

SERFF Tracking Number: NALF-126412308 State: Arkansas
 Filing Company: National Life Insurance Company State Tracking Number: 44648
 Company Tracking Number: 8804(0210) DBPR
 TOI: L09I Individual Life - Flexible Premium Sub-TOI: L09I.001 Single Life
 Adjustable Life
 Product Name: Death Benefit Protection Rider
 Project Name/Number: DBPR on NL AssurePlus Protector/8804(0210)

Filing at a Glance

Company: National Life Insurance Company

Product Name: Death Benefit Protection Rider SERFF Tr Num: NALF-126412308 State: Arkansas
 TOI: L09I Individual Life - Flexible Premium SERFF Status: Closed-Approved- State Tr Num: 44648
 Adjustable Life Closed
 Sub-TOI: L09I.001 Single Life Co Tr Num: 8804(0210) DBPR State Status: Approved-Closed
 Filing Type: Form Reviewer(s): Linda Bird
 Authors: Susan Carey, Laurie Disposition Date: 01/26/2010
 Trombly, Michelle Goodwin, Susan
 Preedom
 Date Submitted: 01/21/2010 Disposition Status: Approved-Closed
 Implementation Date Requested: On Approval Implementation Date:

State Filing Description:

General Information

Project Name: DBPR on NL AssurePlus Protector
 Project Number: 8804(0210)
 Requested Filing Mode: Review & Approval
 Explanation for Combination/Other:
 Submission Type: New Submission
 Overall Rate Impact:
 Filing Status Changed: 01/26/2010

Status of Filing in Domicile: Pending
 Date Approved in Domicile:
 Domicile Status Comments:
 Market Type: Individual
 Group Market Size:
 Group Market Type:
 Explanation for Other Group Market Type:
 State Status Changed: 01/26/2010
 Created By: Susan Preedom
 Corresponding Filing Tracking Number:

Deemer Date:

Submitted By: Susan Preedom

Filing Description:

8804(0210), Death Benefit Protection Rider

9212AR(0210), Life Insurance Application

8531AR(0210), Supplemental Other Insured Rider Life Insurance Application

For Use With Policy Forms:

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8522(0707), Flexible Premium Adjustable Benefit Life Insurance Sex Distinct Version.
8523(0707), Flexible Premium Adjustable Benefit Life Insurance Unisex Version.

Proposed Effective Date: April 1, 2010

Today we submit for your consideration a new Death Benefit Protection Rider and two revised Life Insurance Applications to be used with our Flexible Premium Adjustable Benefit Life Insurance policies written on the contracts noted above. These forms are also being submitted to the Vermont Department of Insurance via Compact filing representing our state of domicile and currently pending there.

Death Benefit Protection Rider, Form 8804

This is a new rider to our portfolio and will not replace any currently approved rider. The Death Benefit Protection Rider will remain in force as long as the accumulated premiums paid, net of the accumulation of withdrawals taken, and net of any debt must, on each Monthly Policy Date, equal at least the accumulated Monthly Guarantee Premiums in effect on each Monthly Policy Date since the Date of Issue. An evaluation of compliance is made on each Monthly Policy Date during the Death Benefit Protection Period. If on any Monthly Policy Date the minimum premium requirement is not met, notification will be sent to the policyholder that the rider will be cancelled if a specified premium is not paid within 61 days from the date we mail said notice. Once the rider is lapsed, it cannot be reinstated, and the underlying policy may become subject to a new grace period subject to its own terms. This rider will be made available at all issue ages 0 – 75. As noted earlier, this rider will only be made available at issue and will have a Death Benefit Protection period of 20 years. It will be available only on Option A policies. There is a charge for this rider for issue ages 51 and older. This rider will be made available on all pension plans except 412(e)(3) plans.

Application for Life Insurance, Form 9212

Form 9212AR(0210) will replace the use of form 9212AR(1008) which was approved by your Department on 07/08/2008. We have revised the application to accommodate its use with the new Death Benefit Protection Rider. It is our intent to use the revised application with today's submitted rider, as well as with all other life insurance products offered through our portfolio of products.

Supplemental Other Insured Rider Application for Life Insurance, Form 8531

This Supplemental Application will be required in conjunction with Life Insurance Application 9212AR(0210) to apply for our Other Insured Rider coverage. All of the changes made to the submitted Application, form 8531AR(0210) were made to the above-mentioned form, 9212AR(0210). Form 8531AR(0210) will replace the use of form 8531AR(0707) which was approved by your Department on 09/06/2007.

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The Flesch Readability Score for the submitted forms are as follows:

Form Number	Form Title	Flesch Score
8804(0210)	Death Benefit Protection Rider.	79.6
9212(0210)	Life Insurance Application.	60.3
8531(0210)	Supplemental Other Insured Rider Application for Life Insurance.	54.0

Also enclosed are sample data pages for the rider. The sample cover page indicates how the existence of the rider on the policy will be communicated on the first page of the data section, and then the rider has its own data page with policy specific information.

Company and Contact

Filing Contact Information

Susan Preedom, Policy Forms Business Analyst
 SPreedom@NationalLife.com
 One National Life Drive
 Montpelier, VT 05604
 802-229-7387 [Phone]
 802-229-3743 [FAX]

Filing Company Information

National Life Insurance Company	CoCode: 66680	State of Domicile: Vermont
One National Life Drive	Group Code: -99	Company Type:
Montpelier, VT 05604	Group Name:	State ID Number:
(802) 229-3333 ext. [Phone]	FEIN Number: 03-0144090	

Filing Fees

Fee Required? Yes
 Fee Amount: \$150.00
 Retaliatory? Yes
 Fee Explanation: Vermont charges \$50 per filing submission.
 Per Company: No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
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National Life Insurance Company \$150.00 01/21/2010 33688086

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Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Linda Bird	01/26/2010	01/26/2010

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Disposition

Disposition Date: 01/26/2010

Implementation Date:

Status: Approved-Closed

Comment:

Rate data does NOT apply to filing.

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Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification	Yes	Yes
Supporting Document	Application	No	No
Supporting Document	Health - Actuarial Justification	No	No
Supporting Document	Outline of Coverage	No	No
Supporting Document	Statement of Variability	Yes	Yes
Supporting Document	Actuarial Memorandum	No	No
Supporting Document	Responsible Officer	Yes	Yes
Form	Death Benefit Protection Rider	Yes	Yes
Form	Life Application	Yes	Yes
Form	Supplemental App	Yes	Yes
Form	AssurePlus DP	Yes	Yes
Form	AssurePlus Unisex DP	Yes	Yes

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Form Schedule

Lead Form Number: 8804(0210)

Schedule Item Status	Form Number	Form Type Form Name	Action	Action Specific Data	Readability	Attachment
	8804(0210)	Policy/Cont Death Benefit ract/Fratern Protection Rider al Certificate: Amendmen t, Insert Page, Endorseme nt or Rider	Initial		79.600	8804.pdf
	9212AR(0210)	Application/Life Application Enrollment Form	Initial		60.300	9212AR.pdf
	8531AR(0210)	Application/ Supplemental App Enrollment Form	Initial		54.000	8531AR.pdf
	NVST	Data/DeclarAssurePlus DP ation Pages	Initial			DataPages- NL- AssurePlusM aleDBPR.pdf
	NVST/U	Data/DeclarAssurePlus Unisex ation PagesDP	Initial			DataPages- NL- AssurePlusUn isexDBPR.pdf

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Cost of this Rider	2
Suspension of Monthly Deductions	2
Suicide Limitation	3
Incontestability	3
Consideration	3
Notice of Pending Termination of this Rider	3
Termination of this Rider	4

DEATH BENEFIT PROTECTION RIDER

We, National Life Insurance Company, guarantee that the policy will remain in force as long as the Conditions of this Rider are met. This guarantee ensures that a Death Benefit will be payable under the policy for as long as this rider remains in force.

The date of issue of this rider is the policy Date of Issue.

MONTHLY GUARANTEE PREMIUM

The Monthly Guarantee Premium specific to this rider is stated in the Data Section. It is subject to change upon increases or decreases in Face Amount, and additions or deletions of rider coverages.

CONDITIONS OF THIS RIDER

The Death Benefit Protection Period is shown in the Data Section. During the Death Benefit Protection Period, to keep this rider in force, the accumulation of premiums paid, net of the accumulation of withdrawals taken, and net of debt must, on each Monthly Policy Date equal at least the accumulated Monthly Guarantee Premiums in effect on each Monthly Policy Date since the Date of Issue. Compliance with this condition will be determined on every Monthly Policy Date during the Death Benefit Protection Period.

Premiums paid and withdrawals made will be accumulated with interest from the date of each premium payment or withdrawal (or from the Monthly Policy Date immediately preceding such date if the premium payment or withdrawal is not made on a Monthly Policy Date) to the Monthly Policy Date on which the evaluation is being made. The Monthly Guarantee Premiums in effect on each prior Monthly Policy Date will similarly be accumulated with interest to the same Monthly Policy Date. The interest rate used in these accumulations will be the Death Benefit Protection Period Interest Rate shown in the Data Section.

INTERACTION WITH WAIVER BENEFITS

A Rider for Waiver of Monthly Deductions will be administered as follows:

1. the Monthly Guarantee Premiums due while Monthly Deductions are being waived according to the terms of the Rider for Waiver of Monthly Deductions will be set equal to zero; and
2. when a period during which Monthly Deductions are waived ends, the Monthly Guarantee Premium will revert to the value at the start of that period.

