-2992B, L-3116B

L-2992A: 6/6/02 under 19373

We are requesting approval for use with any products in our portfolio.

The following provides the name of the current form and an overview of the substantial differences between the current forms and the new forms:

L-3182 (General Purpose Application) – The riders/option in Section 7 was updated to be consistent with our current portfolio; addition of modal premium disclosure language in question # 15; revised premium financing questions #19-24 and incorporated STOLI language; revised all references of PAC to EFT; removed “spouse” references, and revised state mandated fraud warning disclosure language, as required.

L-2991C (Civilian Aviation Underwriting questionnaire)

Questions 7 -11 condensed into 1 question for hours flown, removal of medical certificate question, re-arrangement of various questions but still same content as the current version, state mandated fraud warning language added above signature line.

L-3116B (Scuba & Skin Diving Underwriting Questionnaire)

Depth of Dives Table – revised to add “Less than 50 ft.” and change ranges of other depths to “51 – 100 ft”, “101 – 130 ft.”

Question 4 – revised to read “Mixed Gas Equipment (Nitrox, Trimix, or Heliox).

Question 8 – added “High Altitudes (i.e. mountains, lakes)

Question 9 – added “Depth Records Attempts.”

Question 10 – added “Do you dive for profit” question and state mandated fraud warning language added above signature line.

L-2992B (Foreign Travel & Residence Underwriting Questionnaire)

Revised Section A questions, removed naturalized citizen questions from Section B and moved questions from Section C to Section B, Section D is removed & Section C question 1, time frame changed from 3 years to 12 months; state mandated fraud warning language added above signature line.

For informational purposes, included in this filing is a Statement of Variability, which provides an explanation for the bracketed information shown on the applications, health statement and underwriting questionnaire forms.

Your review for approval, at your earliest convenience, would be appreciated. Please feel free to contact me if you have any questions regarding this filing.

SERFF Tracking Number: NALH-126296100 State: Arkansas
 Filing Company: North American Company for Life and Health State Tracking Number: 43481
 Insurance
 Company Tracking Number: L-3182, L-3186, L-3188, L-3187, L-3185, L-2991C, L-2992B, L-3116B
 TOI: L08 Life - Other Sub-TOI: L08.000 Life - Other
 Product Name: L-3182, L-3186, L-3188, L-3187, L-3185, L-2991C, L-2992B, L-3116B
 Project Name/Number: L-3182, L-3186, L-3188, L-3187, L-3185, L-2991C, L-2992B, L-3116B /L-3182, L-3186, L-3188, L-3187, L-3185, L-2991C, L-2992B, L-3116B

Company and Contact

Filing Contact Information

Paula Kunkel White, Contracts Analyst pwhite@nacolah.com
 525 W. VAN BUREN 800-800-3656 [Phone] 27179 [Ext]
 CHICAGO, IL 60607 312-648-7780 [FAX]

Filing Company Information

North American Company for Life and Health CoCode: 66974 State of Domicile: Iowa
 Insurance
 Principal Office: 4601 Westown Parkway - Group Code: 431 Company Type: Life and Annuity
 Suite 300
 West Des Moines, IA 50266 Group Name: State ID Number:
 (800) 800-3656 ext. [Phone] FEIN Number: 36-2428931

Filing Fees

Fee Required? Yes
 Fee Amount: \$160.00
 Retaliatory? No
 Fee Explanation: \$20 per form X 8 forms = \$160
 Per Company: No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
North American Company for Life and Health Insurance	\$160.00	09/11/2009	30495960

SERFF Tracking Number: NALH-126296100 State: Arkansas
 Filing Company: North American Company for Life and Health State Tracking Number: 43481
 Insurance
 Company Tracking Number: L-3182, L-3186, L-3188, L-3187, L-3185, L-2991C, L-2992B, L-3116B
 TOI: L08 Life - Other Sub-TOI: L08.000 Life - Other
 Product Name: L-3182, L-3186, L-3188, L-3187, L-3185, L-2991C, L-2992B, L-3116B
 Project Name/Number: L-3182, L-3186, L-3188, L-3187, L-3185, L-2991C, L-2992B, L-3116B /L-3182, L-3186, L-3188, L-3187, L-3185, L-2991C, L-2992B, L-3116B

Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Linda Bird	09/16/2009	09/16/2009

SERFF Tracking Number: NALH-126296100 State: Arkansas
Filing Company: North American Company for Life and Health State Tracking Number: 43481
Insurance
Company Tracking Number: L-3182, L-3186, L-3188, L-3187, L-3185, L-2991C, L-2992B, L-3116B
TOI: L08 Life - Other Sub-TOI: L08.000 Life - Other
Product Name: L-3182, L-3186, L-3188, L-3187, L-3185, L-2991C, L-2992B, L-3116B
Project Name/Number: L-3182, L-3186, L-3188, L-3187, L-3185, L-2991C, L-2992B, L-3116B /L-3182, L-3186, L-3188, L-3187, L-3185, L-2991C, L-2992B, L-3116B

Disposition

Disposition Date: 09/16/2009

Implementation Date:

Status: Approved-Closed

Comment:

Rate data does NOT apply to filing.

SERFF Tracking Number: NALH-126296100 State: Arkansas
 Filing Company: North American Company for Life and Health State Tracking Number: 43481
 Insurance
 Company Tracking Number: L-3182, L-3186, L-3188, L-3187, L-3185, L-2991C, L-2992B, L-3116B
 TOI: L08 Life - Other Sub-TOI: L08.000 Life - Other
 Product Name: L-3182, L-3186, L-3188, L-3187, L-3185, L-2991C, L-2992B, L-3116B
 Project Name/Number: L-3182, L-3186, L-3188, L-3187, L-3185, L-2991C, L-2992B, L-3116B /L-3182, L-3186, L-3188, L-3187, L-3185, L-2991C, L-2992B, L-3116B

Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification		Yes
Supporting Document	Application		Yes
Supporting Document	Statement of Variability		Yes
Form	General Purpose Life Application Form		Yes
Form	Policy Change, Conversion & Reinstatement Application		Yes
Form	Application Part II		Yes
Form	Health Statement form		Yes
Form	Convulsive Underwriting Questionnaire		Yes
Form	Civilian Aviation Underwriting Questionnaire		Yes
Form	Scuba & Skin Diving Underwriting Questionnaire		Yes
Form	Foreign Travel & Residence Underwriting Questionnaire		Yes

SERFF Tracking Number: NALH-126296100 State: Arkansas
 Filing Company: North American Company for Life and Health State Tracking Number: 43481
 Insurance
 Company Tracking Number: L-3182, L-3186, L-3188, L-3187, L-3185, L-2991C, L-2992B, L-3116B
 TOI: L08 Life - Other Sub-TOI: L08.000 Life - Other
 Product Name: L-3182, L-3186, L-3188, L-3187, L-3185, L-2991C, L-2992B, L-3116B
 Project Name/Number: L-3182, L-3186, L-3188, L-3187, L-3185, L-2991C, L-2992B, L-3116B /L-3182, L-3186, L-3188, L-3187, L-3185, L-2991C, L-2992B, L-3116B

Form Schedule

Lead Form Number: L-3182

Schedule Item Status	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
	L-3182	Application/ Enrollment Form	General Purpose Life Initial Enrollment Application Form			50.300	L-3182 general app w-brackets 9-11-09.pdf
	L-3187	Application/ Enrollment Form	Policy Change, Conversion & Reinstatement Application	Initial		50.300	L-3187 Policy change app w-brackets 9-11-09.pdf
	L-3186	Application/ Enrollment Form	Application Part II Enrollment Form	Initial		56.100	L-3186 w-brackets 9-11-09.pdf
	L-3188	Other	Health Statement form	Initial		50.900	L-3188 SOH w-brackets 9-11-09.pdf
	L-3185	Other	Convulsive Underwriting Questionnaire	Initial		54.600	L-3185 convulsive w-brackets.pdf
	L-2991C	Other	Civilian Aviation Underwriting Questionnaire	Initial		64.200	L-2991C Civilian Aviation w-brackets.pdf
	L-3116B	Other	Scuba & Skin Diving Underwriting Questionnaire	Initial		61.100	L-3116B scuba w-brackets.pdf
	L-2992B	Other	Foreign Travel & Residence Underwriting Questionnaire	Initial		69.000	L-2992B Foreign Travel w-brackets.pdf



L3182

GENERAL PURPOSE LIFE APPLICATION Part I (Print and Use Black Ink)

PRIMARY INSURED PROPOSED FOR INSURANCE

1. Last Name	First Name	M.I.
--------------	------------	------

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

Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female	Date of Birth	Age	Place of Birth - State / Country	Height (FT. IN.)	Weight (LBS.)	Marital Status
---	---------------	-----	----------------------------------	------------------	---------------	----------------

Social Security Number/Tax ID#	Driver's License Number	Expiration Date	State
--------------------------------	-------------------------	-----------------	-------

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

2a. How long at this address? (If less than 2 years, provide previous address.)

