

SERFF Tracking Number: NALH-127186797 State: Arkansas
 Filing Company: North American Company for Life and Health Insurance State Tracking Number: 48894
 Company Tracking Number: LS169A
 TOI: L09I Individual Life - Flexible Premium Sub-TOI: L09I.101 External Indexed - Single Life
 Adjustable Life
 Product Name: PS169A
 Project Name/Number: PS169A/PS169A

Filing at a Glance

Company: North American Company for Life and Health Insurance

Product Name: PS169A SERFF Tr Num: NALH-127186797 State: Arkansas
 TOI: L09I Individual Life - Flexible Premium SERFF Status: Closed-Approved- State Tr Num: 48894
 Adjustable Life Closed
 Sub-TOI: L09I.101 External Indexed - Single Life Co Tr Num: LS169A State Status: Approved-Closed
 Filing Type: Form Reviewer(s): Linda Bird
 Authors: Carrie Block, Laurie Gruba, Paula Kunkel-White, Gayle Lovorn, Gail Velen
 Date Submitted: 05/26/2011 Disposition Date: 06/02/2011
 Disposition Status: Approved-Closed
 Implementation Date Requested: On Approval Implementation Date:
 State Filing Description:

General Information

Project Name: PS169A
 Project Number: PS169A
 Requested Filing Mode: Review & Approval

Status of Filing in Domicile: Authorized
 Date Approved in Domicile: 05/19/2011
 Domicile Status Comments: The LS172A schedule pages are being filed concurrently with the Interstate Compact and is pending approval. The PS169A has been approved by our domicile state.

Explanation for Combination/Other:
 Submission Type: New Submission
 Overall Rate Impact:

Market Type: Individual
 Individual Market Type:
 Filing Status Changed: 06/02/2011
 State Status Changed: 06/02/2011
 Created By: Paula Kunkel-White
 Corresponding Filing Tracking Number:

Deemer Date:
 Submitted By: Paula Kunkel-White

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Product Name: PS169A
Project Name/Number: PS169A/PS169A
Filing Description:
NAIC# 431-66974 / FEIN#: 36-2428931

New Schedule Page Form - PS169A
New Schedule Page Form - PS172A

Dear Reviewer:

We are filing the above forms for your review and approval.

These forms will be laser printed and we reserve the right to change fonts and layouts. The minimum font size will never be less than 10 point type. Licensed agents of the Company will market these products on an individual basis. No part of this filing contains any unusual or possibly controversial items from normal Company or industry standards.

These are new Schedules of Policy Benefits for use with previously approved Flexible Premium Adjustable Life Insurance policy with Indexed Features Form LS16903 and form LS17203. The LS16903 Policy and the LS17203 Policy were approved by your Department on 1/22/2009 under state tracking number 41335, and 3/17/10, under state tracking number 4498, respectively. These are new forms and are not intended to replace any previously approved forms.

These new schedule page forms, PS169A and PS172A, reduce the Maximum Variable Loan Rate from 10% to 6% for new issues. In addition, the Dow Jones Industrial Average disclosure language has been revised. No other material changes between these new Schedule forms and the previous Schedule forms were made. Attached are the new Schedule of Policy Benefits Forms PS169A and PS172A.

For informational purposes, the Statement of Variability which provides the variable ranges and variable text for each of these plans is attached.

Your review of this filing is appreciated.

Company and Contact

Filing Contact Information

Paula Kunkel White, Contracts Analyst
525 W. VAN BUREN
CHICAGO, IL 60607

pwhite@nacolah.com
800-800-3656 [Phone] 27179 [Ext]
312-648-7780 [FAX]

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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
 Suite 300
 West Des Moines, IA 50266 Group Name: State ID Number:
 (800) 800-3656 ext. [Phone] FEIN Number: 36-2428931

Filing Fees

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

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
North American Company for Life and Health Insurance	\$100.00	05/26/2011	48068539

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Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved- Closed	Linda Bird	06/02/2011	06/02/2011

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Disposition

Disposition Date: 06/02/2011

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	Health - Actuarial Justification		No
Supporting Document	Outline of Coverage		No
Supporting Document	Statements of variability		Yes
Form	Schedule of Policy Benefits		Yes
Form	Schedule of Policy Benefits		Yes

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Form Schedule

Lead Form Number: LS169A

Schedule Item Status	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
	PS172A	Schedule Pages	Schedule of Policy Benefits	Initial		0.000	PS172A Schedule Page.pdf
	PS169A	Schedule Pages	Schedule of Policy Benefits	Initial		0.000	PS169A Schedule Page.pdf

SCHEDULE OF POLICY BENEFITS

OWNER: [MARY DOE] **POLICY NUMBER:** [12345678910]
INSURED: [JOHN DOE] **POLICY DATE:** [01/01/2010]
SEX: [MALE] **SPECIFIED AMOUNT:** \$[100,000]
BENEFICIARY: REFER TO APPLICATION **ISSUE AGE:** [35]
PREMIUM CLASS: [NON-TOBACCO] **PLANNED PERIODIC PREMIUM:** \$[1,061.00]
FREQUENCY: [ANNUAL]
DEATH BENEFIT OPTION: [Level][Increasing] **PLANNED INITIAL PREMIUM:** \$[1,061.00]
LIFE INSURANCE QUALIFICATION TEST: [Guideline Premium Test]
NO LAPSE GUARANTEE PREMIUM: \$[61.62 Monthly]
NO LAPSE GUARANTEE PERIOD END DATE: [1/1/2030]

[Premium includes a \$1.00 per month Civil Service Allotment fee, for a total annual increase of \$12.00.]

PRIMARY BENEFIT

DESCRIPTION	MATURITY DATE
FLEXIBLE PREMIUM ADJUSTABLE LIFE INSURANCE WITH INDEXED FEATURES	[01/01/2095]*

* Even if Planned Periodic Premiums are paid, this Policy may terminate prior to the Maturity Date because the current Cost of Insurance and interest rates are not guaranteed, Policy Loans and Withdrawals may be taken, and You may change your Death Benefit Option, or because of other requested changes to the Specified Amount. We will pay the Net Cash Surrender Value on the Maturity Date. If coverage continues to the Maturity Date, there may be little or no Net Cash Surrender Value payable.

INQUIRIES REGARDING YOUR POLICY SHOULD BE DIRECTED TO YOUR AGENT OR, IF HE OR SHE IS NOT AVAILABLE, TO OUR ADMINISTRATIVE OFFICE AT THE FOLLOWING ADDRESS:

NORTH AMERICAN COMPANY FOR LIFE AND HEALTH INSURANCE
ATTN: CLIENT COMMUNICATIONS
P.O. BOX 5088
SIOUX FALLS, SD 57117-5088
TOLLFREE 1-877-872-0757

THE INSURANCE DEPARTMENT OF THE STATE IN WHICH THIS POLICY WAS DELIVERED MAY BE CONTACTED BY CALLING: [(XXX) XXX-XXX]

POLICY CHARGES AND OTHER INFORMATION

PREMIUM LOAD: [5.00]% Of Premiums Received To Policy Age 100
POLICY EXPENSE CHARGE: [\$8.00] Per Month To Policy Age 100
UNIT EXPENSE CHARGE: [\$0.1600] Per Month Per \$1000 For [20] Policy Years. This Unit Expense Charge Applies Only If There Are No Changes To Specified Amount. The Maximum Unit Expense Charge is \$1.85 Per Month Per \$1000.
PERCENT OF ACCOUNT VALUE CHARGE: Maximum Of [0.029]% Per Month To Policy Age 100
INDEX PERIOD: [12] Consecutive Calendar Months

