

SERFF Tracking Number: NALH-126442970 State: Arkansas
Filing Company: North American Company for Life and Health Insurance State Tracking Number: 44535
Company Tracking Number: FORM 82-47, 82-48
TOI: L08 Life - Other Sub-TOI: L08.000 Life - Other
Product Name: Form 82-47, 82-48
Project Name/Number: Form 82-47, 82-48/Form 82-47, 82-48

Filing at a Glance

Company: North American Company for Life and Health Insurance

Product Name: Form 82-47, 82-48

TOI: L08 Life - Other

Sub-TOI: L08.000 Life - Other

Filing Type: Form

SERFF Tr Num: NALH-126442970 State: Arkansas

SERFF Status: Closed-Approved-Closed
State Tr Num: 44535

Co Tr Num: FORM 82-47, 82-48

Author: Sherry M. Olson

Date Submitted: 01/11/2010

State Status: Approved-Closed

Reviewer(s): Linda Bird

Disposition Date: 01/13/2010

Disposition Status: Approved-Closed

Implementation Date:

Implementation Date Requested: On Approval

State Filing Description:

General Information

Project Name: Form 82-47, 82-48

Project Number: Form 82-47, 82-48

Requested Filing Mode: Review & Approval

Explanation for Combination/Other:

Submission Type: New Submission

Overall Rate Impact:

Filing Status Changed: 01/13/2010

Status of Filing in Domicile: Authorized

Date Approved in Domicile: 01/08/2010

Domicile Status Comments:

Market Type: Individual

Group Market Size:

Group Market Type:

Explanation for Other Group Market Type:

State Status Changed: 01/13/2010

Created By: Sherry M. Olson

Corresponding Filing Tracking Number:

Deemer Date:

Submitted By: Sherry M. Olson

Filing Description:

RE: North American Company for Life and Health Insurance

NAIC #66974 FEIN # 36-2428931

Application for Policy Reinstatement or Change Form 82-47 (10-09)

Statement of Health Form 82-48 (10-09)

We are filing the referenced forms for your review and approval. These forms are laser printed and we reserve the right to change fonts and layouts. We certify that the font size will never be less than the minimum 10-point required by your state.

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Insurance
Company Tracking Number: FORM 82-47, 82-48
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These application forms will be used with North American's approved individual life insurance policies available in the executive deferred compensation market.

Except for references to the company name, these forms are identical to the following Midland National Life Insurance forms, which were approved on 11/18/2009, SERFF Tr # NALH-126380103:

- Form 81-47 (10-09), Application for Policy Reinstatement or Change
- Form 81-48 (10-09), Statement of Health

Form 82-47 (10-09) will replace Form 82-47 (3-07) which was approved by your department on 4-2-2007. It will be used to apply for changes or reinstatements of existing North American policies. In addition to minor language and capitalization changes throughout the form, the primary differences are:

- On page 1, we moved the family history question from page 2 to page 1.
- On page 2:
 - *We added questions for the Name and Address of the physician most recently consulted, the date and reason for most recent consultation and a list of currently prescribed medications.
 - *We updated the content of questions 2 and 3 and revised several items to refer to "disease or disorder".
 - *We reformatted question 5 to provide separate columns for Question Number; Condition/Diagnosis; Approximate Dates/Duration; Treatment; Physician Name & Address.
- On page 3:
 - *We revised the second paragraph to better reflect the application is for policy change or reinstatement.
 - *We added a Taxpayer Identification Number Certification and removed the customer notice regarding the Patriot Act.
- We removed a page containing the Fair Credit Reporting Act Notification, Notice of Insurance Information Practices and the Medical Information Bureau Notification. These notices will be provided to the applicant on a separate form (new Form 82-57 (10-09) that is not part of the application. A copy of Form 82-57 (10-09) is included on an informational basis but is not filed for approval.

Statement of Health and Insurability Form 82-48 (10-09) is a new form. It will be used when a policy is being issued beyond its delivery period or in situations when the application becomes aged based on the date of signatures.

These forms were approved by North American's domicile state of Iowa on 1/8/2010.

If you need any additional information to complete your review, please feel free to contact me at 800-283-5433, ext. 36223 or at solson@sfgmembers.com.