_____ Years _____ Months

2b. Billing Address (If other than residence)	Street	City	State	Zip Code
--	--------	------	-------	----------

2c. Secondary Addressee Billing Yes No If Yes, Provide Secondary Addressee's Name, Street Address, City, State & Zip Code
(Agent cannot qualify as Secondary Addressee)

3. Employer (Company Name and Address)

Occupation (Title and Duties)	Annual Income \$	Net Worth \$
-------------------------------	---------------------	-----------------

4. Contact The Proposed Insured At: <input type="checkbox"/> Residence _____ (CST) <input type="checkbox"/> A.M. <input type="checkbox"/> P.M. <input type="checkbox"/> Business	Residence Telephone Number: Primary Insured () Additional Insured () Cell Phone ()	Business Telephone Number: Primary Insured () Additional Insured () Cell Phone ()
--	--	---

PLAN INFORMATION

5. Amount Applied For \$	Proposed Plan of Insurance	6. For UL: (check if applicable) <input type="checkbox"/> Level <input type="checkbox"/> Increasing <input type="checkbox"/> Return of Premium
-----------------------------	----------------------------	---

7. RIDERS

<p>a. Term Products</p> <p><input type="checkbox"/> [Additional Insured Rider \$ _____]</p> <p><input type="checkbox"/> [Children's Term Insurance Rider (CTR) _____ units]</p> <p><input type="checkbox"/> [Guaranteed Insurability Rider _____ units]</p> <p><input type="checkbox"/> [Monthly Income Endorsement: Initial Lump Sum \$ _____ \$ _____ Monthly for _____ years; Final Lump Sum \$ _____]</p> <p><input type="checkbox"/> [Waiver of Premium Rider]</p> <p><input type="checkbox"/> [Other _____ \$ _____]</p>	<p>b. Permanent Products</p> <p><input type="checkbox"/> [Accidental Death Benefit \$ _____]</p> <p><input type="checkbox"/> [Additional Insured Rider \$ _____]</p> <p><input type="checkbox"/> [Automatic Distribution Option]</p> <p><input type="checkbox"/> [Children's Term Insurance Rider (CTR) _____ units]</p> <p><input type="checkbox"/> [Estate Preservation Rider]</p> <p><input type="checkbox"/> [Guaranteed Insurability Rider _____ units]</p> <p><input type="checkbox"/> [Premium Guarantee Rider]</p> <p><input type="checkbox"/> [Waiver of Monthly Deductions Rider]</p> <p><input type="checkbox"/> [Waiver of Surrender Charge Option]</p> <p><input type="checkbox"/> [Other _____ \$ _____]</p>
---	---

ADDITIONAL INSURED PROPOSED for INSURANCE (Complete Separate Application for Business Associates and Additional Insureds)

8. Last Name _____ First Name _____ M.I. _____

8a. Are you a U.S. Citizen or do you have a permanent Visa? Yes No (If no, complete Foreign Travel and Residence Questionnaire)

Sex: Male Female Date of Birth _____ Age _____ Place of Birth - State / Country _____ Height (FT. IN.) _____ Weight (LBS.) _____ Relationship to Insured _____

Social Security Number/Tax ID# _____ Driver's License Number _____ Expiration Date _____ State _____

9. Employer (Company Name and Address) _____

Occupation (Title and Duties) _____ Annual Income \$ _____

10. DEPENDENT CHILDREN PROPOSED for INSURANCE

Name	Date of Birth	Place of Birth State/Country	Age	Sex	Social Security Number/Tax ID#	Height (FT. IN.)	Weight (LBS.)	Relationship to Proposed Insured

11. OWNER INFORMATION (Complete only if other than Proposed Primary Insured)

Name of Owner(s): If Trust, list all Trustees as well as Name and Date of Trust and complete **Trust Form**. If Owner is a business, complete **Company/Corporate Owned Life Insurance (COLI) Form**.

Owner's Address _____ Street _____ City _____ State _____ Zip Code _____

Relationship to Primary Insured _____ Owner's Social Security/Tax ID # _____ U.S. Citizen Resident Alien - Country _____ Nonresident Alien - Country _____

Name of Contingent Owner(s) _____ Contingent Owner's Social Security/Tax ID # _____

12. PRIMARY BENEFICIARY If percentage shares are not listed below, they will be divided equally among the beneficiaries. Provide Beneficiary(ies) Full Name(s) (If Trust, list Name and Date of Trust and complete Trust Form)

Name	Percent	Relationship to Proposed Primary Insured	Social Security Number/Tax ID#
Total	100	Beneficiary designations do not apply to others covered under Children's Insurance Riders.	

13. CONTINGENT BENEFICIARY If percentage shares are not listed below, they will be divided equally among the beneficiaries. Provide Beneficiary(ies) Full Name(s) (If Trust, list Name and Date of Trust and complete Trust Form)

Name	Percent	Relationship to Proposed Primary Insured	Social Security Number/Tax ID#
Total	100		

14. Has anyone proposed for insurance ever smoked cigarettes, cigars, pipes, or used tobacco in any form, including smokeless tobacco, nicotine patch, gum or other substitutes? Respond Below:

14a. **Proposed Primary Insured:** Yes No If 'yes', provide: Type of product(s) used _____ Amount Used: _____ How often: Daily _____ Weekly _____ Monthly _____ Date of last use: mm/yy _____

14b. **Additional Insured Rider:** Yes No If 'yes', provide: Type of product(s) used _____ Amount Used: _____ How often: Daily _____ Weekly _____ Monthly _____ Date of last use: mm/yy _____

PREMIUM INFORMATION

15. Premium Frequency: Annual Semi-Annual Quarterly Monthly Single Pay Lump Sum \$

Premium Mode: EFT List Billing Direct Billing (A, SA, Q) only Civil Service Allotment Military Government Allotment

List Bill Code _____ Other _____

For term and whole life 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.

Amount of Modal Premium \$ Amount Paid with Application \$

Make all checks payable to: NORTH AMERICAN COMPANY FOR LIFE & HEALTH INSURANCE

16. For EFT Only: Draw Day _____ (1 st - 28 th) Month Day	Account Type <input type="checkbox"/> Checking (attach voided check) <input type="checkbox"/> Savings (must complete 16b)	Authorized Signature(s) of Account Holder(s) X
16a. Initial Draft <input type="checkbox"/> Yes <input type="checkbox"/> No		X
16b. Routing Transit Number	Account Number	Financial Institution Name and Address

REPLACEMENT INFORMATION

17. Does any person proposed for coverage have any life insurance or annuities currently in force or pending? (This includes policies that have or will be sold, assigned or otherwise placed via life settlement, viatical or other agreements.) Yes No If yes, list below:

Name	Company	Policy #	Pending	Issue Yr.	Basic Amount	ADB Amount	WP Amount	Intention of Replacement or Change*
17a.			<input type="checkbox"/>					18a. <input type="checkbox"/> Yes <input type="checkbox"/> No
17b.			<input type="checkbox"/>					18b. <input type="checkbox"/> Yes <input type="checkbox"/> No
17c.			<input type="checkbox"/>					18c. <input type="checkbox"/> Yes <input type="checkbox"/> No
17d.			<input type="checkbox"/>					18d. <input type="checkbox"/> Yes <input type="checkbox"/> No

***Replacement means that the insurance applied for may replace, change or use any value of an existing or pending life insurance policy or annuity. If replacement may be involved, complete applicable replacement form and submit with application. If this is a 1035 Exchange, also complete 1035 Exchange paperwork and submit with application.**

19. Are any of the above policies being used to fund this policy? Yes No
20. Has, or will, any person proposed for insurance, or owner of this policy, been compensated in any way to purchase this policy? Yes No
21. Is the proposed insured(s), or owner of this policy, paying for this policy with his/her own funds? Yes No
22. Will the proceeds of a home equity loan or reverse mortgage transaction be used to pay the premiums on this policy? Yes No
23. Has any person proposed for insurance, or owner of this policy, financed, or intend to finance, all or a portion of the premiums for this policy? If yes, complete Disclosure and Acknowledgement Form for premium financing and submit with application Yes No
24. Has the policy owner, beneficiary, or person proposed for insurance entered into or considering any other agreement with a third party, trust, or other entity, in regard to this policy, including, but not limited to, an agreement to sell, transfer or assign the policy or any policy rights or beneficial interests? Yes No

If the answer is 'Yes' to questions 19, 20, 22 or 24 provide details below. If answer to question 21 is 'No' provide details below.

TO BE COMPLETED BY SOLICITING AGENT

- Does any person covered under this application have any existing life insurance or annuities?..... Yes No
- Is any insurance applied for in this application intended to replace any existing life insurance or annuity?..... Yes No
- If the policy being applied for includes an accelerated death benefit(s), the agent provided the Proposed Primary Insured the Accelerated Benefit Summary and Disclosure Statement(s) prior to or concurrent with this application?..... Yes No
- If a replacement is involved, the application Replacement Notice will be sent to the existing insurer.

25. SPECIAL REQUESTS or DETAILS

TO BE COMPLETED FOR MILITARY PERSONNEL (Including National Guard and Reserves)

26. Permanent Home of Record Street City State Zip Code

27. Military Address Street City State Zip Code

28. Job Duties 29. Are you currently drawing extra duty or hazard pay? Yes No

30. Military Information USA USN USAF Other (Specify) Military ID _____
 Pay Grade _____ Rotation Date _____ Expected Discharge Date _____

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

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

UNDERWRITING QUESTIONS

Question 33 must be completed for all proposed insureds, including CTR. Details to "Yes" answers are to be provided in the Details Section below.

33. Has any person proposed for insurance:	Yes	No
(a) In the past 10 years used barbiturates, hallucinatory drugs, narcotics including crack, ecstasy, opium derivatives, marijuana, LSD, PCP, or any derivatives of these drugs, or been advised by a licensed medical professional to get, or undergone any treatment, counseling or hospitalization for drug abuse? If yes, complete Drug Questionnaire	<input type="checkbox"/>	<input type="checkbox"/>
(b) In the past 10 years been advised by a licensed medical professional to limit your alcohol use or been advised to get, or undergone any treatment or counseling or hospitalization for alcoholism, excessive alcohol use or abuse? Or, have you subsequently consumed alcohol after receiving counseling or treatment for alcohol use? Or, drink on average more than 3 alcoholic drinks per day? If yes, complete Alcohol Questionnaire	<input type="checkbox"/>	<input type="checkbox"/>
(c) In the past 10 years had their driver's license revoked or suspended or been convicted of reckless driving, driving without a valid license, or for driving while under the influence of alcohol or drugs (DWI, DUI)?	<input type="checkbox"/>	<input type="checkbox"/>
(d) Had more than one speeding violation, or any motor vehicle moving violations or accidents or been arrested for driving under the influence of alcohol within the past five years?	<input type="checkbox"/>	<input type="checkbox"/>
(e) In the past 10 years been convicted of any criminal activity, or been held or served time in any type of incarceration, jail, penitentiary, prison, probation, or parole program? Or, have any criminal charges pending against them at this time?	<input type="checkbox"/>	<input type="checkbox"/>
(f) Flown a plane in the past 24 months or plan to fly in the next 12 months as a pilot, copilot, student pilot, military pilot, engineer or in any other capacity except as a regularly scheduled commercial airline pilot or fare-paying passenger? If yes, complete Aviation Questionnaire.	<input type="checkbox"/>	<input type="checkbox"/>
(g) In the past 12 months or in the next 12 months, engaged in or plan to engage in activities including: hang gliding, skydiving, motor vehicle/cycle racing, rock climbing, ballooning, bungee jumping, mountain climbing, motor boat racing, snowmobile racing, ultra light aircraft flying, scuba diving to more than 50 feet in depth, or in caves, ship wrecks or deep seas or other extreme sports? If yes, please complete applicable Underwriting Questionnaire.	<input type="checkbox"/>	<input type="checkbox"/>
(h) In the past 10 years been refused for life insurance or charged an extra premium for life insurance?	<input type="checkbox"/>	<input type="checkbox"/>
(i) Traveled to or resided for more than 30 days outside of the U.S., U.S. territories, Canada, or Japan within the past 12 months or plan to travel to or reside outside of the U.S., U.S. territories, Canada, or Japan in the next 12 months? If yes, complete the Foreign Travel and Residence Questionnaire.	<input type="checkbox"/>	<input type="checkbox"/>
(j) Have any bankruptcy pending or expect to file bankruptcy in the next 12 months?	<input type="checkbox"/>	<input type="checkbox"/>