Monthly Guarantee Premiums due while the Company is crediting Monthly Specified Premiums to the policy according to the terms of a Waiver of Specified Premium Rider attached to the policy will be set equal to those Monthly Specified Premiums being credited.

IMPACT OF WITHDRAWALS AND POLICY LOANS

Withdrawals and policy loans taken against the policy will impact the calculation described in the Conditions of this Rider. If a withdrawal made or a policy loan taken against the policy leaves the policy out of compliance with the Conditions of this Rider, a Notice of Pending Termination of this Rider will be sent to the Owner.

DEFINITION OF LIFE INSURANCE

In order for you and the beneficiary to receive the tax treatment accorded to life insurance contracts by Federal law, the policy to which this rider is attached, must initially qualify and continue to qualify as life insurance under Section 7702 of the Internal Revenue Code of 1986 ("the Code"), as amended, and its rules and regulations. The Definition of Life Insurance Test shown in the policy Data Section is the specific method by which we determine whether your policy meets the Definition of Life Insurance.

A premium will not be accepted which would cause the policy to which this rider is attached to violate the Definition of Life Insurance as defined in the above paragraph. If the minimum premium necessary to satisfy the Conditions of this Rider cannot be paid due to the Definition of Life Insurance premium limitations, this rider will terminate.

COST OF THIS RIDER

The monthly cost of this rider is shown in the Data Section. It will be based on the Face Amount of the policy. If, while this rider is in force, any increase or decrease in the Face Amount is made, the monthly cost of this rider will similarly increase or decrease. The monthly cost of this rider will be deducted from the Accumulated Value of the policy in the same manner as is the Monthly Deduction.

SUSPENSION OF MONTHLY DEDUCTIONS

If, while this rider is in force, the Cash Surrender Value of the policy is not sufficient to cover the Monthly Deductions, Monthly Deductions will be deducted from the Accumulated Value until the Accumulated Value is exhausted, and will thereafter be deferred until such time as the policy has positive Accumulated Value. Monthly Deductions in arrears will not be accumulated with interest.

Upon the death of the Insured, we will waive any Monthly Deductions then in arrears. Otherwise, Monthly Deductions in arrears will be due from policy values upon termination of this rider.

SUICIDE
LIMITATION

If the Insured dies within two years of the date of issue of this rider as the result of suicide, while sane or insane, we will pay only the sum set forth in the Suicide Limitation provision of the policy. Payment will be made to the Beneficiary.

INCONTESTABILITY

After this rider has been in force during the life of the Insured for two years from its date of issue, we will not contest it.

CONSIDERATION

This rider is issued in consideration of the application for this rider and the monthly cost of this rider. This rider and a copy of the application for this rider will become part of the policy on its Date of Issue.

NOTICE OF
PENDING
TERMINATION OF
THIS RIDER

If on any Monthly Policy Date the Conditions of this Rider are not met, the Owner will be sent notice that unless the premium described below is paid during the first 61 days measured from the date we mailed such notice, this rider will terminate. The required premium will be the minimum premium accumulated with interest sufficient to satisfy the Conditions of this Rider on the Monthly Policy Date three months following the Monthly Policy Date on which the failure to meet the Conditions of this Rider prompted the mailing of such notice.

TERMINATION OF
THIS RIDER

This rider will terminate on the earliest of:

1. the end of the 61st day following our mailing of a Notice of Pending Termination of this Rider, if prior to that time the premium described in Notice of Pending Termination of this Rider is not paid; or
2. the date the Death Benefit Option of the policy is changed to Option B;
or
3. the date the policy terminates. If the policy is reinstated, this rider will not be reinstated; or
4. any Monthly Policy Date requested, if before that date we receive at our Home Office written request for termination of this rider; or
5. the end of the Death Benefit Protection Period as stated in this rider's Data Section.

When this rider terminates:

1. all rights under this rider will cease; and
2. it cannot be reinstated; and
3. the policy will be considered separate and complete without this rider.

If this rider terminates while the Accumulated Value of the policy is zero, the policy may enter a Grace Period and an additional payment, as determined by the Grace Period provision of the policy, may be required to keep the policy in force.

Signed for National Life Insurance Company at Montpelier, Vermont, as of the date of issue of this rider, by



President & Chief Executive Officer

Site Location and No.:

Qualified Retirement Plan/Code No.:

Exercising Additional Insurance Option From Base Policy No.:

Policy No.:

Part A - First Proposed Insured Information

1. Name (print first, middle, last)	2. Place of Birth - State/Country	3. Date of Birth	4. Issue at Age
5. Home Address (If mailing address different, provide in Remarks)			
6. Sex <input type="checkbox"/> M <input type="checkbox"/> F	7. Social Sec. #	8. Telephone #'s and best time to call H () W () C ()	
9. Are you a citizen of <input type="checkbox"/> USA <input type="checkbox"/> Other Country		Type of VISA	Alien Registration #.:
10. Employer Name & Address (street, city, state and zip)		11a. Driver's License #	11b. State
		12a. Occupation (w/specific duties)	
12b. Are you actively at work at the customary workplace, doing the usual duties and functions required by the position during the normal work hours and weekly period? <input type="checkbox"/> Yes <input type="checkbox"/> No* *Reason:			

Part B - Policy Information

1. Product Name	2. Amount \$	8. Premium information
3. Term Rider Plan	4. Amount \$	a. Cash with Application \$
5. Universal Life Death Benefit Option <input type="checkbox"/> A - Level <input type="checkbox"/> B - Increasing		b. Planned Periodic Premium \$ (UL, VUL & Cornerstone Series)
6. Definition of Life Insurance Test (Applies to IUL, UL & VUL only. GPT is used if policy NOT a MEC.) <input type="checkbox"/> Guideline Premium Test (GPT) <input type="checkbox"/> Cash Value Accumulation Test (CVAT)		c. Frequency <input type="checkbox"/> Annual <input type="checkbox"/> Semi-Annual <input type="checkbox"/> Quarterly <input type="checkbox"/> Monthly (Group or Pension only, if Variable) <input type="checkbox"/> Single Premium <input type="checkbox"/> COM (Complete #11)
7. Special Billing Type: (N/A for Qualified Pension Business) <input type="checkbox"/> Government Allotment Group No.: <input type="checkbox"/> Payroll Deduction No.:		9. Identify the source of funds for premium payment <input type="checkbox"/> Income/Savings <input type="checkbox"/> Home equity <input type="checkbox"/> Payment by third party <input type="checkbox"/> Loan/Premium Finance <input type="checkbox"/> Other
10. Additional Benefits and Amounts:		
a. Traditional		
<input type="checkbox"/> Accelerated Benefits (ABR)		<input type="checkbox"/> Beneficiary Insurance Option (BIO) (Complete 1445)
<input type="checkbox"/> Accidental Death Benefit (ADB) \$		<input type="checkbox"/> Waiver of Premiums (WP) (N/A on 2nd to Die & Cornerstone Series)
<input type="checkbox"/> Additional Insurance Option (AIO) \$		<input type="checkbox"/> Waiver of Premiums (WP) \$ (Cornerstone Series only) (Annual Premium Waived)
<input type="checkbox"/> Additional Paid-Up Life		<input type="checkbox"/> Other:
Annual Premium (APAR) \$		
<input type="checkbox"/> Payable on a Modal Basis		
Single Premium (SPAR) \$		
b. Universal Life		
<input type="checkbox"/> Accelerated Benefits (ABR)		<input type="checkbox"/> Guaranteed Insurance Option (GIO) (N/A for Surv.) \$
<input type="checkbox"/> Accidental Death Benefit (ADB) \$		<input type="checkbox"/> Other Insured (OIR) (UL & VUL)
<input type="checkbox"/> Additional Protection Benefit (APB) \$ (N/A w/IUL except in PA) (N/A w/Single-Life UL or VUL)		<input type="checkbox"/> Policy Split Option (PSO) (Survivorship only)
<input type="checkbox"/> Automatic Increase (AIR) (N/A w/VUL) <input type="checkbox"/> 2% <input type="checkbox"/> 4% <input type="checkbox"/> 6% (N/A for Survivorship) <input type="checkbox"/> 5% <input type="checkbox"/> 10% <input type="checkbox"/> Stipulated (Survivorship only)		<input type="checkbox"/> Term Rider on First Proposed Insured: (Survivorship only) Level Amount <input type="checkbox"/> Increasing <input type="checkbox"/> Decreasing Dur Yrs
<input type="checkbox"/> Balance Sheet Benefit (IUL & VUL only) (Percent Waived) %		<input type="checkbox"/> Term Rider on Second Proposed Insured: (Survivorship only) Level Amount <input type="checkbox"/> Increasing <input type="checkbox"/> Decreasing Dur Yrs
<input type="checkbox"/> Children's Term (CTR) (UL & VUL) \$		<input type="checkbox"/> Waiver of Monthly Deductions (WMD) (N/A for Survivorship)
<input type="checkbox"/> Continuing Coverage Rider (CCR) (Survivorship only)		<input type="checkbox"/> Waiver of Specified Premium (WSP) (IUL, UL & VUL) \$ (Annual Premium Waived)
<input type="checkbox"/> Death Benefit Protection (DBP) (AssurePlus only)		<input type="checkbox"/> Other
<input type="checkbox"/> Enhanced Death Benefit (EDBR) (Surv. only) Target Age		
<input type="checkbox"/> Estate Preservation Rider (EPR) (Survivorship only) \$		

Part B - Policy Information (Continued)

9. Use of Dividends: (N/A for IUL) (Choose **only one**.)
- Cash (All Products)
 - Additions (Whole Life & UL)
 - Applied (Whole Life & Term only, N/A with COM)
 - Deposits (Whole Life & Term only)
 - DTO Balance to: _____ (Whole Life only, except Cornerstone Series)
 - Internal Paid-Up Insurance (Cornerstone Series Only)
 - Flex Term Rider I - B Decreasing (Whole Life only)
One Yr. Term + Adds = \$ _____
A premium will be charged for this rider.
 - Flex Term Rider II - A Level (Whole Life only)
One Yr. Term = \$ _____, + Adds
A premium will be charged for this rider.