Sincerely,

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Sherry Olson, AIRC
 Senior Contract Analyst
 Corporate Markets Center
 Midland National Life Insurance Company &
 North American Company for Life & Health

Company and Contact

Filing Contact Information

Sherry Olson, Senior Contract Analyst solson@mnlife.com
 2000 44th St. South, Suite 300 701-433-6223 [Phone]
 Fargo, ND 58103 701-433-8223 [FAX]

Filing Company Information

North American Company for Life and Health CoCode: 66974 State of Domicile: Iowa
 Insurance
 Principal Office: 4601 Westown Parkway - Suite 300 Group Code: 431 Company Type: Life and Annuity
 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: \$40.00
 Retaliatory? No
 Fee Explanation: \$20 per application form x 2 forms = \$40
 Per Company: No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
North American Company for Life and Health Insurance	\$40.00	01/11/2010	33439170

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Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Linda Bird	01/13/2010	01/13/2010

Amendments

Schedule	Schedule Item Name	Created By	Created On	Date Submitted
Supporting Document	Form 82-57 (10-09) Consumer Notices	Sherry M. Olson	01/11/2010	01/11/2010

SERFF Tracking Number: NALH-126442970 State: Arkansas
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Disposition

Disposition Date: 01/13/2010

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	Form 82-57 (10-09) Consumer Notices	Yes	Yes
Form	Application for Policy Reinstatement or Change	Yes	Yes
Form	Statement of Health and Insurability	Yes	Yes

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Company Tracking Number: FORM 82-47, 82-48
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Amendment Letter

Submitted Date: 01/11/2010

Comments:

An item was omitted from the Supporting Documents tab

Changed Items:

Supporting Document Schedule Item Changes:

User Added -Name: Form 82-57 (10-09) Consumer Notices

Comment:

Form 82-57 _10-09_.pdf

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Form Schedule

Lead Form Number:

Schedule Item Status	Form Number	Form Type Form Name	Action	Action Specific Data	Readability	Attachment
	Form 82-47 (10-09)	Application/ Enrollment Form	Application for Policy Reinstatement or Change	Initial	50.900	82-47 _10-09_.pdf
	Form 82-48 (10-09)	Application/ Enrollment Form	Statement of Health and Insurability	Initial	53.300	NA Form 82-48 _10-09_.pdf

**Application for
Policy Reinstatement or Change**

1. Name of Insured (First, Middle and Last)		Birth date	Birthplace	Sex	Marital Status			
2. Residence Address (Street, City, State, Zip)			Social Security No.	Height ft. in.	Weight lbs.			
3. Policy Number	4. Occupation / Title and Gross Annual Compensation \$			Telephone # (home): (business):				
5a. Owner Name and Address		5b. Social Security or Tax ID No.						
		5c. Relationship to Proposed Insured						
6. Policy Change requested: <input type="checkbox"/> Reconsideration of Rate Class <input type="checkbox"/> Reinstatement <input type="checkbox"/> Other: _____								
7. Life Insurance and annuities in force and pending: If None, check here: <input type="checkbox"/>								
Company	Policy #	Personal or Business	Pending	Issue Year	Benefit Amount	ADB Amount	WP Amount	Intention of Replacement or Change
			<input type="checkbox"/>					<input type="checkbox"/> Y <input type="checkbox"/> N
			<input type="checkbox"/>					<input type="checkbox"/> Y <input type="checkbox"/> N
			<input type="checkbox"/>					<input type="checkbox"/> Y <input type="checkbox"/> N
			<input type="checkbox"/>					<input type="checkbox"/> Y <input type="checkbox"/> N
			<input type="checkbox"/>					<input type="checkbox"/> Y <input type="checkbox"/> N
			<input type="checkbox"/>					<input type="checkbox"/> Y <input type="checkbox"/> N

Provide details for all "Yes" answers to questions 8-17 below.