DETAILS TO 'YES' ANSWERS FOR QUESTIONS FROM SECTION 33(a) THROUGH 33(j)

Question #	Proposed Insured's Name	Dates and Details

Questions 34 through 37 must be completed for all proposed insureds, including CTR, not subject to a full paramedical exam. Details to "Yes" answers are to be provided in the Details Section below.

34. In the past 10 years, has any person proposed for insurance been diagnosed by a licensed medical professional, treated or advised to get treatment from a licensed medical professional, hospitalized, or presently taking prescription(s) or medication(s) for any of the following disease(s) or disorder(s):
- | | Yes | No |
|--|--------------------------|--------------------------|
| (a) Angina, chest pain, heart attack, heart failure, heart surgery, irregular heartbeat, abnormal EKG, coronary artery bypass, angioplasty, stents, peripheral vascular disease, poor circulation, valvular heart disease, cardiomyopathy or heart murmur? | <input type="checkbox"/> | <input type="checkbox"/> |
| (b) High blood pressure, hypertension or abnormal cholesterol levels? | <input type="checkbox"/> | <input type="checkbox"/> |
| (c) Stroke, seizures, epilepsy, dizziness, fainting, memory disorder or any other neurological or brain disorder? | <input type="checkbox"/> | <input type="checkbox"/> |
| (d) Multiple Sclerosis, neuritis, neuropathy, paralysis, muscular dystrophy, Parkinson's disease or any other disorder of the muscles? | <input type="checkbox"/> | <input type="checkbox"/> |
| (e) Arthritis, chronic pain, fibromyalgia, connective tissue disease, lupus or scleroderma? | <input type="checkbox"/> | <input type="checkbox"/> |
| (f) Cancer, malignancy, tumor, melanoma, lymphoma, Hodgkin's disease or leukemia? | <input type="checkbox"/> | <input type="checkbox"/> |
| (g) Chronic obstructive pulmonary or lung disease, chronic bronchitis, emphysema, sarcoidosis, asthma, shortness of breath, tuberculosis or sleep apnea? | <input type="checkbox"/> | <input type="checkbox"/> |
| (h) Diabetes, abnormal blood sugar, sugar in the urine, disease or disorders of the adrenal, parathyroid, pituitary or thyroid glands? | <input type="checkbox"/> | <input type="checkbox"/> |
| (i) Disorder of the kidney, bladder or urinary system, abnormal PSA, abnormal PAP smear without subsequent normal PAP smear or protein or blood in the urine? | <input type="checkbox"/> | <input type="checkbox"/> |
| (j) Anemia, hemophilia, clotting disorder or any other disorder of the blood? | <input type="checkbox"/> | <input type="checkbox"/> |
| (k) Immune Deficiency disorder (Acquired Immune Deficiency Syndrome (AIDS)), AIDS related complex (ARC) or been told test results indicate exposure to the AIDS virus? | <input type="checkbox"/> | <input type="checkbox"/> |
| (l) Colitis, ulcerative colitis, Crohn's, esophageal varices, peptic or gastric ulcer, intestinal or rectal bleeding, diverticulitis, colon polyps, cirrhosis, hepatitis, liver failure, liver impairment, loss of bowel function or other disease or disorder of the liver or pancreas? | <input type="checkbox"/> | <input type="checkbox"/> |
| (m) Depression, anxiety, stress, eating disorder or any other nervous, mental or emotional condition? | <input type="checkbox"/> | <input type="checkbox"/> |
| (n) Any mental or physical disorder or medically or surgically treated condition not listed above? | <input type="checkbox"/> | <input type="checkbox"/> |
35. Other than indicated above, has any person proposed for insurance:
- | | | |
|--|--------------------------|--------------------------|
| (a) Had a parent or sibling who before age 60 was diagnosed with or died from cardiovascular disease, stroke, cancer (except basal or squamous cell cancer of the skin), Huntington's Chorea, familial polyposis or polycystic kidney disease? If yes, provide age at onset and current age if living. If deceased, age at death. | <input type="checkbox"/> | <input type="checkbox"/> |
| (b) Had a weight gain or loss of 10 or more pounds within the past 12 months for any reason other than pregnancy? | <input type="checkbox"/> | <input type="checkbox"/> |
| (c) In the past 12 months been advised by a licensed medical professional to have a check up, EKG, X-ray, blood or urine test or any other diagnostic test or are you now planning to seek medical advice or treatment for any reason? | <input type="checkbox"/> | <input type="checkbox"/> |
| (d) In the past 12 months been advised by a licensed medical professional to be admitted to a hospital, medical facility, nursing home or assisted living facility? | <input type="checkbox"/> | <input type="checkbox"/> |
36. Is any person proposed for insurance currently taking any prescription medications, herbal remedies or non-prescription medications for any disease or disorder not listed above? If yes, list the medications and remedies and the reasons for which they are taken.....
37. Is any person proposed for insurance currently receiving or have an application pending for any illness or disability benefits or compensation?

DETAILS TO 'YES' ANSWERS FOR QUESTION 34 THROUGH 37

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

38. If not listed above, please provide full name, address and phone numbers of licensed medical professional(s) consulted in the past five years for each person proposed for coverage.

a. Date and findings of last visit:	
b. Tests performed and treatment received:	

CUSTOMER IDENTIFICATION				
Indicate the form of ID presented and used to verify this owner's identity:				
A. Owner #1				
Natural Person/Trust Accounts (info on trustee)				
	Driver's License	State:	Number:	Expiration Date:
	State-issued ID	State:	Number:	Expiration Date:
	Military ID		Number:	Expiration Date:
	Passport	Country:	Number:	Expiration Date:
	Alien Registration Card	Country:	Number:	Expiration Date:
<i>Non-Natural/Business or Corporation</i>				
	Partner or Trust Agreement		Date:	
	Certificate of Incorporation	State:	Date:	
	Business License	State:	Number:	
B. Owner #2				
Natural Person/Trust Accounts (info on trustee)				
	Driver's License	State:	Number:	Expiration Date:
	State-issued ID	State:	Number:	Expiration Date:
	Military ID		Number:	Expiration Date:
	Passport	Country:	Number:	Expiration Date:
	Alien Registration Card	Country:	Number:	Expiration Date:
<i>Non-Natural/Business or Corporation</i>				
	Partner or Trust Agreement		Date:	
	Certificate of Incorporation	State:	Date:	
	Business License	State:	Number:	

IT IS DECLARED that statements and answers in this application, including statements by the Proposed Insured(s) 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 of our Company; (2) the acceptance of any policy issued on this application shall constitute a ratification of any correction or amendment made by the Company. No change in amount, 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 arises or is discovered after completing this application, but before the Policy is effective, as defined herein.

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

Payment of Premium - (check one) This application is C.O.D.; I have elected initial EFT or I have paid \$ _____ with this application in consideration of a Temporary Insurance Agreement. I have read, understand, and agree to the terms of the Temporary Insurance Agreement.

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

TAX PAYER IDENTIFICATION NUMBER CERTIFICATION - Under penalties of perjury, the undersigned applicant(s) (I) certify that:

1. The number shown on this form is my correct taxpayer identification number (or I am waiting for a number to be issued to me), **and**
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. **(Please check appropriate response.)**

FINANCIAL INSTITUTION DISCLOSURE - Insurance products and annuities are not a deposit or other obligation of, or guaranteed by a bank, any affiliate of a bank, or savings association and are not insured by the Federal Deposit Insurance Corporation (FDIC) or any other agency of the United States, a bank, any affiliate of a bank, or savings association, and involve investment risk, including possible loss of value. The approval or disapproval of any extension of credit by the bank or an affiliate is not based on whether or not this insurance is purchased through the bank or through any particular source.

AUTHORIZATION: To determine eligibility for insurance, the undersigned applicant(s) (I) authorize any licensed physician, medical practitioner, health care professional, hospital, clinic, or other medically related facility, laboratory, pharmacy, pharmacy benefit manager, insurance or reinsuring company, viatical company, viatical broker or provider, the Medical Information Bureau, Inc., consumer reporting agency, insurance support organization, independent administrator, or other organization, institution, 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 and any other nonmedical information of me or my minor children to give to North American Company for Life and Health Insurance (the Company) or its legal representative, any and all such information. I also authorize the Company to conduct a personal telephone interview in connection with my application; and to release any such data to its reinsurers, the Medical Information Bureau, or other persons or organizations performing business or legal services in connection with my application, 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 for 30 months (24 months in KS, KY, NM, OK, WV & WY) from the date signed. 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.

[FRAUD WARNING - AR, KY, LA, NM, OH and PA Residents: 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.

