

SERFF Tracking Number: NTAL-126694751 State: Arkansas  
Filing Company: National Teachers Associates Life Insurance Company State Tracking Number: 46063  
Company Tracking Number: 75-400 (4/10)  
TOI: L04I Individual Life - Term Sub-TOI: L04I.500 Other  
Product Name: 75-400 Life and Disability Income Application and Child Rider  
Project Name/Number: /

## Filing at a Glance

Company: National Teachers Associates Life Insurance Company

Product Name: 75-400 Life and Disability Income Application and Child Rider  
SERFF Tr Num: NTAL-126694751 State: Arkansas

TOI: L04I Individual Life - Term  
SERFF Status: Closed-Approved-Closed State Tr Num: 46063

Sub-TOI: L04I.500 Other  
Co Tr Num: 75-400 (4/10) State Status: Approved-Closed  
Filing Type: Form Reviewer(s): Linda Bird

Author: Wm. Bradley Cox  
Disposition Date: 06/28/2010

Date Submitted: 06/25/2010  
Disposition Status: Approved-Closed

Implementation Date Requested: On Approval

Implementation Date:

State Filing Description:

## General Information

Project Name:

Status of Filing in Domicile: Authorized

Project Number:

Date Approved in Domicile: 06/24/2010

Requested Filing Mode:

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: 06/28/2010

Explanation for Other Group Market Type:

State Status Changed: 06/28/2010

Deemer Date:

Created By: Wm. Bradley Cox

Submitted By: Wm. Bradley Cox

Corresponding Filing Tracking Number:

Filing Description:

The above-referenced application is enclosed for your review and approval. The application is new and does not replace any previously submitted forms. It will be used to apply for term life policy series L-2300 (10/05) and disability income policy series GRD-6003 (5/99), which have been previously approved by your department as indicated below:

Form Number Date Approved

L-2300-AR (10/05) 2/10/06

GRD-6003-AR (5/99) 7/16/99

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Additionally, this application may also be used with term life and/or disability income policies that may be subsequently approved by your department. It was filed and approved by our domiciliary state of Texas on June 24, 2010.

When the L-2300 (10/05) term life insurance product was originally filed with your department, we intended initially to utilize this policy form as the basis for a ten year renewable term product with reserves as defined in the original actuarial memorandum dated October 6, 2005 (the "Memorandum").

We now plan to use this same policy form as the basis of an annual renewable term, 5-year term, and 20-year term products as well as the original 10-year term product. In addition, we plan to offer the previously mentioned products with alternative age banding and blended rates in certain markets. We will also continue to offer the 10-year product as originally illustrated in the Memorandum.

Reserves for all products using policy form L-2300 (10/05) will be calculated using the same formulae as set forth in the previously mentioned Memorandum. To clarify that the references in the Memorandum to 10-year renewable term were illustrative only and that the methodologies are not limited to a 10-year term product with select and ultimate sex/smoker distinct reserves, we are also submitting an addendum to the Memorandum.

The rider is new and does not replace any previously submitted forms. It will be used to apply for additional term life insurance benefits for each Insured Child under policy series L-2300 (10/05). It was filed exempt in our domiciliary state of Texas on June 25, 2010.

## Company and Contact

### Filing Contact Information

David Mather, Compliance Analyst david.mather@ntalife.com  
4949 Keller Springs Road 972-532-2133 [Phone] 2577 [Ext]  
Addison, TX 75001 972-532-2194 [FAX]

### Filing Company Information

National Teachers Associates Life Insurance CoCode: 87963 State of Domicile: Texas  
Company  
4949 Keller Springs Road Group Code: Company Type: LAH

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 Product Name: 75-400 Life and Disability Income Application and Child Rider  
 Project Name/Number: /  
 Addison, TX 75001 Group Name: State ID Number:  
 (972) 532-2100 ext. [Phone] FEIN Number: 75-1623431  
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## Filing Fees

Fee Required? Yes  
 Fee Amount: \$50.00  
 Retaliatory? Yes  
 Fee Explanation:  
 Per Company: No

| COMPANY  | AMOUNT  | DATE PROCESSED | TRANSACTION # |
|--|---------|----------------|---------------|
| National Teachers Associates Life Insurance<br>Company | \$50.00 | 06/25/2010     | 37549724      |
| National Teachers Associates Life Insurance<br>Company | \$50.00 | 06/25/2010     | 37554672      |

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## Correspondence Summary

### Dispositions

| Status          | Created By | Created On | Date Submitted |
|-----------------|------------|------------|----------------|
| Approved-Closed | Linda Bird | 06/28/2010 | 06/28/2010     |

### Objection Letters and Response Letters

| Objection Letters         |            |            |                | Response Letters |            |                |
|---------------------------|------------|------------|----------------|------------------|------------|----------------|
| Status                    | Created By | Created On | Date Submitted | Responded By     | Created On | Date Submitted |
| Pending Industry Response | Linda Bird | 06/25/2010 | 06/25/2010     | Wm. Bradley Cox  | 06/25/2010 | 06/25/2010     |

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## Disposition

Disposition Date: 06/28/2010

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  |                      | Yes           |
| Supporting Document | Life & Annuity - Acturial Memo                                     |                      | No            |
| Form                | Application for Disability Income and/or SimpleTerm Life Insurance |                      | Yes           |
| Form                | Children's Rider - Supplemental Term Life Insurance                |                      | Yes           |

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## Objection Letter

Objection Letter Status Pending Industry Response  
Objection Letter Date 06/25/2010  
Submitted Date 06/25/2010  
Respond By Date 07/26/2010

Dear David Mather,

This will acknowledge receipt of the captioned filing.

Objection 1

No Objections

Comment: Regulation 57 was revised effective January 2010, the filing fee is now \$50.00 per form. We will hold your filing in a pending status until the additional \$50.00 is received.

Please feel free to contact me if you have questions.

