

SERFF Tracking Number: EMCN-126895786 State: Arkansas
Filing Company: EMC National Life Company State Tracking Number: 47317
Company Tracking Number: EAP010 (11-10)
TOI: L08 Life - Other Sub-TOI: L08.000 Life - Other
Product Name: Individual Life Applications
Project Name/Number: /

Filing at a Glance

Company: EMC National Life Company
Product Name: Individual Life Applications
TOI: L08 Life - Other

SERFF Tr Num: EMCN-126895786 State: Arkansas
SERFF Status: Closed-Approved- State Tr Num: 47317
Closed

Sub-TOI: L08.000 Life - Other
Filing Type: Form

Co Tr Num: EAP010 (11-10) State Status: Approved-Closed
Reviewer(s): Linda Bird
Author: Michele Johnson Disposition Date: 11/17/2010
Date Submitted: 11/12/2010 Disposition Status: Approved-
Closed

Implementation Date Requested: On Approval
State Filing Description:

Implementation Date:

General Information

Project Name:
Project Number:
Requested Filing Mode: Review & Approval
Explanation for Combination/Other:
Submission Type: New Submission
Overall Rate Impact:
Filing Status Changed: 11/17/2010

Status of Filing in Domicile: Authorized
Date Approved in Domicile: 11/10/2010
Domicile Status Comments:
Market Type: Individual
Group Market Size:
Group Market Type:
Explanation for Other Group Market Type:
State Status Changed: 11/17/2010
Created By: Michele Johnson
Corresponding Filing Tracking Number:

Deemer Date:
Submitted By: Michele Johnson
Filing Description:

The following applications are being filed for approval:
EAP010 – Individual Life Application
EAP011 –Tele-Underwriting Application
EAP012 - Medical Application - Part II

They are new forms and will not replace any existing forms. Our licensed representatives will utilize these applications when meeting with clients applying for our term, whole life, and universal life products. Following are the products currently being offered in your state and their approval dates:

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Individual Universal Life Policy ELP003 (7-08) Approved 07/08/2008 EMCN-125711306

Individual Term Life Policy ELP240 (4-07) Approved 04/16/2007 35618

Individual Whole Life Policy LP300 (10-05) Approved 10/28/2005 30854

We plan to also use these applications with future individual whole life, term and universal life products as they are developed.

This submission contains no unusual or possibly controversial items from normal company or industry standards.

These applications were written to be readable and easily understood by insureds. The forms achieved the following flesch scores:

EAP010 – 52.0

EAP011 – 51.0

EAP012 - 56.0

Bracketed matter shown in the applications is subject to change. The accompanying Statements of Variability provide an explanation of the variable items applicable to these forms.

These applications may be used in both paper and electronic format.

Our electronic application process complies with the Uniform Electronic Transaction Act. The applicant can review and/or correct any information entered into the application screens before signing the application. Appropriate encryption standards have been implemented to prohibit alteration of the application after the applicant has signed it. Once completed, the information is transmitted to the home office via a secured web protocol. At the end of the process the completed application will be printed and be formatted the same as the application submitted in this filing. Both internal and external safeguards for electronic information have been implemented by our Technical Services Department.

Should you have any questions, please contact me at 515-237-2146, or via electronic mail at mjohnson@emcnl.com. Thank you.

Company and Contact

Filing Contact Information

Michele Johnson, Actuarial Analyst
4095 NW Urbandale Dr.
Urbandale, IA 50322

mjohnson@emcnl.com
515-237-2146 [Phone]
515-237-2281 [FAX]

Filing Company Information

<i>SERFF Tracking Number:</i>	<i>EMCN-126895786</i>	<i>State:</i>	<i>Arkansas</i>
<i>Filing Company:</i>	<i>EMC National Life Company</i>	<i>State Tracking Number:</i>	<i>47317</i>
<i>Company Tracking Number:</i>	<i>EAP010 (11-10)</i>		
<i>TOI:</i>	<i>L08 Life - Other</i>	<i>Sub-TOI:</i>	<i>L08.000 Life - Other</i>
<i>Product Name:</i>	<i>Individual Life Applications</i>		
<i>Project Name/Number:</i>	<i>/</i>		
EMC National Life Company	CoCode: 62928	State of Domicile: Iowa	
4095 NW Urbandale Drive	Group Code:	Company Type: L and Health	
Urbandale, IA 50322-7914	Group Name:	State ID Number:	
(515) 645-4000 ext. 4094[Phone]	FEIN Number: 42-0868851		

Filing Fees

Fee Required?	Yes
Fee Amount:	\$150.00
Retaliatory?	No
Fee Explanation:	3 applications being filed
Per Company:	No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
EMC National Life Company	\$150.00	11/12/2010	41856837

SERFF Tracking Number: EMCN-126895786

State: Arkansas

Filing Company: EMC National Life Company

State Tracking Number: 47317

Company Tracking Number: EAP010 (11-10)

