

SERFF Tracking Number: NALH-126935763 State: Arkansas
Filing Company: North American Company for Life and Health State Tracking Number: 47473
Insurance
Company Tracking Number: L-3197 & L-3198
TOI: L08 Life - Other Sub-TOI: L08.000 Life - Other
Product Name: L-3197 & L-3198
Project Name/Number: L-3197 & L-3198 /L-3197 & L-3198

Filing at a Glance

Company: North American Company for Life and Health Insurance

Product Name: L-3197 & L-3198

TOI: L08 Life - Other

Sub-TOI: L08.000 Life - Other

Filing Type: Form

SERFF Tr Num: NALH-126935763 State: Arkansas

SERFF Status: Closed-Approved-
Closed State Tr Num: 47473

Co Tr Num: L-3197 & L-3198

Authors: Laurie Gruba, Paula
Kunkel-White, Gayle Lovorn, Gail
Velen

Date Submitted: 12/07/2010

State Status: Approved-Closed

Reviewer(s): Linda Bird

Disposition Date: 12/08/2010

Disposition Status: Approved-
Closed

Implementation Date:

Implementation Date Requested: On Approval

State Filing Description:

General Information

Project Name: L-3197 & L-3198

Project Number: L-3197 & L-3198

Requested Filing Mode: Review & Approval

Explanation for Combination/Other:

Submission Type: New Submission

Overall Rate Impact:

Filing Status Changed: 12/08/2010

Status of Filing in Domicile: Authorized

Date Approved in Domicile: 12/06/2010

Domicile Status Comments:

Market Type: Individual

Group Market Size:

Group Market Type:

Explanation for Other Group Market Type:

State Status Changed: 12/08/2010

Created By: Gayle Lovorn

Corresponding Filing Tracking Number:

Deemer Date:

Submitted By: Laurie Gruba

Filing Description:

We are filing the above forms for your review and approval. They are designed for general use with any product in our current portfolio, as well as products approved in the future. These forms are laser printed and we reserve the right to change fonts and layouts. We certify the font size will never be less than 10 point type.

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

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These forms are new. Upon approval, they will replace the following forms:

Form Number	Approval Date
L-2960C	7/2/2003
L-2961A03	8/9/1999

These applications will be used when an agent chooses to use our Tele-Interview application process. The following is an overview of the process.

- The Part 1 application is completed face to face and signed by the applicant and our licensed agent at time of application and point of sale. Any applicable forms, such as a Replacement Notice, are provided at time this time. If a replacement is involved, the notice is completed and signed by the applicant and agent. A copy is left with the applicant, along with a copy of all sales material used in the sales presentation. The agent submits a copy of the completed replacement notice and sales proposals used in the presentation to the insurance company with the application.
- The agent then forwards the completed Part 1 and any other required forms (HIV consent, Replacement, etc.) to the insurance company and the data is entered into our computer system.
- The applicant is then contacted via telephone by our contracted call center vendor. The interviewer asks the applicant all the questions contain in the Part 2, records the answers accordingly, and obtains a voice signature for the Part 2.
- After the Part 2 application is completed through the telephone interview, it is transmitted electronically to our company and a paramedical visit is scheduled. The paramedical examiner then visits the client to obtain physical measurements, blood pressure readings, blood, and urine specimens.
- The paramedical examiner then forwards the measurements, readings, and specimens to Clinical Reference Laboratory for processing.
- After the underwriting decision is made, the applicant is informed of the decision. If the application is approved, a policy is issued and delivered by the soliciting agent. If the application is declined, the applicant is informed by mail using our established adverse underwriting procedures.

A Statement of Variability which provides an explanation for the bracketed information shown on the application forms in included in this filing for informational purposes.

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

Company and Contact

Filing Contact Information

SERFF Tracking Number: NALH-126935763 State: Arkansas
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Gayle Lovorn, Senior Contracts Analyst glovorn@nacolah.com
 525 W. Van Buren 800-800-3656 [Phone] 87609 [Ext]
 Chicago, IL 60607 312-648-7797 [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: \$100.00
 Retaliatory? No
 Fee Explanation: \$50 x 2 forms
 Per Company: No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
North American Company for Life and Health Insurance	\$100.00	12/07/2010	42726755

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Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved- Closed	Linda Bird	12/08/2010	12/08/2010

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Disposition

Disposition Date: 12/08/2010

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
Form	Application Part 1		Yes
Form	Application Part 2		Yes

