

SERFF Tracking Number: NALH-126468837 State: Arkansas
Filing Company: North American Company for Life and Health Insurance State Tracking Number: 44967
Company Tracking Number: L-3187A, L-3194
TOI: L09I Individual Life - Flexible Premium Sub-TOI: L09I.001 Single Life
Adjustable Life
Product Name: L-3187A, L-3194
Project Name/Number: L-3187A, L-3194/L-3187A, L-3194

Filing at a Glance

Company: North American Company for Life and Health Insurance

Product Name: L-3187A, L-3194 SERFF Tr Num: NALH-126468837 State: Arkansas
TOI: L09I Individual Life - Flexible Premium SERFF Status: Closed-Approved- State Tr Num: 44967
Adjustable Life Closed
Sub-TOI: L09I.001 Single Life Co Tr Num: L-3187A, L-3194 State Status: Approved-Closed
Filing Type: Form Reviewer(s): Linda Bird
Disposition Date: 02/24/2010
Authors: Laurie Gruba, Paula Kunkel-White, Gayle Lovorn
Date Submitted: 02/23/2010 Disposition Status: Approved-Closed
Implementation Date: Implementation Date:

Implementation Date Requested: On Approval
State Filing Description:

General Information

Project Name: L-3187A, L-3194 Status of Filing in Domicile: Authorized
Project Number: L-3187A, L-3194 Date Approved in Domicile: 02/23/2010
Requested Filing Mode: Review & Approval Domicile Status Comments:
Explanation for Combination/Other: Market Type: Individual
Submission Type: New Submission Group Market Size:
Overall Rate Impact: Group Market Type:
Filing Status Changed: 02/24/2010 Explanation for Other Group Market Type:
State Status Changed: 02/24/2010
Deemer Date: Created By: Paula Kunkel-White
Submitted By: Paula Kunkel-White Corresponding Filing Tracking Number:
Filing Description:
North American Company for Life and Health Insurance
NAIC No.: 431-66974 / FEIN No.: 36-2428931

Policy Change, Conversion and Reinstatement Application, L-3187A
Short form Reinstatement Application, L-3194

SERFF Tracking Number: NALH-126468837 State: Arkansas
Filing Company: North American Company for Life and Health State Tracking Number: 44967
Insurance
Company Tracking Number: L-3187A, L-3194
TOI: L09I Individual Life - Flexible Premium Sub-TOI: L09I.001 Single Life
Adjustable Life
Product Name: L-3187A, L-3194
Project Name/Number: L-3187A, L-3194/L-3187A, L-3194

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

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

The Policy Change, Conversion and Reinstatement Application, Form L-3187, was previously approved under SERFF # NALH-126296100, state tracking number 43481, on 9/16/2009. This approved application form was never implemented or released for agent or home office use. The substantial form revisions from the previously approved form include:

1. Removal of Payment of Premium paragraph on page 6; and
2. Included policy and certificate language references; and
3. Replaced "check o matic" terminology with "EFT" on page 1 instructions.

The Short Form Reinstatement Application form is a new form and does not replace any form currently on file. This application was designed to be used when a policy is terminated. It will allow the policy owner to reinstate the policy with limited underwriting if the application is completed and returned within approximately 30 days of the policy termination. If the application is not received within the specified time frame and the policy owner does wish to reinstate the policy, the full Policy Change, Conversion and Reinstatement application form must be completed and submitted.

We are requesting approval of these application forms use with any products in our portfolio.