CO Residents: 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 contract holder or claimant for the purpose of defrauding or attempting to defraud the contract holder 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.

DC and TN Residents: Warning: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits, if false information materially related to a claim was provided by the applicant.

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

VA and WA Residents: 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.]

Accelerated Death Benefit: If the policy being applied for includes an accelerated death benefit(s), the Proposed Primary Insured 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 Proposed Primary Insured the Accelerated Benefit Summary and Disclosure Statement(s) prior to or concurrent with this application.

SIGNATURES			
Signed At (City, State)			Date
Signature of Proposed Primary Insured (If 15 Years or Older), or Legal Guardian (If Primary Proposed Insured is a Minor)		Signature of Proposed Additional Insured	
X		X	
Signature of Owner (If other than Proposed Primary Insured) (If Owner is Corporation, Trust, or other Entity, include Title of Signee.)			
X			
Signature of Soliciting Agent	Print Agent's Last Name	Agent Code	Telephone Number ()
X			Cell Phone Number ()
Other Agent (Print)		% Credit	Agent Code
Other Agent (Print)		% Credit	Agent Code



Instructions/Information

1. Answer Medical/Insurability questions if: (a) reinstating (b) increasing face amount (c) adding benefits or riders (d) requesting change to non smoker status (or if original plan did not distinguish between smokers and non-smokers and non-smoker rates are desired.) (e) Death Benefit Option (f) rating reduction/removal (g) Exchanging. 2. Must remit full modal premium or check-o-matic authorization to complete the change. 3. Be certain to obtain owner's signature.

Section A – To be completed for all requests. Check appropriate box.

- Change Review Rating Reinstatement Conversion Class Change
 Increase Add Rider Decrease Option Change
 Exchange Exchange Commission Option: A B

EXISTING COVERAGE: UNIVERSAL LIFE INDEX UNIVERSAL LIFE WHOLE LIFE TERM RIDER

Policy Number

PRIMARY PROPOSED INSURED

2. Last Name _____ First Name _____ M.I. _____

2a. Are you a U.S. Citizen, or do you have a permanent Visa? Yes No

Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female	Date of Birth	Age	Place of Birth - State / Country	Height (FT. IN.)	Weight (LBS.)	Marital Status
---	---------------	-----	----------------------------------	------------------	---------------	----------------

Social Security Number	Driver's License Number	Expiration Date	State
------------------------	-------------------------	-----------------	-------

3. RESIDENCE ADDRESS Street _____ City _____ State _____ Zip Code _____

3a. How long at this address? (If less than 2 years, provide previous address.)

_____ Years _____ Months

3b. BILLING ADDRESS Street _____ City _____ State _____ Zip Code _____
(If other than residence)

3c. SECONDARY ADDRESS Street _____ City _____ State _____ Zip Code _____

4. Employer (Company Name and Address)

Occupation (Title and Duties)	Net Income \$ _____	Annual Income \$ _____	Net Worth \$ _____
-------------------------------	------------------------	---------------------------	-----------------------

5. CONTACT THE PROPOSED INSURED AT: <input type="checkbox"/> RESIDENCE <input type="checkbox"/> BUSINESS _____ (CST) <input type="checkbox"/> A.M. <input type="checkbox"/> P.M.	RESIDENCE TELEPHONE NUMBER Primary Insured (_____) Additional Insured (_____) Cell Phone (_____)	BUSINESS TELEPHONE NUMBER Primary Insured (_____) Additional Insured (_____) Cell Phone (_____)
--	---	--

Section B – To be completed for Changes and Conversions.

6. Death Benefit Option Return of Premium For Conversions the balance of the Plan or Rider is to be continued in force
 Level DB Increasing terminated
 decreased

Name of New Plan	New Policy Date Mo. Yr.	\$ Amount of Insurance	Telemed <input type="checkbox"/> YES <input type="checkbox"/> NO	For Applicable Products Only: <input type="checkbox"/> Guideline Level Premium Test <input type="checkbox"/> Cash Value Accumulation Test
------------------	------------------------------	------------------------	---	---

Non-Smoker Preferred Smoker Preferred Tobacco
 Standard Non Tobacco Smoker Standard Tobacco Super Preferred Non Tobacco
 Preferred Non Tobacco Preferred Plus Non Tobacco

11. PRIMARY BENEFICIARY If percentage shares are not listed below, they will be divided equally among the beneficiaries Provide Beneficiary(ies) Full Name(s) (If Trust, list Name and Date of Trust and complete Trust Form)			
Name	Percent	Relationship to Primary Insured	Social Security Number/Tax ID#
Total	100		

12. CONTINGENT BENEFICIARY If percentage shares are not listed below, they will be divided equally among the beneficiaries Provide Beneficiary(ies) Full Name(s) (If Trust, list Name and Date of Trust and complete Trust Form)			
Name	Percent	Relationship to Primary Insured	Social Security Number/Tax ID#
Total	100		

NOTE: PRIMARY BENEFICIARY designations do not apply to others covered under Family/Children's Provision Riders.

13. Has anyone proposed for insurance ever smoked cigarettes, cigars, pipes, or used tobacco in any form, including smokeless tobacco, nicotine patch, gum or other substitutes?

13a. Primary Insured: Yes No If 'yes', provide: Type of product(s) used _____
Amount Used: _____ How often: Daily _____ Weekly _____ Monthly _____ Date of last use mm/yy _____

13b. Additional Insured Rider/Spouse: Yes No If 'yes', provide: Type of product(s) used _____
Amount Used: _____ How often: Daily _____ Weekly _____ Monthly _____ Date of last use mm/yy _____

PREMIUM INFORMATION

14. Premium Frequency: Annual Semi-Annual Quarterly Monthly Single Pay Lump Sum \$
Premium Mode: EFT List Billing Direct Billing (A, SA, Q) only Civil Service Allotment Military Government Allotment
Other _____ List Bill Code _____

For term and whole life 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.

Amount of Modal Premium \$ Amount Paid with Application \$ (Receipt valid only if amount paid with application is entered here.)

Make all checks payable to: NORTH AMERICAN COMPANY FOR LIFE AND HEALTH INSURANCE

15. FOR EFT ONLY: DRAW DAY _____ (1 ST -28 TH) Month _____ Day _____ 15a. Initial Draft <input type="checkbox"/> Yes <input type="checkbox"/> No	ACCOUNT TYPE <input type="checkbox"/> Checking (attach voided check) <input type="checkbox"/> Savings (must complete 15b)	AUTHORIZED SIGNATURE(S) OF ACCOUNT HOLDER(S) X
		X
15b. Routing Transit Number	Account Number	Financial Institution Name and Address

REPLACEMENT INFORMATION

16. Does any person proposed for coverage have any life insurance and annuities currently in force or pending? (This includes policies that have or will be sold, assigned or otherwise placed via life settlement, viatical or other agreements, or that you intend to replace, cancel, or sell:) Yes No If yes, list below

Name	Company	Policy #	Pending	Issue Yr.	Basic Amount	ADB Amount	WP Amount	Intention of Replacement or Change*
16a.			<input type="checkbox"/>					17a. <input type="checkbox"/> Yes <input type="checkbox"/> No
16b.			<input type="checkbox"/>					17b. <input type="checkbox"/> Yes <input type="checkbox"/> No
16c.			<input type="checkbox"/>					17c. <input type="checkbox"/> Yes <input type="checkbox"/> No
16d.			<input type="checkbox"/>					17d. <input type="checkbox"/> Yes <input type="checkbox"/> No

*Replacement means that the insurance applied for may replace, change or use any value of an existing or pending life insurance policy or annuity. If replacement may be involved, complete applicable replacement form and submit with application.
Also complete section 18
If this is a 1035 Exchange, also complete 1035 Exchange paperwork and submit with application.

18. I (We) originally purchased the above product on or around: _____ Please print the name of the Agent that you bought the product from: If known. _____

Approximate net value to be received from exchanged product: \$ _____ Surrender charge that may be incurred on this transaction: \$ _____ Front End Load (if any) at time of original product purchase: \$ _____ or _____%

It is my (our) intention to reinvest the net value received from this transaction into: Universal Life Indexed Life Other Will this transaction result in a taxable event? Yes No Does this transaction qualify as a non-taxable exchange under IRS Section 1035 rules? Yes No *Complete 1035 papers.

The reason for changing the product MUST be provided! Please be specific, and clearly show the advantages of this transaction to the policyholder.

I (We) have discussed and understand the option of transferring my (our) contract fund. I (We) understand, I (we) may pay a surrender charge on my (our) original purchase and that, when I (we) purchase a new product that the surrender charge and other applicable product provisions will start anew. In the event the new policy is not accepted during the free look period, all value will be returned to the original policy and treated in accordance with its provisions.

19. Are any of the above policies being used to fund this policy? Yes No

20. Has, or will, any person proposed for insurance, or owner of this policy, been compensated in any way to purchase this policy? Yes No

21. Is the proposed insured(s), or owner of this policy, paying for this policy with his/her own funds? Yes No

22. Will the proceeds of a home equity loan or reverse mortgage transaction be used to pay the premiums on this policy? Yes No

23. Has any person proposed for insurance, or owner of this policy, financed, or intend to finance, all or a portion of the premiums for this policy? If yes, complete Disclosure and Acknowledgement Form for premium financing and submit with application Yes No

24. Has the policy owner, beneficiary, or person proposed for insurance entered into or considering any other agreement with a third party, trust, or other entity, in regard to this policy, including, but not limited to, an agreement to sell, transfer or assign the policy or any policy rights or beneficial interests? Yes No

If the answer is 'Yes' to questions 19, 20, 22 or 24 provide details below. If answer to question 21 is 'No' provide details below.