10. Automatic Payment of Premium
- Requested Not Requested
-
11. I authorize the Company to draft monthly payments from my account. (Attach a void check/deposit slip)
- Checking Draft on the:
- Savings 1st 15th
- Money Market 8th 22nd
-
12. Send premium notices to: Owner
- First Proposed Insured Other: (street, city, state & zip)
- _____
- _____

Part C - Owner Information

- Insured
- Individual (Other than Insured):
- (Legal Name & Relationship): _____ Date of Birth: _____ ,
while living; thereafter
- (Legal Name & Relationship): _____ Date of Birth: _____
while living; thereafter
- (check one) the insured or Estate of the last survivor of the named owners.
- Note:** If neither box is checked, the final owner will be the estate of the last survivor of the named owners.
- Business Entity:
- (Full Legal Name): _____ , a (State): _____ ,
- Corporation Limited Partnership Limited Liability Company or General Partnership, or its successors, if any;
otherwise the final owner will be the insured.
- Trust: (Current Trustee(s)) _____ , trustee(s) under the
(Trust Name) _____
trust between said trustee(s) and (Trustor/Grantor) _____ , as heretofore or
hereafter amended, or the successors in said trust, while trust is existent; otherwise the final owner will be the insured.
- Qualified Pension or Profit Sharing Trust (Name of Trust Agreement) _____
- _____

1. Owner Taxpayer ID No.: _____ Owner Daytime Telephone #: () _____
2. Owner Complete Address: _____

Part D - Beneficiary Information (Complete if Insured is owner; otherwise the beneficiary will be the owner.)

(Provide full names, addresses, date of birth and relationship to Insured)

Primary:

Secondary:

Note: If the policy is owned by a qualified pension or profit sharing plan, all payments are protected by the Spendthrift Provision.

Part E - General Information about the First Proposed Insured (If 'Yes', provide details in Remarks on page 9)

1. Have you used any type of product containing nicotine within the last 24 months? Yes No
 Product Type: _____ Frequency: _____ Date Last Used: _____
2. Have you ever applied for life, health, or disability insurance or reinstatement of same, which was declined, postponed, rated or modified in any way? Yes No
3. Are you or do you have any intention of becoming a member of a military organization? Yes No
4. Have you ever been convicted of a felony or misdemeanor? Yes No
5. Have you had any moving vehicle violations in the last 3 years, or a suspended license or a DUI conviction in the last 5 years? Yes No
6. Have there been any bankruptcy proceedings against you within the last 7 years? Yes No
7. Within the past 6 months have you applied for or do you currently have any applications pending for life or disability insurance? Yes No
8. Have you been offered any cash incentive or other consideration (such as free insurance) as an inducement to apply for or become an insured under this life insurance policy, or have you been involved in any discussions about the possible sale or transfer of this policy to an unrelated third party, such as (but not limited to) a life settlement company or investor group? Yes No

(If 'Yes', to questions 9-11 complete form 1480, Avocation, Aviation & Foreign Travel Supplemental Application)

9. Within the last 3 years, have you participated in or do you intend to participate in any type of racing; scuba, skin, sport or sky diving; competition sport; parachuting or hang gliding; BASE or bungee cord jumping; big game hunting; mountain climbing; cave exploring; rodeos or snowmobiling? Yes No
10. Do you participate in any aviation activity other than as a fare paying passenger? Yes No
11. Do you intend to travel or reside outside of the USA for more than 2 weeks in a year? Yes No

Part F - Replacement Information (If 'Yes', Replacement forms must be provided; list company name and policy numbers).

1. Do you have any existing life insurance policies or annuity contracts? Yes No

2. Has there been or will there be a lapse, surrender, replacement, reissue, conversion, or change to reduce amount, premium, or period of coverage of any existing life, disability or annuity contract if the applied for policy or rider is issued? Yes No
3. Will there be any substantial borrowing on any life insurance policy if the applied for policy or rider is issued? Yes No
 List Company Name(s) and Policy Number(s)

Part G - Current Policy Information about the First Proposed Insured

NONE IN FORCE Type: B=Business G=Group P=Personal

Company Name	Type	Total in Force \$	Total with WP \$	Total ADB \$	Date of Issue	Paid to Date

Part H - Health History of the First Proposed Insured (Complete Part H if money was collected with this application or a NL exam is not being done. Do **not** complete Part H if this application is being submitted for the Pension underwriting classes of Guaranteed Issue, Simplified Underwriting, or Automatic Issue.)
Provide details, dates, and results for any 'Yes' answer to questions 1-10 in Remarks on page 9.

- | | | | | | | |
|--|--------|------|---------------------|------|---------|--|
| 1. Height | Weight | lbs. | Change in last year | lbs. | Reason? | |
| <hr/> | | | | | | |
| 2. Are you taking any medication? | | | | | | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 3. Is your health impaired in any way? | | | | | | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 4. Have you ever applied for or received disability or worker's compensation from any source? | | | | | | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 5. At any time during the last 10 years have you: | | | | | | |
| a. made the decision or been advised to reduce alcohol or drug intake, or used drugs not prescribed by a physician? | | | | | | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| b. been a member of a support group, such as AA or NA? | | | | | | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 6. At any time during the last 10 years have you been diagnosed or treated by a member of the medical profession or taken medication for: | | | | | | |
| a. Chest Pain, Heart Murmur, Rheumatic Fever or Anemia | | | | | | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| b. Habitual Cough, Asthma, Emphysema or Sleep Apnea | | | | | | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| c. Ulcer, Jaundice or Chronic Indigestion | | | | | | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| d. Stroke, Dizzy Spells, Epilepsy, Convulsions, Paralysis or Unconsciousness | | | | | | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| e. Heart, Veins, Arteries, Blood or Blood Pressure Disorder | | | | | | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| f. Lung or Respiratory Tract Disorder | | | | | | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| g. Esophagus, Stomach, Intestinal, Rectum, Liver or Gall Bladder Disorder | | | | | | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| h. Kidney, Bladder, Prostate, Genito-Urinary Organs, Pelvic Organs or Breast Disease | | | | | | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| i. Eyes, Ears, Nose or Throat Disorder | | | | | | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| j. Brain, Nervous System Disorder or Headaches | | | | | | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| k. Spine, Bones, Muscles, Joints, Skin or Gland Disorder | | | | | | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| l. Cancer, Polyp or Other Tumor | | | | | | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| m. Gout, Arthritis, Back Pain or Back Disorder | | | | | | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| n. High Blood Sugar or Diabetes | | | | | | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| o. Protein, Sugar, Casts, Pus or Blood in the Urine | | | | | | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| p. Renal Colic or Kidney Stone | | | | | | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| q. Depression, Anxiety or any other Psychological Condition | | | | | | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| r. Alzheimer's or Dementia | | | | | | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 7. Within the past 10 years have you tested positive for exposure to the Human Immunodeficiency Virus (HIV), or has a physician or other medical professional diagnosed you as having Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC) or AIDS related conditions? | | | | | | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 8. Within the past 5 years have you: | | | | | | |
| a. had x-rays, electrocardiograms or other diagnostic tests? | | | | | | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| b. been admitted to a hospital, or have you planned or been advised to enter a hospital for observation, operation or treatment of any kind? | | | | | | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| c. consulted any medical professional other than your personal physician? | | | | | | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 9. Do you have any pending appointments with any medical professional within the next 30 days? | | | | | | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 10. To the best of your knowledge, has any member of your family had diabetes, cancer, heart disease, Huntington's Disease or polycystic kidney disease? | | | | | | <input type="checkbox"/> Yes <input type="checkbox"/> No |

11. Name and Address of Personal Physician (<i>If none, so state</i>)	Date last seen	Reason consulted & outcome

12. Family History	Age if alive	State of Health	Age at death	Cause of death
Father	_____	_____	_____	_____
Mother	_____	_____	_____	_____
Siblings	_____	_____	_____	_____
Siblings	_____	_____	_____	_____

Part I - Qualified Retirement Business ONLY

1. Issue Date: _____ 2. (Check one.) Sex Neutral Sex Distinct

(Answer a & b only for Simplified Underwriting)

3. Full Underwriting Guaranteed Issue Automatic Issue
 Simplified Underwriting (If either questions a or b are answered 'Yes', provide the following details in Remarks on Page 9. Nature of ailment, date, duration and names and addresses of attending physicians.)
 a. Have you been admitted to, or been advised to be admitted to a hospital or medical facility in the past 90 days by a member of the medical profession? Yes No
 b. In the past two years have you been treated for or advised by a member of the medical profession to seek treatment for heart problems (including angina), stroke, or cancer, or been treated for or diagnosed as having AIDS or AIDS Related Complex (ARC)? Yes No

Part J - Children's Term Rider & Juvenile Coverage (Complete if Issue Ages 0-14, OR if CTR is requested. Complete HIPAA for each child)

Complete the following questions for Children's Term Rider only:

1. Names and Dates of Birth of all Children to be covered _____
2. To the best of your knowledge: (If 'Yes', give details, including the name and address of any physician in Remarks on Page 9)
 a. Is any Child's health impaired in any way? Yes No
 b. Has any Child shown any signs of abnormal physical or mental development? Yes No
 c. Does any Child not reside with you? Yes No
 d. Does any Child take medication prescribed by a doctor? Yes No

Complete the following questions for Juvenile Coverage only:

3. Does Proposed Insured live with parent? Yes No
 (If 'No', explain details in Remarks on Page 9. Give name and relationship of person with whom the Proposed Insured lives.)
4. Full Name of Applicant: _____
5. Relationship to Proposed Insured: _____
6. To the best of your knowledge: (If 'Yes', explain details in Remarks on Page 9)
 a. Has the Proposed Insured shown any signs of abnormal physical or mental development? Yes No
 b. Has the Proposed Insured been seen by any physician or other practitioner for advice, treatment or examination within the past five years? Yes No
 c. Name and address of Primary Care Physician. Include reason and date last seen.