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

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

Company and Contact

Filing Contact Information

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

Filing Company Information

North American Company for Life and Health CoCode: 66974 State of Domicile: Iowa
Insurance
Principal Office: 4601 Westown Parkway - Group Code: 431 Company Type: Life and Annuity

SERFF Tracking Number: NALH-126468837 State: Arkansas
 Filing Company: North American Company for Life and Health State Tracking Number: 44967
 Insurance
 Company Tracking Number: L-3187A, L-3194
 TOI: L09I Individual Life - Flexible Premium Sub-TOI: L09I.001 Single Life
 Adjustable Life
 Product Name: L-3187A, L-3194
 Project Name/Number: L-3187A, L-3194/L-3187A, L-3194

Suite 300

West Des Moines, IA 50266
 (800) 800-3656 ext. [Phone]

Group Name:
 FEIN Number: 36-2428931

State ID Number:

Filing Fees

Fee Required? Yes
 Fee Amount: \$100.00
 Retaliatory? No
 Fee Explanation: \$50 per form X 2 forms = \$100
 Per Company: No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
North American Company for Life and Health Insurance	\$100.00	02/23/2010	34392237

SERFF Tracking Number: NALH-126468837 State: Arkansas
 Filing Company: North American Company for Life and Health State Tracking Number: 44967
 Insurance
 Company Tracking Number: L-3187A, L-3194
 TOI: L09I Individual Life - Flexible Premium Sub-TOI: L09I.001 Single Life
 Adjustable Life
 Product Name: L-3187A, L-3194
 Project Name/Number: L-3187A, L-3194/L-3187A, L-3194

Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Linda Bird	02/24/2010	02/24/2010

SERFF Tracking Number: NALH-126468837 State: Arkansas
Filing Company: North American Company for Life and Health State Tracking Number: 44967
Insurance
Company Tracking Number: L-3187A, L-3194
TOI: L09I Individual Life - Flexible Premium Sub-TOI: L09I.001 Single Life
Adjustable Life
Product Name: L-3187A, L-3194
Project Name/Number: L-3187A, L-3194/L-3187A, L-3194

Disposition

Disposition Date: 02/24/2010

Implementation Date:

Status: Approved-Closed

Comment:

Rate data does NOT apply to filing.

SERFF Tracking Number: NALH-126468837 State: Arkansas
 Filing Company: North American Company for Life and Health State Tracking Number: 44967
 Insurance
 Company Tracking Number: L-3187A, L-3194
 TOI: L09I Individual Life - Flexible Premium Sub-TOI: L09I.001 Single Life
 Adjustable Life
 Product Name: L-3187A, L-3194
 Project Name/Number: L-3187A, L-3194/L-3187A, L-3194

Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification		Yes
Supporting Document	Application		Yes
Supporting Document	Health - Actuarial Justification		No
Supporting Document	Outline of Coverage		No
Supporting Document	Statement of variability		Yes
Form	Policy Change, Conversion & Reinstatement Application		Yes
Form	Short Form Reinstatement Application		Yes

SERFF Tracking Number: NALH-126468837 State: Arkansas
 Filing Company: North American Company for Life and Health State Tracking Number: 44967
 Insurance
 Company Tracking Number: L-3187A, L-3194
 TOI: L09I Individual Life - Flexible Premium Sub-TOI: L09I.001 Single Life
 Adjustable Life
 Product Name: L-3187A, L-3194
 Project Name/Number: L-3187A, L-3194/L-3187A, L-3194

Form Schedule

Lead Form Number: L-3187A

Schedule Item Status	Form Number	Form Type Form Name	Action	Action Specific Data	Readability	Attachment
	L-3187A	Application/ Policy Change, Enrollment Conversion & Form Reinstatement Application	Revised	Replaced Form #: L- 3187 Previous Filing #: 43481	50.300	L-3187A brackets.pdf
	L-3194	Application/ Short Form Enrollment Reinstatement Form Application	Initial		50.000	L-3194 brackets.pdf



Application for Policy or Certificate Conversion, Change, or Reinstatement

1. Instructions/Information

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

Section A - To be completed for ALL requests. Check appropriate box.