Sincerely,

Linda Bird

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## Response Letter

Response Letter Status Submitted to State  
Response Letter Date 06/25/2010  
Submitted Date 06/25/2010

Dear Linda Bird,

### Comments:

### Response 1

Comments: Additional fees have been submitted via EFT. Thank you.

### Related Objection 1

Comment:

Regulation 57 was revised effective January 2010, the filing fee is now \$50.00 per form. We will hold your filing in a pending status until the additional \$50.00 is received.

### Changed Items:

No Supporting Documents changed.

No Form Schedule items changed.

No Rate/Rule Schedule items changed.

Sincerely,  
Wm. Bradley Cox

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## Form Schedule

### Lead Form Number:

| Schedule Item Status | Form Number         | Form Type Form Name   | Action  | Action Specific Data | Readability | Attachment                                      |
|----------------------|---------------------|---|---------|----------------------|-------------|---|
|                      | 75-400 (4/10)       | Application/ Enrollment Form and/or SimpleTerm Life Insurance | Initial |                      | 50.400      | 75-400 (4.10).pdf<br>75-400 (4.10) John Doe.pdf |
|                      | L-2300-TCR-B (5/10) | Certificate Amendmen t, Insert Page, Endorseme nt or Rider    | Initial |                      | 54.400      | L-2300-TCR-B (5.10).pdf                         |

**NATIONAL TEACHERS ASSOCIATES  
LIFE INSURANCE COMPANY**

P.O. Box 802207, Dallas, Texas 75380  
Phone (888) 671-6771 Fax (972) 532-2180

**Check if applicable:**

- Name Change
- Policy Reinstatement
- Plan Change:  
Policy # \_\_\_\_\_
- Other \_\_\_\_\_



**APPLICATION FOR DISABILITY INCOME AND/OR SIMPLETERM™ LIFE INSURANCE**

APPLICANT: Please supply all of the following important information. It will be used to determine your eligibility for coverage, including age, height, weight, occupation, and responses to medical information below.

|  |               |  |               |                   |  |                            |                    |      |       |
|--|---------------|--|---------------|-------------------|--|----------------------------|--------------------|------|-------|
| Name of Proposed Primary Insured (Last, First, Middle Initial)   |               |  |               |                   |  | Social Security No.<br>- - |                    |      |       |
| Sex  | Date of Birth | Age (Maximum 64)   | Height        | Weight            | (For Statistics Only)<br><input type="checkbox"/> Smoker <input type="checkbox"/> Non-Smoker |                            |                    |      |       |
| Address  |               |  |               |                   |  | E-mail Address             |                    |      |       |
| City   |               | County or Parish   | State         | Zip               | CODES  | St.                        | Cnty.              | City | Bldg. |
| Home Phone<br>( )  |               | Work Phone<br>( )  |               | Cell Phone<br>( ) |  |                            |                    |      |       |
| Best place and time to call (before 5 pm)<br><input type="checkbox"/> HM <input type="checkbox"/> WK <input type="checkbox"/> CELL / <input type="checkbox"/> AM _____ <input type="checkbox"/> PM _____ |               |  | School System |                   |  | School or Business         |                    |      |       |
| Current Annual Pre-tax Income<br>\$  |               | Occupation (Min. 30 hrs./week required for disability coverages) |               |                   |  |                            | Occupational Group |      |       |

|                                   |  |               |                                      |  |               |
|-----------------------------------|--|---------------|--------------------------------------|--|---------------|
| Primary Death Benefit Beneficiary |  | Relationship  | Contingent Death Benefit Beneficiary |  | Relationship  |
| Address                           |  | Date of Birth | Address                              |  | Date of Birth |

Application for Disability Income Policy

|                                      |  |   |   |
|--------------------------------------|--|---|---|
| Monthly Disability Applied For<br>\$ | Elimination Period (days)<br>Injury _____ Sickness _____ | Max. Benefit Period (months)<br>Injury _____ Sickness _____ | Optional<br>Riders: <input type="checkbox"/> Hosp. Inpatient \$ _____ / day<br><input type="checkbox"/> Other _____ |
|--------------------------------------|--|---|---|

Application for SimpleTerm™ Life Insurance Policy

|  |  |   |
|--|--|---|
| <input type="checkbox"/> Term Life Face Amount Applied for<br>\$ _____ | <input type="checkbox"/> \$5,000 Child Rider Face Amount | <input type="checkbox"/> AD&D Rider Face Amount<br>\$ _____ |
|--|--|---|

|   |   |  |  |                     |           |     |
|---|---|--|--|---------------------|-----------|-----|
| <b>FOR<br/>CHILD LIFE<br/>INSURANCE<br/>RIDER</b> | Names of Dependent Children (Last, First, Middle) (use additional paper if necessary) |  |  | Social Security No. | Birthdate | Sex |
|   |   |  |  |                     |           |     |

Owner and/or  Payor of Policy if Other than Proposed Insured

|                        |         |     |
|------------------------|---------|-----|
| Relationship           | Address |     |
| City                   | State   | Zip |
| Social Security Number |         |     |

**COVERAGE WILL BE AUTOMATICALLY DECLINED FOR ANY "YES" RESPONSE TO QUESTIONS 1-4.**

1.  No  Yes For Disability Income Policy only, are you **pregnant**?
2.  No  Yes Are you currently **not working** because of sickness or an injury; **on leave** from work; **disabled**; or **under the care of a hospital, long term care facility, or nursing home**?
3.  No  Yes Within the past 10 years, have you been **prescribed insulin** or **insulin refills**; or have you **ever** been diagnosed with **Type I diabetes**?
4. Within the past 10 years, have you: (i) **had symptoms of**, (ii) **received medical advice for**, (iii) **been diagnosed with**, (iv) **received treatment or surgery for**, or (v) **been prescribed medication for**:
  - No  Yes a. **Cancer** (including internal / in situ / melanoma Cancer, but excluding other skin cancers)?
  - No  Yes b. Any disease, disorder, or abnormality of the **cardiovascular system or heart**, such as coronary artery disease, heart disease, heart attack, diagnostic heart catheterization, or any heart surgery (excluding: mitral valve prolapse; heart murmur; and an irregular heartbeat not treated with medication or surgery)?