<p>Yes No</p> <p><input type="checkbox"/> <input type="checkbox"/> 8. Are you a U.S. citizen? (If "No", complete appropriate questionnaire.)</p> <p><input type="checkbox"/> <input type="checkbox"/> 9. Do you intend to travel outside the U.S. or Canada within the next 2 years? (If "Yes", complete appropriate questionnaire.)</p> <p><input type="checkbox"/> <input type="checkbox"/> 10. Do you participate in or do you intend to participate in aviation related sports, powered or competitive vehicle racing, sky or scuba diving, mountain climbing, or any other hazardous sport or activity? (If "Yes", complete appropriate questionnaire.)</p> <p><input type="checkbox"/> <input type="checkbox"/> 11. Have you ever been convicted of, or are you awaiting trial for, a felony?</p> <p><input type="checkbox"/> <input type="checkbox"/> 12. Have you ever had an application for insurance declined, postponed or rated?</p> <p>13. Your driver's license #: _____ State: _____</p>	<p>Yes No</p> <p>14. Within the past 10 years, have you been convicted of or pled guilty to:</p> <p><input type="checkbox"/> <input type="checkbox"/> a) Moving violations?</p> <p><input type="checkbox"/> <input type="checkbox"/> b) Driving under the influence of alcohol and/or drugs?</p> <p><input type="checkbox"/> <input type="checkbox"/> 15. Have you been a pilot or crew member during the past 3 years or have any intention of becoming a pilot, student pilot, or crew member in any type of aircraft? (If "Yes", complete appropriate questionnaire.)</p> <p>16. Have you ever used:</p> <p><input type="checkbox"/> <input type="checkbox"/> a) Cigarettes? Date last used: _____</p> <p><input type="checkbox"/> <input type="checkbox"/> b) Other nicotine products: Date last used: _____</p> <p><input type="checkbox"/> <input type="checkbox"/> 17. Do you have any family history of heart disease, cancer, high blood pressure, diabetes, hemophilia, Huntington's chorea, polycystic kidney disease or any congenital disorder?</p>
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Details for questions 8-17:

1a. Name and address of Personal Physician:
1b. Date and reason last consulted:
1c. Name and Address of physician most recently consulted if different than above:
1d. Date and reason for most recent consultation:
1e. List any currently prescribed medications:
<p>2. Have you ever had or been treated for:</p> <p>Yes No</p> <p><input type="checkbox"/> <input type="checkbox"/> a. Elevated cholesterol, high blood pressure, transient ischemic attack (TIA), stroke or circulation disorder?</p> <p><input type="checkbox"/> <input type="checkbox"/> b. Chest pain, heart attack, heart murmur, irregular heart rate, or other disease or disorder of the heart?</p> <p><input type="checkbox"/> <input type="checkbox"/> c. Cancer, tumor, polyp, blood or immune system disease or disorder?</p> <p><input type="checkbox"/> <input type="checkbox"/> d. Diabetes, kidney, or urinary disease or disorder?</p> <p><input type="checkbox"/> <input type="checkbox"/> e. Crohn's disease, colitis, ulcer, diverticulitis, hepatitis, or any disease of the esophagus or liver?</p> <p><input type="checkbox"/> <input type="checkbox"/> f. Sleep apnea, asthma, emphysema, lung or respiratory disease or disorder?</p> <p><input type="checkbox"/> <input type="checkbox"/> g. Depression, mental illness, anxiety or seizure disorder?</p> <p><input type="checkbox"/> <input type="checkbox"/> h. Breast, uterus, ovaries, testicles or prostate disease or disorder, or sexually transmitted diseases?</p> <p><input type="checkbox"/> <input type="checkbox"/> i. Arthritis, lupus, fibromyalgia or other skin, bone, joint or muscle disease or disorder?</p> <p><input type="checkbox"/> <input type="checkbox"/> j. Any injury, disease, or illness not indicated above?</p> <p>3. Other than above, have you ever:</p> <p><input type="checkbox"/> <input type="checkbox"/> a. Within the last 5 years, consulted any other physician or medical practitioner, or had an electrocardiogram (EKG), chest X-ray or any lab test or study?</p> <p><input type="checkbox"/> <input type="checkbox"/> b. Within the last 5 years, received medical treatment or advice, including medication, or been hospitalized or had surgery?</p> <p><input type="checkbox"/> <input type="checkbox"/> c. Applied for, or received benefits, because of accident, sickness, or disability?</p> <p><input type="checkbox"/> <input type="checkbox"/> d. Sought or received treatment for, or been arrested for, the use of alcohol, marijuana, or drugs?</p> <p><input type="checkbox"/> <input type="checkbox"/> e. Used narcotics, cocaine, LSD, marijuana, amphetamines, or barbiturates, unless administered on the advice of a physician?</p> <p>4. In the past 10 years have you:</p> <p><input type="checkbox"/> <input type="checkbox"/> Been diagnosed or treated by a member of the medical profession for immune deficiency disorder, Acquired Immune Deficiency Syndrome (AIDS), or AIDS Related Complex (ARC)?</p>

5. Details for questions 2-4. Give details for each YES answer.

Question Number	Condition/Diagnosis	Approximate Dates/Duration	Treatment	Physician Name & Address

Agreement and Authorization

Each person who signs below represents and agrees that the statements and answers recorded on this application are given to obtain this insurance and are true, complete, and correctly recorded. Fraud or material misrepresentation in the application will make this agreement invalid, and the only liability of North American Company for Life and Health Insurance shall be to refund any advance payment made.