Change Review Rating Reinstatement Conversion Class Change
 Increase Add Rider Decrease Option Change Exchange

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

Policy or Certificate Number

PRIMARY PROPOSED INSURED

2. Last Name _____ First Name _____ Middle Initial _____

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

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

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

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

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

_____ Years _____ Months

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

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

4. Employer (Company Name and Address)

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

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

Section B - To be completed for Changes and Conversions

6. Death Benefit Option Level Increasing Return of Premium

For Conversions, the balance of the Plan or Rider is to be:
 continued in force terminated decreased

Telemed: Yes No

Name of New Plan	New Policy/Certificate Date _____ Mo. _____ Yr.	\$ Amount of Insurance
------------------	--	------------------------

For Applicable Products Only:
 Guideline Level Premium Test
 Cash Value Accumulation Test

<input type="checkbox"/> Non-Smoker	<input type="checkbox"/> Preferred Smoker	<input type="checkbox"/> Preferred Tobacco	<input type="checkbox"/> Preferred Non-Tobacco
<input type="checkbox"/> Standard Non-Tobacco	<input type="checkbox"/> Smoker	<input type="checkbox"/> Standard Tobacco	<input type="checkbox"/> Super Preferred Non-Tobacco
			<input type="checkbox"/> Preferred Plus Non-Tobacco

Exchange Commission Option: A B

NORTH AMERICAN COMPANY-ADMINISTRATIVE OFFICE: P. O. BOX 5088, SIOUX FALLS, SD 57117 • PRINCIPAL OFFICE: WEST DES MOINES, IA
 Telephone: (877) 872-0757 • Fax: (605) 373-2190 • www.nacolah.com

6a. In the boxes below, enter the amount of changes only. NOTE: The Total Amount/Units column should reflect the new TOTAL after the change.

RIDER/BENEFIT	ADD	DELETE	TRANSFER	INCREASE BY	DECREASE BY	CONVERT	OTHER	Total Amount
Base Plan *								
CTR								
Chronic Illness Rider								
AIR								
WP								
WoSC								
ADB								
WMD								
PGR								
GIR/OPAI								
ABE								
AIO (Term Only)								
Other								

(CTR) Childrens Rider
 (AIR) Add'l Insured Rider
 (WP) Waiver of Premium
 (WoSC) Waiver of Surrender Charge
 (ADB) Accidental Death Benefit

(WMD) Waiver of Monthly Deduction
 (PGR) Premium Guarantee Rider
 (GIR) Guaranteed Insurability Rider / (OPAI) Option to Purchase Add'l Insurance
 (ABE) Accelerated Benefit Endorsement
 (AIO) Additional Insurance Option

* Please review your policy or certificate contract as a decrease may result in a surrender charge being assessed.

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

7. Last Name First Name Middle Initial

7a. Are you a U.S. Citizen or do you have a permanent Visa? Yes No

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

Social Security Number Driver's License Number Expiration Date State

8. Employer (Company Name and Address)

Occupation (Title and Duties) Annual Income \$

9. DEPENDENT CHILDREN PROPOSED FOR INSURANCE

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

10. 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 Trust Form.

OWNER ADDRESS Street City State Zip Code

Relationship to Primary Insured Owner's Social Security Number or Tax ID #

REPLACEMENT INFORMATION

16. Does any person proposed for coverage 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 or Certificate Number	Pending	Issue Yr.	Basic Amount	ADB Amount	WP Amount	Intention of Replacement Or Change *
16a.			<input type="checkbox"/>					17a. <input type="checkbox"/> Yes <input type="checkbox"/> No
16b.			<input type="checkbox"/>					17b. <input type="checkbox"/> Yes <input type="checkbox"/> No
16c.			<input type="checkbox"/>					17c. <input type="checkbox"/> Yes <input type="checkbox"/> No
16d.			<input type="checkbox"/>					17d. <input type="checkbox"/> Yes <input type="checkbox"/> No

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

18. I(We) originally purchased the above insurance on or around (date):	Please print the name of the Agent that you bought the original insurance from, if known.	
Approximate net value to be received from exchange product: \$ _____	Surrender charge that may be incurred on This transaction: \$ _____	Front End Load (if any) at time of original product purchase: \$ _____ or _____ %
It is my (Our) intention to reinvest the net value Received from this transaction into: <input type="checkbox"/> Universal Life <input type="checkbox"/> Indexed Life <input type="checkbox"/> Other	Will this transaction result in a taxable event? <input type="checkbox"/> Yes <input type="checkbox"/> No	Does this transaction qualify as a non-taxable exchange under IRS Section 1035 rules? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, complete 1035 Exchange paperwork.