**I have reviewed all responses provided  
in this application for accuracy.**

Initial \_\_\_\_\_

No  Yes

No  Yes

No  Yes

No  Yes

No  Yes

No  Yes

5.  No  Yes

- c. Any disease, disorder, or abnormality of the **circulatory system** (including arteries, veins, vessels, and lymph nodes; excluding high blood pressure if controlled)?
- d. **Stroke, transient ischemic attack** (TIA or mini-stroke), or any disease of the **brain**?
- e. **Kidney (renal) failure or insufficiency, liver failure, or cirrhosis** of the liver?
- f. **Emphysema** or chronic obstructive pulmonary disease (**COPD**)?
- g. **Psychosis** (including schizophrenia, manic depression (bipolar), and severe/major depression)?
- h. Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC), or tested positive for antibodies to the AIDS virus (**HIV positive**)?

In the past 3 years, have you been hospitalized or undergone surgery for any disease, disorder, or abnormality of the **back, neck, spine, bones, or joints** (including rheumatoid arthritis, osteoarthritis or degenerative joint disease)? If yes, explain: \_\_\_\_\_

6. Name, city, and phone number of your primary care physician: \_\_\_\_\_

7.  No  Yes

Is the policy for which you are applying intended to replace or change any of your existing policies? If yes, identify type (disability or life), company, and benefit amount: \_\_\_\_\_

8.  Yes

I understand that the disability income coverage for which I may be applying does not provide benefits for loss attributable to preexisting medical conditions for 2 years after the Issue Date.

9.  No  Yes

I request a delayed Issue Date of \_\_\_\_\_ for by disability income policy and agree that preexisting conditions will be determined as of the delayed Issue Date.

**MODE OF PAYMENT**

**Initial Premium with Application:**  Check Attached \*  Credit Card Payment  Other \_\_\_\_\_

**Recurring Payments:**

Monthly  Other \_\_\_\_\_  
 Bank Draft  Credit Card  
 Payroll Deduction  Other \_\_\_\_\_

**Policy and Optional Riders:**

Life Ins. \$ \_\_\_\_\_  
Disability Ins. \$ \_\_\_\_\_  
Total Premium \$ \_\_\_\_\_

\* When a check is provided as a payment, National Teachers Associates Life Insurance Company (NTA) may use the information from the check to make a one-time electronic funds transfer (EFT) from your account or to process the payment as a check transaction. If we use information from the check to make an EFT, funds may be withdrawn from your account the same day that NTA receives your check. You may not receive the cancelled check from your financial institution.

**BANK DRAFT AUTHORIZATION**

**USE ACCOUNT INFO. FROM:**  Initial Premium Check **OR**  Specimen Check (attached)

I request and authorize National Teachers Associates Life Insurance Company to make withdrawals against the bank account selected above, or any account subsequently named by me, and such bank(s) to process these withdrawals as if I had signed them for the purpose of collecting premiums under the policy. If the said account is replaced by an account in another bank, this request and authorization shall also apply to such other bank. I understand that I have the right to receive notice of each electronic debit entry that varies in amount from the previous entry, but I elect to receive such notice only when such entry differs from the previous entry by more than \$200.

X \_\_\_\_\_ / \_\_\_\_ / \_\_\_\_  
Signature exactly as it appears on bank records Date Signed

Requested first draft date (1-28 only)

**WARNING: 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.**

I, (or we) certify that I have read or had read to me the completed application and submit it as my offer for the purchase of insurance. I understand that I have no coverage unless and until the policy is issued by the Company. I represent that the answers are true and correct and realize that any fraudulent statement or material misrepresentation in the application may result in a loss of coverage. I authorize the Company to call me on a recorded phone call to clarify or verify certain information in this application and agree that a transcript of such recording can be made a part of my application for insurance. No oral statement between the agent and me will be binding on the Company. No person to be covered under this policy is currently receiving benefits under Medicare or Medicaid. A copy of this application will be valid as if it were an original. I agree to be bound by the Arbitration Program for the resolution of disputes under the Federal Arbitration Act if included in any policy for which I am applying. I also certify that I have received a copy of the Company's privacy notice and privacy practices.

DATED AT \_\_\_\_\_, THIS \_\_\_\_\_ DAY OF \_\_\_\_\_  
City and State Day Month Year

X \_\_\_\_\_ X \_\_\_\_\_  
Signature of Proposed Primary Insured Signature of Owner/Payor if other than Proposed Primary Insured

I certify that I have truly and accurately recorded on this Application the information supplied by the applicant.

\_\_\_\_\_  
Licensed Agent Signature Printed agent name License ID No. Agent No.  
**4949 Keller Springs Road, Addison, TX 75001** **1-800-TALK-NTA**  
Address Phone



**National Teachers Associates Life Insurance Company**  
 4949 Keller Springs Road • Addison, Texas 75001 • (888) 671-6771

**Authorization for Release of Health-Related Information**

**This Authorization Complies with HIPAA Privacy Rule**

By executing this Authorization, I authorize all health care providers that have been involved in my care, diagnosis or treatment (including, but not limited to, physicians, hospitals, clinics, medical practitioners, and other medically related facilities) to disclose my medical records (including, but not limited to, patient histories, progress notes, test results, x-rays and other diagnostic information) to employees of National Teachers Associates Life Insurance Company and affiliated entities involved in determining eligibility for an insurance policy or processing a claim. This Authorization may be required to obtain an insurance policy or to determine eligibility for benefits.

National Teachers Associates Life Insurance Company and affiliated entities may disclose my medical records and the information contained in those medical records to business associates, affiliated third parties, or other organizations (such as reinsurers), for the purposes stated above and as permitted by law. I also understand that when my medical records and the information contained in those medical records are disclosed pursuant to this Authorization, they may be re-disclosed and may no longer be protected by federal privacy laws.