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Form Schedule

Lead Form Number: L-3197

Schedule Item Status	Form Number	Form Type Form Name	Action	Action Specific Data	Readability	Attachment
	L-3197	Application/ Application Part 1 Enrollment Form	Initial		50.000	L-3197 App Part 1.pdf
	L-3198	Application/ Application Part 2 Enrollment Form	Initial		50.800	L-3198 App Part 2.pdf



L3197

[ADVANCED APPLICATION PART 1]

PRIMARY INSURED PROPOSED FOR INSURANCE

1. Last Name		First Name			M.I.	
Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female	Date of Birth	Age	Place of Birth – State / Country	Height (FT. IN)	Weight (LBS.)	Marital Status
Social Security Number/Tax ID #		Driver's License Number			State	
2. Residence Address (If P.O. Box, include Street Address)		Street	City	State	Zip Code	
2a. How long at this address? (If less than 2 years, provide previous address.)						
_____ Years		_____ Months				
2b. Billing Address (If different than residence)		Street	City	State	Zip Code	
2c. Secondary Addressee Billing <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Provide Secondary Addressee's Name, Street Address, City, State & Zip Code (Agent cannot qualify as Secondary Addressee)						
3. Employer (Company Name and Address)						
Occupation (Title and Duties)		Years with current Employer: _____		Annual Income	Net Worth	
		Are you actively at work? <input type="checkbox"/> Yes <input type="checkbox"/> No		\$ _____	\$ _____	
4. CONTACT THE PROPOSED INSURED AT:		RESIDENCE TELEPHONE NUMBER		BUSINESS TELEPHONE NUMBER		
<input type="checkbox"/> Residence		Primary Insured (_____) _____		Primary Insured (_____) _____		
_____ (CST) <input type="checkbox"/> AM <input type="checkbox"/> PM		Additional Insured (_____) _____		Additional Insured (_____) _____		
<input type="checkbox"/> Business		Cell Phone (_____) _____		Cell Phone (_____) _____		
		Email Address: _____				

PLAN INFORMATION

5. Amount Applied For \$ _____	Proposed Plan of Insurance	6. For UL Death Benefit Option: (Check One) <input type="checkbox"/> Level <input type="checkbox"/> Increasing <input type="checkbox"/> Return of Premium
7. RIDERS		
a. <u>Term Products</u>		
<input type="checkbox"/> Additional Insured Rider	\$ _____) _____
<input type="checkbox"/> Children's Term Insurance (CTR)	_____ units	
<input type="checkbox"/> Guaranteed Insurability Rider	_____ units	
<input type="checkbox"/> Waiver of Premium Rider		
<input type="checkbox"/> Other _____	\$ _____	
b. <u>Permanent Products</u>		
<input type="checkbox"/> Accidental Death Benefit	\$ _____) _____
<input type="checkbox"/> Additional Insured Rider	\$ _____	
<input type="checkbox"/> Automatic Distribution Option		
<input type="checkbox"/> Children's Term Insurance (CTR)	_____ units	
<input type="checkbox"/> Estate Preservation Rider		
<input type="checkbox"/> Guaranteed Insurability Rider	_____ units	
<input type="checkbox"/> Premium Guarantee Rider		
<input type="checkbox"/> Waiver of Monthly Deductions Rider		
<input type="checkbox"/> Waiver of Surrender Charge Option		
<input type="checkbox"/> Other _____	\$ _____	

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

8. Last Name	First Name	M.I.
8a. Are you a U.S. Citizen or do you have a permanent Visa? <input type="checkbox"/> Yes <input type="checkbox"/> No (If no, complete Foreign Travel and Residence Questionnaire)		
Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female	Date of Birth	Age
	Place of Birth – State / Country	Height (FT. IN)
	Weight (LBS.)	Relationship to Primary Insured
Social Security /Tax ID #	Driver's License Number	State
9. Employer (Company Name and Address)		
Occupation (Title and Duties)		Annual Income \$

10. DEPENDENT CHILDREN PROPOSED FOR INSURANCE (complete only if rider coverage applied for)

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

To be completed by Parent or Legal Guardian

10a. Has any child proposed for insurance ever been diagnosed or treated by a licensed medical professional for: heart disease; cancer; tumor; diabetes; jaundice; mental disease, bone or muscle disorder; respiratory disease; or alcohol or drug abuse?..... Yes No

10b. Has any child proposed for insurance ever received a moving violation, driven under the influence of alcohol or drugs, or had his/her driver's license suspended or revoked? Yes No

Provide details below to "Yes" answers for Questions 10a. and 10b.