8. a. Height in shoes: _____ ft. _____ in.
 b. Weight in clothes: _____ pounds
 c. Change in weight in past year: _____ Gain _____ Loss Reason: _____
 d. If less than 1 year old, weight at birth: _____

9. Amount of Insurance in force on Proposed Insured, the Applicant and other members of Proposed Insured's family:

	Company	Amount
Proposed Insured	_____	\$ _____
Applicant	_____	\$ _____
Proposed Insured's father	_____	\$ _____
Proposed Insured's mother	_____	\$ _____
Brothers and sisters of Proposed Insured (If none, so state)	Age	
_____	_____	\$ _____
_____	_____	\$ _____
_____	_____	\$ _____
_____	_____	\$ _____

Complete for Joint Life or Primary Other Insured Only (For additional Other Insureds, use form 8531)

Part K - Second Proposed Insured or Primary Other Insured Information

1. Name (print first, middle, last)	2. Place of Birth - State/Country	3. Date of Birth	4. Issue at Age
5. Home Address (If mailing address different, provide in Remarks)			
6. Sex <input type="checkbox"/> M <input type="checkbox"/> F	7. Social Sec. #	8. Telephone #'s and best time to call H () W () C ()	
9. Are you a citizen of <input type="checkbox"/> USA <input type="checkbox"/> Other Country _____ Type of VISA _____ Alien Registration #: _____			
10. Employer Name & Address (street, city, state and zip)		11a. Driver's License #	11b. State
		12a. Occupation (w/specific duties)	
12b. Are you actively at work at the customary workplace, doing the usual duties and functions required by the position during the normal work hours and weekly period? <input type="checkbox"/> Yes <input type="checkbox"/> No* *Reason: _____			
13. First Proposed Insured, Relationship and S.S.# (for use with UL & VUL)		14. Face Amount (POI fill in Face Amount if different than Base Amount.) \$	
15. Primary Beneficiary for Primary Other Insured, Relationship & S.S. # (for use with UL & VUL)		16. Identify the source of funds for premium payment <input type="checkbox"/> Income/Savings <input type="checkbox"/> Home equity <input type="checkbox"/> Payment by third party <input type="checkbox"/> Loan/Premium Finance <input type="checkbox"/> Other _____	

Part L - General Information about the Second Proposed Insured or Primary Other Insured
(If 'Yes', provide details in Remarks on page 9)

1. Have you used any type of product containing nicotine within the last 24 months?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Product Type: _____ Frequency: _____ Date Last Used: _____	
2. Have you ever applied for life, health, or disability insurance or reinstatement of same, which was declined, postponed, rated or modified in any way?	<input type="checkbox"/> Yes <input type="checkbox"/> No
3. Are you or do you have any intention of becoming a member of a military organization?	<input type="checkbox"/> Yes <input type="checkbox"/> No
4. Have you ever been convicted of a felony or misdemeanor?	<input type="checkbox"/> Yes <input type="checkbox"/> No
5. Have you had any moving vehicle violations in the last 3 years, or a suspended license or a DUI conviction in the last 5 years?	<input type="checkbox"/> Yes <input type="checkbox"/> No
6. Have there been any bankruptcy proceedings against you within the last 7 years?	<input type="checkbox"/> Yes <input type="checkbox"/> No
7. Within the past 6 months have you applied for or do you currently have any applications pending for life or disability insurance?	<input type="checkbox"/> Yes <input type="checkbox"/> No
8. Have you been offered any cash incentive or other consideration (such as free insurance) as an inducement to apply for or become an insured under this life insurance policy, or have you been involved in any discussions about the possible sale or transfer of this policy to an unrelated third party, such as (but not limited to) a life settlement company or investor group?	<input type="checkbox"/> Yes <input type="checkbox"/> No
(If 'Yes', to questions 9-11 complete form 1480, Avocation, Aviation & Foreign Travel Supplemental Application)	
9. Within the last 3 years, have you participated in or do you intend to participate in any type of racing; scuba, skin, sport or sky diving; competition sport; parachuting or hang gliding; BASE or bungee cord jumping; big game hunting; mountain climbing; cave exploring; rodeos or snowmobiling?	<input type="checkbox"/> Yes <input type="checkbox"/> No
10. Do you participate in any aviation activity other than as a fare paying passenger?	<input type="checkbox"/> Yes <input type="checkbox"/> No
11. Do you intend to travel or reside outside of the USA for more than 2 weeks in a year?	<input type="checkbox"/> Yes <input type="checkbox"/> No
12. Are you legally married to the First Proposed Insured?	<input type="checkbox"/> Yes <input type="checkbox"/> No
<i>(This question must be answered if either EPR or PSO is requested in the Additional Benefits and Amounts section)</i>	

Part M - Replacement Information (If 'Yes', Replacement forms must be provided; list company name and policy numbers)

1. Do you have any existing life insurance policies or annuity contracts?	<input type="checkbox"/> Yes <input type="checkbox"/> No
2. Has there been or will there be a lapse, surrender, replacement, reissue, conversion, or change to reduce amount, premium, or period of coverage of any existing life, disability or annuity contract if the applied for policy or rider is issued?	<input type="checkbox"/> Yes <input type="checkbox"/> No
3. Will there be any substantial borrowing on any life insurance policy if the applied for policy or rider is issued?	<input type="checkbox"/> Yes <input type="checkbox"/> No
<i>List Company Name(s) and Policy Number(s) in Remarks</i>	

Part N - Current Policy Information about the Second Proposed Insured or Primary Other Insured

<input type="checkbox"/> NONE IN FORCE						
Type: B=Business G=Group P=Personal						
Company Name	Type	Total in Force \$	Total with WP \$	Total ADB \$	Date of Issue	Paid to Date

Complete for Joint Life or Primary Other Insured Only

Part O - Health History of the Second Proposed Insured or Primary Other Insured (Complete Part O if money was collected with this application or a NL exam is not being done.)

Provide details, dates, and results for any 'Yes' answer to questions 1-10 in Remarks on page 9.

- | | | | | | | |
|--|--------|------|---------------------|------|---------|--|
| 1. Height | Weight | lbs. | Change in last year | lbs. | Reason? | |
| <hr/> | | | | | | |
| 2. Are you taking any medication? | | | | | | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 3. Is your health impaired in any way? | | | | | | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 4. Have you ever applied for or received disability or worker's compensation from any source? | | | | | | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 5. At any time during the last 10 years have you: | | | | | | |
| a. made the decision or been advised to reduce alcohol or drug intake, or used drugs not prescribed by a physician? | | | | | | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| b. been a member of a support group, such as AA or NA? | | | | | | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 6. At any time during the last 10 years have you been diagnosed or treated by a member of the medical profession or taken medication for: | | | | | | |
| a. Chest Pain, Heart Murmur, Rheumatic Fever or Anemia | | | | | | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| b. Habitual Cough, Asthma, Emphysema or Sleep Apnea | | | | | | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| c. Ulcer, Jaundice or Chronic Indigestion | | | | | | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| d. Stroke, Dizzy Spells, Epilepsy, Convulsions, Paralysis or Unconsciousness | | | | | | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| e. Heart, Veins, Arteries, Blood or Blood Pressure Disorder | | | | | | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| f. Lung or Respiratory Tract Disorder | | | | | | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| g. Esophagus, Stomach, Intestinal, Rectum, Liver or Gall Bladder Disorder | | | | | | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| h. Kidney, Bladder, Prostate, Genito-Urinary Organs, Pelvic Organs or Breast Disease | | | | | | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| i. Eyes, Ears, Nose or Throat Disorder | | | | | | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| j. Brain, Nervous System Disorder or Headaches | | | | | | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| k. Spine, Bones, Muscles, Joints, Skin or Gland Disorder | | | | | | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| l. Cancer, Polyp or Other Tumor | | | | | | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| m. Gout, Arthritis, Back Pain or Back Disorder | | | | | | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| n. High Blood Sugar or Diabetes | | | | | | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| o. Protein, Sugar, Casts, Pus or Blood in the Urine | | | | | | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| p. Renal Colic or Kidney Stone | | | | | | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| q. Depression, Anxiety or any other Psychological Condition | | | | | | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| r. Alzheimer's or Dementia | | | | | | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 7. Within the past 10 years have you tested positive for exposure to the Human Immunodeficiency Virus (HIV), or has a physician or other medical professional diagnosed you as having Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC) or AIDS related conditions? | | | | | | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 8. Within the past 5 years have you: | | | | | | |
| a. had x-rays, electrocardiograms or other diagnostic tests? | | | | | | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| b. been admitted to a hospital, or have you planned or been advised to enter a hospital for observation, operation or treatment of any kind? | | | | | | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| c. consulted any medical professional other than your personal physician? | | | | | | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 9. Do you have any pending appointments with any medical professional within the next 30 days? | | | | | | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 10. To the best of your knowledge, has any member of your family had diabetes, cancer, heart disease, Huntington's Disease or polycystic kidney disease? | | | | | | <input type="checkbox"/> Yes <input type="checkbox"/> No |

11. Name and Address of Personal Physician (<i>If none, so state</i>)	Date last seen	Reason consulted & outcome

12. Family History	Age if alive	State of Health	Age at death	Cause of death
Father	_____	_____	_____	_____
Mother	_____	_____	_____	_____
Siblings	_____	_____	_____	_____
Siblings	_____	_____	_____	_____

Complete for Variable Products Only

Part P - Variable Insurance Information

Following questions to be completed by the Applicant.