I understand that I may revoke this Authorization in writing, except to the extent that National Teachers Associates Life Insurance Company or an affiliated entity has acted in reliance upon this Authorization. My revocation **in writing** must be submitted to:

National Teachers Associates Life Insurance Company  
 Attn: Director of Compliance  
 4949 Keller Springs Road • Addison, Texas 75001

This Authorization will expire two (2) years from the date that this Authorization is signed.

I understand that I have the right to a copy of this Authorization and I agree that a copy of this Authorization is as valid as the original.

\_\_\_\_\_  
 Signature of Individual Whose Information is to be Disclosed

\_\_\_\_\_  
 Date

\_\_\_\_\_  
 Printed Name of Individual

\_\_\_\_\_  
 Policy Number





**NATIONAL TEACHERS ASSOCIATES  
LIFE INSURANCE COMPANY**  
P.O. Box 802207, Dallas, Texas 75380  
Phone (888) 671-6771 Fax (972) 532-2180

Check if applicable:  
 Name Change  
 Policy Reinstatement  
 Plan Change:  
 Policy # \_\_\_\_\_  
 Other \_\_\_\_\_



**APPLICATION FOR DISABILITY INCOME AND/OR SIMPLETERM™ LIFE INSURANCE**

APPLICANT: Please supply all of the following important information. It will be used to determine your eligibility for coverage, including age, height, weight, occupation, and responses to medical information below.

|  |   |  |   |   |   |  |       |                 |  |  |
|--|---|--|---|---|---|--|-------|-----------------|--|--|
| Name of Proposed Primary Insured (Last, First, Middle Initial)<br><i>Doe, John A</i>   |   |  |   |   | Social Security No.<br><i>123-45-6789</i>   |  |       |                 |  |  |
| Sex<br><i>M</i>  | Date of Birth<br><i>1-1-74</i>  | Age (Maximum 64)<br><i>36</i>  | Height<br><i>6'2"</i>                                     | Weight<br><i>190 lbs</i>                                    | (For Statistics Only)<br><input type="checkbox"/> Smoker <input checked="" type="checkbox"/> Non-Smoker |  |       |                 |  |  |
| Address<br><i>123 Main Street</i>  |   |  |   |   | E-mail Address<br><i>J.Doe@hotmail.com</i>  |  |       |                 |  |  |
| City<br><i>Dallas</i>  | County or Parish<br><i>Dallas</i>   | State<br><i>TX</i>   | Zip<br><i>75000</i>                                       | St.   | Cnty.   | City   | Bldg. | CODES           |  |  |
| Home Phone<br><i>(214) 867-5309</i>  |   | Work Phone<br><i>(214) 867-5309</i>  |   | Cell Phone<br><i>(214) 867-5309</i>                         |   |  |       |                 |  |  |
| Best place and time to call (before 5 pm)<br><input checked="" type="checkbox"/> HOME <input checked="" type="checkbox"/> WORK <input type="checkbox"/> CELL <input type="checkbox"/> FAX <i>9</i> <input type="checkbox"/> PM |   | School System<br><i>D155</i>   |   |   | School or Business<br><i>Carter H.S.</i>  |  |       |                 |  |  |
| Current Annual Pre-tax Income<br>\$ <i>50,000</i>  |   | Occupation (Min. 30 hrs./week required for disability coverages)<br><i>Teacher</i> |   |   |   | Occupational Group   |       |                 |  |  |
| Primary Death Benefit Beneficiary<br><i>Jane A Doe</i>   |   | Relationship<br><i>Wife</i>  | Contingent Death Benefit Beneficiary<br><i>Jane C Doe</i> |   |   | Relationship<br><i>Daughter</i>  |       |                 |  |  |
| Address<br><i>123 Main Street</i>  |   | Date of Birth<br><i>1-1-77</i>   | Address<br><i>123 Main Street</i>                         |   |   | Date of Birth<br><i>1-1-04</i>   |       |                 |  |  |
| <input checked="" type="checkbox"/> Application for Disability Income Policy   |   |  |   |   |   |  |       |                 |  |  |
| Monthly Disability Applied For<br>\$ _____   |   | Elimination Period (days)<br>Injury _____ Sickness _____                           |   | Max. Benefit Period (months)<br>Injury _____ Sickness _____ |   | Optional <input type="checkbox"/> Hosp. Inpatient \$ _____ / day<br>Riders: <input type="checkbox"/> Other _____ |       |                 |  |  |
| <input checked="" type="checkbox"/> Application for SimpleTerm™ Life Insurance Policy  |   |  |   |   |   |  |       |                 |  |  |
| <input type="checkbox"/> Term Life Face Amount Applied for<br>\$ _____   |   | <input checked="" type="checkbox"/> \$5,000 Child Rider Face Amount                |   |   | <input type="checkbox"/> AD&D Rider Face Amount<br>\$ _____   |  |       |                 |  |  |
| FOR CHILD LIFE INSURANCE RIDER   | Names of Dependent Children (Last, First, Middle) (use additional paper if necessary)<br><i>Doe, Jane C</i> |  |   | Social Security No.<br><i>345-67-8112</i>                   |   | Birthdate<br><i>1-1-04</i>   |       | Sex<br><i>F</i> |  |  |
| <input type="checkbox"/> Owner and/or <input type="checkbox"/> Payor of Policy if Other than Proposed Insured  |   | Relationship   | Address   |   |   |  |       |                 |  |  |
| City   |   | State  | Zip   |   | Social Security Number  |  |       |                 |  |  |

COVERAGE WILL BE AUTOMATICALLY DECLINED FOR ANY "YES" RESPONSE TO QUESTIONS 1-4.