Question # Name of Dependent Details

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

NAME OF OWNER(S) If Trust, list all Trustees as well as Name and Date of Trust and complete Certificate of Trust Agreement. If Owner is a business, complete Company/Corporate Owned Life Insurance (COLI) Consent Form.

Owner's Address	Street	City	State	Zip Code
Relationship to Proposed Primary Insured	Owner's Social Security/Tax ID #	<input type="checkbox"/> U.S. Citizen <input type="checkbox"/> Resident Alien – Country _____ <input type="checkbox"/> Nonresident Alien – Country _____		
Name of Contingent Owner(s)		Contingent Owner's Social Security/Tax ID #		

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

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

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

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

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

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

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

PREMIUM INFORMATION

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

For term and whole life policies or certificates, if you elect to pay premium on a basis other than annual, you may pay more premium than would be required if you paid premium on an annual basis.

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

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

16. FOR EFT ONLY: DRAW DATE _____ (1 ST -28 TH) Month Day	ACCOUNT TYPE <input type="checkbox"/> Checking (attach voided check)	AUTHORIZED SIGNATURE(S) OF ACCOUNT HOLDER(S) X
16a. Initial Draft <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Savings (must completed 15b)	X
16b. Routing Transit Number	Account Number	Financial Institution Name and Address

REPLACEMENT INFORMATION

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

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

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

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

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

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

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

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

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

Provide details here for "Yes" answers to Questions 19, 20, 22 or 24 and "No" answer to Question 21.

TO BE COMPLETED BY SOLICITING AGENT

If the policy or certificate being applied for includes an accelerated death benefit(s), the agent provided the Proposed Primary Insured the Accelerated Benefit Summary and Disclosure Statement(s) prior to or concurrent with this application? Yes No

Does any person covered under this application have any existing life insurance or annuities? Yes No

Is any insurance applied for in this application intended to replace any existing life insurance or annuity? Yes No

The agent will leave a copy of all sales material used in the sales presentation with the applicant. If a replacement is involved, the applicable Replacement Notice will be sent to the existing insurer.

25. PRELIMINARY HEALTH QUESTION

Within the past 10 years, has any Proposed Insured been diagnosed or treated by a licensed medical professional for diabetes requiring insulin, internal cancer, melanoma, heart disease, stroke, alcoholism, drug abuse or chronic obstructive pulmonary disease? (If yes, identify which condition and provide name, address, and phone number of physician(s) who treated the proposed insured in Special Requests or Details Section below Yes No

26. SPECIAL REQUESTS OR DETAILS

[Empty box for special requests or details]

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

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

CUSTOMER IDENTIFICATION Indicate the form of ID presented and used to verify this owner's identity.

A. Owner #1			
Natural Person/Trust Accounts (info on trustee)			
<input type="checkbox"/> Driver's License	State:	Number:	Expiration Date:
<input type="checkbox"/> State Issued ID	State:	Number	Expiration Date:
<input type="checkbox"/> Military ID		Number	Expiration Date
<input type="checkbox"/> Passport	Country:	Number	Expiration Date:
<input type="checkbox"/> Alien Registration Card	Country:	Number:	Expiration Date:
Non-Natural/Business or Corporation			
<input type="checkbox"/> Partner or Trust Agreement		Date:	
<input type="checkbox"/> Certificate of Incorporation	State:	Date:	
<input type="checkbox"/> Business License	State:	Number:	

B. Owner #2

Natural Person/Trust Accounts (info on trustee)

<input type="checkbox"/> Driver's License	State:	Number:	Expiration Date:
<input type="checkbox"/> State Issued ID	State:	Number	Expiration Date:
<input type="checkbox"/> Military ID		Number	Expiration Date
<input type="checkbox"/> Passport	Country:	Number	Expiration Date:
<input type="checkbox"/> Alien Registration Card	Country:	Number:	Expiration Date:
Non-Natural/Business or Corporation			
<input type="checkbox"/> Partner or Trust Agreement		Date:	
<input type="checkbox"/> Certificate of Incorporation	State:	Date:	
<input type="checkbox"/> Business License	State:	Number:	

IT IS DECLARED that statements and answers in this application, including statements by the Proposed Insured(s) in any medical questionnaire or supplement that become part of this application, are complete and true to the best knowledge and belief of the undersigned. **IT IS AGREED THAT:** (1) any waiver or modification of this application will not be effective unless in writing and signed by the President, or the Secretary; (2) the acceptance of any policy or certificate or policy change or certificate change issued on this application shall constitute a ratification of any correction or amendment made by the Company. No change in amount, risk classification, plan of insurance, or benefits shall be effective unless agreed to in writing by the applicant(s). The undersigned **FURTHER AGREES** to immediately advise the Company of any change to any of the responses contained in the application, including any change in the health or habits of any Proposed Insured(s), that arises or is discovered after completing this application, but before the policy or certificate or policy change or certificate change is effective, as defined herein.