25. SPECIAL REQUESTS or DETAILS

TO BE COMPLETED FOR MILITARY PERSONNEL (Including National Guard and Reserves)				
26. Permanent Home of Record	Street	City	State	Zip Code
27. Military Address	Street	City	State	Zip Code
28. Job Duties	29. Are you currently drawing extra duty or hazard pay? <input type="checkbox"/> Yes <input type="checkbox"/> No			
30. Military Information	<input type="checkbox"/> USA	<input type="checkbox"/> USN	<input type="checkbox"/> USAF	<input type="checkbox"/> Other (Specify) _____
Pay Grade _____	Rotation Date _____	Military ID _____		
31. Has the Proposed Insured, applied to be a member of, or been a member of a special forces, special or hazardous duty organization? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, provide specific details.				
32. Has the Proposed Insured been alerted to, volunteered for, or received formal orders to a hazardous area or overseas assignment? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, provide specific details.				

UNDERWRITING QUESTIONS

Questions 33 must be completed for all proposed insureds, including CTR. Details to "Yes" answers are to be provided in the Details Section below.

33. Has any person proposed for insurance:	Yes	No
(a) In the past 10 years used barbiturates, hallucinatory drugs, narcotics including crack, ecstasy, opium derivatives, marijuana, LSD, PCP, or any derivatives of these drugs, or been advised by a licensed medical professional to get, or undergone any treatment, counseling or hospitalization for drug abuse?	<input type="checkbox"/>	<input type="checkbox"/>
(b) In the past 10 years been advised by a licensed medical professional to limit your alcohol use or been advised to get, or undergone any treatment or counseling or hospitalization for alcoholism, excessive alcohol use or abuse? Or, have you subsequently consumed alcohol after receiving counseling or treatment for alcohol use? Or, drink on average more than 3 alcoholic drinks per day?	<input type="checkbox"/>	<input type="checkbox"/>
(c) In the past 10 years had their driver's license revoked or suspended or been convicted of reckless driving, driving without a valid license, or for driving while under the influence of alcohol or drugs (DWI, DUI)?	<input type="checkbox"/>	<input type="checkbox"/>
(d) Had more than one speeding violation, or any motor vehicle moving violations or accidents or been arrested for driving under the influence of alcohol within the past five years?	<input type="checkbox"/>	<input type="checkbox"/>
(e) In the past 10 years been convicted of any criminal activity, or been held or served time in any type of incarceration, jail, penitentiary, prison, probation, or parole program? Or, have any criminal charges pending against them at this time?	<input type="checkbox"/>	<input type="checkbox"/>
(f) Flown a plane in the past 24 months or plan to fly in the next 12 months as a pilot, copilot, student pilot, military pilot, engineer or in any other capacity except as a regularly scheduled commercial airline pilot or fare-paying passenger?	<input type="checkbox"/>	<input type="checkbox"/>
(g) In the past 12 months or in the next 12 months, engaged in or plan to engage in activities including: hang gliding, skydiving, motor vehicle/cycle racing, rock climbing, ballooning, bungee jumping, mountain climbing, motor boat racing, snowmobile racing, ultra light aircraft flying, scuba diving to more than 50 feet in depth, or in caves, ship wrecks or deep seas or other extreme sports?	<input type="checkbox"/>	<input type="checkbox"/>
(h) In the past 10 years been refused for life insurance or charged an extra premium for life insurance?	<input type="checkbox"/>	<input type="checkbox"/>
(i) Traveled to or resided for more than 30 days outside of the U.S., U.S. territories, Canada, or Japan within the past 12 months or plan to travel to or reside outside of the U.S., U.S. territories, Canada, or Japan in the next 12 months?	<input type="checkbox"/>	<input type="checkbox"/>
(j) Have any bankruptcy pending or expect to file bankruptcy in the next 12 months? If yes, complete complete a Financial Supplement. . .	<input type="checkbox"/>	<input type="checkbox"/>

DETAILS TO 'YES' ANSWERS FOR QUESTIONS FROM SECTION 33(a) THROUGH 33(j)

Question #	Proposed Insured's Name	Dates and Details

Questions 34 through 37 must be completed for all proposed insureds, including CTR, not subject to a full paramedical exam. Details to "Yes" answers are to be provided in the Details Section below.

34. In the past 10 years, has any person proposed for insurance been diagnosed by a licensed medical professional, treated or advised to get treatment from a licensed medical professional, hospitalized, or presently taking prescription(s) or medication(s) for any of the following disease(s) or disorder(s):
- | | Yes | No |
|--|--------------------------|--------------------------|
| (a) Angina, chest pain, heart attack, heart failure, heart surgery, irregular heartbeat, abnormal EKG, coronary artery bypass, angioplasty, stents, peripheral vascular disease, poor circulation, valvular heart disease, cardiomyopathy or heart murmur? | <input type="checkbox"/> | <input type="checkbox"/> |
| (b) High blood pressure, hypertension or abnormal cholesterol levels?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| (c) Stroke, seizures, epilepsy, dizziness, fainting, memory disorder or any other neurological or brain disorder? | <input type="checkbox"/> | <input type="checkbox"/> |
| (d) Multiple Sclerosis, neuritis, neuropathy, paralysis, muscular dystrophy, Parkinson's disease or any other disorder of the muscles? | <input type="checkbox"/> | <input type="checkbox"/> |
| (e) Arthritis, chronic pain, fibromyalgia, connective tissue disease, lupus or scleroderma? | <input type="checkbox"/> | <input type="checkbox"/> |
| (f) Cancer, malignancy, tumor, melanoma, lymphoma, Hodgkin's disease or leukemia? | <input type="checkbox"/> | <input type="checkbox"/> |
| (g) Chronic obstructive pulmonary or lung disease, chronic bronchitis, emphysema, sarcoidosis, asthma, shortness of breath, tuberculosis or sleep apnea? | <input type="checkbox"/> | <input type="checkbox"/> |
| (h) Diabetes, abnormal blood sugar, sugar in the urine, disease or disorders of the adrenal, parathyroid, pituitary or thyroid glands? | <input type="checkbox"/> | <input type="checkbox"/> |
| (i) Disorder of the kidney, bladder or urinary system, abnormal PSA, abnormal pap smear without subsequent normal pap smear or protein or blood in the urine? | <input type="checkbox"/> | <input type="checkbox"/> |
| (j) Anemia, hemophilia, clotting disorder or any other disorder of the blood? | <input type="checkbox"/> | <input type="checkbox"/> |
| (k) Immune Deficiency disorder (Acquired Immune Deficiency Syndrome (AIDS)), AIDS related complex (ARC) or been told test results indicate exposure to the AIDS virus? | <input type="checkbox"/> | <input type="checkbox"/> |
| (l) Colitis, ulcerative colitis, Crohn's, esophageal varices, peptic or gastric ulcer, intestinal or rectal bleeding, diverticulitis, colon polyps, cirrhosis, hepatitis, liver failure, liver impairment, loss of bowel function or other disease or disorder of the liver or pancreas? | <input type="checkbox"/> | <input type="checkbox"/> |
| (m) Depression, anxiety, stress, eating disorder or any other nervous, mental or emotional condition? | <input type="checkbox"/> | <input type="checkbox"/> |
| (n) Any mental or physical disorder or medically or surgically treated condition not listed above? | <input type="checkbox"/> | <input type="checkbox"/> |
35. Other than indicated above, has any person proposed for insurance:
- | | | |
|---|--------------------------|--------------------------|
| (a) Had a parent or sibling who before age 60 was diagnosed with or died from cardiovascular disease, stroke, cancer (except basal or squamous cell cancer of the skin), Huntington's Chorea, familial polyposis or polycystic kidney disease? If yes, provide age at onset and current age if living. If deceased, age at death..... | <input type="checkbox"/> | <input type="checkbox"/> |
| (b) Had a weight gain or loss of 10 or more pounds within the past 12 months for any reason other than pregnancy? | <input type="checkbox"/> | <input type="checkbox"/> |
| (c) In the past 12 months been advised by a licensed medical professional to have a check up, EKG, X-ray, blood or urine test or any other diagnostic test or are you now planning to seek medical advise or treatment for any reason? | <input type="checkbox"/> | <input type="checkbox"/> |
| (d) In the past 12 months been advised by a licensed medical professional to be admitted to a hospital, medical facility, nursing home or assisted living facility? | <input type="checkbox"/> | <input type="checkbox"/> |
36. Is any person proposed for insurance currently taking any prescription medications, herbal remedies or non-prescription medications for any disease or disorder not listed above? If yes, list the medications and remedies and the reasons for which they are taken.....
- Yes No
37. Is any person proposed for insurance currently receiving or have an application pending for any illness or disability benefits or compensation?
- Yes No

DETAILS TO 'YES' ANSWERS FOR QUESTION 34 THROUGH 37

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

38. If not listed above, please provide full name, address and phone numbers of personal physician(s) and any other physician(s) consulted in the past five years for each person proposed for coverage.

a. Date and findings of last visit:

b. Tests performed and treatment received:

CUSTOMER IDENTIFICATION				
Indicate the form of ID presented and used to verify this owner's identity:				
A. Owner #1				
Natural Person/Trust Accounts (info on trustee)				
	Driver's License	State:	Number:	Expiration Date:
	State-issued ID	State:	Number:	Expiration Date:
	Military ID		Number:	Expiration Date:
	Passport	Country:	Number:	Expiration Date:
	Alien Registration Card	Country:	Number:	Expiration Date:
Non-Natural/Business or Corporation				
	Partner or Trust Agreement		Date:	
	Certificate of Incorporation	State:	Date:	
	Business License	State:	Number:	
B. Owner #2				
Natural Person/Trust Accounts (info on trustee)				
	Driver's License	State:	Number:	Expiration Date:
	State-issued ID	State:	Number:	Expiration Date:
	Military ID		Number:	Expiration Date:
	Passport	Country:	Number:	Expiration Date:
	Alien Registration Card	Country:	Number:	Expiration Date:
Non-Natural/Business or Corporation				
	Partner or Trust Agreement		Date:	
	Certificate of Incorporation	State:	Date:	
	Business License	State:	Number:	

IT IS DECLARED that statements and answers in this application, including statements by the Proposed Insured(s) 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 Company. No change in amount, 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 arises 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 state of health described in all parts of this application; or (2) take effect only as specified in the Temporary Insurance Agreement, if issued.