- No  Yes For Disability Income Policy only, are you pregnant?
- No  Yes Are you currently **not working** because of sickness or an injury; on leave from work; disabled; or under the care of a hospital, long term care facility, or nursing home?
- No  Yes Within the past 10 years, have you been prescribed insulin or insulin refills; or have you ever been diagnosed with **Type I diabetes**?
- Within the past 10 years, have you: (i) had symptoms of, (ii) received medical advice for, (iii) been diagnosed with, (iv) received treatment or surgery for, or (v) been prescribed medication for:
  - No  Yes a. **Cancer** (including internal / in situ / melanoma Cancer, but excluding other skin cancers)?
  - No  Yes b. Any disease, disorder, or abnormality of the **cardiovascular system or heart**, such as coronary artery disease, heart disease, heart attack, diagnostic heart catheterization, or any heart surgery (excluding: mitral valve prolapse; heart murmur; and an irregular heartbeat not treated with medication or surgery)?



- No  Yes
5.  No  Yes In the past 3 years, have you been hospitalized or undergone surgery for any disease, disorder, or abnormality of the **back, neck, spine, bones, or joints** (including rheumatoid arthritis, osteoarthritis or degenerative joint disease)? If yes, explain: \_\_\_\_\_
6. Name, city, and phone number of your primary care physician: \_\_\_\_\_
7.  No  Yes Is the policy for which you are applying intended to replace or change any of your existing policies? If yes, identify type (disability or life), company, and benefit amount: \_\_\_\_\_ \$ \_\_\_\_\_
8.  Yes I understand that the disability income coverage for which I may be applying does not provide benefits for loss attributable to preexisting medical conditions for 2 years after the Issue Date.
9.  No  Yes I request a delayed Issue Date of \_\_\_\_\_ for by disability income policy and agree that preexisting conditions will be determined as of the delayed Issue Date.

| MODE OF PAYMENT   |  | Recurring Payments:                         | Policy and Optional Riders: |
|-------------------|--|---|-----------------------------|
| Initial Premium   | <input checked="" type="checkbox"/> Check Attached * | <input checked="" type="checkbox"/> Monthly | Life Ins. \$ _____          |
| with Application: | <input type="checkbox"/> Credit Card Payment         | <input type="checkbox"/> Bank Draft         | Disability Ins. \$ _____    |
|                   | <input type="checkbox"/> Other _____                 | <input type="checkbox"/> Payroll Deduction  | Total Premium \$ _____      |
|                   |  | <input type="checkbox"/> Other _____        |                             |

\* When a check is provided as a payment, National Teachers Associates Life Insurance Company (NTA) may use the information from the check to make a one-time electronic funds transfer (EFT) from your account or to process the payment as a check transaction. If we use information from the check to make an EFT, funds may be withdrawn from your account the same day that NTA receives your check. You may not receive the cancelled check from your financial institution.

| BANK DRAFT AUTHORIZATION   | USE ACCOUNT INFO. FROM:   |
|--|---|
|  | <input type="checkbox"/> Initial Premium Check OR<br><input type="checkbox"/> Specimen Check (attached) |
| I request and authorize National Teachers Associates Life Insurance Company to make withdrawals against the bank account selected above, or any account subsequently named by me, and such bank(s) to process these withdrawals as if I had signed them for the purpose of collecting premiums under the policy. If the said account is replaced by an account in another bank, this request and authorization shall also apply to such other bank. I understand that I have the right to receive notice of each electronic debit entry that varies in amount from the previous entry, but I elect to receive such notice only when such entry differs from the previous entry by more than \$200. |   |
| X <u>John A. Doe</u><br>Signature exactly as it appears on bank records  | <u>6 / 1 / 10</u><br>Date Signed  |
|  | Requested first draft date (1-28 only)<br><u>15</u>   |

**WARNING: 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.**

I, (or we) certify that I have read or had read to me the completed application and submit it as my offer for the purchase of insurance. I understand that I have no coverage unless and until the policy is issued by the Company. I represent that the answers are true and correct and realize that any fraudulent statement or material misrepresentation in the application may result in a loss of coverage. I authorize the Company to call me on a recorded phone call to clarify or verify certain information in this application and agree that a transcript of such recording can be made a part of my application for insurance. No oral statement between the agent and me will be binding on the Company. No person to be covered under this policy is currently receiving benefits under Medicare or Medicaid. A copy of this application will be valid as if it were an original. I agree to be bound by the Arbitration Program for the resolution of disputes under the Federal Arbitration Act if included in any policy for which I am applying. I also certify that I have received a copy of the Company's privacy notice and privacy practices.

DATED AT Dallas TX, THIS 1 DAY OF June 2010

City and State Day Month Year

X John A. Doe X \_\_\_\_\_  
Signature of Proposed Primary Insured Signature of Owner/Payor if other than Proposed Primary Insured

I certify that I have truly and accurately recorded on this Application the information supplied by the applicant.

John F. Doe Licensed Agent Signature  
John F. Doe Printed agent name  
4949 Keller Springs Road, Addison, TX 75001 Address  
111-1 License ID No. 111 Agent No.  
1-800-TALK-NTA Phone



**National Teachers Associates Life Insurance Company**  
 4949 Keller Springs Road • Addison, Texas 75001 • (888) 671-6771

**Authorization for Release of Health-Related Information**

**This Authorization Complies with HIPAA Privacy Rule**

By executing this Authorization, I authorize all health care providers that have been involved in my care, diagnosis or treatment (including, but not limited to, physicians, hospitals, clinics, medical practitioners, and other medically related facilities) to disclose my medical records (including, but not limited to, patient histories, progress notes, test results, x-rays and other diagnostic information) to employees of National Teachers Associates Life Insurance Company and affiliated entities involved in determining eligibility for an insurance policy or processing a claim. This Authorization may be required to obtain an insurance policy or to determine eligibility for benefits.

National Teachers Associates Life Insurance Company and affiliated entities may disclose my medical records and the information contained in those medical records to business associates, affiliated third parties, or other organizations (such as reinsurers), for the purposes stated above and as permitted by law. I also understand that when my medical records and the information contained in those medical records are disclosed pursuant to this Authorization, they may be re-disclosed and may no longer be protected by federal privacy laws.