GUARANTEED INTEREST RATE: 3.00% Per Year

MAXIMUM STANDARD POLICY LOAN INTEREST RATE: 6.00% Per Year Payable In Arrears

MAXIMUM VARIABLE INTEREST POLICY LOAN INTEREST RATE: 6.00% Per Year Payable In Arrears

INITIAL POLICY YEAR FOR NET ZERO COST POLICY LOANS: [6th]

INITIAL POLICY YEAR FOR VARIABLE INTEREST POLICY LOANS: [6th]

INITIAL POLICY YEAR FOR STANDARD POLICY LOANS: [1st]

INTEREST BONUS ON THE FIXED ACCOUNT: [0.75] % In Policy Years [11 and Thereafter] **

INTEREST BONUS ON THE INDEX ACCOUNT VALUE: [0.75] % In Policy Years [11 and Thereafter]

INITIAL COMPARISON FOR MINIMUM ACCOUNT VALUE: [01/01/2018]

SUBSEQUENT COMPARISONS FOR MINIMUM ACCOUNT VALUE: Every [8] Policy Years Thereafter

WITHDRAWAL PROCESSING FEE: [\$25.00]

MINIMUM WITHDRAWAL AMOUNT: [\$500.00]

MAXIMUM WITHDRAWAL PERCENTAGE: 50% In First Policy Year; 90% Thereafter

MINIMUM SPECIFIED AMOUNT: [\$25,000]

MINIMUM INCREASE AMOUNT: [\$25,000]

MINIMUM UNSCHEDULED PREMIUM PAYMENT: [\$25.00]

BASIS OF VALUES: 2001 CSO, Sex Distinct, Composite, Age Last Birthday Mortality Tables

** Conditions may apply. See Section 6.2.3: Interest Bonus on the Fixed Account for details.

SCHEDULE OF POLICY BENEFITS (CONTINUED)

INDEX SELECTIONS:

INDEX SELECTION	INDEX	INDEX CREDITING METHOD	MINIMUM INDEX PARTICIPATION RATE ¹	MINIMUM INDEX CAP RATE ¹
1	S&P 500 [®]	ANNUAL POINT-to-POINT	100%	4%
2	S&P 500 [®]	MONTHLY POINT-to-POINT	100%	1.25%
3	S&P 500 [®]	DAILY AVERAGING	40%	N/A
4	S&P 500 [®]	ANNUAL INVERSE POINT-to-POINT	100%	3%
5	Uncapped S&P 500 [®]	ANNUAL POINT-to-POINT	10%	N/A
6	DJIA SM	ANNUAL POINT-to-POINT	100%	4%
7	DJIA SM	DAILY AVERAGING	40%	N/A
8	NASDAQ-100 [®]	ANNUAL POINT-to-POINT	100%	3%
9	S&P MidCap 400 [®]	ANNUAL POINT-to-POINT	100%	3%
10	S&P MidCap 400 [®]	DAILY AVERAGING	30%	N/A
11	Russell 2000 [®]	ANNUAL POINT-to-POINT	100%	3%
12	Russell 2000 [®]	DAILY AVERAGING	30%	N/A
13	EURO STOXX 50 [®]	ANNUAL POINT-to-POINT	100%	3%
14	Multi-Index Group: S&P 500 [®] EURO STOXX 50 [®] Russell 2000 [®]	MULTI-INDEX ANNUAL POINT-to-POINT Multi-Index Weight Best-Performing Index Weight: 50% Second-Best Performing Index Weight: 30% Third-Best Performing Index Weight: 20%	100%	3%

¹Guaranteed while this Policy remains in effect.

[The term “S&P 500[®]” refers to THE STANDARD & POOR’S 500[®] COMPOSITE STOCK PRICE INDEX
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SCHEDULE OF POLICY BENEFITS (CONTINUED)

INDEX SELECTIONS (CONTINUED):

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 - **The merchantability and the fitness for a particular purpose or use of the DJIA or its data;**
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[THE NASDAQ-100[®] STOCK PRICE INDEX

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SCHEDULE OF POLICY BENEFITS (CONTINUED)

INDEX SELECTIONS (CONTINUED):

[THE EURO STOXX 50[®] INDEX

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SCHEDULE OF POLICY BENEFITS (CONTINUED)

ADDITIONAL BENEFITS PROVIDED BY ENDORSEMENT OR RIDER

DESCRIPTION OF ADDITIONAL POLICY BENEFITS	YEARS PAYABLE/ EXPIRY DATE	BENEFIT UNITS OR AMOUNT	ANNUAL PREMIUM
[Accidental Death Benefit]	[01/01/2045]	[\$100,000.00]	[\$96.00]
[Children's Insurance Term Rider]	[01/01/2040]	[\$5,000.00]	[\$30.00]
[Waiver of Monthly Deductions Rider]	[01/01/2040]	[N/A]	[\$40.05]
[Guaranteed Insurability Rider]	[01/01/2025]	[\$20,000.00]	[\$28.80]
Accelerated Benefit Endorsement Maximum Accelerated Death Benefit: \$1,000,000 Terminal Illness: Maximum Election: The Smaller Of 75% Of The Death Benefit On Election Date Or \$750,000 Life Expectancy To Qualify For Benefits: 24 months Or Less Chronic Illness: Maximum of Each Election: The Smaller Of 24% Of The Death Benefit On Initial Election Date Or \$240,000 Cumulative Accelerated Benefit Percentage: [50%]	[01/01/2095]	[N/A]	[NONE]

SCHEDULE OF POLICY BENEFITS (CONTINUED)

TABLE OF SURRENDER CHARGES PER \$1,000

<u>Policy</u> <u>Year</u>	<u>Surrender</u> <u>Factor</u>	<u>Charge</u>	<u>Policy</u> <u>Year</u>	<u>Surrender</u> <u>Factor</u>	<u>Charge</u>
1	[\$20.50		12	[\$9.02	
2	20.09		13	6.97	
3	19.68		14	4.51	
4	18.86		15	2.05	
5	18.04		16+	0.00]	
6	17.22				
7	16.40				
8	15.17				
9	13.94				
10	12.71				
11	11.07]				

CORRIDOR PERCENTAGE TABLE

<u>Policy Age</u>	<u>Corridor</u> <u>Percentage</u>	<u>Policy Age</u>	<u>Corridor</u> <u>Percentage</u>
0-40	[250%	60	[130%
41	243%	61	128%
42	236%	62	126%
43	229%	63	124%
44	222%	64	122%
45	215%	65	120%
46	209%	66	119%
47	203%	67	118%
48	197%	68	117%
49	191%	69	116%
50	185%	70	115%
51	178%	71	113%
52	171%	72	111%
53	164%	73	109%
54	157%	74	107%
55	150%	75 – 90	105%
56	146%	91	104%
57	142%	92	103%
58	138%	93	102%
59	134%]	94	101%
		95+	100%]

SCHEDULE OF POLICY BENEFITS (CONTINUED)

**TABLE OF GUARANTEED COST OF INSURANCE RATES
MAXIMUM MONTHLY COST OF INSURANCE RATES PER \$1,000 OF NET AMOUNT OF RISK**