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

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

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

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

- 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 backup withholding because: (a) I am exempt from backup withholding, or (b) I have not been notified by the Internal Revenue Service that I am subject to backup withholding as a result of a failure to report all interest or dividends, or (c) the IRS has notified me that I am no longer subject to backup withholding. (Please check appropriate response.)

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

AUTHORIZATION: To determine eligibility for insurance, the undersigned applicant(s) authorize any licensed physician, licensed medical practitioner, health care professional, hospital, clinic, or other medically related facility, laboratory, pharmacy or pharmacy benefit manager, insurance or reinsuring company, viatical company, viatical broker or provider, the Medical Information Bureau, Inc., consumer reporting agency, insurance support organization, independent administrator, or governmental agency or group policyholder, or person, or employer having information available as to diagnosis, prescription history, medications prescribed, treatment and prognosis with respect to information regarding alcoholism, drug abuse, and psychiatric care or any physical or mental condition and/or treatment of me or my minor children and any other nonmedical information of me or my minor children to give to North American Company for Life and Health Insurance (the Company) or its legal representative, any and all such information. I also authorize the Company to conduct a personal telephone interview in connection with my application; and to release any such data to its reinsurers, the Medical Information Bureau, or other persons or organizations performing business or legal services in connection with my application, or as required by law when given a copy of this authorization. I understand that I may request to be interviewed in connection with the preparation of an investigative consumer report. I understand that I am entitled to receive a copy of the investigative consumer report upon request. This authorization is valid for 30 months (24 months in KS, KY, ND, NE, NH, NM, OK, WV & WY) from the date signed. I may revoke this authorization for information not then obtained by notifying the Company in writing. Such revocation will not be effective until received by the Company. I understand that I or any authorized representative will receive a copy of this authorization upon request.

FRAUD WARNING

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

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

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

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

Accelerated Death Benefit: If the policy or certificate being applied for includes an accelerated death benefit(s), the undersigned applicant(s) understands and acknowledges: (1) Receipt of such benefits may affect eligibility for public assistance programs and benefits may be taxable; (2) Payment of this benefit will reduce the Insured's death benefit; (3) There is no additional premium for this benefit, but there is an administrative charge when the benefit is exercised; and (4) The applicant(s) was provided the Accelerated Benefit Summary and Disclosure Statement(s) prior to or concurrent with this application.

SIGNATURES

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



L3198

[ADVANCED APPLICATION PART 2]

PERSONAL INFORMATION

1. Last Name		First Name	M.I.
1a. Are you a U.S. Citizen or do you have a permanent Visa? <input type="checkbox"/> Yes <input type="checkbox"/> No (If No, complete Foreign Travel and Residence Questionnaire)			
1b. Have you ever used a different name? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, give name used and time period. _____			
Social Security Number/Tax ID #	Driver's License Number		State

UNDERWRITING AND LIFESTYLE INFORMATION

2. Have you ever smoked cigarettes, cigars, pipes, or used tobacco in any form, including smokeless tobacco, nicotine patch, gum or other substitutes? Yes No
 If "yes" provide: Type of product(s) used: _____
 Amount Used: _____ How often: Daily _____ Weekly _____ Monthly _____ Date of last use: mm/yy _____
Please provide Details to "Yes" answers for Questions 4. through 5. in the Details section following these questions.