Payment of Premium - (check one) This application is C.O.D.; I have elected initial EFT or I have paid \$ _____ with this application in consideration of a Temporary Insurance Agreement. I have read, understand, and agree to the terms of the Temporary Insurance Agreement.

The undersigned applicant(s) acknowledges receipt of the Fair Credit Reporting Act notice/MIB, Inc., Notice and Notice of Insurance of Information Practices.

TAX PAYER IDENTIFICATION NUMBER CERTIFICATION - Under penalties of perjury, I certify that:

1. The number shown on this form is my correct taxpayer identification number (or I am waiting for a number to be issued to me), **and**
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. **(Please check appropriate response.)**

FINANCIAL INSTITUTION DISCLOSURE - Insurance products and annuities are not a deposit or other obligation of, or guaranteed by a bank, any affiliate of a bank, or savings association and are not insured by the Federal Deposit Insurance Corporation (FDIC) or any other agency of the United States, a bank, any affiliate of a bank, or savings association, and involve investment risk, including possible loss of value. The approval or disapproval of any extension of credit by the bank or an affiliate is not based on whether or not this insurance is purchased through the bank or through any particular source.

AUTHORIZATION: To determine eligibility for insurance, The undersigned applicant(s) (I) authorize any licensed physician, medical practitioner, health care professional, hospital, clinic, or other medically related facility, laboratory, pharmacy or pharmacy benefit manager, insurance or reinsuring company, viatical company, viatical broker or provider, the Medical Information Bureau, Inc., consumer reporting agency, insurance support organization, independent administrator, or other organization, institution, 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 and any other nonmedical information of me or my minor children to give to North American Company for Life and Health Insurance (the Company) or its legal representative, any and all such information. I also authorize the Company to conduct a personal telephone interview in connection with my application; and to release any such data to its reinsurers, the Medical Information Bureau, or other persons or organizations performing business or legal services in connection with my application, 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 for 30 months (24 months in KS, KY, NM, OK, WV & WY) from the date signed. 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.

[FRAUD WARNING - AR, KY, LA, NM, OH and PA Residents: 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.

CO Residents: 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 contractholder or claimant for the purpose of defrauding or attempting to defraud the contractholder 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.

DC and TN Residents: Warning: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits, if false information materially related to a claim was provided by the applicant.

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

VA and WA Residents: 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.]

Accelerated Death Benefit: If the policy being applied for includes an accelerated death benefit(s), the undersigned applicant 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 or I, the applicant was provided the Accelerated Benefit Summary and Disclosure Statement(s) prior to or concurrent with this application.

SIGNATURES				
Signed At (City, State)			Date	
Signature of Proposed Primary Insured (If 15 Years or Older), or Legal Guardian (If Primary Proposed Insured is a Minor)		Signature of Proposed Additional Insured		
X		X		
Signature of Owner(s) (If other than Proposed Primary Insured) (If Owner is Corporation, Trust, or other Entity, include Title of Signee.)		Spouse Consent (AK, AZ, CA, ID, LA, NM, NV, TX, WA, WI)		
X				
Signature of Soliciting Agent		Print Agent's Last Name	Agent Code	Telephone Number ()
X				Cell Phone Number ()
Other Agent (Print)	% Credit	Agent Code	General Agent (Print)	Agent Code



**APPLICATION
PART II**

A Member of the Sammons Financial Group

Proposed Insured (Please Print)	First Name	M.I.	Last Name	Birth Date (Month, Day, Year)	Social Security Number
---------------------------------	------------	------	-----------	-------------------------------	------------------------

1. Have you ever smoked cigarettes, cigars, pipes, or used tobacco in any form, including smokeless tobacco, nicotine patch, gum or other substitutes?

Yes No If 'yes', provide: Type of product(s) used _____
Amount Used: _____ How often: Daily _____ Weekly _____ Monthly _____ Date of last use mm/yy _____

2. In the past 10 years, have you ever had or been diagnosed by a licensed medical professional, treated or advised to get treatment from a licensed medical professional, hospitalized, or presently taking prescription(s) or medication(s) for any of the following disease(s) or disorder(s):

	Yes	No
(a) Angina, chest pain, heart attack, heart failure, heart surgery, irregular heartbeat, abnormal EKG, coronary artery bypass, angioplasty, stents, peripheral vascular disease, poor circulation, valvular heart disease, cardiomyopathy or heart murmur?	<input type="checkbox"/>	<input type="checkbox"/>
(b) High blood pressure, hypertension or abnormal cholesterol levels?	<input type="checkbox"/>	<input type="checkbox"/>
(c) Stroke, seizures, epilepsy, dizziness, fainting, memory disorder or any other neurological or brain disorder?	<input type="checkbox"/>	<input type="checkbox"/>
(d) Multiple Sclerosis, neuritis, neuropathy, paralysis, muscular dystrophy, Parkinson's disease or any other disorder of the muscles?	<input type="checkbox"/>	<input type="checkbox"/>
(e) Arthritis, chronic pain, fibromyalgia, connective tissue disease, lupus or scleroderma?	<input type="checkbox"/>	<input type="checkbox"/>
(f) Cancer, malignancy, tumor, melanoma, lymphoma, Hodgkin's disease or leukemia?	<input type="checkbox"/>	<input type="checkbox"/>
(g) Chronic obstructive pulmonary or lung disease, chronic bronchitis, emphysema, sarcoidosis, asthma, shortness of breath, tuberculosis or sleep apnea?	<input type="checkbox"/>	<input type="checkbox"/>
(h) Diabetes, abnormal blood sugar, sugar in the urine, disease or disorders of the adrenal, parathyroid, pituitary or thyroid glands?	<input type="checkbox"/>	<input type="checkbox"/>
(i) Disorder of the kidney, bladder or urinary system, abnormal PSA, abnormal PAP smear without subsequent normal PAP smear or protein or blood in the urine?	<input type="checkbox"/>	<input type="checkbox"/>
(j) Anemia, hemophilia, clotting disorder or any other disorder of the blood?	<input type="checkbox"/>	<input type="checkbox"/>
(k) Immune Deficiency disorder (Acquired Immune Deficiency Syndrome (AIDS), AIDS related complex (ARC) or been told test results indicate exposure to the AIDS virus?	<input type="checkbox"/>	<input type="checkbox"/>
(l) Colitis, ulcerative colitis, Crohn's, esophageal varices, peptic or gastric ulcer, intestinal or rectal bleeding, diverticulitis, colon polyps, cirrhosis, hepatitis, liver failure, liver impairment, loss of bowel function or other disease or disorder of the liver or pancreas?	<input type="checkbox"/>	<input type="checkbox"/>
(m) Depression, anxiety, stress, eating disorder or any other nervous, mental or emotional condition?	<input type="checkbox"/>	<input type="checkbox"/>
(n) Any mental or physical disorder or medically or surgically treated condition not listed above?	<input type="checkbox"/>	<input type="checkbox"/>

3. Other than indicated above, have you:

(a) Used barbiturates, hallucinatory drugs, narcotics including crack, ecstasy, opium derivatives, marijuana, LSD, PCP, or any derivatives of these drugs, or been advised by a licensed medical professional to get, or undergone any treatment, counseling or hospitalization for drug abuse?	<input type="checkbox"/>	<input type="checkbox"/>
(b) Been advised by a licensed medical professional to limit your alcohol use or been advised to get, or undergone any treatment or counseling or hospitalization for alcoholism, excessive alcohol use or abuse? Or, have you subsequently consumed alcohol after receiving counseling or treatment for alcohol use? Or, drink on average more than 3 alcoholic drinks per day?	<input type="checkbox"/>	<input type="checkbox"/>
(c) Had a parent or sibling who before age 60 was diagnosed with or died from cardiovascular disease, stroke, cancer (except basal or squamous cell cancer of the skin), Huntington's Chorea, familial polyposis or polycystic kidney disease? If yes, provide age at onset and current age if living. If deceased, age at death.....	<input type="checkbox"/>	<input type="checkbox"/>
(d) Had a weight gain or loss of 10 or more pounds within the past 12 months for any reason other than pregnancy?	<input type="checkbox"/>	<input type="checkbox"/>
(e) In the past 12 months been advised by a licensed medical professional to have a check up, EKG, X-ray, blood or urine test or any other diagnostic test or are you now planning to seek medical advice or treatment for any reason?	<input type="checkbox"/>	<input type="checkbox"/>
(f) In the past 12 months been advised by a licensed medical professional to be admitted to a hospital, medical facility, nursing home or assisted living facility?	<input type="checkbox"/>	<input type="checkbox"/>

4. Are you currently taking any prescription medications, herbal remedies or non-prescription medications for any disease or disorder not listed above? If yes, list the medications and remedies and the reasons for which they are taken.

5. Are you currently receiving or have an application pending for any illness or disability benefits or compensation?

DETAILS TO 'YES' ANSWERS FOR QUESTION 2 THROUGH 5

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

6. If not listed above, please provide full name, address and phone numbers of licensed medical professional(s) consulted in the past five years. Include date and findings of last visit and tests performed and treatment received.

The above statements and answers are true and complete to the best of my knowledge and belief. I agree that such statements and answers shall be part of the application and are made to induce the North American Life and Health Insurance Company to issue the policy or certificate applied for.

PART III – MEDICAL EXAMINER'S REPORT

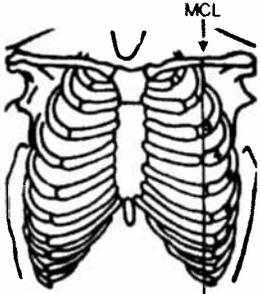
7a. Height (In Shoes)	Weight (Clothed)	Chest (Full Inspiration)	Chest (Forced Expiration)	Abdomen, at Umbilicus	b. Did you weigh? c. Did you measure? d. Is appearance unhealthy or older than stated age?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
ft. in.	lbs.	in.	in.	in.			

8. Blood Pressure (Record ALL readings)	1st	2nd	3rd	9. Pulse	At Rest	After Exercise	3 Minutes Later
Systolic				Rate			
Diastolic 5th phase				Irregularities per min.			