Policy Age	Cost	Policy Age	Cost
[35	0.10	[86	12.03
36	0.11	87	13.35
37	0.12	88	14.78
38	0.12	89	16.30
39	0.13	90	17.84
40	0.14	91	19.38
41	0.16	92	21.01
42	0.17	93	22.77
43	0.19	94	24.65
44	0.21	95	26.57
45	0.23	96	28.47
46	0.25	97	30.55
47	0.27	98	32.82
48	0.29	99	35.30
49	0.30	100	0.00
50	0.33	101	0.00
51	0.36	102	0.00
52	0.39	103	0.00
53	0.44	104	0.00
54	0.49	105	0.00
55	0.54	106	0.00
56	0.61	107	0.00
57	0.66	108	0.00
58	0.72	109	0.00
59	0.79	110	0.00
60	0.87	111	0.00
61	0.97	112	0.00
62	1.09	113	0.00
63	1.21	114	0.00
64	1.35	115	0.00
65	1.48	116	0.00
66	1.62	117	0.00
67	1.76	118	0.00
68	1.92	119+	0.00]
69	2.08		
70	2.27		
71	2.51		
72	2.79		
73	3.08		
74	3.39		
75	3.74		
76	4.13		
77	4.59		
78	5.12		
79	5.72		
80	6.39		
81	7.12		
82	7.90		
83	8.76		
84	9.73		
85	10.82]		

SCHEDULE OF PROTECTED DEATH BENEFIT AMOUNTS

The amounts shown in this Schedule are used only in the determination of the Protected Death Benefit Account. The Protected Death Benefit Account does NOT represent an independent dollar account that can be accessed by You. The Protected Death Benefit Account is not an addition to Your Account Value, Cash Surrender Value or any other Account described in the Policy.

Protected Death Benefit Interest Rate: [4.00%] Per Year For All Policy Years

Protected Death Benefit Minimum Age: [65]

Protected Death Benefit Expense Charge: [\$8] Per Month

TABLE OF PROTECTED DEATH BENEFIT PERCENTAGES:

<u>Policy Age</u>	<u>Percentage</u>
[65	[87%
66	87%
67	87%
68	87%
69	87%
70	87%
71	87%
72	87%
73	87%
74	87%
75+]	91%]

SCHEDULE OF PROTECTED DEATH BENEFIT AMOUNTS (CONTINUED)

TABLE OF GUARANTEED PROTECTED DEATH BENEFIT MONTHLY COST OF INSURANCE RATES PER \$1,000

Policy Age	<u>MALE</u>					<u>FEMALE</u>				
	[Super Pref. NT]	[Pref. NT]	[Non Tobacco]	[Pref. Tobacco]	[Standard Tobacco]	[Super Pref. NT]	[Pref. NT]	[Non Tobacco]	[Pref. Tobacco]	[Standard Tobacco]
[65	[1.29	[1.29	[1.29	[2.26	[2.26	[0.90	[0.90	[0.90	[1.70	[1.70
66	1.42	1.42	1.42	2.44	2.44	0.98	0.98	0.98	1.83	1.83
67	1.56	1.56	1.56	2.62	2.62	1.07	1.07	1.07	1.98	1.98
68	1.70	1.70	1.70	2.81	2.81	1.16	1.16	1.16	2.14	2.14
69	1.85	1.85	1.85	3.00	3.00	1.27	1.27	1.27	2.31	2.31
70	2.03	2.03	2.03	3.22	3.22	1.39	1.39	1.39	2.51	2.51
71	2.24	2.24	2.24	3.47	3.47	1.53	1.53	1.53	2.73	2.73
72	2.51	2.51	2.51	3.82	3.82	1.68	1.68	1.68	2.98	2.98
73	2.80	2.80	2.80	4.16	4.16	1.85	1.85	1.85	3.25	3.25
74	3.10	3.10	3.10	4.51	4.51	2.03	2.03	2.03	3.55	3.55
75	3.44	3.44	3.44	4.92	4.92	2.23	2.23	2.23	3.85	3.85
76	3.78	3.78	3.78	5.33	5.33	2.44	2.44	2.44	4.15	4.15
77	4.18	4.18	4.18	5.81	5.81	2.68	2.68	2.68	4.48	4.48
78	4.65	4.65	4.65	6.38	6.38	2.93	2.93	2.93	4.84	4.84
79	5.20	5.20	5.20	7.02	7.02	3.21	3.21	3.21	5.22	5.22
80	5.80	5.80	5.80	7.70	7.70	3.51	3.51	3.51	5.63	5.63
81	6.48	6.48	6.48	8.48	8.48	3.94	3.94	3.94	6.23	6.23
82	7.18	7.18	7.18	9.25	9.25	4.42	4.42	4.42	6.89	6.89
83	7.94	7.94	7.94	10.06	10.06	4.90	4.90	4.90	7.52	7.52
84	8.78	8.78	8.78	10.94	10.94	5.42	5.42	5.42	8.19	8.19
85	9.73	9.73	9.73	12.00	12.00	6.02	6.02	6.02	8.87	8.87
86	10.78	10.78	10.78	13.16	13.16	6.54	6.54	6.54	9.42	9.42
87	11.94	11.94	11.94	14.42	14.42	7.36	7.36	7.36	10.33	10.33
88	13.18	13.18	13.18	15.75	15.75	8.22	8.22	8.22	11.24	11.24
89	14.49	14.49	14.49	17.13	17.13	9.13	9.13	9.13	12.15	12.15
90	15.87	15.87	15.87	18.55	18.55	9.95	9.95	9.95	12.86	12.86
91	17.14	17.14	17.14	19.80	19.80	10.28	10.28	10.28	12.89	12.89
92	18.47	18.47	18.47	21.07	21.07	11.06	11.06	11.06	13.46	13.46
93	19.87	19.87	19.87	22.40	22.40	12.28	12.28	12.28	14.48	14.48
94	21.36	21.36	21.36	23.77	23.77	13.87	13.87	13.87	15.81	15.81
95	22.93	22.93	22.93	25.31	25.31	15.89	15.89	15.89	17.96	17.96
96	24.49	24.49	24.49	26.77	26.77	17.92	17.92	17.92	20.02	20.02
97	26.16	26.16	26.16	28.32	28.32	20.06	20.06	20.06	22.14	22.14
98	27.97	27.97	27.97	29.97	29.97	20.27	20.27	20.27	22.07	22.07
99	29.93	29.93	29.93	31.73	31.73	21.37	21.37	21.37	22.96	22.96
100+]	0.00]	0.00]	0.00]	0.00]	0.00]	0.00]	0.00]	0.00]	0.00]	0.00]

SCHEDULE OF POLICY BENEFITS

POLICY SPECIFICATIONS

OWNER:	[MARY DOE]	POLICY NUMBER:	[12345678910]
INSURED:	[JOHN DOE]	POLICY DATE:	[5/01/2008]
SEX:	[MALE]	SPECIFIED AMOUNT:	[\$100,000]
BENEFICIARY:	REFER TO APPLICATION	ISSUE AGE:	[35]
PREMIUM CLASS:	[NON-TOBACCO]	PLANNED PERIODIC PREMIUM:	[\$728.00]
		FREQUENCY:	[ANNUAL]
DEATH BENEFIT OPTION:	[LEVEL]	INITIAL PREMIUM RECEIVED:	[\$728.00]

ROPDB GROWTH RATE: [0%]

LIFE INSURANCE QUALIFICATION TEST: [Guideline Premium Test]

WAIVER OF SURRENDER CHARGE OPTION MONTHLY RATE PER \$1,000: \$[0.00]

WAIVER OF SURRENDER CHARGE OPTION PERIOD ENDS: [Not Applicable]

NO LAPSE GUARANTEE PREMIUM: \$[38.50 Monthly]

NO LAPSE GUARANTEE PERIOD END DATE: [5/1/2023]

PRIMARY BENEFIT

DESCRIPTION	MATURITY DATE
FLEXIBLE PREMIUM ADJUSTABLE LIFE INSURANCE WITH INDEXED FEATURES	[5/01/2093]*

* It is possible that coverage will lapse prior to the Maturity Date shown, if premiums paid are insufficient to continue coverage to such date.