It is agreed that the Policy will not be reinstated or a change will not be effected, and the Company will have no liability until: (a) this application is approved; and (b) all money required for reinstatement and/or change has been paid. This must be during the lifetime of any person proposed for insurance; also, his or her eligibility and health must remain as described in this application. If these requirements are met, insurance will be in effect on the effective date of the reinstatement or change. By accepting the reinstated policy or changed policy, the Owner consents to any changes the Company has made under "Home Office Endorsements," except that changes in the insurance amount, the risk class, or the insurance plan will be made only with the Owner's written consent. Each person who signs below acknowledges that he or she has read and understands this application and has received copies of the Fair Credit Reporting Act Notification, Notice of Insurance Information Practices, and the Medical Information Bureau Notification.

I authorize any physician, medical practitioner, hospital, clinic, other medical or medically related facility, insurance or reinsuring company, Medical Information Bureau (MIB), consumer reporting agency, or employer having information available as to diagnosis, treatment, and prognosis with respect to any physical or mental condition and/or treatment of me and any information as to employment, other insurance coverage, or other non-medical information about me to give to the Company or its reinsurers, any and all such information. I authorize all of these sources, except MIB, to give records or knowledge to any agency that the Company employs to collect and transmit such information. The Company will not release any information to any person or organization **except** to reinsuring companies, MIB, or other persons or organizations performing business or legal services in connection with my application or claim, or as may be otherwise lawfully required or as I may authorize later. 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. I understand that I may request a copy of this authorization and that a photographic copy will be as valid as the original, and either shall remain in effect for a period of two years from the date signed. I have the right to revoke this authorization by notifying the Company in writing. The Company may rely on my authorization prior to receiving my notice of revocation.

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.

TAXPAYER IDENTIFICATION NUMBER CERTIFICATION – Under penalties of perjury, I certify that 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 I am not subject to back up 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 failure to report all interest or dividends, or (c) the IRS has notified me that I am no longer subject to backup withholding.

FRAUD STATEMENT – Any person who, with the intent to defraud or knowing that he/she is facilitating a fraud against an insurer, submits an application or files a claim containing false or deceptive statements is/may be guilty of insurance fraud and may be subject to fines and penalties.

Home Office Endorsements.

Signed at _____ Date _____
City State

Signature of Proposed Insured

Signature of Owner (If Owner is corporation, trust or other entity, include title of signee.)

Agent certification

(1) To the best of my knowledge and belief, the answers given to the questions in this application are full, complete, and true, and there is nothing adversely affecting the insurability of any person proposed for insurance, except as stated in this application; (2) that I gave the Medical Information Bureau Notification, Notice of Insurance Information Practices and Fair Credit Reporting Act Notification to the Proposed Insured; (3) to the best of my knowledge and belief, the applicant **does** **does not** have any existing life insurance or annuities; and, the insurance applied for **does** **does not** replace existing insurance.

Signature of Agent Date Agent's No.

STATEMENT OF HEALTH AND INSURABILITY

Name of Proposed Insured: _____ Policy Number(s): _____

- | | | |
|--|--------------------------|--------------------------|
| Since the date of the original application: | YES | NO |
| 1. have you consulted or been treated by any physician or practitioner or had any physical disability or impairment, sickness, injury, surgery or mental disorder? | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. have you had a physical examination, lab tests, EKG or X-ray procedures? | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. have you used tobacco in any form? If yes, give form used and date last used in "Details". | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. have you made an application for insurance which has been declined, postponed or modified? | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. do you have any other applications for insurance pending with another company(ies) at this time? | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. have you changed occupation? If yes, give current occupation (employer name and duties) in "Details". | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. have you engaged in or expect to engage in any of the following: aviation activities as a pilot or crew member; scuba diving; automobile, motorcycle, or motor boat racing; mountain climbing; rodeo competition; sky-diving or other hazardous activities? | <input type="checkbox"/> | <input type="checkbox"/> |

If any question above is answered "Yes", please explain in the "Details" section.