- 1. Have you received a current prospectus which describes the variable nature of this product and the utilization of a Separate Account or a Variable Account?
2. Do you believe that this Policy will meet your insurance needs and financial objectives?
3. Do you understand that the Cash Surrender Value and Death Benefit may increase or decrease based on the policy's investment return, even to the extent of being reduced to zero?

Part Q - Telephone Transaction Agreement

Unless waived below, I appoint the Company as my agent to act upon telephoned instructions reasonably believed to be authorized by me. I hereby ratify any telephoned instructions so given and consent to the tape recording of these instructions.

Representative(s):

I do not authorize the Company to accept telephone instructions.

Part R - Investment Information (Do NOT complete Part R if participating in Illuminations.)

- 1. Do you want monthly charges deducted from the Money Market sub-account?
(If 'No', charges will be deducted from the General Account or the Fixed Account and all sub-accounts on a pro rata basis.)

Note: Elect Portfolio Rebalancing (2.a.) or Dollar Cost Averaging, (2.b.) but not both. (See Investment Allocation, form 9201)

- 2.a. I elect the following for Portfolio Rebalancing:
Annual
Quarterly
Semi-Annual (only option for VUL)

OR

- 2.b. I elect monthly Dollar Cost Averaging. Transfer funds from the Money Market sub-account using the allocation provided on the Investment Allocation, form 9201.

The amount and duration of the Death Benefit may increase or decrease daily as described in the DEATH BENEFIT AND POLICY CHANGES section of the policy at issue. The dollar amount of the Death Benefit is not guaranteed.

The investment in this policy could be lost entirely, depending on the performance of the Separate Account or Variable Account, and as a result the Death Benefit may terminate unless additional premium payments are made to keep this policy in force.

Part T - Agreement & Authorization (Continued)

I (we), the Proposed Insured(s), or Parent of the Proposed Insured, authorize any physician, medical practitioner, hospital, clinic, or other medically related facility, insurer or reinsurer, the Medical Information Bureau, Inc. (MIB), consumer reporting agency, or employer having information as to:

- diagnosis, treatment and prognosis of any physical or mental condition of me (us) or any of my (our) minor children on whose life I (we) have applied for insurance;
- any non-medical information of me (us) or such minor children;

to give National Life Insurance Company, herein called National Life, or its authorized representative, any and all such information.

I (we) authorize National Life to request a copy of my (our) driving record(s) from the state motor vehicle department.

I (we) authorize National Life to obtain an investigative consumer report. I (we) understand that I am (we are) entitled to be interviewed by the consumer reporting agency that prepares any such report, as long as I (we) can reasonably be contacted during normal business hours.

I (we) wish to be interviewed if an investigative consumer report is prepared.

This information may be used to determine eligibility for life or health insurance or claims for benefits, and I (we) authorize National Life to release any of this information to the MIB and/or Reinsurers and other life insurance companies in which I (we) have insurance or from which I (we) seek insurance or benefits.

I (we) authorize National Life to redisclose the information to:

- Any person performing a business or legal function for its benefit;
- An attending physician for diagnostic or treatment purposes;
- Government authorities to prevent insurance related illegal activities;
- Persons conducting medical or statistical studies for National Life;
- Persons having an authorization specifically permitting the redisclosure;

and when required by law. In making this authorization, I (we) waive any right to prohibit redisclosure to an affiliate of National Life where the redisclosure is related to the servicing of my (our) policy.

This authorization shall remain valid for 30 months from the date shown below.

I (we) understand I (we) have a right to receive a copy of this authorization. A copy of this authorization shall be as valid as the original. I (we) acknowledge receipt of copies of the prenotifications relating to investigative consumer reports and the MIB.

NOTICE: 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.

Part U - Owner's Taxpayer ID Number Certification

Under penalties of perjury, I certify that (1) the number shown on this application is my correct taxpayer identification number; (2) the IRS has never notified me that I am subject to backup withholding, or has notified me that I am no longer subject to such withholding or I am exempt from such withholding; and (3) I am a U.S. person (including a U.S. resident alien). You must cross out item 2 if you have been notified by the IRS that you are currently subject to backup withholding because of underreporting interest or dividends on your tax return.

Part V - Signatures

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

Signed at (City & State) _____ Date (mm/dd/yyyy) _____

First Proposed Insured age 15 & up (or Parent or Guardian)

Applicant (Sign name in full if other than Proposed Insured)

Second Proposed Insured (Sign name in full)

Primary Other Insured (Sign name in full)

Soliciting Agent/Representative (Sign name in full)

Owner (If other than Applicant or Proposed Insured)

For Check-O-Matic Only (If Depositor other than Applicant/Owner)
Depositor (Exactly as it appears on bank records)

(Exercise of AIO Only)
Owner of Base Policy

Supplemental Other Insured Rider Application

Part A - Proposed Other Insured Information

1. Name (print first, middle, last)		2. Home Address (street, city, state and zip)				
3. Place of Birth - State/Country	4. Date of Birth	5. Issue at Age	6. Sex <input type="checkbox"/> M <input type="checkbox"/> F	7. Social Sec. #		
8. Telephone #'s and best time to call H () W () C ()			9a. Driver's License #		9b. State	
10. Are you a citizen of <input type="checkbox"/> USA <input type="checkbox"/> Other Country _____ Type of VISA _____ Alien Registration #: _____						
11. Face Amount \$ _____		12. Employer Name & Address (street, city, state and zip)		13a. Occupation (w/specific duties)		
13b. Are you actively at work at the customary workplace, doing the usual duties and functions required by the position during the normal work hours and weekly period? <input type="checkbox"/> Yes <input type="checkbox"/> No* *Reason: _____						
14. Proposed Other Insured, Relationship and S.S.#			15. Proposed Other Insured Beneficiary, Relationship & S.S. #			
16. Identify the source of funds for premium payment <input type="checkbox"/> Income/Savings <input type="checkbox"/> Home equity <input type="checkbox"/> Payment by third party <input type="checkbox"/> Loan/Premium Finance <input type="checkbox"/> Other _____						

Part B - General Information about the Proposed Other Insured (If 'Yes', provide details in Remarks on page 3)

1. Have you used any type of product containing nicotine within the last 24 months? Yes No
Product Type: _____ Frequency: _____ Date Last Used: _____
2. Have you ever applied for life, health, or disability insurance or reinstatement of same, which was declined, postponed, rated or modified in any way? Yes No
3. Are you or do you have any intention of becoming a member of a military organization? Yes No
4. Have you ever been convicted of a felony or misdemeanor? Yes No
5. Have you had any moving vehicle violations in the last 3 years, or a suspended license or a DUI conviction in the last 5 years? Yes No
6. Have there been any bankruptcy proceedings against you within the last 7 years? Yes No
7. Within the past 6 months have you applied for or do you currently have any applications pending for life or disability insurance? Yes No
8. Have you been offered any cash incentive or other consideration (such as free insurance) as an inducement to apply for or become an insured under this life insurance policy, or have you been involved in any discussions about the possible sale or transfer of this policy to an unrelated third party, such as (but not limited to) a life settlement company or investor group? Yes No

(If 'Yes', to questions 9-11 complete form 1480, Avocation, Aviation & Foreign Travel Supplemental Application)

9. Within the last 3 years, have you participated in or do you intend to participate in any type of racing; scuba, skin, sport or sky diving; competition sport; parachuting or hang gliding; BASE or bungee cord jumping; big game hunting; mountain climbing; cave exploring; rodeos or snowmobiling? Yes No
10. Do you participate in any aviation activity other than as a fare paying passenger? Yes No
11. Do you intend to travel or reside outside of the USA for more than 2 weeks in a year? Yes No

Part C - Replacement Information (If 'Yes', Replacement forms must be provided; list company name and policy numbers)

1. Do you have any existing life insurance policies or annuity contracts? Yes No
2. Has there been or will there be a lapse, surrender, replacement, reissue, conversion, or change to reduce amount, premium, or period of coverage of any existing life, disability or annuity contract if the applied for policy or rider is issued? Yes No
3. Will there be any substantial borrowing on any life insurance policy if the applied for policy or rider is issued? Yes No
List Company Name(s) and Policy Number(s) in Remarks

Part D - Current Policy Information about the Proposed Other Insured

NONE IN FORCE Type: B=Business G=Group P=Personal

Company Name	Type	Total in Force \$	Total with WP \$	Total ADB \$	Date of Issue	Paid to Date

Part E - Health History of the Proposed Other Insured (Complete Part E if money was collected with this application or a NL exam is not being done.