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

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

- 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 any 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

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

TO BE COMPLETED BY SOLICITING AGENT

- Does any person covered under this application have any existing life insurance or annuities? Yes No
- Is any insurance applied for in this application intended to replace any existing life insurance or annuity? Yes No
- If the policy 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
- If a replacement is involved, the application Replacement Notice will be sent to the existing insurer.

25. SPECIAL REQUESTS OR DETAILS

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

26. Permanent Home of Record Street City State Zip Code

27. Military Address Street City State Zip Code

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

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

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

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

UNDERWRITING QUESTIONS

Questions for 33 must be completed for ALL Proposed Insureds, including CTR. Details to "Yes" answers are to be provided in the Details Section below.

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

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

Question #	Proposed Insured's Name	Dates and Details

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

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

DETAILS TO 'YES' ANSWERS FOR QUESTIONS 34 THROUGH 37

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

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

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

CUSTOMER IDENTIFICATION			
Indicate the form of ID presented and used to verify this owner's identity:			
A. Owner #1			
Natural Person/Trust Accounts (info on trustee)			
<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, 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 not take effect until approved by the Company and 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.

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

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

1. The number shown on this form is my correct taxpayer identification number (or I am waiting for a number to be issued to me), **and**
2. I am not subject to backup withholding because: (a) I am exempt from backup withholding, or (b) I have not been notified by the Internal Revenue Service that I am subject to backup withholding as a result of a failure to report all interest or dividends, or (c) the IRS has notified me that I am no longer subject to backup withholding. **(Please check appropriate response.)**

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

AUTHORIZATION: To determine eligibility for insurance, the undersigned applicant(s) authorize any licensed physician, medical practitioner, health care professional, hospital, clinic, or other medically related facility, laboratory, pharmacy or pharmacy benefit manager, insurance or reinsuring company, viatical company, viatical broker or provider, the Medical Information Bureau, Inc., consumer reporting agency, insurance support organization, independent administrator, or other organization, institution, or person, or employer having information available as to diagnosis, prescription history, medications prescribed, treatment and prognosis with respect to information regarding alcoholism, drug abuse, and psychiatric care or any physical or mental condition and/or treatment of me or my minor children and any other nonmedical information of me or my minor children to give to North American Company for Life and Health Insurance (the Company) or its legal representative, any and all such information. I also authorize the Company to conduct a personal telephone interview in connection with my application; and to release any such data to its reinsurers, the Medical Information Bureau, or other persons or organizations performing business or legal services in connection with my application, or as required by law when given a copy of this authorization. I understand that I may request to be interviewed in connection with the preparation of an investigative consumer report. I understand that I am entitled to receive a copy of the investigative consumer report upon request. This authorization is valid for 30 months (24 months in KS, KY, 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 contractholder or claimant for the purpose of defrauding or attempting to defraud the contractholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

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

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; and (4) The agent or I, the applicant was provided the Accelerated Benefit Summary and Disclosure Statement(s) prior to or concurrent with this application.

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



APPLICATION FOR REINSTATEMENT

To be completed in consideration of any person proposed to be covered under the reinstated policy or certificate.

Name of Proposed Insured(s)	Policy or Certificate Number
-----------------------------	------------------------------

Since the date of the original application or examination, whichever is earlier, for the above policy or certificate, has any person to be covered by the reinstated policy or certificate:

A. Had any change in health? Yes No
If yes, indicate dates, names and addresses of hospitals and all physicians seen, with reason for each visit.

Physician/Hospital	Address	Dates	Reason

B. Consulted, been examined, or treated by a physician or medical practitioner? Yes No
If yes, indicate dates, names and addresses of all physicians seen with the reason for each visit.

Physician/Hospital	Address	Dates	Reason

C. Made any change in occupation, the use of tobacco or drugs, participation in hazardous sports or flying or been arrested for any reason? Yes No
If yes, provide full details.