TOI: L08 Life - Other

Sub-TOI: L08.000 Life - Other

Product Name: Individual Life Applications

Project Name/Number: /

Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Linda Bird	11/17/2010	11/17/2010

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Disposition

Disposition Date: 11/17/2010

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
Supporting Document	Application		No
Supporting Document	Statements of Variability		Yes
Form	Application for Individual Life Insurance		Yes
Form	Teleunderwriting Application for Individual Life Insurance		Yes
Form	Application for Life Insurance - Part II		Yes

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Form Schedule

Lead Form Number: EAP010 (11-10)

Schedule Item Status	Form Number	Form Type Form Name	Action	Action Specific Data	Readability	Attachment
	EAP010 (11-10)	Application/ Enrollment Form Individual Life Insurance	Initial		52.000	EAP010.pdf
	EAP011 (11-10)	Application/ Enrollment Form Teleunderwriting Application for Individual Life Insurance	Initial		51.000	EAP011.pdf
	EAP012 (11-10)	Application/ Enrollment Form Application for Life Insurance - Part II	Initial		56.000	EAP012.pdf



National Life Company

[P.O. Box 9144 ■ Des Moines, IA 50306-9144
1.800.232.5818 ■ www.EMCNationalLife.com]

Application *for* **Individual Life** **Insurance**

**Use for all fully
underwritten life products**

Do not use for Workplace products

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

— ALWAYS DETACH AND GIVE TO APPLICANT —

FAIR CREDIT REPORTING ACT

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

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

NOTIFICATION REGARDING THE MEDICAL INFORMATION BUREAU

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

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

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

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

CONDITIONAL COVERAGE RECEIPT

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

TERMS AND CONDITIONS

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

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

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

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

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

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

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

EMC NATIONAL LIFE COMPANY
[P.O. BOX 9144 • DES MOINES, IA 50306-9144]

INDIVIDUAL LIFE INSURANCE APPLICATION

PRINT IN BLACK INK

1. Proposed Insured Name (First, M.I., Last)	Age	Birthdate Mo-Day-Yr	Birth State	Social Security Number	Sex	Height	Weight
COMPLETE FOR FAMILY / BUSINESS COVERAGE							
Spouse/Other Insured Name							
Child/Other Insured Name							
Child/Other Insured Name							

Address: _____
No. & Street City State Zip

Proposed Insured's phone numbers (include area codes): Home (____) _____ Business (____) _____

If we need to contact you, we should call: Home Business Time _____ A.M. P.M.

Are all proposed insureds U.S. Citizens? Yes No If no, provide details in Section 6 and send copy of permanent resident visa.

Employment	Employer Name	Occupation (Duties)	# of Years	Total of Annual Earned & Unearned Income
Insured				\$
Spouse (if applying)				\$
Other Insured (if applying)				\$

2. Beneficiary: Primary Applicant (If a trust is the beneficiary, record name and date of the trust)

	Name (First, M.I., Last)	Date of Birth	Social Security #	Relationship	%
Primary					
Contingent					

Beneficiary: Spouse/Other Insureds (If a trust is the beneficiary, record name and date of the trust)

	Name (First, M.I., Last)	Date of Birth	Social Security #	Relationship	%
Primary					
Contingent					

3. Owner (Complete only if Owner is other than Proposed Insured. If Joint Ownership, specify details in Section 6. If a trust is the owner, provide a copy of the trust.)

	Name (First, M.I., Last)	Address	Birthdate	Soc. Sec./TIN	Relationship
First Owner					
Contingent Owner					



8. Premium Options

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

9. Has any person proposed for coverage:

- | | Yes | No |
|---|--------------------------|--------------------------|
| A. Have any other application for personal insurance pending? | <input type="checkbox"/> | <input type="checkbox"/> |
| B. Applied for life, health, or disability insurance or reinstatement which was declined, postponed, rated, restricted or modified?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| C. Engaged in aviation activity other than as a passenger? (If yes, complete 1,2, 3, 4, 5 and 6) | <input type="checkbox"/> | <input type="checkbox"/> |
| (1) Number of hours flown last 12 months _____ | | |
| (2) Number of hours contemplated over next 12 months _____ | | |
| (3) Total number of hours flown _____ | | |
| (4) License type _____ | | |
| (5) Type of flying _____ | | |
| (6) Instrument Flight Rating (IFR)?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| D. Engaged in ballooning, sky diving, racing, mountain climbing, rodeo competition, SCUBA diving (max depth _____) or any hazardous sport or activity? Intentions to engage in such activities over next 12 months: activity _____ frequency _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| E. Within the past three years, had a driver's license suspended or revoked for any reason, or been charged with or convicted of driving while intoxicated or under the influence of a controlled substance, or with any moving violation involving a motor vehicle? If yes, list below the name(s), date(s) and details including the driver's license number(s).... | <input type="checkbox"/> | <input type="checkbox"/> |
| F. Plead guilty or been convicted of a felony or have any such charges currently pending? | <input type="checkbox"/> | <input type="checkbox"/> |
| G. Currently a member of the military, military reserve or National Guard, whether active or inactive, or has the proposed insured entered into a written agreement to enter the armed services? If yes, list below name, branch, rank and duties..... | <input type="checkbox"/> | <input type="checkbox"/> |
| H. Do you intend to travel outside the U.S. or Canada or change your country of residence in the next 24 months? (If yes, list countries, cities, duration and purpose of travel in the details section below) | <input type="checkbox"/> | <input type="checkbox"/> |
| I. (1) Now use tobacco or any nicotine substitute?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| (2) Ever used tobacco or any nicotine substitute? If yes, provide date when stopped _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| If yes to I(1) or (2), indicate below name of person and type of tobacco or nicotine substitute used (cigarettes, pipe, cigar, chew, patch, gum, other) | | |