I understand that I may revoke this Authorization in writing, except to the extent that National Teachers Associates Life Insurance Company or an affiliated entity has acted in reliance upon this Authorization. My revocation **in writing** must be submitted to:

National Teachers Associates Life Insurance Company  
 Attn: Director of Compliance  
 4949 Keller Springs Road • Addison, Texas 75001

This Authorization will expire two (2) years from the date that this Authorization is signed.

I understand that I have the right to a copy of this Authorization and I agree that a copy of this Authorization is as valid as the original.

John A. Lee  
 Signature of Individual Whose Information is to be Disclosed

6/1/10  
 Date

John A. Lee  
 Printed Name of Individual

111  
 Policy Number



H





# NATIONAL TEACHERS ASSOCIATES LIFE INSURANCE COMPANY

4949 Keller Springs Road ◦ Addison, Texas 75001 ◦ (888) 671-6771

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## CHILDREN'S RIDER – SUPPLEMENTAL TERM LIFE INSURANCE

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### PAYMENT OF RIDER DEATH BENEFIT.

The Company, subject to the terms and conditions of this Rider and the applicable provisions of the Policy to which it is attached, agrees to pay the Rider Death Benefit for each Insured Child who dies while the Policy and this Rider are in force in the amount shown on the Policy Schedule Page for this Rider. The Company will pay the Rider Death Benefit upon receipt at its Home Office of due proof that the death of an Insured Child has occurred: (a) while the insurance coverage under this Rider for the Insured Child is in full force; (b) after the Insured Child has at least attained the age of 14 days; and (c) prior to the Expiration of Coverage. The Rider Death Benefit is subject to reduction by the "Suicide" provision described below.

If settlement is not made within 30 days after receipt of proof of the death of the Insured Child and any other documentation that we may require to properly pay the Rider Death Benefit, then the Company will pay interest upon the proceeds at the Reserve Interest Rate provided on the Schedule Page.

Any Rider Death Benefit payable under this Rider shall be paid to the Policy Owner, if living. If the Policy Owner is not living at the time of the death of the Insured Child, the Rider Death Benefit will be paid to the Beneficiary of the Policy. If the Policy Owner and Beneficiaries under the Policy are deceased, the proceeds shall be payable to the executors or administrators of the Insured Child's estate on account of whose death the payment is to be made.

### GENERAL PROVISIONS.

**Contract.** This Rider is a legal contract between the Company and the Policy Owner. Any change or waiver of the Rider terms must be in writing and signed by the President or Secretary and endorsed on this Rider. This Rider is a part of the Policy to which it is attached and is subject to all of the Policy definitions, provisions, exceptions and limitations that are not inconsistent with this Rider. The benefits provided under this Rider are not covered by any other optional rider attached to the Policy, including an accidental death and dismemberment coverage and/or accelerated life insurance benefit rider.

We have issued this Rider in consideration of: (1) this Rider application (if an application is required for coverage under this Rider, a copy of the application is attached to and made a part of the Policy); and (2) the advance payment of the premiums specified for this Rider on the Schedule Page of the Policy during the entire period from the Rider Effective Date through the date that the Rider terminates.

**Effective Date.** The effective date of this Rider is the Effective Date shown on the Schedule Page of the Policy for this Rider. All Rider years and anniversaries shall be computed from the Effective Date of this Rider.

**Expiration of Coverage.** This Rider shall expire and all coverage shall cease on the Policy Plan Date of the Policy following the 65th birthday of the Insured. Insurance coverage on each Insured Child shall expire on the anniversary date of this Rider following the Insured Child's 25th birthday.

**Incontestability.** After this Rider has been in force during the lifetime of the Insured Child for the later of two years from the Policy Plan Date or the effective date of any Policy Reinstatement (if applicable), the validity of this Rider cannot be contested except as permitted by law.

**Insured Child.** Insured Child shall include any children, stepchildren or legally adopted children as of the Rider Effective Date. Thereafter, each child born to or legally adopted by the Insured and the person who was his or her legal spouse on the Rider Effective Date shall automatically become an Insured Child upon attainment of the age of 14 days or upon the date of legal adoption (whichever is later) provided that this Rider is then in force and the date of any such legal adoption is prior to the 18<sup>th</sup> birthday of such child. The Policy Owner is not required to provide the Company with notice of the birth or adoption of a child automatically included as an Insured Child (as described above).

**Ownership.** During the lifetime of the Insured, the Policy Owner has the same rights in this Rider as provided in the Policy, except as modified herein.

**Reinstatement.** Reinstatement of the Policy shall include reinstatement of this Rider, but only upon evidence satisfactory to the Company of the insurability of each Insured Child who would be insured under the Rider. If this Rider is so reinstated, no liabilities, benefits or privileges shall exist with respect to any Insured Child who died, or whose term of insurance expired, prior to the date of Reinstatement.

**Suicide.** If the death of the Insured occurs in the manner and within the time period set out in the “Suicide” provisions of the Policy, the liability of the Company under this Rider shall thereupon automatically cease. If an Insured Child commits suicide while sane or insane within 2 years from the Rider Effective Date, then the total liability of the Company under the Rider will be limited to the amount of premiums paid for the Rider from the Rider Effective Date, less any Policy indebtedness.

#### **TERMINATION.**

Except as otherwise provided, this Rider shall terminate upon the first of the following to occur: (1) the Expiration of Coverage; (2) when the Policy terminates; (3) the date when the Policy becomes paid-up (either through payment of all premiums provided by the Policy or through operation of a non-forfeiture benefit); (4) receipt at the Home Office of a written request to cancel this Rider together with the Policy Schedule Page for suitable endorsement; or (5) change of the Policy to a new policy in accordance with any exchange privilege contained in the Policy. The acceptance of a premium for a period subsequent to the termination of this Rider shall not make the Company liable or constitute a waiver of the termination of this Rider. Any premium so accepted shall be refunded.