Provide details, dates, and results for any 'Yes' answer to questions 1-10 in Remarks on page 3.

- | | | | | | | |
|--|--------|------|---------------------|------|---------|--|
| 1. Height | Weight | lbs. | Change in last year | lbs. | Reason? | |
| 2. Are you taking any medication? | | | | | | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 3. Is your health impaired in any way? | | | | | | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 4. Have you ever applied for or received disability or worker's compensation from any source? | | | | | | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 5. At any time during the last 10 years have you: | | | | | | |
| a. made the decision or been advised to reduce alcohol or drug intake, or used drugs not prescribed by a physician? | | | | | | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| b. been a member of a support group, such as AA or NA? | | | | | | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 6. At any time during the last 10 years have you been diagnosed or treated by a member of the medical profession or taken medication for: | | | | | | |
| a. Chest Pain, Heart Murmur, Rheumatic Fever or Anemia | | | | | | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| b. Habitual Cough, Asthma, Emphysema or Sleep Apnea | | | | | | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| c. Ulcer, Jaundice or Chronic Indigestion | | | | | | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| d. Stroke, Dizzy Spells, Epilepsy, Convulsions, Paralysis or Unconsciousness | | | | | | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| e. Heart, Veins, Arteries, Blood or Blood Pressure Disorder | | | | | | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| f. Lung or Respiratory Tract Disorder | | | | | | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| g. Esophagus, Stomach, Intestinal, Rectum, Liver or Gall Bladder Disorder | | | | | | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| h. Kidney, Bladder, Prostate, Genito-Urinary Organs, Pelvic Organs or Breast Disease | | | | | | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| i. Eyes, Ears, Nose or Throat Disorder | | | | | | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| j. Brain, Nervous System Disorder or Headaches | | | | | | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| k. Spine, Bones, Muscles, Joints, Skin or Gland Disorder | | | | | | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| l. Cancer, Polyp or Other Tumor | | | | | | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| m. Gout, Arthritis, Back Pain or Back Disorder | | | | | | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| n. High Blood Sugar or Diabetes | | | | | | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| o. Protein, Sugar, Casts, Pus or Blood in the Urine | | | | | | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| p. Renal Colic or Kidney Stone | | | | | | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| q. Depression, Anxiety or any other Psychological Condition | | | | | | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| r. Alzheimer's or Dementia | | | | | | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 7. Within the past 10 years have you tested positive for exposure to the Human Immunodeficiency Virus (HIV), or has a physician or other medical professional diagnosed you as having Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC) or AIDS related conditions? | | | | | | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 8. Within the past 5 years have you: | | | | | | |
| a. had x-rays, electrocardiograms or other diagnostic tests? | | | | | | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| b. been admitted to a hospital, or have you planned or been advised to enter a hospital for observation, operation or treatment of any kind? | | | | | | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| c. consulted any medical professional other than your personal physician? | | | | | | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 9. Do you have any pending appointments with any medical professional within the next 30 days? | | | | | | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 10. To the best of your knowledge, has any member of your family had diabetes, cancer, heart disease, Huntington's Disease or polycystic kidney disease? | | | | | | <input type="checkbox"/> Yes <input type="checkbox"/> No |

11. Name and Address of Personal Physician (If none, so state)	Date last seen	Reason consulted & outcome

12. Family History	Age if alive	State of Health	Age at death	Cause of death
Father	_____	_____	_____	_____
Mother	_____	_____	_____	_____
Siblings	_____	_____	_____	_____
Siblings	_____	_____	_____	_____

Part G - Agreement & Authorization (Continued)

I (we), the Proposed Insured(s), authorize any physician, medical practitioner, hospital, clinic, or other medically related facility, insurer or reinsurer, the Medical Information Bureau, Inc. (MIB), consumer reporting agency, or employer having information as to:

- diagnosis, treatment and prognosis of any physical or mental condition of me (us) or any of my (our) minor children on whose life I (we) have applied for insurance;
- any non-medical information of me (us) or such minor children;

to give National Life Insurance Company, herein called National Life, or its authorized representative, any and all such information.

I (we) authorize National Life to request a copy of my (our) driving record(s) from the state motor vehicle department.

I (we) authorize National Life to obtain an investigative consumer report. I (we) understand that I am (we are) entitled to be interviewed by the consumer reporting agency that prepares any such report, as long as I (we) can reasonably be contacted during normal business hours.

I (we) wish to be interviewed if an investigative consumer report is prepared.

This information may be used to determine eligibility for life or health insurance or claims for benefits, and I (we) authorize National Life to release any of this information to the MIB and/or Reinsurers and other life insurance companies in which I (we) have insurance or from which I (we) seek insurance or benefits.

I (we) authorize National Life to redisclose the information to:

- Any person performing a business or legal function for its benefit;
- An attending physician for diagnostic or treatment purposes;
- Government authorities to prevent insurance related illegal activities;
- Persons conducting medical or statistical studies for National Life;
- Persons having an authorization specifically permitting the redisclosure;

and when required by law. In making this authorization, I (we) waive any right to prohibit redisclosure to an affiliate of National Life where the redisclosure is related to the servicing of my (our) policy.

This authorization shall remain valid for 30 months from the date shown below.

I (we) understand I (we) have a right to receive a copy of this authorization. A copy of this authorization shall be as valid as the original. I (we) acknowledge receipt of copies of the prenotifications relating to investigative consumer reports and the MIB.

NOTICE: 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.

Part H - Owner's Taxpayer ID Number Certification

Under penalties of perjury, I certify that (1) the number shown on this application is my correct taxpayer identification number; (2) the IRS has never notified me that I am subject to backup withholding, or has notified me that I am no longer subject to such withholding or I am exempt from such withholding; and (3) I am a U.S. person (including a U.S. resident alien). You must cross out item 2 if you have been notified by the IRS that you are currently subject to backup withholding because of underreporting interest or dividends on your tax return.

Part I - Signatures

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

Signed at (City & State) _____ Date (mm/dd/yyyy) _____

Proposed Other Insured (Sign name in full)

Applicant (Sign name in full if other than Proposed Other Insured)

Soliciting Agent/Representative (Sign name in full)

For Check-O-Matic Only (If Depositor other than Applicant/Owner)
Depositor (Exactly as it appears on bank records)

Owner (If other than Applicant or Proposed Other Insured)

(who code/agency #)

DATA SECTION

POLICY NUMBER: [NL1234567]

INSURED: [ETHAN ALLEN]

ISSUE AGE: [35]

FACE AMOUNT: [\$100,000.00]

OWNER: [AS STATED IN THE APPLICATION UNLESS LATER CHANGED]
BENEFICIARY: [AS STATED IN THE APPLICATION UNLESS LATER CHANGED]

MONTHLY POLICY DATE: [15TH]

DEATH BENEFIT OPTION: [A]

MINIMUM INITIAL PREMIUM: [\$34.00]
MONTHLY GUARANTEED PREMIUM: [\$38.99]

PLANNED PERIODIC PREMIUM: [\$59.66] PAYABLE [MONTHLY]
FOR PREMIUM PAYMENT PERIOD: [APR 15, 2010 TO APR 15, 2095]

THIS POLICY MAY TERMINATE PRIOR TO THE END OF THE PREMIUM PAYMENT PERIOD IF PREMIUMS PAID ARE INSUFFICIENT TO CONTINUE COVERAGE. PREMIUMS IN ADDITION TO THE PLANNED PERIODIC PREMIUM MAY BE NECESSARY TO KEEP THIS COVERAGE IN FORCE.

POLICY LOANS AND WITHDRAWALS WILL REDUCE THE CASH SURRENDER VALUE OF THIS POLICY AND MAY RESULT IN TERMINATION OF THIS POLICY PRIOR TO THE DEATH OF THE INSURED.

MINIMUM FACE AMOUNT: [\$25,000.00]
MINIMUM WITHDRAWAL FEE: \$500.00

ADDITIONAL BENEFIT RIDERS:
[DEATH BENEFIT PROTECTION RIDER]

THE LOAN INTEREST RATE IS VARIABLE. THE LOAN INTEREST RATE AT THE EFFECTIVE DATE IS [5.60%]

DATA SECTION

GUARANTEED BASIS OF CALCULATIONS

FACE AMOUNT: [\$100,000.00]
 EFFECTIVE DATE: [APR 15, 2010]

ACCUMULATED VALUE INTEREST RATE: 0.2466270% COMPOUNDED MONTHLY, WHICH
 IS EQUIVALENT TO 3.00% COMPOUNDED PER
 YEAR.

MORTALITY TABLE: COMMISSIONERS 2001 CSO ULTIMATE [MALE NON-SMOKER]
 AGE NEAREST BIRTHDAY

THE INSURED HAS BEEN CLASSIFIED A [NON-SMOKER].