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

10. Family History: Has any person proposed for coverage had a parent/sibling who was diagnosed with or died of heart disease, kidney disease, diabetes, cancer, stroke or other hereditary disease?

	Proposed Insured		Spouse/Other Insured	
	Age if Living	Age at Death/Cause or if Living, Age at Diagnosis/Cause	Age if Living	Age at Death/Cause or if Living, Age at Diagnosis/Cause
Father				
Mother				
Sibling				

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

- | | Yes | No |
|---|--------------------------|--------------------------|
| A. Has any person proposed for coverage: | | |
| (1) Had high blood pressure, elevated cholesterol, chest pain or angina, heart attack, or disease or disorder of the heart, heart valves, blood clot, blood vessels, stroke, Transient Ischemic Attack, speech defect or paralysis? | <input type="checkbox"/> | <input type="checkbox"/> |
| (2) Had any diagnosis or treatment for: cancer, tumor, polyps, basal or squamous cell carcinoma, abnormal moles or lesions, dysplastic nevi, leukemia, blood disorder, epilepsy, nervous or mental disorder, diabetes, hepatitis, disease or disorder of the pancreas, stomach or intestines, lungs including asthma or emphysema, brain or nervous system, kidney, bladder, breast or liver? | <input type="checkbox"/> | <input type="checkbox"/> |

Yes No

- (3) Been diagnosed as having or been treated for Human Immunodeficiency Virus (HIV), Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC) by a member of the medical profession?
- (4) Been diagnosed as having or been treated for any immune deficiency disorder or autoimmune or connective tissue disease or disorder (not HIV related)?
- (5) Except as prescribed by a physician, ever used marijuana, heroin, cocaine, barbiturates or other illegal drugs, joined any organization, received or had treatment or counseling for drug or alcohol abuse?
- (6) Within the past five years, seen a physician or received treatment for any disease or condition not stated above?
- B. Is any person proposed for coverage taking prescription medication?
- C. Is any person proposed for coverage currently awaiting surgery, diagnostic/screening testing, results of diagnostic/screening testing or been advised to have diagnostic/screening testing or consultation with a medical practitioner?
- D. Has any person proposed for coverage had any abnormal diagnostic or screening tests?
- E. Has any person proposed for coverage had any weight change in the past year?

Give complete details below to all Yes answers. Use box on page 3 if additional space is needed.

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

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

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

Primary
Other
- B. Monthly Benefit Amount applied for: Primary Insured \$ _____ Other Insured \$ _____
- C. Elimination Period (select 30, 60 or 90 days)
 Primary Insured: 30 days 60 days 90 days Other Insured: 30 days 60 days 90 days
- D. Has any person proposed for coverage:

	Yes	No
(1) Within the past 5 years, received Disability, Worker's Comp. or Pension Benefits?	<input type="checkbox"/>	<input type="checkbox"/>
(2) Within the past 5 years, received medical care for the muscles, bones, joints, including but not limited to the neck, back, spine or feet or any other nerve disorder or treatment of any muscular or neuromuscular disorder?	<input type="checkbox"/>	<input type="checkbox"/>
(3) Within the past 5 years, received treatment or been diagnosed with arthritis, gout, bursitis or rheumatism?	<input type="checkbox"/>	<input type="checkbox"/>
(4) Had any physical or occupational therapy or had therapy recommended?	<input type="checkbox"/>	<input type="checkbox"/>
(5) Had any prior complications of pregnancy or currently pregnant?	<input type="checkbox"/>	<input type="checkbox"/>
- E. Is each person proposed for coverage actively at work now and worked at least 30 hours a week for the last three months except for minor illnesses of one week or less or pregnancy?
- F. Any other Disability Income Policies in force? (Note: You do not need to include short term disability policies of 26 weeks or less)
- (1) If yes, for every person proposed for coverage, note the amount of monthly coverage for each policy \$ _____ and maximum benefit periods _____.
- G. Describe employment duties below for each person proposed for Rider coverage (what you do, types of machines used)

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

FRAUD INFORMATION: The Company is relying on the information in this application to qualify all persons proposed for coverage under this insurance policy. Any false statement or misrepresentation may result in loss of coverage under this policy. Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison. Caution: Read your state's specific fraud warning (as applicable.)