3. In the past 10 years, have you:

- a. Used barbiturates, hallucinatory drugs, narcotics, including crack, ecstasy, opium derivatives, marijuana, LSD, PCP, or any derivatives of these drugs, or been advised by a licensed medical professional to get treatment or undergone any treatment, counseling or hospitalization for drug abuse?..... Yes No
- b. Been advised by a licensed medical professional to limit your alcohol use or been advised to get treatment or undergone any treatment, counseling or hospitalization for alcoholism, excessive alcohol use or abuse? Or, have you subsequently consumed alcohol after receiving counseling or treatment for alcohol use? Or, do you drink on average more than three alcoholic drinks per day? Yes No
- c. Had your driver's license revoked or suspended or been convicted of reckless driving, driving without a valid license, or for driving while under the influence of alcohol or drugs (DWI, DUI)? Yes No
- d. Been convicted of any criminal activity, or been held or served time in any type of incarceration, jail, penitentiary, prison, probation, or parole program? Or, have any criminal charges pending against you at this time? Yes No
- e. Been refused life insurance or charged an extra premium for life insurance? Yes No

4. Have you:

- a. Had more than one speeding violation, or any motor vehicle moving violations or accidents or been arrested for driving under the influence of alcohol within the past five years? Yes No
- b. Flown a plane in the past 24 months or plan to fly in the next 12 months as a pilot, copilot, student pilot, military pilot, engineer or in any other capacity except as a regularly scheduled commercial airline pilot or fare-paying passenger? Yes No
- c. In the past 12 months or in the next 12 months, engaged in, or plan to engage in, activities including: hang gliding, skydiving, motor vehicle/cycle racing, rock climbing, ballooning, bungee jumping, mountain climbing, motor boat racing, snowmobile racing, ultra light aircraft flying, scuba diving to more than 50 feet in depth, or in caves, ship wrecks or deep seas or other extreme sports? Yes No
- d. Traveled to or resided for more than 30 days outside of the U.S., U.S. territories, Canada, or Japan within the past 12 months or plan to travel to or reside outside of the U.S., U.S. territories, Canada, or Japan in the next 12 months? Yes No
- e. Filed for bankruptcy that is pending or expect to file bankruptcy in the next 12 months? Yes No

DETAIL SECTION FOR 'YES' ANSWERS FOR QUESTIONS 3. THROUGH 4. ABOVE

Question #	Details

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5. Who is your primary physician or health care provider? If None, check here

Physician or Health Care Provider Name/Address/Telephone	Date Last Consulted	Reason Seen and Results of Visit (include diagnosis, treatment given, medication prescribed)

6 a. What is your current height and weight? _____ FT. _____ IN. _____ LBS
 b. Have you gained or lost more than 15 pounds in the last year? Yes No

Please provide Details to "Yes" answers for Questions 7. through 10. in Details section following these questions.

7. In the past 10 years, have you been diagnosed by a licensed medical professional, treated or advised to get treatment from a licensed medical professional, hospitalized, or are you presently taking prescription(s) or medication(s) or had any medical procedures for any of the following:
- a. Angina, chest pain, heart attack, heart failure, heart surgery, irregular heartbeat, abnormal EKG, coronary artery bypass, angioplasty, stents, peripheral vascular disease, poor circulation, valvular heart disease, cardiomyopathy or heart murmur? Yes No
 - b. High blood pressure, hypertension or abnormal cholesterol levels? Yes No
 - c. Stroke, seizures, epilepsy, dizziness, fainting, memory disorder or any other neurological or brain disorder? Yes No
 - d. Multiple Sclerosis, neuritis, neuropathy, paralysis, muscular dystrophy, Parkinson's disease or any other disorder of the muscles? Yes No
 - e. Arthritis, chronic pain, fibromyalgia, connective tissue disease, lupus or scleroderma? Yes No
 - f. Cancer, malignancy, tumor, melanoma, lymphoma, Hodgkin's disease or leukemia? Yes No
 - g. Chronic obstructive pulmonary or lung disease, chronic bronchitis, emphysema, sarcoidosis, asthma, shortness of breath, tuberculosis or sleep apnea? Yes No
 - h. Diabetes, abnormal blood sugar, sugar in the urine, disease or disorders of the adrenal, parathyroid, pituitary or thyroid glands? Yes No
 - i. Disorder of the kidney, bladder or urinary system, abnormal PSA, abnormal pap smear without subsequent normal pap smear or protein or blood in the urine? Yes No
 - j. Anemia, hemophilia, clotting disorder or any other disorder of the blood? Yes No
 - k. Immune Deficiency disorder (Acquired Immune Deficiency Syndrome (AIDS)), AIDS related complex (ARC) or been told test results indicate exposure to the AIDS virus? Yes No
 - l. Colitis, ulcerative colitis, Crohn's, esophageal varices, peptic or gastric ulcer, intestinal or rectal bleeding, diverticulitis, colon polyps, cirrhosis, hepatitis, liver failure, liver impairment, loss of bowel function or other disease or disorder of the liver or pancreas? Yes No
 - m. Depression, anxiety, stress, eating disorder or any other nervous, mental or emotional condition? Yes No
 - n. Any mental or physical disorder or medically or surgically treated condition not listed above? Yes No