DETAILS:

Question Number	Date	Detail

Any person who, with the intent to defraud or knowing that he/she is facilitating a fraud against an insurer, submits an application or files a claim containing false or deceptive statements is/may be guilty of insurance fraud and may be subject to fines and penalties.

I hereby agree that all of the statements above are 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.

Signature of proposed insured

Date

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Supporting Document Schedules

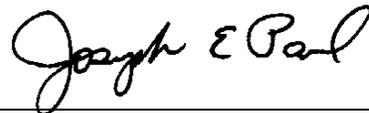
	Item Status:	Status Date:
<p>Satisfied - Item: Flesch Certification</p> <p>Comments: Rule & Regulation 49 does not apply to applications Bulletin 15-2009 replaces Bulletin 11-99 and is not applicable to applications</p> <p>Attachments: 82-47, 82-48 readability.pdf 82-47, 82-48 AR Cert.pdf</p>		
<p>Bypassed - Item: Application</p> <p>Bypass Reason: Application forms submitted on Form Schedule</p> <p>Comments:</p>		
<p>Satisfied - Item: Form 82-57 (10-09) Consumer Notices</p> <p>Comments:</p> <p>Attachment: Form 82-57 _10-09_.pdf</p>		

READABILITY CERTIFICATE

Name and Address of Insurer North American Company for Life and Health Insurance
Corporate Markets Center
2000 44th Street South, Ste. 300 Fargo, ND 58103

I hereby 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) listed below meet your minimum readability requirements of your state.

<u>FORM NUMBER</u>	<u>DESCRIPTION</u>	<u>SCORE</u>
Form 82-47 (10-09)	Application for Policy Reinstatement or Change	50.9
Form 82-48 (10-09)	Statement of Health and Insurability	53.3



Signature

Joseph E. Paul, FSA, MAAA
Typed Name

Vice President – Corporate Markets Operations
Title

January 5, 2010
Date

TO: Arkansas Department of Insurance
FROM: North American Company for Life and Health Insurance
DATE: January 11, 2010
RE: Form 82-47 (10-09), Form 82-48 (10-09)

North American Company certifies that the referenced forms comply with Arkansas Regulation 19 § 10B regarding unfair sex discrimination in insurance.

Carmen R. Walter

Carmen R. Walter, FSA, MAAA
Director of Product Development
Corporate Markets
North American Company for Life and Health Insurance

Date: January 11, 2010

Leave with Applicant

Fair Credit Reporting Act Notification

As part of North American Company for Life and Health Insurance's normal procedure of processing applications, we may obtain an investigative consumer report concerning such information as to your character, general reputation, and personal characteristics, except as may be related directly or indirectly to your sexual orientation. We will obtain this information through interviews with your friends, neighbors, and associates. You may make a written request to be personally interviewed when such a report is being prepared. You have the right to make a written request to receive a copy of the investigative consumer report. Further information on the nature and scope of the report, if one is made, is available upon request from North American Company for Life and Health Insurance.

Notice of Insurance Information Practices

You are our most important source of information, but personal information may also be collected from other persons. Such information, as well as other personal or privileged information our agent or we subsequently collect, may, in certain circumstances, be disclosed to third parties without your authorization.

We have established procedures to give you access to all personal information collected. You may request correction of such information in our files that you believe to be inaccurate.

We will provide a more complete description of the information practices of North American Company for Life and Health Insurance upon your request, in accordance with the requirements of the Insurance Information and Privacy Protection Law in effect in your state of residence.

Medical Information Bureau Notification

Information regarding your insurability will be treated as confidential. North American Company for Life and Health Insurance or its reinsurers may, however, make a brief report thereon to the MIB, Inc., formerly known as Medical Information Bureau, a not-for-profit membership organization of insurance companies, which operates an information exchange on behalf of its members. If you apply to another MIB member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, MIB, upon request, will supply such company with the information about you in its file. Upon receipt of a request from you, MIB will arrange disclosure of any information in your file. Please contact MIB at 866-692-6901 (TTY 866-346-3642). If you question the accuracy of the information in MIB's file, you may contact MIB and seek a correction in accordance with the procedures set forth in the Fair Credit Reporting Act. The address of MIB's information office is 50 Braintree Hill Park, Suite 400, Braintree, Massachusetts 02184-8734. North American Company for Life and Health Insurance or its reinsurers may also release information from its file to other insurance companies to whom you may apply for life or health insurance, or to whom a claim for benefits may be submitted. Information for consumers about MIB may be obtained on its website at www.mib.com.