TABLE OF GUARANTEED MAXIMUM COST OF INSURANCE RATES
 (PER \$1,000 PER MONTH)

<u>ATTAINED</u> <u>AGE</u>	<u>RATE</u>	<u>ATTAINED</u> <u>AGE</u>	<u>RATE</u>	<u>ATTAINED</u> <u>AGE</u>	<u>RATE</u>
35	0.09000	57	0.57000	79	5.10000
36	0.10000	58	0.62000	80	5.69000
37	0.10000	59	0.68000	81	6.36000
38	0.11000	60	0.74000	82	7.06000
39	0.11000	61	0.83000	83	7.82000
40	0.12000	62	0.93000	84	8.66000
41	0.13000	63	1.04000	85	9.60000
42	0.14000	64	1.16000	86	10.64000
43	0.16000	65	1.29000	87	11.78000
44	0.18000	66	1.42000	88	13.01000
45	0.19000	67	1.55000	89	14.31000
46	0.21000	68	1.69000	90	15.66000
47	0.23000	69	1.84000	91	16.94000
48	0.24000	70	2.01000	92	18.28000
49	0.26000	71	2.21000	93	19.70000
50	0.28000	72	2.47000	94	21.19000
51	0.30000	73	2.74000	95	22.77000
52	0.33000	74	3.03000	96	24.22000
53	0.36000	75	3.35000	97	25.77000
54	0.41000	76	3.69000	98	27.43000
55	0.46000	77	4.09000	99	29.21000
56	0.51000	78	4.56000		

DATA SECTION

GUARANTEED BASIS OF CALCULATIONS

DEFINITION OF LIFE INSURANCE TEST: [GUIDELINE PREMIUM TEST]

[GUIDELINE SINGLE PREMIUM: \$ 13,048.54]

[GUIDELINE LEVEL PREMIUM: \$ 1,150.41]

TABLE OF DEATH BENEFIT STANDARD FACTORS

<u>ATTAINED AGE</u>	<u>DEATH BENEFIT FACTOR</u>	<u>ATTAINED AGE</u>	<u>DEATH BENEFIT FACTOR</u>	<u>ATTAINED AGE</u>	<u>DEATH BENEFIT FACTOR</u>
0 - 40	2.50	54	1.57	68	1.17
41	2.43	55	1.50	69	1.16
42	2.36	56	1.46	70	1.15
43	2.29	57	1.42	71	1.13
44	2.22	58	1.38	72	1.11
45	2.15	59	1.34	73	1.09
46	2.09	60	1.30	74	1.07
47	2.03	61	1.28	75 - 90	1.05
48	1.97	62	1.26	91	1.04
49	1.91	63	1.24	92	1.03
50	1.85	64	1.22	93	1.02
51	1.78	65	1.20	94+	1.01
52	1.71	66	1.19		
53	1.64	67	1.18		

DATA SECTION

FACE AMOUNT: [\$100,000.00]
EFFECTIVE DATE: [APR 15, 2010]

PERCENT OF PREMIUM EXPENSE CHARGE: 6.00%

MONTHLY EXPENSE CHARGE PER THOUSAND:

Years 1-5: [\$0.1575]
Years 6+: [\$0.0000]

MONTHLY POLICY FEE: \$5.00

SURRENDER CHARGES

TWELVE MONTH PERIOD BEGINNING	SURRENDER CHARGE
[APR 15, 2010	\$ 644.00
APR 15, 2011	618.00
APR 15, 2012	592.00
APR 15, 2013	565.00
APR 15, 2014	537.00
APR 15, 2015	508.00
APR 15, 2016	478.00
APR 15, 2017	448.00
APR 15, 2018	416.00
APR 15, 2019	384.00
APR 15, 2020	351.00
APR 15, 2021	316.00
APR 15, 2022	281.00
APR 15, 2023	245.00
APR 15, 2024	207.00
APR 15, 2025	168.00
APR 15, 2026	128.00
APR 15, 2027	87.00
APR 15, 2028	44.00
APR 15, 2029 AND LATER	00.00]

DATA SECTION

DEATH BENEFIT PROTECTION RIDER

POLICY NUMBER: [NL1234567]

INSURED: [ETHAN ALLEN]

EFFECTIVE DATE: [APR 15, 2010]

GUARANTEED MONTHLY COST PER \$1,000 OF FACE AMOUNT: [\$0.00]

DEATH BENEFIT PROTECTION INTEREST RATE: 5.00%

THE DEATH BENEFIT PROTECTION PERIOD IS IN EFFECT THROUGH [APR 14, 2030]

(who code/agency #)

DATA SECTION

POLICY NUMBER: [NL1234567]

INSURED: [ETHAN ALLEN]

ISSUE AGE: [35]

FACE AMOUNT: [\$100,000.00]

OWNER: [AS STATED IN THE APPLICATION UNLESS LATER CHANGED]
BENEFICIARY: [AS STATED IN THE APPLICATION UNLESS LATER CHANGED]

MONTHLY POLICY DATE: [15TH]

DEATH BENEFIT OPTION: [A]

MINIMUM INITIAL PREMIUM: [\$34.00]
MONTHLY GUARANTEED PREMIUM: [\$38.06]

PLANNED PERIODIC PREMIUM: [\$57.75] PAYABLE [MONTHLY]
FOR PREMIUM PAYMENT PERIOD: [APR 15, 2010 TO APR 15, 2095]

THIS POLICY MAY TERMINATE PRIOR TO THE END OF THE PREMIUM PAYMENT PERIOD IF PREMIUMS PAID ARE INSUFFICIENT TO CONTINUE COVERAGE. PREMIUMS IN ADDITION TO THE PLANNED PERIODIC PREMIUM MAY BE NECESSARY TO KEEP THIS COVERAGE IN FORCE.

POLICY LOANS AND WITHDRAWALS WILL REDUCE THE CASH SURRENDER VALUE OF THIS POLICY AND MAY RESULT IN TERMINATION OF THIS POLICY PRIOR TO THE DEATH OF THE INSURED.

MINIMUM FACE AMOUNT: [\$25,000.00]
MINIMUM WITHDRAWAL FEE: \$500.00

ADDITIONAL BENEFIT RIDERS:
[DEATH BENEFIT PROTECTION RIDER]

THE LOAN INTEREST RATE IS VARIABLE. THE LOAN INTEREST RATE AT THE EFFECTIVE DATE IS [5.60%].

DATA SECTION

GUARANTEED BASIS OF CALCULATIONS

FACE AMOUNT: [\$100,000.00]
 EFFECTIVE DATE: [APR 15, 2010]

ACCUMULATED VALUE INTEREST RATE: 0.2466270% COMPOUNDED MONTHLY, WHICH
 IS EQUIVALENT TO 3.00% COMPOUNDED PER
 YEAR.

MORTALITY TABLE: COMMISSIONERS 2001 CSO ULTIMATE [NON-SMOKER]
 AGE NEAREST BIRTHDAY

THE INSURED HAS BEEN CLASSIFIED A [NON-SMOKER].

TABLE OF GUARANTEED MAXIMUM COST OF INSURANCE RATES
 (PER \$1,000 PER MONTH)

<u>ATTAINED</u> <u>AGE</u>	<u>RATE</u>	<u>ATTAINED</u> <u>AGE</u>	<u>RATE</u>	<u>ATTAINED</u> <u>AGE</u>	<u>RATE</u>
[35	0.09000	57	0.55000	79	4.67000
36	0.09000	58	0.60000	80	5.19000
37	0.10000	59	0.65000	81	5.80000
38	0.10000	60	0.72000	82	6.43000
39	0.11000	61	0.80000	83	7.11000
40	0.12000	62	0.89000	84	7.85000
41	0.13000	63	0.99000	85	8.67000
42	0.14000	64	1.10000	86	9.55000
43	0.15000	65	1.22000	87	10.56000
44	0.17000	66	1.33000	88	11.64000
45	0.18000	67	1.45000	89	12.76000
46	0.20000	68	1.59000	90	13.88000
47	0.22000	69	1.72000	91	14.78000
48	0.23000	70	1.89000	92	15.81000
49	0.25000	71	2.07000	93	17.02000
50	0.27000	72	2.30000	94	18.40000
51	0.29000	73	2.55000	95	19.99000
52	0.32000	74	2.82000	96	21.50000
53	0.36000	75	3.10000	97	23.11000
54	0.40000	76	3.42000	98	23.99000
55	0.45000	77	3.78000	99	25.23000]
56	0.50000	78	4.20000		

DATA SECTION

GUARANTEED BASIS OF CALCULATIONS

DEFINITION OF LIFE INSURANCE TEST: [GUIDELINE PREMIUM TEST]

[GUIDELINE SINGLE PREMIUM: \$ 12,776.81]

[GUIDELINE LEVEL PREMIUM: \$ 1,123.42]

TABLE OF DEATH BENEFIT STANDARD FACTORS

<u>ATTAINED AGE</u>	<u>DEATH BENEFIT FACTOR</u>	<u>ATTAINED AGE</u>	<u>DEATH BENEFIT FACTOR</u>	<u>ATTAINED AGE</u>	<u>DEATH BENEFIT FACTOR</u>
0 - 40	2.50	54	1.57	68	1.17
41	2.43	55	1.50	69	1.16
42	2.36	56	1.46	70	1.15
43	2.29	57	1.42	71	1.13
44	2.22	58	1.38	72	1.11
45	2.15	59	1.34	73	1.09
46	2.09	60	1.30	74	1.07
47	2.03	61	1.28	75 - 90	1.05
48	1.97	62	1.26	91	1.04
49	1.91	63	1.24	92	1.03
50	1.85	64	1.22	93	1.02
51	1.78	65	1.20	94+	1.01
52	1.71	66	1.19		
53	1.64	67	1.18		

DATA SECTION

FACE AMOUNT: [\$100,000.00]
EFFECTIVE DATE: [APR 15, 2010]

PERCENT OF PREMIUM EXPENSE CHARGE: 6.00%

MONTHLY EXPENSE CHARGE PER THOUSAND:

Years 1-5: [\$0.1650]
Years 6+: [\$0.0000]

MONTHLY POLICY FEE: \$5.00

SURRENDER CHARGES

TWELVE MONTH PERIOD BEGINNING	SURRENDER CHARGE
[APR 15, 2010	\$ 621.00
APR 15, 2011	596.00
APR 15, 2012	571.00
APR 15, 2013	545.00
APR 15, 2014	518.00
APR 15, 2015	490.00
APR 15, 2016	461.00
APR 15, 2017	432.00
APR 15, 2018	402.00
APR 15, 2019	370.00
APR 15, 2020	338.00
APR 15, 2021	305.00
APR 15, 2022	271.00
APR 15, 2023	236.00
APR 15, 2024	200.00
APR 15, 2025	162.00
APR 15, 2026	124.00
APR 15, 2027	84.00
APR 15, 2028	43.00
APR 15, 2029 AND LATER	00.00]

DATA SECTION

DEATH BENEFIT PROTECTION RIDER

POLICY NUMBER: [NL1234567]

INSURED: [ETHAN ALLEN]

EFFECTIVE DATE: [APR 15, 2010]

GUARANTEED MONTHLY COST PER \$1,000 OF FACE AMOUNT: [\$0.00]

DEATH BENEFIT PROTECTION INTEREST RATE: 5.00%

THE DEATH BENEFIT PROTECTION PERIOD IS IN EFFECT THROUGH [APR 14, 2030]

SERFF Tracking Number: NALF-126412308 State: Arkansas
 Filing Company: National Life Insurance Company State Tracking Number: 44648
 Company Tracking Number: 8804(0210) DBPR
 TOI: L09I Individual Life - Flexible Premium Sub-TOI: L09I.001 Single Life
 Adjustable Life
 Product Name: Death Benefit Protection Rider
 Project Name/Number: DBPR on NL AssurePlus Protector/8804(0210)

Supporting Document Schedules

	Item Status:	Status Date:
Satisfied - Item: Flesch Certification		
Comments:		
Attachment: Certification of Readability non-IIPRC.pdf		

	Item Status:	Status Date:
Bypassed - Item: Application		
Bypass Reason: Not applicable to this filing.		
Comments:		

	Item Status:	Status Date:
Bypassed - Item: Health - Actuarial Justification		
Bypass Reason: Not applicable to this filing.		
Comments:		

	Item Status:	Status Date:
Bypassed - Item: Outline of Coverage		
Bypass Reason: Not applicable to this filing.		
Comments:		

	Item Status:	Status Date:
Satisfied - Item: Statement of Variability		
Comments:		
Attachment: StmtVarNLAssurePlus.pdf		

SERFF Tracking Number: NALF-126412308 State: Arkansas
Filing Company: National Life Insurance Company State Tracking Number: 44648
Company Tracking Number: 8804(0210) DBPR
TOI: L09I Individual Life - Flexible Premium Sub-TOI: L09I.001 Single Life
Adjustable Life
Product Name: Death Benefit Protection Rider
Project Name/Number: DBPR on NL AssurePlus Protector/8804(0210)

Item Status:

Status

Date:

Satisfied - Item: Responsible Officer

Comments:

Attachment:

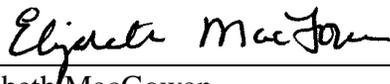
ResponsibleOfficer.pdf

National Life Insurance Company
Certification of Readability

We certify that, to the best of our knowledge and belief, each of the forms listed below meets the minimum reading ease score required by the Interstate Insurance Product Regulation Commission standards. The scores were calculated using the Flesch Reading Ease Test.

<u>Form Number</u>	<u>Flesch Score</u>
8804(0210)	79.6
9212(0210)	60.3
8531(0210)	54.0

12/23/2009
Date



Elizabeth MacGowan,
Vice President - Protection Products

**Statement of Variability for Data Pages
For Form 8804(0210)**

The Data Pages within the submitted filing contain brackets, used to designate variable items that may be unique for each policyholder or issue of the submitted rider.

Descriptions of the bracketed items follow:

EFFECTIVE DATE: This provides the Effective Date of the policy within the Data Pages.

POLICY NUMBER: This 7-digit number is the unique policy number by which we distinguish each policy issued on this form. This number appears on the Data Pages.

INSURED: This is the Insured's name, and will be unique to each Insured. This appears within the Data Pages.

ISSUE AGE: This is the issue age of the named Insured and appears within the Data Pages.

FACE AMOUNT: This amount will be unique to the policy based on each individual situation and appears within the Data Pages.

OWNER: This is the Owner's name, and will be unique to each Owner. This appears within the Data Pages. The statement "As stated in the application unless later changed" may appear to identify the owner, unless or until a revised Data Page is prepared to specify a new owner. In these circumstances, the name of the new owner will be stated, such name being unique to each owner.

BENEFICIARY: The statement "As stated in the application unless later changed" will appear to identify the beneficiary, unless or until a revised Data Page is prepared to specify a new beneficiary. In these circumstances, the name of the new beneficiary will be stated, such name being unique to each beneficiary.

MONTHLY POLICY DATE: This can take the variables of the "1st" through the "31st".

DEATH BENEFIT OPTION: This can take the variables of "A (LEVEL)" or "B (INCREASING)".

MINIMUM INITIAL PREMIUM: This is the lowest premium that will be accepted on this policy.

MONTHLY GUARANTEED PREMIUM: This is the premium that determines whether the rider is in force. The rider remains in force if the accumulated premiums paid less withdrawals and debt is greater than or equal to the accumulated Monthly Guarantee Premiums. Accumulations are made at the DEATH BENEFIT PROTECTION INTEREST RATE.

PLANNED PERIODIC PREMIUM: This is the premium that the applicant has asked be billed. It's value is unique to the interests of each applicant.

PREMIUM INTERVAL: This denotes the number of premiums payable each year, as requested by the applicant in establishing his or her planned periodic premium and premium interval and can take the variables of "AT ISSUE", "ANNUALLY", "SEMI-ANNUALLY", "QUARTERLY", "MONTHLY" or "CHECK-O-MATIC".

FOR PREMIUM PAYMENT PERIOD: This date varies based on the Effective Date and Attained Age 100 of the Insured..

MINIMUM FACE AMOUNT: The Minimum Face Amount for an Individual is \$25,000. For Pension policies the minimum is \$5,000 for standard rate classes and \$25,000 for preferred rate classes.

MORTALITY TABLE: COMMISSIONERS 2001 CSO ULTIMATE, AGE NEAREST BIRTHDAY. The variables that can be added to this are: "MALE NON-SMOKER", "MALE SMOKER", "FEMALE NON-SMOKER", AND "FEMALE SMOKER".

THE INSURED HAS BEEN CLASSIFIED: This may take the variables of “ELITE NON-SMOKER”, “PREFERRED NON-SMOKER”, “STANDARD NON-SMOKER”, “PREFERRED SMOKER”, AND “SMOKER”. All Juvenile issues will be “STANDARD NON-SMOKER”.

TABLE OF GUARANTEED MAXIMUM COST OF INSURANCE RATES: Range of variables for Male is 0.02 to 83.33. Range of variables for Female is 0.02 to 23.09. Range of variables for Unisex is 0.02 to 26.66.

DEFINITION OF LIFE INSURANCE: This may take the variable of “GUIDELINE PREMIUM TEST” or “CASH VALUE ACCUMULATION TEST”.

GUARANTEED MONTHLY COST PER \$1,000 OF FACE AMOUNT: This cost is unique to the rider based on each individual situation.

LOAN INTEREST RATE: This percentage varies from 5.00% to the Published Monthly Average of the Moody’s Corporate Bond Yield Average – Monthly Average Corporates for the calendar month ending two months before the calendar month in which the Policy Anniversary occurs.

DEATH BENEFIT PROTECTION PERIOD IS IN EFFECT THROUGH: This is the last day the rider will be in effect.

MONTHLY EXPENSE CHARGE PER THOUSAND: This charge is variable and is based upon the issue age, sex, risk class, and duration. The maximum charge would be 3.0850 for sex distinct issues and 3.0552 for unisex issues. The minimum charge would be 0.0525 for sex distinct issues and 0.0607 for unisex issues. This charge is fixed for each individual policy. The charge that appears on the Data Page is the guaranteed value of this charge.

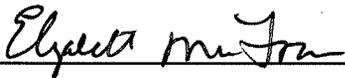
SURRENDER CHARGES: Range of variables per \$1,000 would be \$1.46 for Male age 0 to \$22.24 for Male age 85. Range of variables per \$1,000 would be \$1.15 for Female age 0 to \$24.06 for Female age 85. Range of variables per \$1,000 would be \$1.40 for Unisex age 0 to \$22.73 for Unisex age 85.

National Life Insurance Company
Responsible Officer Certification
To Accompany Policy Form Submissions

Regarding: 8804(0210), Death Benefit Protection Rider

I, Elizabeth MacGowan, am the Vice-President of Product Development at National Life Insurance Company. My responsibilities include life insurance illustrations, and I am an officer of National Life Insurance Company.

1. National Life Insurance Company will provide its agents with disclosure information about the expense allocation method used in the product illustrations for the policy forms referenced above.
2. The scales used in insurer authorized illustrations are those scales certified by the illustration actuary.
3. Policies applied for in this state have illustrations that meet the format requirements of the illustration regulation.



Date 1/13/10

Elizabeth MacGowan
Vice-President – Product Development
Responsible Officer for National Life Insurance Company