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

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

KANSAS - Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance may be guilty of a crime as determined by a court of law.

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

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

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

NEW MEXICO - Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to civil fines and criminal penalties.

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

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

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

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

AUTHORIZATION TO OBTAIN AND DISCLOSE INFORMATION

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

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

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

By my signature below, I acknowledge that any agreements I have made to restrict my Protected Health Information do not apply to this authorization and I instruct any Medical Provider to release and disclose my entire medical record without restriction.

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

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

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

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

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

X _____
Signature of Proposed Insured or Personal Representative Printed Name Date

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

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

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

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



National Life Company

[P.O. Box 9144 ■ Des Moines, IA 50306-9144
1.800.232.5818 ■ www.EMCNationalLife.com]

Teleunderwriting Application *for* Individual Life Insurance

for Medically Underwritten Amounts of Coverage

Fax application to [ESP at 1-888-801-6003]

AND

Fax to Home Office at [1-800-439-9526] or

Mail original application to Home Office.

See page 5 for further instructions

— ALWAYS DETACH AND GIVE TO APPLICANT —

FAIR CREDIT REPORTING ACT

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

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

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

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

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

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

CONDITIONAL COVERAGE RECEIPT

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

TERMS AND CONDITIONS

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

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

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

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

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

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

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

EMC NATIONAL LIFE COMPANY
 [P.O. BOX 9144 • DES MOINES, IA 50306-9144]

TELEUNDERWRITING INDIVIDUAL LIFE INSURANCE APPLICATION

PRINT IN BLACK INK

1. Proposed Insured Name (First, M.I., Last)	Age	Birthdate Mo-Day-Yr	Birth State	Social Security Number	Sex	Height	Weight
COMPLETE FOR FAMILY / BUSINESS COVERAGE							
Spouse/Other Insured Name							
Child/Other Insured Name							
Child/Other Insured Name							

Address: _____
 No. & Street City State Zip

Proposed Insured's phone numbers (include area codes): Home (____) _____ Business (____) _____

If we need to contact you, we should call: Home Business Time _____ A.M. P.M.

Are all proposed insureds U.S. Citizens? Yes No If no, provide details in Section 6 and send copy of permanent resident visa.

Employment	Employer Name	Occupation (Duties)	# of Years	Total of Annual Earned & Unearned Income
Insured				\$
Spouse (if applying)				\$
Other Insured (if applying)				\$

2. Beneficiary: Primary Applicant (If a trust is the beneficiary, record name and date of the trust)

	Name (First, M.I., Last)	Date of Birth	Social Security #	Relationship	%
Primary					
Contingent					

Beneficiary: Spouse/Other Insureds (If a trust is the beneficiary, record name and date of the trust)

	Name (First, M.I., Last)	Date of Birth	Social Security #	Relationship	%
Primary					
Contingent					

3. Owner (Complete only if Owner is other than Proposed Insured. If Joint Ownership, specify details in Section 6. If a trust is the owner, provide a copy of the trust.)

	Name (First, M.I., Last)	Address	Birthdate	Soc. Sec./TIN	Relationship
First Owner					
Contingent Owner					



8. Premium Options

Mode: <input type="checkbox"/> Annual <input type="checkbox"/> Semiannual <input type="checkbox"/> Quarterly <input type="checkbox"/> Monthly Check Plan <input type="checkbox"/> List Bill <input type="checkbox"/> Other _____] Premium: [Planned Periodic \$ _____ Extra Single/Lump Sum \$ _____ Estimated 1035/Lump Sum \$ _____] Amount Paid with Application \$ _____