Since any later born or adopted child will automatically become an Insured Child (subject to the “Insured Child” provision above), the Company will not automatically terminate this Rider when the youngest Insured Child known to the Company attains the age of 25. However, as indicated above, the Policy Owner may submit a written request to cancel this Rider. Such cancellation will only be effective when received by the Company.

IN WITNESS WHEREOF, National Teachers Associates Life Insurance Company has caused this Rider to be executed for us by our:

  
President

SERFF Tracking Number: NTAL-126694751 State: Arkansas  
Filing Company: National Teachers Associates Life Insurance State Tracking Number: 46063  
Company  
Company Tracking Number: 75-400 (4/10)  
TOI: L04I Individual Life - Term Sub-TOI: L04I.500 Other  
Product Name: 75-400 Life and Disability Income Application and Child Rider  
Project Name/Number: /

## Supporting Document Schedules

|   | Item Status: | Status Date: |
|---|--------------|--------------|
| <b>Satisfied - Item:</b> Flesch Certification |              |              |
| <b>Comments:</b>                              |              |              |
| <b>Attachments:</b>                           |              |              |
| AR Read Cert.pdf                              |              |              |
| AR 19 Cert.pdf                                |              |              |

|                                      | Item Status: | Status Date: |
|--------------------------------------|--------------|--------------|
| <b>Satisfied - Item:</b> Application |              |              |
| <b>Comments:</b>                     |              |              |
| <b>Attachment:</b>                   |              |              |
| 75-400 (4.10).pdf                    |              |              |



# NATIONAL TEACHERS ASSOCIATES LIFE INSURANCE COMPANY

4949 Keller Springs Road • Addison, Texas 75001-5910  
(972) 532-2100 • Fax (972) 532-2194  
www.ntalife.com

## ARKANSAS

I hereby certify that to the best of my knowledge and belief the following forms, according to the  
Flesh test, have these readability scores:

Defined terms and headings have been excluded for purposes of the calculation of the  
Readability score.

| FORM   | FORM NO.            | SCORE |
|--|---------------------|-------|
| Children's Rider - Supplemental<br>Term Life Insurance                 | L-2300-TCR-B (5/10) | 54.4  |
| Application for Disability Income<br>and/or Simple Term Life Insurance | 75-400 (4/10)       | 50.4  |

Signed

William Bradley Cox  
General Counsel and  
Vice President

Date

6-28-10

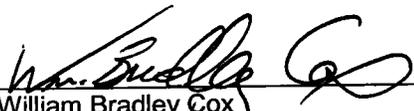


**NATIONAL TEACHERS ASSOCIATES  
LIFE INSURANCE COMPANY**

4949 Keller Springs Road • Addison, Texas 75001-5910  
(972) 532-2100 • Fax (972) 532-2194  
[www.ntalife.com](http://www.ntalife.com)

**ARKANSAS**

To the best of my knowledge, this submission meets the requirements of the Rule and Regulation 19 and the applicable requirements of the Arkansas Department of Insurance.

Signed   
William Bradley Cox  
General Counsel and  
Vice President

Date 6-28-10

**NATIONAL TEACHERS ASSOCIATES  
LIFE INSURANCE COMPANY**

P.O. Box 802207, Dallas, Texas 75380  
Phone (888) 671-6771 Fax (972) 532-2180

**Check if applicable:**

- Name Change
- Policy Reinstatement
- Plan Change:  
Policy # \_\_\_\_\_
- Other \_\_\_\_\_



**APPLICATION FOR DISABILITY INCOME AND/OR SIMPLETERM™ LIFE INSURANCE**

APPLICANT: Please supply all of the following important information. It will be used to determine your eligibility for coverage, including age, height, weight, occupation, and responses to medical information below.

|  |               |  |                  |        |                   |  |                    |      |       |
|--|---------------|--|------------------|--------|-------------------|--|--------------------|------|-------|
| Name of Proposed Primary Insured (Last, First, Middle Initial)   |               |  |                  |        |                   | Social Security No.<br>- -   |                    |      |       |
| Sex  | Date of Birth |  | Age (Maximum 64) | Height | Weight            | (For Statistics Only)<br><input type="checkbox"/> Smoker <input type="checkbox"/> Non-Smoker |                    |      |       |
| Address  |               |  |                  |        |                   | E-mail Address   |                    |      |       |
| City   |               | County or Parish   | State            | Zip    | CODES             | St.  | Cnty.              | City | Bldg. |
| Home Phone<br>( )  |               | Work Phone<br>( )  |                  |        | Cell Phone<br>( ) |  |                    |      |       |
| Best place and time to call (before 5 pm)<br><input type="checkbox"/> HM <input type="checkbox"/> WK <input type="checkbox"/> CELL / <input type="checkbox"/> AM _____ <input type="checkbox"/> PM _____ |               |  | School System    |        |                   | School or Business   |                    |      |       |
| Current Annual Pre-tax Income<br>\$  |               | Occupation (Min. 30 hrs./week required for disability coverages) |                  |        |                   |  | Occupational Group |      |       |

|                                   |  |               |                                      |  |               |
|-----------------------------------|--|---------------|--------------------------------------|--|---------------|
| Primary Death Benefit Beneficiary |  | Relationship  | Contingent Death Benefit Beneficiary |  | Relationship  |
| Address                           |  | Date of Birth | Address                              |  | Date of Birth |

Application for Disability Income Policy

|                                      |  |   |   |
|--------------------------------------|--|---|---|
| Monthly Disability Applied For<br>\$ | Elimination Period (days)<br>Injury _____ Sickness _____ | Max. Benefit Period (months)<br>Injury _____ Sickness _____ | Optional<br>Riders: <input type="checkbox"/> Hosp. Inpatient \$ _____ / day<br><input type="checkbox"/> Other _____ |
|--------------------------------------|--|---|---|