POLICY CHARGES AND OTHER INFORMATION

PREMIUM LOAD: [0.00]% Of Premiums Received To Policy Age 100

POLICY EXPENSE CHARGE: \$[8.00] Per Month To Policy Age 100

UNIT EXPENSE CHARGE: Maximum Of \$[0.1475] Per Month Per \$1000 To Policy Age 100

PERCENT OF ACCOUNT CHARGE: Maximum Of [0.05%] Per Month To Policy Age 100

INDEX PERIOD: 12 Consecutive Calendar Months

GUARANTEED INTEREST RATE: 3.00% Per Year

INTEREST BONUS ON THE FIXED ACCOUNT: [0.5%] Per Year In Policy Years [16 And Thereafter]

INTEREST BONUS ON THE INDEX ACCOUNT: [0.5%] In Policy Years [16 And Thereafter]

INITIAL COMPARISON FOR MINIMUM ACCOUNT VALUE: [05/01/2016]

SUBSEQUENT COMPARISONS FOR MINIMUM ACCOUNT VALUE: Every [8] Policy Years Thereafter

MAXIMUM VARIABLE LOAN INTEREST RATE: 6% Per Year Payable In Arrears

MAXIMUM STANDARD POLICY LOAN INTEREST RATE: 6.00% Per Year Payable In Arrears

SCHEDULE OF POLICY BENEFITS (CONTINUED)

INDEX SELECTIONS:

INDEX SELECTION	INDEX	INDEX CREDITING METHOD	MINIMUM INDEX PARTICIPATION RATE ¹	MINIMUM INDEX CAP RATE ¹
1	[S&P 500 [®]]	[POINT-to-POINT]	[100%]	[4%]
2	[S&P 500 [®]]	[DAILY AVERAGING]	[40%]	[N/A]
3	[DJIA SM]	[POINT-to-POINT]	[100%]	[4%]
4	[DJIA SM]	[DAILY AVERAGING]	[40%]	[N/A]
5	[EURO STOXX 50 [®]]	[POINT-to-POINT]	[100%]	[3%]
6	[Uncapped S&P 500]	[POINT-to-POINT]	[10%]	[N/A]
7	[Multi-Index Group:] [S&P 500 [®]] [EURO STOXX 50 [®]] [Russell 2000 [®]]	[MULTI-INDEX ANNUAL POINT-to-POINT] [Multi-Index Weight] [Best-Performing Index Weight: 50%] [Second-Best Performing Index Weight 30%] [Third-Best Performing Index Weight: 20%]	[100%]	[3%]

¹Guaranteed while this Policy remains in effect.

[The term “S&P 500[®]” refers to THE STANDARD & POOR’S 500[®] COMPOSITE STOCK PRICE INDEX

This Index does not include dividends paid by the underlying companies.

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SCHEDULE OF POLICY BENEFITS (CONTINUED)

INDEX SELECTIONS (CONTINUED):

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 - The merchantability and the fitness for a particular purpose or use of the DJIA or its data;
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SCHEDULE OF POLICY BENEFITS (CONTINUED)

ADDITIONAL BENEFITS PROVIDED BY ENDORSEMENT OR RIDER

DESCRIPTION OF ADDITIONAL POLICY BENEFITS	YEARS PAYABLE/ EXPIRY DATE	BENEFIT UNITS OR AMOUNT	ANNUAL PREMIUM
[NONE]	[N/A]	[N/A]	[N/A]

INQUIRIES REGARDING YOUR POLICY SHOULD BE DIRECTED TO YOUR AGENT OR, IF HE OR SHE IS NOT AVAILABLE, TO OUR ADMINISTRATIVE OFFICE AT THE FOLLOWING ADDRESS:

NORTH AMERICAN COMPANY FOR LIFE AND HEALTH INSURANCE
ATTN: CLIENT COMMUNICATIONS
P.O. BOX 5088
SIOUX FALLS, SD 57117-5088
1-877-872-0757

SCHEDULE OF POLICY BENEFITS (CONTINUED)

TABLE OF SURRENDER CHARGES PER \$1,000

<u>Policy Year</u>	<u>Surrender Charge Factor</u>	<u>Policy Year</u>	<u>Surrender Charge Factor</u>
1	[\$13.50	9	[\$12.15
2	13.50	10	10.80
3	13.50	11	9.45
4	13.50	12	8.10
5	13.50	13	6.75
6	13.50	14	4.05
7	13.50	15+	0]
8	13.50]		

If the Waiver of Surrender Charge Option is selected, the Surrender Charges will be waived. However, if this Policy is surrendered and subsequently transferred, directly or indirectly, to another insurance company to achieve an exchange under Section 1035 of the Internal Revenue Code, We reserve the right to deduct the Surrender Charges as described in Section 6.12.

CORRIDOR PERCENTAGE TABLE

<u>Policy Age</u>	<u>Corridor Percentage</u>	<u>Policy Age</u>	<u>Corridor Percentage</u>
[0-40	250%	60	130%
41	243%	61	128%
42	236%	62	126%
43	229%	63	124%
44	222%	64	122%
45	215%	65	120%
46	209%	66	119%
47	203%	67	118%
48	197%	68	117%
49	191%	69	116%
50	185%	70	115%
51	178%	71	113%
52	171%	72	111%
53	164%	73	109%
54	157%	74	107%
55	150%	75 – 90	105%
56	146%	91	104%
57	142%	92	103%
58	138%	93	102%
59	134%	94	101%
		95+	100%]

SCHEDULE OF POLICY BENEFITS (CONTINUED)

**TABLE OF GUARANTEED COST OF INSURANCE RATES
MAXIMUM MONTHLY COST OF INSURANCE PER \$1,000**

<u>POLICY AGE</u>	<u>COST</u>	<u>POLICY AGE</u>	<u>COST</u>	<u>POLICY AGE</u>	<u>COST</u>
35	0.10	57	0.66	79	5.72
36	0.11	58	0.72	80	6.39
37	0.12	59	0.79	81	7.12
38	0.12	60	0.87	82	7.90
39	0.13	61	0.97	83	8.76
40	0.14	62	1.09	84	9.73
41	0.16	63	1.21	85	10.82
42	0.17	64	1.35	86	12.03
43	0.19	65	1.48	87	13.35
44	0.21	66	1.62	88	14.78
45	0.23	67	1.76	89	16.30
46	0.25	68	1.92	90	17.84
47	0.27	69	2.08	91	19.38
48	0.29	70	2.27	92	21.01
49	0.30	71	2.51	93	22.77
50	0.33	72	2.79	94	24.65
51	0.36	73	3.08	95	26.57
52	0.39	74	3.39	96	28.47
53	0.44	75	3.74	97	30.55
54	0.49	76	4.13	98	32.82
55	0.54	77	4.59	99	35.30
56	0.61	78	5.12	100+	0.00

SCHEDULE OF PROTECTED DEATH BENEFIT AMOUNTS

The amounts shown in this Schedule are used only in the determination of the Protected Death Benefit Account. The Protected Death Benefit Account does NOT represent an independent dollar account that can be accessed by You. The Protected Death Benefit Account is not an addition to Your Account Value, Cash Surrender Value or any other Account described in the Policy.