9. Has any person proposed for coverage:

- | | Yes | No |
|--|--------------------------|--------------------------|
| A. Have any other application for personal insurance pending? | <input type="checkbox"/> | <input type="checkbox"/> |
| B. Applied for life, health, or disability insurance or reinstatement which was declined, postponed, rated, restricted or modified?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| C. Engaged in aviation activity other than as a passenger? (If yes, complete 1,2, 3, 4, 5 and 6) | <input type="checkbox"/> | <input type="checkbox"/> |
| (1) Number of hours flown last 12 months _____ | | |
| (2) Number of hours contemplated over next 12 months _____ | | |
| (3) Total number of hours flown _____ | | |
| (4) License type _____ | | |
| (5) Type of flying _____ | | |
| (6) Instrument Flight Rating (IFR)?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| D. Engaged in ballooning, sky diving, racing, mountain climbing, rodeo competition, SCUBA diving (max depth _____) or any hazardous sport or activity? Intentions to engage in such activities over next 12 months: activity _____ frequency _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| E. Within the past three years, had a driver's license suspended or revoked for any reason, or been charged with or convicted of driving while intoxicated or under the influence of a controlled substance, or with any moving violation involving a motor vehicle? If yes, list below name(s), date(s) and details including the driver's license number(s)..... | <input type="checkbox"/> | <input type="checkbox"/> |
| F. Plead guilty or been convicted of a felony or have any such charges currently pending? | <input type="checkbox"/> | <input type="checkbox"/> |
| G. Currently a member of the military, military reserve or National Guard, whether active or inactive, or has the proposed insured entered into a written agreement to enter the armed services? If yes, list below name, branch, rank and duties..... | <input type="checkbox"/> | <input type="checkbox"/> |
| H. Do you intend to travel outside the U.S. or Canada or change your country of residence in the next 24 months? (If yes, list countries, cities, duration and purpose of travel in the details section below) | <input type="checkbox"/> | <input type="checkbox"/> |
| I. (1) Now use tobacco or any nicotine substitute?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| (2) Ever used tobacco or any nicotine substitute? If yes, provide date when stopped _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| If yes to I(1) or (2), indicate below name of person and type of tobacco or nicotine substitute used (cigarettes, pipe, cigar, chew, patch, gum, other) | | |

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

10. Child Rider Supplement (Answer questions A-E if applying for a Children's Term Rider)

- | | Yes | No |
|---|--------------------------|--------------------------|
| Have any of the Children listed in section 2 now or in the past 10 years been treated by a Medical Practitioner as having had: (if yes, give details below and which child) | | |
| A. Cancer in any form? | <input type="checkbox"/> | <input type="checkbox"/> |
| B. Heart or coronary disease? | <input type="checkbox"/> | <input type="checkbox"/> |
| C. Diabetes, disorder of the lung, kidney, stomach, liver, intestine or rheumatic fever, or mental condition or disorder | <input type="checkbox"/> | <input type="checkbox"/> |
| D. Acquired Immune Deficiency Syndrome (AIDS)? | <input type="checkbox"/> | <input type="checkbox"/> |
| E. Other than above, has any child proposed for coverage seen a physician for any health or physical condition not listed? You do not need to mention diagnostic tests such as blood tests or X rays performed more than five years ago. (You need not reveal any AIDS/HIV (Human Immunodeficiency Virus) consultation or testing done at anonymous counseling and testing sites and AIDS/HIV testing is limited to FDA licensed blood tests) | <input type="checkbox"/> | <input type="checkbox"/> |

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

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

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

Primary Other

B. Monthly Benefit Amount applied for: Primary Insured \$ _____ Other Insured \$ _____

C. Elimination Period (select 30, 60 or 90 days)

Primary Insured: 30 days 60 days 90 days Other Insured: 30 days 60 days 90 days

D. Has any person proposed for coverage:

Yes **No**

(1) Within the past 5 years, received Disability, Worker's Comp. or Pension Benefits?

(2) Within the past 5 years, received medical care for the muscles, bones, joints, including but not limited to the neck, back, spine or feet or any other nerve disorder or treatment of any muscular or neuromuscular disorder?

(3) Within the past 5 years, received treatment or been diagnosed with arthritis, gout, bursitis or rheumatism?

(4) Had any physical or occupational therapy or had therapy recommended?

(5) Had any prior complications of pregnancy or currently pregnant?

E. Is each person proposed for coverage actively at work now and worked at least 30 hours a week for the last three months except for minor illnesses of one week or less or pregnancy?

F. Any other Disability Income Policies in force? (Note: You do not need to include short term disability policies of 26 weeks or less)

(1) If yes, for every person proposed for coverage, note the amount of monthly coverage for each policy \$ _____ and maximum benefit periods _____.

G. Describe employment duties below for each person proposed for Rider coverage (what you do, types of machines used)

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

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

Under penalties of perjury, by my signature on this form on page 5, I certify that:

1. The number shown on this form on page 1 is my correct taxpayer identification number, **and**
2. I am not subject to backup withholding either because: **(a)** I am exempt from backup withholding, or **(b)** I have not been notified by the Internal Revenue Service (IRS) that I am subject to backup withholding as a result of a failure to report all interest or dividends, or **(c)** the IRS has notified me that I am no longer subject to backup withholding, **and**
3. I am a U.S. person (including a U.S. resident alien).

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

FRAUD INFORMATION: The Company is relying on the information in this application to qualify all persons proposed for coverage under this insurance policy. Any false statement or misrepresentation may result in loss of coverage under this policy. Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison. Caution: Read your state's specific fraud warning (as applicable.)

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

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

KANSAS - Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance may be guilty of a crime as determined by a court of law.

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

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

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

NEW MEXICO - Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to civil fines and criminal penalties.

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

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

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

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

AUTHORIZATION TO OBTAIN AND DISCLOSE INFORMATION

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

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

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

By my signature below, I acknowledge that any agreements I have made to restrict my Protected Health Information do not apply to this authorization and I instruct any Medical Provider to release and disclose my entire medical record without restriction.