10. Heart: Is there any: Enlargement Yes No Dyspnea Yes No
Murmur(s) Yes No Edema Yes No
(describe below – if more than one, describe separately)

1st Murmur 2nd Murmur

Location Indicate:

Constant <input type="checkbox"/>			
Inconstant <input type="checkbox"/>			
Transmitted <input type="checkbox"/>			
Localized <input type="checkbox"/>			
Systolic <input type="checkbox"/>		Apex by <input checked="" type="checkbox"/>	
Presystolic <input type="checkbox"/>		Murmur area by <input type="checkbox"/>	
Diastolic <input type="checkbox"/>		Point of greatest intensity by <input type="checkbox"/>	
Soft (Gr. 1-2) <input type="checkbox"/>		Transmission by <input type="checkbox"/>	
Mod. (Gr. 3-4) <input type="checkbox"/>			
Loud (Gr. 5-6) <input type="checkbox"/>			
After exercise: <input type="checkbox"/>			
Increased <input type="checkbox"/>			
Absent <input type="checkbox"/>			
Unchanged <input type="checkbox"/>			
Decreased <input type="checkbox"/>			

Please give your diagnosis of the lesion and any other comments.

11. Is there on examination any abnormality of the following: (Circle applicable items and give details.)

(a) Eyes, ears, nose, mouth, pharynx?.....	Yes	No
(b) Skin (incl. scars); lymph nodes; varicose veins or peripheral arteries?.....	<input type="checkbox"/>	<input type="checkbox"/>
(c) Nervous system (include reflexes, gait, paralysis)?.....	<input type="checkbox"/>	<input type="checkbox"/>
(d) Respiratory system?.....	<input type="checkbox"/>	<input type="checkbox"/>
(e) Abdomen (include scars)?.....	<input type="checkbox"/>	<input type="checkbox"/>
(f) Genitourinary system (include prostate)?.....	<input type="checkbox"/>	<input type="checkbox"/>
(g) Endocrine system (include thyroid and breasts)?.....	<input type="checkbox"/>	<input type="checkbox"/>

Details of "Yes" answers. (Identify item.)

To be completed by either medical or paramedical examiner.

1. How long have you known Proposed Insured?	Yes	No
2. Has the Proposed Insured ever consulted you professionally? ..	<input type="checkbox"/>	<input type="checkbox"/>
3. Are you related in any way to Proposed Insured or Agent?	<input type="checkbox"/>	<input type="checkbox"/>
4. Are you a business associate of either the Proposed Insured or Agent?	<input type="checkbox"/>	<input type="checkbox"/>
If yes, which one and how associated?		
5. Are you aware of any additional information which might have a bearing upon the Proposed Insured's insurability?	<input type="checkbox"/>	<input type="checkbox"/>
(A confidential report may be sent to the Medical Director.)		

Send Urine Specimen To Laboratory In Container Provided. If Blood Specimen Is Required, Send To Laboratory In Kit Provided.

Other Services Performed With This Examination:	Is urine specimen being sent to laboratory? <input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Resting EKG <input type="checkbox"/> Chest X-ray <input type="checkbox"/> Venipuncture	Is person examined menstruating? <input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Treadmill EKG <input type="checkbox"/> DBS <input type="checkbox"/> Other	

I certify that I made this examination at	Examination made at
_____ A.M.	<input type="checkbox"/> my office <input type="checkbox"/> Individual's Place of Business
_____ P.M. on the _____ day of _____,	<input type="checkbox"/> Individual's Residence <input type="checkbox"/> Other

Examiner's Signature	Examination Fee	Tax I.D. or S.S. No. (IMPORTANT: Payment cannot be made without number.)
----------------------	-----------------	--

Examiner's Name (Print Full Name)	Examination Authorized By (Name of Agent – Please Print)
-----------------------------------	--

Examiner's Address (Street, City, State, Zip)	Examiner's Telephone Number ()
---	---------------------------------------

Please fax this report to

AUTHORIZATION: To determine eligibility for insurance, the undersigned applicant(s) (I) authorize any licensed physician, medical practitioner, health care professional, hospital, clinic, or other medically related facility, laboratory, pharmacy or pharmacy benefit manager, insurance or reinsuring company, viatical company, viatical broker or provider, the Medical Information Bureau, Inc., consumer reporting agency, insurance support organization, independent administrator, or other organization, institution, 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 and any other nonmedical information of me or my minor children to give to North American Company for Life and Health Insurance (the Company) or its legal representative, any and all such information. I also authorize the Company to conduct a personal telephone interview in connection with my application; and to release any such data to its reinsurers, the Medical Information Bureau, or other persons or organizations performing business or legal services in connection with my application, 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 for 30 months (24 months in KS, KY, NM, OK, WV & WY) from the date signed. 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.

FRAUD WARNING - AR, KY, LA, NM, OH and PA Residents: 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.

CO Residents: 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 certificate holder or claimant for the purpose of defrauding or attempting to defraud the certificate holder 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.

DC and TN Residents: Warning: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits, if false information materially related to a claim was provided by the applicant.

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

VA and WA Residents: 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.

Signed At (City and State)		Date
Witness Signature	Proposed Insured Signature	

North American Company • Administrative Office • P. O. Box 5089 • Sioux Falls, SD 57117-5089 • Principal Office • Des Moines, IA 50266
 Purple Team: (866) 606-2943 • Fax: (800) 978-7959 • Gold Team: (800) 869-9100 • Fax: (800) 951-9430



North American Company
for Life and Health Insurance



L3188

A Member of the Sammons Financial Group

STATEMENT OF HEALTH AND INSURABILITY

(To be completed by Proposed Insured or Additional Insured)

Completed as a condition to the delivery or change of:

Name of Proposed Insured	Policy Number
--------------------------	---------------

1. Since the date of the original application or examination, whichever is earlier, for the above policy, no person to be covered by the policy:

A. Has had any change in health (list any exceptions). Yes No

B. Has consulted, been examined, or treated by a physician or medical practitioner (list any exceptions).

C. Has made any change in occupation, the use of tobacco or drugs, participation in hazardous sports or flying or been arrested for any reason (list any exceptions).

D. Has made application to another life insurance company (list any exceptions).

2. Have you been declined, postponed or issued a life insurance policy on a modified basis?

[Fraud Warning:

DC residents: 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.

FL residents: 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.

LA residents: 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.

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

ME residents: 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 denial of insurance benefits.

TN residents: Warning: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits, if false information materially related to a claim was provided by the applicant.]

IT IS DECLARED that all the above statements are complete and true. Unless all questions are truthfully answered No, it is understood that no coverage will take effect until the Health Statement is reviewed and accepted by the company.

PROPOSED INSURED if 15 YEARS OR OLDER (Signature)	SIGNED AT (City, State)	DATE
PARENT or GUARDIAN IF PROPOSED INSURED UNDER AGE 15 (Signature)	SIGNATURE OF PROPOSED ADDITIONAL INSURED	
APPLICANT SOCIAL SECURITY NUMBER	SOLICITING AGENT (Signature)	
OWNER'S SIGNATURE		



North American Company
for Life and Health Insurance

A Member of the Sammons Financial Group



L3185

CONVULSIVE QUESTIONNAIRE

TO BE COMPLETED BY THE APPLICANT

Date of First Seizure/Convulsion		Date of Birth	Height
Name of Doctor Supervising Your Condition		Address of Doctor	
How Long Have You Been Under His Care?		Date of Last Visit	
Are You Taking Medication for This Condition?			
What Kind?		How Often?	
Have You Been Treated by Any Other Doctor?		When?	
What is the Duration of Seizures? (In Minutes)		What Was the Date of Your Last Seizure?	
How Many Seizures Have You Had? Total		Last Year?	Two to Three Years Ago?
Do You Lose Consciousness During a Seizure?			
What is Your Present Occupation?		Length of Employment? Yrs. Mos.	
Please Describe Your Duties			
Do You Now or Have You Ever Used Alcoholic Beverages?			
If Yes, How Often?		Quantity?	
Has Your Condition Been Classed as:		Petit Mal?	Grand Mal?
Other?		Jacksonian?	
		If Other, Please Describe	
Are You Aware of or Have You Ever Been Told That You Have Any Other Impairments?			
If Yes, Please Describe			

North American Company • Administrative Office • P. O. Box 5089 • Sioux Falls, SD 57117-5089 • Principal Office • Des Moines, IA 50266
Purple Team: (866) 606-2943 • Fax: (800) 978-7959 • Gold Team: (800) 669-9100 • Fax: (800) 951-9430

[Fraud Warning:

FL residents: 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.

LA residents: 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.

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

ME residents: 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 denial of insurance benefits.]

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

Witness	Signature of Proposed Insured	Date
---------	-------------------------------	------

If more space is needed, attach an additional page and please sign and date each additional page.



North American Company
 for Life and Health Insurance
 Principal Office: 4601 Westown Parkway, Suite 300
 West Des Moines, IA 50266
 A Member of the Sammons Financial Group



L2991C

Civilian Aviation Questionnaire

Please answer all questions and provide details where requested.

Name of Proposed Insured:	Date of Birth:
---------------------------	----------------

1. Are you a student Pilot?

- Yes
- No

2. Are you a licensed Pilot?

- Yes
- No

3. Please check all appropriate certificates:

- Private
- Commercial
- Airline Transport
- Flight Instructor
- Instrument Rating (IFR)

4. Do you fly outside the United States or plan to in the future?

- Yes
- No

If yes, please provide details:

5. Do you fly for pay?

- Yes
- No

If Yes, in what capacity?

6. What is the purpose of your flying? (Check all that apply)

- | | |
|---------------------------------------|--|
| <input type="checkbox"/> Pleasure | <input type="checkbox"/> Business |
| <input type="checkbox"/> Charter | <input type="checkbox"/> Aerobatic |
| <input type="checkbox"/> Air Taxi | <input type="checkbox"/> Corporate |
| <input type="checkbox"/> Crop Dusting | <input type="checkbox"/> Flight Instructor |

7. Have you had any flying related accidents, been grounded, or reprimanded for violation of air regulations?

- Yes
- No

If yes, please provide details:

8. Have you ever flown experimental aircraft, gliders, hang gliders, ultralites, and homebuilt aircraft or do you intend to do so in the future?