Protected Death Benefit Interest Rate: [4.00%] Per Year For All Policy Years

Protected Death Benefit Minimum Age: [65]

Protected Death Benefit Expense Charge: [\$8] Per Month

TABLE OF PROTECTED DEATH BENEFIT PERCENTAGES:

<u>Policy Age</u>	<u>Percentage</u>
[65	[87%
66	87%
67	87%
68	87%
69	87%
70	87%
71	87%
72	87%
73	87%
74	87%
75+]	91%]

SCHEDULE OF PROTECTED DEATH BENEFIT AMOUNTS (CONTINUED)

TABLE OF GUARANTEED PROTECTED DEATH BENEFIT MONTHLY COST OF INSURANCE RATES PER \$1,000

Policy Age	<u>MALE</u>					<u>FEMALE</u>				
	[Super Pref. NT]	[Pref. NT]	[Non Tobacco]	[Pref. Tobacco]	[Standard/ Tobacco]	[Super Pref. NT]	[Pref. NT]	[Non Tobacco]	[Pref. Tobacco]	[Standard/ Tobacco]
65	1.29	1.29	1.29	2.26	2.26	0.90	0.90	0.90	1.70	1.70
66	1.42	1.42	1.42	2.44	2.44	0.98	0.98	0.98	1.83	1.83
67	1.56	1.56	1.56	2.62	2.62	1.07	1.07	1.07	1.98	1.98
68	1.70	1.70	1.70	2.81	2.81	1.16	1.16	1.16	2.14	2.14
69	1.85	1.85	1.85	3.00	3.00	1.27	1.27	1.27	2.31	2.31
70	2.03	2.03	2.03	3.22	3.22	1.39	1.39	1.39	2.51	2.51
71	2.24	2.24	2.24	3.47	3.47	1.53	1.53	1.53	2.73	2.73
72	2.51	2.51	2.51	3.82	3.82	1.68	1.68	1.68	2.98	2.98
73	2.80	2.80	2.80	4.16	4.16	1.85	1.85	1.85	3.25	3.25
74	3.10	3.10	3.10	4.51	4.51	2.03	2.03	2.03	3.55	3.55
75	3.44	3.44	3.44	4.92	4.92	2.23	2.23	2.23	3.85	3.85
76	3.78	3.78	3.78	5.33	5.33	2.44	2.44	2.44	4.15	4.15
77	4.18	4.18	4.18	5.81	5.81	2.68	2.68	2.68	4.48	4.48
78	4.65	4.65	4.65	6.38	6.38	2.93	2.93	2.93	4.84	4.84
79	5.20	5.20	5.20	7.02	7.02	3.21	3.21	3.21	5.22	5.22
80	5.80	5.80	5.80	7.70	7.70	3.51	3.51	3.51	5.63	5.63
81	6.48	6.48	6.48	8.48	8.48	3.94	3.94	3.94	6.23	6.23
82	7.18	7.18	7.18	9.25	9.25	4.42	4.42	4.42	6.89	6.89
83	7.94	7.94	7.94	10.06	10.06	4.90	4.90	4.90	7.52	7.52
84	8.78	8.78	8.78	10.94	10.94	5.42	5.42	5.42	8.19	8.19
85	9.73	9.73	9.73	12.00	12.00	6.02	6.02	6.02	8.87	8.87
86	10.78	10.78	10.78	13.16	13.16	6.54	6.54	6.54	9.42	9.42
87	11.94	11.94	11.94	14.42	14.42	7.36	7.36	7.36	10.33	10.33
88	13.18	13.18	13.18	15.75	15.75	8.22	8.22	8.22	11.24	11.24
89	14.49	14.49	14.49	17.13	17.13	9.13	9.13	9.13	12.15	12.15
90	15.87	15.87	15.87	18.55	18.55	9.95	9.95	9.95	12.86	12.86
91	17.14	17.14	17.14	19.80	19.80	10.28	10.28	10.28	12.89	12.89
92	18.47	18.47	18.47	21.07	21.07	11.06	11.06	11.06	13.46	13.46
93	19.87	19.87	19.87	22.40	22.40	12.28	12.28	12.28	14.48	14.48
94	21.36	21.36	21.36	23.77	23.77	13.87	13.87	13.87	15.81	15.81
95	22.93	22.93	22.93	25.31	25.31	15.89	15.89	15.89	17.96	17.96
96	24.49	24.49	24.49	26.77	26.77	17.92	17.92	17.92	20.02	20.02
97	26.16	26.16	26.16	28.32	28.32	20.06	20.06	20.06	22.14	22.14
98	27.97	27.97	27.97	29.97	29.97	20.27	20.27	20.27	22.07	22.07
99	29.93	29.93	29.93	31.73	31.73	21.37	21.37	21.37	22.96	22.96
100+	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00

SERFF Tracking Number: NALH-127186797 State: Arkansas
 Filing Company: North American Company for Life and Health State Tracking Number: 48894
 Insurance
 Company Tracking Number: LS169A
 TOI: L09I Individual Life - Flexible Premium Sub-TOI: L09I.101 External Indexed - Single Life
 Adjustable Life
 Product Name: PS169A
 Project Name/Number: PS169A/PS169A

Supporting Document Schedules

	Item Status:	Status Date:
Satisfied - Item: Flesch Certification Comments: Attachment: State of Arkansas Certifications.pdf		

	Item Status:	Status Date:
Satisfied - Item: Application Comments: The application L-3182 approved by the Dept on 9/16/09 under state tracking number 43481. The application L-3187A approved by the Dept on 2/24/10 under state tracking number 44967. The applications L-3197 & L-3198 approved by the Dept on 12/8/10 under state tracking number 47473. Attachments: L-3182 nationwide.pdf L-3187A.pdf L-3197 App Part 1.pdf L-3198 App Part 2.pdf		

	Item Status:	Status Date:
Satisfied - Item: Statements of variability Comments: Attachments: Stmtnt of Variability LS16903 & PS169A.pdf Statement of Variability LS17203 & PS172A.pdf		

STATE OF ARKANSAS

Certificate of Compliance

Forms PS169A and PS172A

On behalf of Midland National Life Insurance Company, I certify the company is in compliance with:

Rule and Regulation 19.

Rule and Regulation 34 for Universal Life Insurance.

Rule and Regulation 49 – each policyholder will be provided a life and health guaranty notice at time of issue.

A.C.A. § 23-79-138 for Policy Information Requirements – each policy will contain the contact information of the policyholder's service office, soliciting agent and the state insurance department.