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

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

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

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

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

X _____
 Signature of Proposed Insured or Personal Representative Printed Name Date

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

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

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

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



National Life Company

P.O. Box 9144 • Des Moines, IA 50306-9144 • 1.800.232.5818 • www.EMCNationalLife.com

EMC NATIONAL LIFE COMPANY
[P.O. BOX 9144 • DES MOINES, IA 50306-9144]

Proposed Insured Name (First, M.I., Last)	Birthdate Mo-Day-Yr

1. **Name and address of your personal physician? (if none, so state)** _____

A. Date and reason last consulted? _____

B. What treatment was given or medication prescribed? _____

2. **Have you ever been diagnosed, treated, tested positive for, or been given medical advice by a member of the medical profession for a disease or disorder such as:**

- | | Yes | No |
|--|--------------------------|--------------------------|
| A. Disorder of eyes, ears, nose or throat? | <input type="checkbox"/> | <input type="checkbox"/> |
| B. Dizziness, fainting, convulsions, epilepsy, headache; brain, nervous system, mental or nervous disorder? | <input type="checkbox"/> | <input type="checkbox"/> |
| C. Shortness of breath, persistent hoarseness or cough, blood spitting; bronchitis, pleurisy, asthma, emphysema, tuberculosis or chronic respiratory or lung disorder? | <input type="checkbox"/> | <input type="checkbox"/> |
| D. High blood pressure, elevated cholesterol, chest pain or angina, heart attack, or disease or disorder of the heart, heart valves, blood clot, blood vessels, stroke, Transient Ischemic Attack, speech defect or paralysis? | <input type="checkbox"/> | <input type="checkbox"/> |
| E. Jaundice, intestinal bleeding; ulcer, hernia, appendicitis, colitis, diverticulitis, hemorrhoids, recurrent indigestion, hepatitis or other disorder of the stomach, intestines, liver, pancreas or gall bladder?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| F. Sugar, albumin, blood or pus in urine; stone or other disorder of kidney, bladder; prostate, breast, reproductive organs or sexually transmitted disease? | <input type="checkbox"/> | <input type="checkbox"/> |
| G. Diabetes, pancreatitis, thyroid or other endocrine disorders? | <input type="checkbox"/> | <input type="checkbox"/> |
| H. Neuritis, sciatica, rheumatism, arthritis, gout or disorder of the muscles, joints or bones, including but not limited to the spine, neck or back? | <input type="checkbox"/> | <input type="checkbox"/> |
| I. Deformity, amputation, paralysis or condition causing disability?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| J. Cancer, leukemia, tumor, cyst, polyps, lymph nodes, hematological or blood disorders, basal or squamous cell carcinoma, abnormal moles or lesions or dysplastic nevi? | <input type="checkbox"/> | <input type="checkbox"/> |
| K. Allergies; anemia or other disorder of the blood? | <input type="checkbox"/> | <input type="checkbox"/> |
| L. An immune deficiency or autoimmune or connective tissue disease, skin or similar disorder (not HIV related)?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| M. Human Immunodeficiency Virus (HIV), Acquired Immune Deficiency Syndrome (AIDS), or the AIDS related complex (ARC) by a member of the medical profession? | <input type="checkbox"/> | <input type="checkbox"/> |

Details of "Yes" answers. (Identify Question Number, Circle Applicable Items: Include diagnoses, medications, dates, duration and names and addresses of all attending physicians and medical facilities.

3. **Except as prescribed by a physician, ever used marijuana, heroin, cocaine, barbiturates or other illegal drugs, joined any organization, received or had treatment or counseling for drug or alcohol abuse?**



- | | Yes | No |
|---|--------------------------|--------------------------|
| 4. Have you had any change in weight in the past year? | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Are you currently taking prescription medication? | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Other than above, have you within the past five years: | | |
| A. Had a checkup, consultation, illness, injury, surgery? .. | <input type="checkbox"/> | <input type="checkbox"/> |
| B. Been a patient in a hospital, clinic, sanatorium, or other medical facility? | <input type="checkbox"/> | <input type="checkbox"/> |
| C. Had electrocardiogram, X-ray or any other abnormal diagnostic/screening test? | <input type="checkbox"/> | <input type="checkbox"/> |
| D. Currently awaiting surgery, diagnostic/screening testing, results of diagnostic/screening testing or been advised to have diagnostic/screening testing or consultation with a medical practitioner? | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. Have you ever had military service deferment, rejection or discharge because of a physical or mental condition? | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. Have you ever requested or received a pension, benefits or payment because of an injury, sickness or disability? | <input type="checkbox"/> | <input type="checkbox"/> |
| 9. Females Only: | | |
| A. Have you ever had any disorder of menstruation, pregnancy or the female organs or breasts? | <input type="checkbox"/> | <input type="checkbox"/> |
| B. To the best of your knowledge and belief, are you now pregnant? | <input type="checkbox"/> | <input type="checkbox"/> |
| 10. Family History: Had a parent/sibling who was diagnosed with or died of heart disease, kidney disease, diabetes, cancer or stroke or any other hereditary disease? Or diagnosed with tuberculosis, high blood pressure, mental illness or suicide? | | |

Details of "Yes" answers. (Identify Question Number, Circle Applicable Items: Include diagnoses, medications, dates, duration and names and addresses of all attending physicians and medical facilities.