- Yes
- No

If yes, please provide details:

9. How many hours have you flown in the last

12 months? _____

24 months? _____

What is your total hours flown? _____

10. What type of aircraft have you flown in the past 36 months?

Make	Model	Year Built	Hours
------	-------	------------	-------

11. What aircraft will you fly in the next 12 months? Provide the number of hours expected.

Make	Model	Year Built	Hours
------	-------	------------	-------

[Fraud Warning:

FL residents: 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.

LA residents: 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.

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

ME residents: 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 denial of insurance benefits.]

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

Signed at:	Date:
Witness:	Signature of Proposed Insured:

If more space is needed attach additional page, please sign and date each additional page.



Scuba & Skin Diving Questionnaire

Name of Proposed Insured:	Date of Birth:
---------------------------	----------------

Please complete if you have engaged in or contemplate engaging in any form or skin or scuba diving in the future.

Depth of Dives (feet)	Pleasure				Commercial			
	Last 12 Months		Next 12 Months		Last 12 Months		Next 12 Months	
	Number of dives	Average time per dive	Number of dives	Average time per dive	Number of dives	Average time per dive	Number of dives	Average time per dive
Less than 50 ft.								
51 - 100 ft.								
101 - 130 ft.								
Greater than 130 ft.								

1. Level of Certification: Basic Open Water Advanced Open Water Master Diver
 Other: _____
2. Date of last Certification: _____
3. Do you engage in specialty/technical diving? Yes No
If Yes, have you received special training? Yes No If Yes, go to question #4. If No, go to question #5.
4. Specialty/Technical Certification: Cave Wreck Ice Deep Mixed Gas Equipment (Nitrox, Trimix, or Heliox)
 Other: _____
5. What organization did you receive your certification from? PADI NAUI YMCA
 Other: _____
6. Total number of dives: _____
7. Date of last dive: _____
8. Location of Dives Ocean/Sea Inland Waters Lakes Rivers High Altitudes (i.e. mountains, lakes)
 Other: _____
9. Purpose for Diving: Recreation Commercial Instruction Photography Hunting
 Wreck/Salvage Retrieval Depth Records Attempts Other: _____
10. Do you ever dive for profit? Yes No If Yes, please explain: _____
11. Do you dive alone? Yes No
If Yes, please explain: _____
12. Have you ever experienced or been treated for Decompression Illness, including Decompression Sickness (DCS) or Arterial Gas Embolism (AGE-also known as air embolism)? Yes No
If Yes, please explain: _____
13. Have you ever had a diving accident? Yes No
If Yes, please explain: _____

[Fraud Warning:

FL residents: 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.

LA residents: 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.

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

ME residents: 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 denial of insurance benefits.]

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

Signed at:	Date:
Witness:	Signature of Proposed Insured:

If more space is needed attach additional page, please sign and date each additional page.



L2992B

FOREIGN TRAVEL AND RESIDENCE QUESTIONNAIRE

Name: _____ Date of Birth: _____

SECTION A: CITIZENSHIP

1. Are you a citizen of the U.S.? Yes (If Yes, go to Section C.) No (If No, go to Section B.)

SECTION B: NON-U.S. CITIZEN

1. What country are you now a citizen? _____
2. Indicate type of visa: Permanent Visa (Give Alien Registration #) _____
 Temporary Visa (Give Expiration Date) _____
 No Visa (Provide complete details) _____
3. Indicate purpose of visa (work, student, government employee, etc.): _____
4. Have you applied for U.S. citizenship? Yes No
5. Do you also maintain a foreign residence? Yes No
 If so, what is the address? _____
6. Where does your immediate family (spouse and children) reside? _____
7. When do you plan to return to your native country (duration and expected frequency)? _____
8. How long have you lived in the U.S.? _____
9. Complete Section C.

SECTION C: FOREIGN TRAVEL OR RESIDENCE

1. Did you live or travel outside the U.S. in the past 12 months? Yes No

City	Country	Purpose (give full details)	Date	Length of Stay

2. Do you plan to live or travel outside the U.S. in the next 12 months? Yes No

City	Country	Purpose (give full details)	Date	Length of Stay

3. Indicate type of foreign environment (Metropolitan, Rural/Agricultural, Primitive/Native, etc.): _____

4. Comments: _____

[Fraud Warning:

FL residents: 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.

LA residents: 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.

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

ME residents: 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 denial of insurance benefits.]

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

Signed at _____ Date _____

Witness

Signature of Proposed Insured

SERFF Tracking Number: NALH-126296100 State: Arkansas
 Filing Company: North American Company for Life and Health State Tracking Number: 43481
 Insurance
 Company Tracking Number: L-3182, L-3186, L-3188, L-3187, L-3185, L-2991C, L-2992B, L-3116B
 TOI: L08 Life - Other Sub-TOI: L08.000 Life - Other
 Product Name: L-3182, L-3186, L-3188, L-3187, L-3185, L-2991C, L-2992B, L-3116B
 Project Name/Number: L-3182, L-3186, L-3188, L-3187, L-3185, L-2991C, L-2992B, L-3116B /L-3182, L-3186, L-3188, L-3187, L-3185, L-2991C, L-2992B, L-3116B

Supporting Document Schedules

Item Status: **Status Date:**

Satisfied - Item: Flesch Certification

Comments:

Attachments:

READABILITY CERTIFICATE.pdf

AR L&H Reg 19 Certification.pdf

Item Status: **Status Date:**

Satisfied - Item: Application

Comments:

Application form being filed for approval

Item Status: **Status Date:**

Satisfied - Item: Statement of Variability

Comments:

Attachment:

Statement of Variability.pdf

READABILITY CERTIFICATE

I certify that Readability has been tested under the Flesch Readability formula set forth by Rudolph Flesch in his book, The Art of Readability Writing and that the form(s) meet your minimum readability requirements for the form(s) listed below:

<u>Form Number</u>	<u>Description</u>	<u>Score</u>
L-3182	General Purpose Life Application Part I	50.3
L-3187	Application for Policy Conversion, Change or Reinstatement	50.3
L-3186	Application Part II	56.1
L-3188	Statement of Health and Insurability	50.9
L-3185	Convulsive Questionnaire	54.6
L-2991C	Civilian Aviation Questionnaire	64.2
L-3116B	Scuba & Skin Diving Questionnaire	61.1
L-2992B	Foreign Travel and Residence Questionnaire	69.0



Timothy Reuer, FSA, MAAA
Vice President - Product Development
North American Company for Life and Health Insurance

August 31, 2009

Date

Rule & Regulation 19 Certification

Form No(s): _____

This filing meets the provisions of this Rule as well as all applicable requirements of the Arkansas Insurance Department.

Date: _____

Statement of Variability for Life Insurance Applications, Underwriting Questionnaires & Health Statement

The following is a list of items that have been bracketed within the specified life insurance application form, underwriting questionnaire and health statement form along with an explanation for the bracketing.

L-3182 - General Purpose Life Application form:

1. Riders section (bottom page 1) – The riders have been bracketed so as to reserve the remove them from the application form when discontinued, right to change the rider name, or add new riders approved by the Department, without re-filing this application.
2. New Business team names and contact numbers (bottom of page 1) – Has been bracketed so as to reserve the right to revise or remove them if teams change without re-filing this application.
3. Administrative Office address and Principal Office address (bottom of page 1) – Has been bracketed so as to reserve the right to change or delete it without re-filing this application.
4. State specific fraud warnings (page 7) – The state mandated fraud warning language was bracketed so as to reserve the right to add, revise or delete the language if required by a state or add additional state fraud warning language in the future without having to re-file this application.

L-3186 Application Part II form:

1. New Business team names and contact numbers (bottom of each page) – Has been bracketed so as to reserve the right to revise or remove them if teams change without re-filing this application.
2. Administrative Office address and Principal Office address (bottom of each page) – Has been bracketed so as to reserve the right to change or delete it without re-filing this application.
3. State specific fraud warnings (page 3) – The state mandated fraud warning language was bracketed so as to reserve the right to add, revise or delete the language if required by a state or add additional state fraud warning language in the future without having to re-file this application.

L-3187 - Policy Change, Conversion, Change or Reinstatement Application form:

1. New Business team names and contact numbers (bottom of page 1) – Has been bracketed so as to reserve the right to revise or remove them if teams change without re-filing this application.
2. Administrative Office address and Principal Office address (bottom of page 1) – Has been bracketed so as to reserve the right to change or delete it without re-filing this application.
3. Riders section (6a page 2) – The riders have been bracketed so as to reserve the remove them from the application form when discontinued, right to change the rider name, or add new riders approved by the Department, without re-filing this application.
4. State specific fraud warnings (page 8) – The state mandated fraud warning language was bracketed so as to reserve the right to add, revise or delete the language if required by a state or add additional state fraud warning language in the future without having to re-file this application.

(L-3185, L-2991C, L-3116B, L-2992B) Underwriting Questionnaire forms:

1. New Business team names and contact numbers (bottom of each page) – Has been bracketed so as to reserve the right to revise or remove them if teams change without re-filing this application.
2. Administrative Office address and Principal Office address (bottom of each page) – Has been bracketed so as to reserve the right to change or delete it without re-filing this application.
3. State specific fraud warnings (page 2) – The state mandated fraud warning language was bracketed so as to reserve the right to add, revise or delete the language if required by a state or add additional state fraud warning language in the future without having to re-file this application.

L-3188 - Health Statement form:

1. New Business team names and contact numbers (bottom of each page) – Has been bracketed so as to reserve the right to revise or remove them if teams change without re-filing this application.
2. Administrative Office address and Principal Office address (bottom of each page) – Has been bracketed so as to reserve the right to change or delete it without re-filing this application.
3. State specific fraud warnings (page 2) – The state mandated fraud warning language was bracketed so as to reserve the right to add, revise or delete the language if required by a state or add additional state fraud warning language in the future without having to re-file this application.