Paula Kunkel-White, CLU, FALU, FLMI, AIRC, ALHC
Senior Contracts Analyst

Date: 5/26/2011



L3182

GENERAL PURPOSE LIFE APPLICATION Part I (Print and Use Black Ink)

PRIMARY INSURED PROPOSED FOR INSURANCE

1. Last Name	First Name	M.I.
--------------	------------	------

1a. Are you a U.S. Citizen or do you have a permanent Visa? Yes No (If no, complete Foreign Travel and Residence Questionnaire)

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

Social Security Number/Tax ID#	Driver's License Number	Expiration Date	State
--------------------------------	-------------------------	-----------------	-------

2. Residence Address (If P. O. Box include Street Address)	Street	City	State	Zip Code
---	--------	------	-------	----------

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

_____ Years _____ Months

2b. Billing Address (If other than residence)	Street	City	State	Zip Code
--	--------	------	-------	----------

2c. Secondary Addressee Billing Yes No If Yes, Provide Secondary Addressee's Name, Street Address, City, State & Zip Code
(Agent cannot qualify as Secondary Addressee)

3. Employer (Company Name and Address)

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

4. Contact The Proposed Insured At: <input type="checkbox"/> Residence <input type="checkbox"/> Business _____ (CST) <input type="checkbox"/> A.M. <input type="checkbox"/> P.M.	Residence Telephone Number: Primary Insured () Additional Insured () Cell Phone ()	Business Telephone Number: Primary Insured () Additional Insured () Cell Phone ()
--	---	--

PLAN INFORMATION

5. Amount Applied For \$	Proposed Plan of Insurance	6. For UL: (check if applicable) <input type="checkbox"/> Level <input type="checkbox"/> Increasing <input type="checkbox"/> Return of Premium
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7. RIDERS

<p>a. Term Products</p> <p><input type="checkbox"/> Additional Insured Rider \$ _____</p> <p><input type="checkbox"/> Children's Term Insurance Rider (CTR) _____ units</p> <p><input type="checkbox"/> Guaranteed Insurability Rider _____ units</p> <p><input type="checkbox"/> Monthly Income Endorsement: Initial Lump Sum \$ _____ \$ _____ Monthly for _____ years; Final Lump Sum \$ _____</p> <p><input type="checkbox"/> Waiver of Premium Rider</p> <p><input type="checkbox"/> Other _____ \$ _____</p>	<p>b. Permanent Products</p> <p><input type="checkbox"/> Accidental Death Benefit \$ _____</p> <p><input type="checkbox"/> Additional Insured Rider \$ _____</p> <p><input type="checkbox"/> Automatic Distribution Option</p> <p><input type="checkbox"/> Children's Term Insurance Rider (CTR) _____ units</p> <p><input type="checkbox"/> Estate Preservation Rider</p> <p><input type="checkbox"/> Guaranteed Insurability Rider _____ units</p> <p><input type="checkbox"/> Premium Guarantee Rider</p> <p><input type="checkbox"/> Waiver of Monthly Deductions Rider</p> <p><input type="checkbox"/> Waiver of Surrender Charge Option</p> <p><input type="checkbox"/> Other _____ \$ _____</p>
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ADDITIONAL INSURED PROPOSED for INSURANCE (Complete Separate Application for Business Associates and Additional Insureds)

8. Last Name _____ First Name _____ M.I. _____

8a. Are you a U.S. Citizen or do you have a permanent Visa? Yes No (If no, complete Foreign Travel and Residence Questionnaire)

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

Social Security Number/Tax ID# _____ Driver's License Number _____ Expiration Date _____ State _____

9. Employer (Company Name and Address) _____

Occupation (Title and Duties) _____ Annual Income \$ _____

10. DEPENDENT CHILDREN PROPOSED for INSURANCE

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

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

Name of Owner(s): If Trust, list all Trustees as well as Name and Date of Trust and complete **Trust Form**. If Owner is a business, complete **Company/Corporate Owned Life Insurance (COLI) Form**.

Owner's Address _____ Street _____ City _____ State _____ Zip Code _____

Relationship to Primary Insured _____ Owner's Social Security/Tax ID # _____ U.S. Citizen Resident Alien - Country _____ Nonresident Alien - Country _____

Name of Contingent Owner(s) _____ Contingent Owner's Social Security/Tax ID # _____

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

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

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

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

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

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

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

PREMIUM INFORMATION

15. Premium Frequency: Annual Semi-Annual Quarterly Monthly Single Pay Lump Sum \$

Premium Mode: EFT List Billing Direct Billing (A, SA, Q) only Civil Service Allotment Military Government Allotment

List Bill Code _____ Other _____

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

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

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

16. For EFT Only: Draw Day _____ (1 st - 28 th) Month Day	Account Type <input type="checkbox"/> Checking (attach voided check) <input type="checkbox"/> Savings (must complete 16b)	Authorized Signature(s) of Account Holder(s) <input checked="" type="checkbox"/> <input type="text"/>
16a. Initial Draft <input type="checkbox"/> Yes <input type="checkbox"/> No		<input checked="" type="checkbox"/> <input type="text"/>
16b. Routing Transit Number	Account Number	Financial Institution Name and Address

REPLACEMENT INFORMATION

17. Does any person proposed for coverage have any life insurance or annuities currently in force or pending? (This includes policies that have or will be sold, assigned or otherwise placed via life settlement, viatical or other agreements.) Yes No If yes, list below:

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

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

19. Are any of the above policies being used to fund this policy? Yes No
20. Has, or will, any person proposed for insurance, or owner of this policy, been compensated in any way to purchase this policy? Yes No
21. Is the proposed insured(s), or owner of this policy, paying for this policy 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? Yes No
23. Has any person proposed for insurance, or owner of this policy, financed, or intend to finance, all or a portion of the premiums for this policy? If yes, complete Disclosure and Acknowledgement Form for premium financing and submit with application Yes No
24. Has the policy owner, beneficiary, or person proposed for insurance entered into or considering any other agreement with a third party, trust, or other entity, in regard to this policy, including, but not limited to, an agreement to sell, transfer or assign the policy or any policy 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 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

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

26. Permanent Home of Record	Street	City	State	Zip Code
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27. Military Address	Street	City	State	Zip Code
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28. Job Duties	29. Are you currently drawing extra duty or hazard pay? <input type="checkbox"/> Yes <input type="checkbox"/> No
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30. Military Information <input type="checkbox"/> USA <input type="checkbox"/> USN <input type="checkbox"/> USAF <input type="checkbox"/> Other (Specify) _____	Military ID _____
Pay Grade _____	Rotation Date _____ Expected Discharge Date _____

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

Question 33 must be completed for all proposed insureds, including CTR. Details to "Yes" answers are to be provided in the Details Section below.

		Yes	No
33. Has any person proposed for insurance:			
(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? If yes, complete Drug Questionnaire	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(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? If yes, complete Alcohol Questionnaire.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(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)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(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?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(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?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(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? If yes, complete Aviation Questionnaire.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(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? If yes, please complete applicable Underwriting Questionnaire..	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(h) In the past 10 years been refused for life insurance or charged an extra premium for life insurance?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(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? If yes, complete the Foreign Travel and Residence Questionnaire.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(j) Have any bankruptcy pending or expect to file bankruptcy in the next 12 months?	<input type="checkbox"/>	<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

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)				
	Driver's License	State:	Number:	Expiration Date:
	State-issued ID	State:	Number:	Expiration Date:
	Military ID		Number:	Expiration Date:
	Passport	Country:	Number:	Expiration Date:
	Alien Registration Card	Country:	Number:	Expiration Date:
<i>Non-Natural/Business or Corporation</i>				
	Partner or Trust Agreement		Date:	
	Certificate of Incorporation	State:	Date:	
	Business License	State:	Number:	
B. Owner #2				
Natural Person/Trust Accounts (info on trustee)				
	Driver's License	State:	Number:	Expiration Date:
	State-issued ID	State:	Number:	Expiration Date:
	Military ID		Number:	Expiration Date:
	Passport	Country:	Number:	Expiration Date:
	Alien Registration Card	Country:	Number:	Expiration Date:
<i>Non-Natural/Business or Corporation</i>				
	Partner or Trust Agreement		Date:	
	Certificate of Incorporation	State:	Date:	
	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 of our Company; (2) the acceptance of any policy 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 is effective, as defined herein.