	Age if Living	Age at Death/Cause	If Living, Age at Diagnosis/Cause
Father			
Mother			
Sibling			

I, the undersigned, represent, agree to and understand that all of the answers and statements in this application are true and complete to the best of my knowledge and belief, that the statements and answers in the application are the basis for any policy issued by the Company and that no information about me will be considered to have been given to the Company unless it is stated in the application. I agree that this application and any policy, amendments and riders shall constitute the entire contract.

Dated at _____ this _____ day of _____, 20_____.

Witnessed _____
Examiner

Signature of Proposed Insured

11. A.		Males Only				
Height (in shoes)		Weight (clothed)	Chest (full inspiration)	Chest (forced expiration)	Abdomen (at umbilicus)	
ft.	in.	lbs.	in.	in.	in.	

B. Did you weigh? Yes No Did you measure? Yes No

C. Is appearance unhealthy or older than stated age? Yes No

12. Blood Pressure (record ALL readings)

Systolic			
Diastolic	4th phase		
		5th phase	

13. Pulse:

	At Rest	After Exercise	3 Minutes Later
Rate			
Irregularities per min.			

QUESTIONS 14-16 FOR MD EXAMINATION ONLY

14. Heart: Is there any:

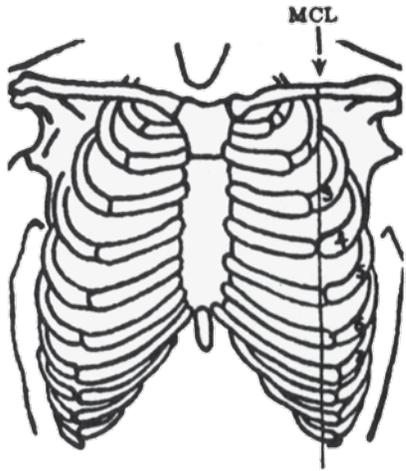
Enlargement Yes No Dyspnea Yes No Murmur(s) Yes No Edema Yes No
 (describe below – if more than one, describe separately)

Location

--	--

- Constant
- Inconstant
- Transmitted
- Localized
- Systolic
- Presystolic
- Diastolic
- Soft (Gr. 1-2)
- Mod. (Gr. 3-4)
- Loud (Gr. 5-6)
- After Exercise:
- Increased
- Absent
- Unchanged
- Decreased

- Indicate:
- Apex by
 - Murmur area by
 - Point of greatest intensity by
 - Transmission by



For comments and your impression

15. Is there, on examination, any abnormality of the following:

- | | | |
|--|--------------------------|--------------------------|
| (circle applicable items and give details) | Yes | No |
| A. Eyes, ears, nose, mouth, pharynx?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| B. Skin (incl. scars); lymph nodes; edema or peripheral arteries?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| C. Nervous system (include reflexes, gait, paralysis)? | <input type="checkbox"/> | <input type="checkbox"/> |
| D. Respiratory system?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| E. Abdomen (include scars)? | <input type="checkbox"/> | <input type="checkbox"/> |
| F. Genitourinary system (include prostate)? | <input type="checkbox"/> | <input type="checkbox"/> |
| G. Endocrine system (include thyroid and breasts)? | <input type="checkbox"/> | <input type="checkbox"/> |
| H. Musculoskeletal system (include spine, joints, amputations, deformities)? | <input type="checkbox"/> | <input type="checkbox"/> |

16. Are you aware of additional medical history? Yes No
 (Please explain. You may send a confidential report to the Medical Director)

Details of "Yes" answers. (Identify them)

PLEASE NOTE: SIGNATURE REQUIRED ON NEXT PAGE

Additional Details of "Yes" answers or any special observations or comments.

[Empty box for additional details]

PLEASE PRINT

Examined at: Examiner's Office Applicant's Residence or Business

Tax I.D. Number _____

How long have you known Applicant? _____

Fee \$ _____

Time of Examination _____ A.M. P.M.

Dr. Name _____

Signed _____

Address _____

Mail completed examination to Home Office

SERFF Tracking Number: EMCN-126895786

State: Arkansas

Filing Company: EMC National Life Company

State Tracking Number: 47317

Company Tracking Number: EAP010 (11-10)

TOI: L08 Life - Other

Sub-TOI: L08.000 Life - Other

Product Name: Individual Life Applications

Project Name/Number: /

Supporting Document Schedules

Item Status:

Status

Date:

Satisfied - Item: Flesch Certification

Comments:

Readability certification attached.