8. Other than indicated above, in the past 12 months, have you been advised by a licensed medical professional to:

- a. Have a check up, EKG, X-ray, blood or urine test or any other diagnostic test or are you now planning to seek medical advice or treatment for any reason? Yes No
- b. Be admitted to a hospital, medical facility, nursing home or assisted living facility? Yes No

9. Are you currently taking any prescription medications, herbal remedies or non-prescription medications for any condition, disease or disorder not listed above? Yes No
 If yes, list the medications and remedies and the reasons for which they are taken.

10. Are you currently receiving or have an application pending for any illness or disability benefits or compensation? Yes No

DETAILS SECTION FOR 'YES' ANSWERS FOR QUESTIONS 7. THROUGH 10. ABOVE

Question #	Proposed Insured's Name	Date, Diagnosis, Treatment, Results and Duration	Name, Address and Phone # of Attending Physician and Hospital
11. If not listed above, please provide full name, address and phone numbers of personal physician(s) and any other physician(s) consulted in the past five years.			
11a. Date and findings of last visit:			
11b. Tests performed and treatment received:			

FAMILY HISTORY

12. Do you have or did you have a parent or brother or sister who, before age 60, was diagnosed with or died from cardiovascular disease, cancer (except basal or squamous cell cancer of the skin), Huntington's Chorea, familial polyposis, or polycystic kidney disease? Yes No

If Yes, provide details in Family Health Chart below, including age at onset, if still living

Family Health Chart					
Provide age and present health status or, if deceased, state age at death and cause of death					
	LIVING			DECEASED	
	Current Age	Age at Onset	Condition	Age at Death	Cause of Death
Father					
Mother					
Brother(s)					
Sister(s)					

AGREEMENT

By my physical signature affixed below or my voice signature, which I understand is attached to this application electronically, I acknowledge that this Agreement has been read in full to me. IT IS AGREED THAT: (1) any waiver or modification of this application will not be effective unless in writing and signed by the President, or the Secretary; (2) the acceptance of any policy or certificate or policy change or certificate change issued on this application shall constitute a ratification of any correction or amendment made by the Company. No change in amount, issue age, risk classification, plan of insurance, or benefits shall be effective unless agreed to in writing by the applicant(s). The undersigned FURTHER AGREES to immediately advise the Company of any change to any of the responses contained in the application, including any change in the health or habits of any Proposed Insured(s), that arises or is discovered after completing this application, but before the Policy or Certificate or policy change or certificate change is effective, as defined herein.

Check appropriate box:

- No Exceptions or Corrections
- See Exceptions or Corrections in Details section below.

DETAILS: _____

FRAUD WARNING

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

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

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

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

SIGNATURES

Signed At (City, State)		Date
Signature of Proposed Primary Insured (If 15 Years or Older), or Legal Guardian (If Primary Proposed Insured is a Minor)	Signature of Proposed Additional Insured	
X	X	
Signatures of Owner(s) (If other than Proposed Primary Insured) (If Owner is Corporation, Trust or other Entity, include Title of Signee.)		
X		

SERFF Tracking Number: NALH-126935763 State: Arkansas
Filing Company: North American Company for Life and Health State Tracking Number: 47473
Insurance
Company Tracking Number: L-3197 & L-3198
TOI: L08 Life - Other Sub-TOI: L08.000 Life - Other
Product Name: L-3197 & L-3198
Project Name/Number: L-3197 & L-3198 /L-3197 & L-3198

Supporting Document Schedules

Item Status:

Status

Date:

Satisfied - Item: Flesch Certification

Comments:

Attachments:

Readability Certification.pdf

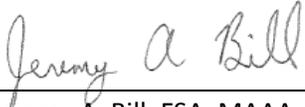
AR L&H Reg 19 Certification.pdf

READABILITY CERTIFICATE

Name and Address of Insurer North American Company for Life & Health Insurance
525 West Van Buren
Chicago, Illinois 60607

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>
L-3197	Tele-Interview Application Part 1	50
L-3198	Tele-Interview Application Part 2	50.8



Jeremy A. Bill, FSA, MAAA
Second Vice President, Product Development

December 6, 2010
Date

Rule & Regulation 19 Certification

Form No(s): _____

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

Date: _____