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

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

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

TAX PAYER IDENTIFICATION NUMBER CERTIFICATION - Under penalties of perjury, the undersigned applicant(s) (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) (I) authorize any licensed physician, medical practitioner, health care professional, hospital, clinic, or other medically related facility, laboratory, pharmacy, 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, OH and PA Residents: Any person who knowingly, and with intent to defraud any insurance company or other person, files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

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

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

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.

VA and 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.

Accelerated Death Benefit: If the policy being applied for includes an accelerated death benefit(s), the Proposed Primary Insured 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 provided the Proposed Primary Insured 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 <input type="text"/>		X <input type="text"/>	
Signature of Owner (If other than Proposed Primary Insured) (If Owner is Corporation, Trust, or other Entity, include Title of Signee.)			
X <input type="text"/>			
Signature of Soliciting Agent	Print Agent's Last Name	Agent Code	Telephone Number ()
X <input type="text"/>			Cell Phone Number ()
Other Agent (Print)			% Credit
Other Agent (Print)			Agent Code



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.

<input type="checkbox"/> Change	<input type="checkbox"/> Review Rating	<input type="checkbox"/> Reinstatement	<input type="checkbox"/> Conversion	<input type="checkbox"/> Class Change
<input type="checkbox"/> Increase	<input type="checkbox"/> Add Rider	<input type="checkbox"/> Decrease	<input type="checkbox"/> Option Change	<input type="checkbox"/> Exchange

EXISTING COVERAGE: UNIVERSAL LIFE INDEX UNIVERSAL 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
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Social Security Number	Driver's License Number	Expiration Date	State
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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 \$
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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 Primary Insured () _____ Additional Insured () _____ Cell Phone () _____	BUSINESS TELEPHONE NUMBER Primary Insured () _____ Additional Insured () _____ Cell Phone () _____
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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

Name of New Plan	New Policy/Certificate Date _____ Mo. _____ Yr.	\$ Amount of Insurance	Telemed: <input type="checkbox"/> Yes <input type="checkbox"/> No
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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

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 (WMD) Waiver of Monthly Deduction
 (AIR) Add'l Insured Rider (PGR) Premium Guarantee Rider
 (WP) Waiver of Premium (GIR) Guaranteed Insurability Rider / (OPAI) Option to Purchase Add'l Insurance
 (WoSC) Waiver of Surrender Charge (ABE) Accelerated Benefit Endorsement
 (ADB) Accidental Death Benefit (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><input type="checkbox"/></p>	<p>No</p> <p><input type="checkbox"/></p>
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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



[ADVANCED APPLICATION PART 1]

PRIMARY INSURED PROPOSED FOR INSURANCE

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

PLAN INFORMATION

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

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

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

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

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

To be completed by Parent or Legal Guardian

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

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

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

Question # Name of Dependent Details

Question #	Name of Dependent	Details

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

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

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

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

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

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

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

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

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

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

PREMIUM INFORMATION

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

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

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

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

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

REPLACEMENT INFORMATION

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

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

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

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

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

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

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

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

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

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

TO BE COMPLETED BY SOLICITING AGENT

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

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

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

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

25. PRELIMINARY HEALTH QUESTION

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

26. SPECIAL REQUESTS OR DETAILS

[Empty box for special requests or details]

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

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

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

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

B. Owner #2

Natural Person/Trust Accounts (info on trustee)

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

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

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

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

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

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

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

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

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

FRAUD WARNING

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

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

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

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

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

SIGNATURES

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



[ADVANCED APPLICATION PART 2]

PERSONAL INFORMATION

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

UNDERWRITING AND LIFESTYLE INFORMATION

2. Have you ever smoked cigarettes, cigars, pipes, or used tobacco in any form, including smokeless tobacco, nicotine patch, gum or other substitutes? Yes No
 If "yes" provide: Type of product(s) used: _____
 Amount Used: _____ How often: Daily _____ Weekly _____ Monthly _____ Date of last use: mm/yy _____

Please provide Details to "Yes" answers for Questions 4. through 5. in the Details section following these questions.

3. In the past 10 years, have you:

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

4. Have you:

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

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

Question #	Details

--	--

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

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

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

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

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

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

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

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

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

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

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

FAMILY HISTORY

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

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

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

AGREEMENT

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

Check appropriate box:

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

DETAILS: _____

FRAUD WARNING

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

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

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

SIGNATURES

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

Statement of Variability - Policy Form Series LS16903 with Schedule page form PS169A

With the exception of the variables specific to the individual policyholder, the following is a list of bracketed items and the corresponding range of text and/or values. Some of the items are bracketed for future flexibility.

Bracketed Item	Variable Text/Range
Premium Class	Super Preferred Non-Tobacco, Preferred Non-Tobacco, Preferred Tobacco, Non-Tobacco, Standard Tobacco
Death Benefit Option	1 (Level), 2 (Increasing) (ROPDB)
Return of Premium Death Benefit Growth Rate	0% - 2%
Life Insurance Qualification Test	Guideline Premium Test or Cash Value Accumulation Test
Waiver of Surrender Charge Option Monthly Rate per \$1000	\$0.00 - \$0.08
Waiver of Surrender Charge Option Period ends	Not Applicable or 14 Years from Policy Date
No Lapse Guarantee Period End Date	5 – 20 Years from Policy Date (varies by Issue Age)
Premium Load	0% - 5% per month
Policy Expense Charge	\$0 - \$10 per month
Unit Expense Charge	\$0 - \$2.50 per month (varies by Issue Age, Sex, Premium Class, Specified Amount)
Percent of Account Charge	0% - 0.05% per month for 0-100 policy years (length varies by issue age)
Interest Bonus on Fixed Account	0% - 1.00% Policy Years 10 – 100
Interest Bonus on Index Account	0% - 1.00% Policy Years 10 – 100
Initial Comparison for Minimum Account Value	5-10 policy years
Subsequent Comparison for Minimum Account Value	Every 5-10 policy years after initial comparison
Initial Policy Year for Variable Interest Loans	1-10
Initial Policy Year for Standard Loans	1-10
Initial Policy Year for Net Zero Cost Loans	1-10
Withdrawal Processing Fee	\$0 - \$50
Minimum Withdrawal Amount	\$100 - \$1,000
Minimum Specified Amount	\$50,000 - \$100,000
Minimum Increase Amount	\$10,000 - \$50,000
Minimum Unscheduled Premium Payment	\$0 - \$100