Attachment:

AR Read Cert.pdf

Item Status:

Status

Date:

Satisfied - Item: Statements of Variability

Comments:

Statements of variability attached.

Attachments:

Stmnt of Variability EAP010.pdf

Stmnt of Variability EAP011.pdf

Stmnt of Variability EAP012.pdf

READABILITY

CERTIFICATION

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

<u>Form Number</u>	<u>Flesch Score</u>
EAP010 (11-10)	52.0
EAP011 (11-10)	51.0
EAP012 (11-10)	56.0



Mark C. Rowley, FSA, MAAA
Vice President, Managing Actuary
November 12, 2010

EMC National Life Company
Statement of Variability

Application for Individual Life Insurance EAP010 (11-10)

- 1. Company Address –**
Cover Page, Fair Credit Reporting/MIB/Conditional Receipt Page, Page 1, and Page 7
In the event of a change in the company address, the new information will be shown.
- 2. Company Phone Number .**
Cover Page
In the event of a change in the company phone number, the new information will be shown.
- 3. Company Website Address .**
Cover Page
In the event of a change in the company website address, the new information will be shown.
- 4. MIB, Inc. Address –**
Fair Credit Reporting/MIB/Conditional Receipt Page
In the event of a change in address for MIB, Inc. the new information will be shown.
- 5. MIB, Inc. Phone Number–**
Fair Credit Reporting/MIB/Conditional Receipt Page
In the event of a change in phone number for MIB, Inc. the new information will be shown.
- 6. MIB, Inc. Website Address–**
Fair Credit Reporting/MIB/Conditional Receipt Page
In the event of a change in website address for MIB, Inc. the new information will be shown.
- 7. Plan of Insurance –**
Page 2 – Section 7
This section contains a box with each of the products currently being sold and the riders available for each product. As the products available in our portfolio change (new ones added or current ones discontinued) the boxes will reflect these changes. Also, the riders available under each product will change for the same reasons.
- 8. Planned Premium Amounts –**
Page 3 – Question 8
Currently with our products there are the options of paying a planned periodic or lump sum payment, or both. We would like the option in the future to offer other planned payment periods, such as a 10 year pay or Paid Up at 65.
- 9. Mode -**
Page 3 – Question 8
We currently offer payment modes of single premium, annual, semiannual, quarterly and monthly check plan. We would like the option to change the modes that are offered in the future.

EMC National Life Company
Statement of Variability

Teleunderwriting Application for Individual Life Insurance EAP011 (11-10)

- 1. Company Address –
Cover Page, Fair Credit Reporting/MIB/Conditional Receipt Page, Page 1, and Page 7**
In the event of a change in the company address, the new information will be shown.
- 2. Company Phone Number .**
Cover Page
In the event of a change in the company phone number, the new information will be shown.
- 3. Company Website Address .**
Cover Page
In the event of a change in the company website address, the new information will be shown.
- 4. Company Fax Number .**
Cover Page
In the event of a change in the company fax number, the new information will be shown.
- 5. Teleunderwriting Vendor Fax Number .**
Cover Page
In the event of a change in the vendor or their fax number, the new information will be shown.
- 6. MIB, Inc. Address –
Fair Credit Reporting/MIB/Conditional Receipt Page**
In the event of a change in address for MIB, Inc. the new information will be shown.
- 7. MIB, Inc. Phone Number–
Fair Credit Reporting/MIB/Conditional Receipt Page**
In the event of a change in phone number for MIB, Inc. the new information will be shown.
- 8. MIB, Inc. Website Address–
Fair Credit Reporting/MIB/Conditional Receipt Page**
In the event of a change in website address for MIB, Inc. the new information will be shown.
- 9. Plan of Insurance –
Page 2 – Section 7**
This section contains a box with each of the products currently being sold and the riders available for each product. As the products available in our portfolio change (new ones added or current ones discontinued) the boxes will reflect these changes. Also, the riders available under each product will change for the same reasons.
- 10. Planned Premium Amounts –
Page 3 – Question 8**

Currently with our products there are the options of paying a planned periodic or lump sum payment, or both. We would like the option in the future to offer other planned payment periods, such as a 10 year pay or Paid Up at 65.
- 11. Mode -
Page 3 – Question 8**
We currently offer payment modes of single premium, annual, semiannual, quarterly and monthly check plan. We would like the option to change the modes that are offered in the future.

EMC National Life Company
Statement of Variability

Application for Life Insurance – Part II - EAP012 (11-10)

**1. Company Address –
Cover Page**

In the event of a change in the company address, the new information will be shown.

**2. Company Phone Number .
Cover Page**

In the event of a change in the company phone number, the new information will be shown.

**3. Company Website Address .
Cover Page**

In the event of a change in the company website address, the new information will be shown.