D. Made application to another life insurance company? Yes No
If yes, give dates and names of companies applied to, with details as to the status of the application(s).

E. Been declined, postponed or issued a life insurance policy or certificate on a modified basis? Yes No
 If yes, provide full details.

IT IS DECLARED that the statements and answers in this reinstatement application are complete and true as they relate to every person to be covered under the reinstated policy or certificate, to the best knowledge and belief of the undersigned. IT IS AGREED: (1) that no waiver or modification shall bind the Company unless in writing and signed by the President, a Vice President, or Secretary; (2) that no insurance shall be considered in effect under this reinstatement application unless and until the application for reinstatement has been approved by the Company at its Administrative Office and the full premium has been paid while all persons to be covered under the reinstated policy or certificate are alive.

AUTHORIZATION: To determine eligibility for insurance, the undersigned applicant(s) authorize any licensed physician, medical practitioner, health care professional, hospital, clinic, or other medically related facility, laboratory, pharmacy or pharmacy benefit manager, insurance or reinsuring company, viatical company, viatical broker or provider, the Medical Information Bureau, Inc., consumer reporting agency, insurance support organization, independent administrator, or other organization, institution, or person, or employer having information available as to diagnosis, prescription history, medications prescribed, treatment and prognosis with respect to information regarding alcoholism, drug abuse, and psychiatric care or any physical or mental condition and/or treatment of me or my minor children and any other nonmedical information of me or my minor children to give to North American Company for Life and Health Insurance (the Company) or its legal representative, any and all such information. I also authorize the Company to conduct a personal telephone interview in connection with my application; and to release any such data to its reinsurers, the Medical Information Bureau, or other persons or organizations performing business or legal services in connection with my application, or as required by law when given a copy of this authorization. I understand that I may request to be interviewed in connection with the preparation of an investigative consumer report. I understand that I am entitled to receive a copy of the investigative consumer report upon request. This authorization is valid for 30 months (24 months in KS, KY, ND, NE, 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 and OH 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, 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

LA, 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.

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

SIGNED AT (City, State)		DATE
Signature of Proposed Insured (If 15 Years or Older), or Legal Guardian X	Signature of Proposed Insured (If 15 Years or Older), or Legal Guardian X	
Signature of Proposed Insured (If 15 Years or Older), or Legal Guardian X	Spouse Consent (AK, AZ, CA, ID, LA, NM, NV, TX, WA, WI) X	
Signature of Proposed Insured (If 15 Years or Older), or Legal Guardian X	Signature of Owner(s) (If other than Proposed Insured) (If Owner is Corporation, Trust, or other Entity, include Title of Signee.) X	

SERFF Tracking Number: NALH-126468837 State: Arkansas
 Filing Company: North American Company for Life and Health State Tracking Number: 44967
 Insurance
 Company Tracking Number: L-3187A, L-3194
 TOI: L09I Individual Life - Flexible Premium Sub-TOI: L09I.001 Single Life
 Adjustable Life
 Product Name: L-3187A, L-3194
 Project Name/Number: L-3187A, L-3194/L-3187A, L-3194

Supporting Document Schedules

	Item Status:	Status Date:
<p>Satisfied - Item: Flesch Certification Comments: Attachments: READABILITY CERTIFICATE.pdf AR L&H Reg 19 Certification.pdf</p>		
<p>Satisfied - Item: Application Comments: Application form being filed for approval</p>		
<p>Bypassed - Item: Outline of Coverage Bypass Reason: not applicable to this application filing Comments:</p>		
<p>Satisfied - Item: Statement of variability Comments: Attachment: Statement of Variability.pdf</p>		

READABILITY CERTIFICATE

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

<u>Form Number</u>	<u>Description</u>	<u>Score</u>
L-3187A	Application for Policy Conversion, Change or Reinstatement	50.3
L-3194	Short Forms Reinstatement Application	50.0



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

February 23, 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: _____

Statement of Variability for Life Insurance Applications

The following is a list of items that have been bracketed within the specified life insurance application forms, along with an explanation for the bracketing.

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

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

L-3194 – Short Form Reinstatement Application:

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