Application for SimpleTerm™ Life Insurance Policy

|  |  |   |
|--|--|---|
| <input type="checkbox"/> Term Life Face Amount Applied for<br>\$ _____ | <input type="checkbox"/> \$5,000 Child Rider Face Amount | <input type="checkbox"/> AD&D Rider Face Amount<br>\$ _____ |
|--|--|---|

|   |   |  |  |                     |           |     |
|---|---|--|--|---------------------|-----------|-----|
| <b>FOR<br/>CHILD LIFE<br/>INSURANCE<br/>RIDER</b> | Names of Dependent Children (Last, First, Middle) (use additional paper if necessary) |  |  | Social Security No. | Birthdate | Sex |
|   |   |  |  |                     |           |     |

Owner and/or  Payor of Policy if Other than Proposed Insured

|                        |         |     |
|------------------------|---------|-----|
| Relationship           | Address |     |
| City                   | State   | Zip |
| Social Security Number |         |     |

**COVERAGE WILL BE AUTOMATICALLY DECLINED FOR ANY "YES" RESPONSE TO QUESTIONS 1-4.**

1.  No  Yes For Disability Income Policy only, are you **pregnant**?
2.  No  Yes Are you currently **not working** because of sickness or an injury; **on leave** from work; **disabled**; or **under the care of a hospital, long term care facility, or nursing home**?
3.  No  Yes Within the past 10 years, have you been **prescribed insulin** or **insulin refills**; or have you **ever** been diagnosed with **Type I diabetes**?
4. Within the past 10 years, have you: (i) **had symptoms of**, (ii) **received medical advice for**, (iii) **been diagnosed with**, (iv) **received treatment or surgery for**, or (v) **been prescribed medication for**:
  - No  Yes a. **Cancer** (including internal / in situ / melanoma Cancer, but excluding other skin cancers)?
  - No  Yes b. Any disease, disorder, or abnormality of the **cardiovascular system or heart**, such as coronary artery disease, heart disease, heart attack, diagnostic heart catheterization, or any heart surgery (excluding: mitral valve prolapse; heart murmur; and an irregular heartbeat not treated with medication or surgery)?



**I have reviewed all responses provided  
in this application for accuracy.**

Initial \_\_\_\_\_

No  Yes

No  Yes

No  Yes

No  Yes

No  Yes

No  Yes

5.  No  Yes

- c. Any disease, disorder, or abnormality of the **circulatory system** (including arteries, veins, vessels, and lymph nodes; excluding high blood pressure if controlled)?
- d. **Stroke, transient ischemic attack** (TIA or mini-stroke), or any disease of the **brain**?
- e. **Kidney (renal) failure or insufficiency, liver failure, or cirrhosis** of the liver?
- f. **Emphysema** or chronic obstructive pulmonary disease (**COPD**)?
- g. **Psychosis** (including schizophrenia, manic depression (bipolar), and severe/major depression)?
- h. Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC), or tested positive for antibodies to the AIDS virus (**HIV positive**)?

In the past 3 years, have you been hospitalized or undergone surgery for any disease, disorder, or abnormality of the **back, neck, spine, bones, or joints** (including rheumatoid arthritis, osteoarthritis or degenerative joint disease)? If yes, explain: \_\_\_\_\_

6. Name, city, and phone number of your primary care physician: \_\_\_\_\_

7.  No  Yes

Is the policy for which you are applying intended to replace or change any of your existing policies? If yes, identify type (disability or life), company, and benefit amount: \_\_\_\_\_

\$ \_\_\_\_\_

8.  Yes

I understand that the disability income coverage for which I may be applying does not provide benefits for loss attributable to preexisting medical conditions for 2 years after the Issue Date.

9.  No  Yes

I request a delayed Issue Date of \_\_\_\_\_ for by disability income policy and agree that preexisting conditions will be determined as of the delayed Issue Date.

**MODE OF PAYMENT**

**Initial Premium with Application:**  Check Attached \*  Credit Card Payment  Other \_\_\_\_\_

**Recurring Payments:**

Monthly  Other \_\_\_\_\_  
 Bank Draft  Credit Card  
 Payroll Deduction  Other \_\_\_\_\_

**Policy and Optional Riders:**

Life Ins. \$ \_\_\_\_\_  
Disability Ins. \$ \_\_\_\_\_  
Total Premium \$ \_\_\_\_\_

\* When a check is provided as a payment, National Teachers Associates Life Insurance Company (NTA) may use the information from the check to make a one-time electronic funds transfer (EFT) from your account or to process the payment as a check transaction. If we use information from the check to make an EFT, funds may be withdrawn from your account the same day that NTA receives your check. You may not receive the cancelled check from your financial institution.

**BANK DRAFT AUTHORIZATION**

**USE ACCOUNT INFO. FROM:**  Initial Premium Check **OR**  Specimen Check (attached)

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X \_\_\_\_\_ / \_\_\_\_ / \_\_\_\_  
Signature exactly as it appears on bank records Date Signed

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DATED AT \_\_\_\_\_, THIS \_\_\_\_\_ DAY OF \_\_\_\_\_  
City and State Day Month Year

X \_\_\_\_\_ X \_\_\_\_\_  
Signature of Proposed Primary Insured Signature of Owner/Payor if other than Proposed Primary Insured

I certify that I have truly and accurately recorded on this Application the information supplied by the applicant.

\_\_\_\_\_  
Licensed Agent Signature Printed agent name License ID No. Agent No.  
**4949 Keller Springs Road, Addison, TX 75001**  
Address Phone  
**1-800-TALK-NTA**



**National Teachers Associates Life Insurance Company**  
 4949 Keller Springs Road • Addison, Texas 75001 • (888) 671-6771

**Authorization for Release of Health-Related Information**

**This Authorization Complies with HIPAA Privacy Rule**

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This Authorization will expire two (2) years from the date that this Authorization is signed.

I understand that I have the right to a copy of this Authorization and I agree that a copy of this Authorization is as valid as the original.

\_\_\_\_\_  
 Signature of Individual Whose Information is to be Disclosed

\_\_\_\_\_  
 Date

\_\_\_\_\_  
 Printed Name of Individual

\_\_\_\_\_  
 Policy Number