Alternate Flat Decrease Charge	\$0 - \$500
Cost of Insurance Discount Factor	1.000 – 1.005
Index Selections	The Indexes have been bracketed in the event an Index is discontinued or substantially changed and can no longer be utilized by the company. If this occurs the index name and corresponding disclosure will not print for future issues of the policy. If a new Index is added, it will be submitted along with the revised schedule pages to the Department for prior approval, if required.
Index Disclosures	This text is prescribed by each Index and is bracketed in the event the Index changes to the required disclosure text. This text will not be changed unless required by the Index.
Minimum Index Participation Rate – Annual Point to Point, Monthly Point-to-Point, & Multi-Index Annual Point-to-Point	50% - 120%
Minimum Index Participation Rate – Daily Averaging	10% - 40%
Minimum Index Cap Rate – Annual Point-to-Point & Multi-Index Annual Point-to-Point	2% - 4%
Minimum Index Cap Rate – Monthly Point-to-Point	1% - 2%
Best-Performing Index Weight – Multi-Index Annual Point-to-Point	0% - 100%
Second-Best-Performing Index Weight – Multi-Index Annual Point to-Point	0% - 100%
Third-Best-Performing Index Weight – Multi-Index Annual Point-to-Point	0% - 100%
Surrender Charge Factor	Varies by Sex, Issue Age, Policy Year
Corridor Percentage Table	Varies by Policy Age, Sex, Policy Year
Protected Death Benefit Interest Rate	2% - 4%
Protected Death Benefit Minimum Age	45 to 65
Protected Death Benefit Expense Charge	\$5 to \$10
Protected Death Benefit Percentages	85% to 91%

Statement of Variability - Policy Form Series LS17203 w/Schedule Pages PS172

The following is a list of bracketed items and the corresponding range of text and/or values. Some of the items are bracketed for future flexibility.

The following criteria are used to determine the value of each bracketed item:

- Consumer demands and preferences
- The market conditions and the competitive environment.
- The economic environment and its impact on our investment portfolio.
- The Company's experience for lapses, mortality and expenses

Bracketed Item	Variable Text/Range
Owner	Varies with consumer
Policy Number	Varies with consumer
Insured	Varies with consumer
Policy Date	Varies with consumer
Sex	Varies with consumer
Specified Amount	Varies with consumer
Issue Age	Varies with consumer
Premium Class	Super Preferred Plus Non tobacco, Preferred Non Tobacco, Preferred Tobacco, Standard Non Tobacco, Standard Tobacco. If a policy is table rated, additional text applies: Rated Tobacco, Rated Non-Tobacco The monthly cost of insurance is increased by xx%. The annual cost of insurance is increased by \$x.xx per thousand of Specified Amount until xx/xx/xxxx. If the policy has a flat extra rating, additional text applies: The annual cost of insurance is increased by \$x.xx per thousand of Specified Amount until xx/xx/xxxx. The dollar range for the Flat extra is \$1.00-\$200.00 The table rating range is 25% - 400%
Planned Periodic Premium	Amount varies by consumer; annually, semi-annual, quarterly, monthly
Frequency	Annual, semi-annual, quarterly, monthly
Death Benefit Option	The consumer can choose one of two Death Benefit Options: Level or Increasing
Initial Premium Received	Varies with consumer
Life Insurance Qualification Test	Guideline Premium Test or Cash Value Accumulation Test
No Lapse Guarantee Premium	Varies with consumer (varies by Issue Age, Sex, Premium Class, and Specified Amount)
No Lapse Guarantee Period End Date	5-20 Years from Policy Date (varies by Issue Age of the Insured)
Civil Service Allotment	Premium includes a \$1.00 per month Civil Service Allotment fee, for a total annual increase of \$12.00. This sentence will print on the schedule if the insured chooses Civil Service Allotment as a premium mode.
Maturity Date	Varies with consumer
Premium Load	This load is currently the same for all consumers and is bracketed for future flexibility. Range of Variability: 0% - 20%

Policy Expense Charge	This charge is currently the same for all consumers and is bracketed for future flexibility. Range of Variability: \$0 - \$10 per month
Unit Expense Charge	Range of Variability: \$0.0225 - \$2.40 per month (varies by Issue Age, Sex, Premium Class, and Specified Amount)
Percent of Account Charge	0% - 0.50% per month for 0-100 policy years (length varies by issue age)
Index Period	Range of Variability: 1 month to 24 months
Initial Policy Year for Net Zero Loans	This item is bracketed for future flexibility. The Company currently permits Net Zero Cost Loans beginning in Policy Year 6. Range of Variability: 6-11
Initial Policy Year for Variable Interest Loans	1-10 The bracketing of the initial year is intended to allow the flexibility of which type of policy loan would be available in what year. Either a Variable Interest Loan or Standard Loan or both will be available when there is cash surrender value.
Initial Policy Year for Standard Loans	1-10 The bracketing of the initial year is intended to allow the flexibility of which type of policy loan would be available in what year Either a Variable Interest Loan or Standard Loan or both will be available when there is cash surrender value.
Interest Bonus on the Fixed Account	0.25% - 1.00% Policy Years 10-100
Index Bonus on the Index Account Value	0.25% - 1.00% Policy Years 10-100
Initial Comparisons for Minimum Account Value	5-10 policy years
Subsequent Comparisons for Minimum Account Value	Every 5-10 policy years after initial comparison
Withdrawal Processing Fee	\$0 - \$50
Minimum Withdrawal Amount	\$100 - \$1,000
Minimum Specified Amount	\$25,000 - \$250,000
Minimum Increase Amount	\$10,000 - \$50,000
Minimum Unscheduled Premium Payment	\$0 - \$100
Index Selections	The Indexes have been bracketed in the event an Index is discontinued or substantially changed and can no longer be utilized by the company. If this occurs the index name and corresponding disclosure will not print for future issues of the policy. If a new Index is added, it will be submitted along with the revised schedule pages to the Department for prior approval, if required.
Minimum Index Participation Rate – Annual Point to Point, Annual Inverse Point-to-Point, Monthly Point-to-Point, & Multi-Index Annual Point-to-Point	50% - 120%
Minimum Index Participation Rate – Daily Averaging	10% - 40%
Minimum Index Cap Rate – Annual Point-to-Point, Annual Inverse Point-to-Point & Multi-Index Annual Point-to-Point	2% - 4%
Minimum Index Cap Rate –	1% - 2%

Monthly Point-to-Point	
Best-Performing Index Weight – Multi-Index Annual Point-to-Point	0% - 100%
Second-Best-Performing Index Weight – Multi-Index Annual Point to-Point	0% - 100%
Third-Best-Performing Index Weight – Multi-Index Annual Point-to-Point	0% - 100%
Index Disclosures	This text is prescribed by each Index and is bracketed in the event the Index changes to the required disclosure text. This text will not be changed unless required by the Index.
Surrender Charge Factor	Range of Variability: \$0 - \$60 (Varies by Issue Age, Sex, Premium Class and Policy Year)
Corridor Percentage	Varies with consumer
Guaranteed Cost of Insurance Rates	Varies with consumer
Additional Benefits Provided by Endorsement or Rider	<p>Endorsements and Riders are optional and/or specific underwriting criteria must be met for the insured. The expiry date, benefit units and annual premium would vary by insured.</p> <p>Accelerated Benefit Endorsement</p> <p>Chronic Illness - specific underwriting criteria must be met.</p> <p>Cumulative Accelerated Benefit Percentage = Range of Variability 25% -75%</p> <p>Previously approved riders may be added to this policy in the future.</p>
Schedule of Protected Death Benefit Amounts	
Protected Death Benefit Interest Rate	2% - 5%
Protected Death Benefit Minimum Age	45 to 65
Protected Death Benefit Expense Charge	\$5 to \$15
Protected Death Benefit Percentages	40% to 91%
Premium Classes	Preferred Plus Non tobacco, Preferred Non Tobacco, Preferred Tobacco, Non Tobacco, Standard Tobacco
Guaranteed Protected Death Benefit Monthly Cost of Insurance Rates	Varies with consumer