

SERFF Tracking Number: NALH-127189091 State: Arkansas  
Filing Company: North American Company for Life and Health Insurance State Tracking Number: 48927  
Company Tracking Number: FORM 4580 5-11  
TOI: L08 Life - Other Sub-TOI: L08.000 Life - Other  
Product Name: Form 4580 5-11  
Project Name/Number: Form 4580 5-11/Form 4580 5-11

## Filing at a Glance

Company: North American Company for Life and Health Insurance

Product Name: Form 4580 5-11

TOI: L08 Life - Other

Sub-TOI: L08.000 Life - Other

Filing Type: Form

SERFF Tr Num: NALH-127189091 State: Arkansas

SERFF Status: Closed-Approved-  
Closed State Tr Num: 48927

Co Tr Num: FORM 4580 5-11

Author: Sherry M. Olson

Date Submitted: 05/27/2011

State Status: Approved-Closed

Reviewer(s): Linda Bird

Disposition Date: 06/08/2011

Disposition Status: Approved-  
Closed

Implementation Date:

Implementation Date Requested: On Approval

State Filing Description:

## General Information

Project Name: Form 4580 5-11

Project Number: Form 4580 5-11

Requested Filing Mode: Review & Approval

Explanation for Combination/Other:

Submission Type: New Submission

Overall Rate Impact:

Deemer Date:

Submitted By: Sherry M. Olson

Filing Description:

RE: North American Company for Life and Health Insurance

NAIC #66974 FEIN # 36-24228931

Verification of Medical Exam, Form 4580 5-11

Status of Filing in Domicile: Pending

Date Approved in Domicile:

Domicile Status Comments: Submitted to North  
American's domicile state of Iowa on 5/26/11

Market Type: Individual

Individual Market Type:

Filing Status Changed: 06/08/2011

State Status Changed: 06/08/2011

Created By: Sherry M. Olson

Corresponding Filing Tracking Number:

We are filing the referenced form for your review and approval. This is a new form and not intended to replace any existing form. This form is laser printed and we reserve the right to change fonts and layouts. We certify that the font size will never be less than the minimum 10-point required by your state.

SERFF Tracking Number: NALH-127189091 State: Arkansas  
Filing Company: North American Company for Life and Health State Tracking Number: 48927  
Insurance  
Company Tracking Number: FORM 4580 5-11  
TOI: L08 Life - Other Sub-TOI: L08.000 Life - Other  
Product Name: Form 4580 5-11  
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This form will be used with North American's current and future approved individual life insurance application forms and policies available in the executive deferred compensation market. It will be used to amend the proposed insured's application to North American when North American accepts another insurer's medical exam of the proposed insured.

Except for the form number and references to the company name, this form is identical to Midland National Life Insurance Company Form 4562 4-11, which was approved by your department on 4/14/2011, Filing # NALH-127122032.

If you need any additional information to complete your review, please feel free to contact me at 800-283-5433, ext. 36223 or at solson@sfgmembers.com.

Sincerely,

Sherry Olson  
Senior Contract Analyst  
Corporate Markets Center  
Midland National Life Insurance Company &  
North American Company for Life & Health  
Insurance

## Company and Contact

### Filing Contact Information

Sherry Olson, Senior Contract Analyst solson@mnlife.com  
2000 44th St. South, Suite 300 701-433-6223 [Phone]  
Fargo, ND 58103 701-433-8223 [FAX]

### Filing Company Information

North American Company for Life and Health CoCode: 66974 State of Domicile: Iowa  
Insurance  
Principal Office: 4601 Westown Parkway - Group Code: 431 Company Type: Life and Annuity  
Suite 300  
West Des Moines, IA 50266 Group Name: State ID Number:  
(800) 800-3656 ext. [Phone] FEIN Number: 36-2428931

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## Filing Fees

SERFF Tracking Number: NALH-127189091 State: Arkansas  
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Fee Required? Yes  
Fee Amount: \$50.00  
Retaliatory? No  
Fee Explanation: \$50 per form  
Per Company: No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
North American Company for Life and Health Insurance	\$50.00	05/27/2011	48149782

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## Correspondence Summary

### Dispositions

Status	Created By	Created On	Date Submitted
Approved- Closed	Linda Bird	06/08/2011	06/08/2011

SERFF Tracking Number: NALH-127189091 State: Arkansas  
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Product Name: Form 4580 5-11  
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## Disposition

Disposition Date: 06/08/2011

Implementation Date:

Status: Approved-Closed

Comment:

Rate data does NOT apply to filing.

SERFF Tracking Number: NALH-127189091 State: Arkansas  
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 Company Tracking Number: FORM 4580 5-11  
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Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification	No	No
Supporting Document	Application	No	No
Supporting Document	Statement of Variability	No	No
Form	Amendment of Application	No	No

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## Form Schedule

### Lead Form Number:

Schedule Item Status	Form Number	Form Type Form Name	Action	Action Specific Data	Readability	Attachment
	Form 4580 5-11	Policy/Cont ract/Fratern al Certificate: Amendmen t, Insert Page, Endorseme nt or Rider Application	Initial		53.720	NACOLAH Form 4580 5-11 Verification of Medical Exam brackets.pdf



**North American Company for Life and Health Insurance**

[Principal Office: 4350 Westown Parkway • West Des Moines • IA • 50266

Corporate Markets Center: 2000 44<sup>th</sup> Street South, Suite 300 • Fargo • ND • 58103]

**Amendment of Application**

I hereby amend my application for Policy \_\_\_\_\_ as follows:

**VERIFICATION OF MEDICAL EXAM**

In support of my (our) application for life insurance, I (we) have supplied to North American Company for Life and Health Insurance a copy of an exam for:

\_\_\_\_\_ completed by \_\_\_\_\_ on \_\_\_\_\_.

I (we) do hereby verify and reaffirm the responses made by the person proposed for life insurance of such physical examination and declare that to the best of my (our) knowledge and belief there has been no change in the applicant's health since the date of such physical examination.

This amendment shall be part of the application for the above-numbered policy.

CHANGES OR ALTERATIONS TO THIS FORM WILL NOT BE ACCEPTED.

Signed at \_\_\_\_\_  
City State

\_\_\_\_\_  
Signature of Owner

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Insured

\_\_\_\_\_  
Date

To the best of my knowledge and belief the above statement regarding the insured's health are full, complete and true.

\_\_\_\_\_  
Signature of Agent/Producer

\_\_\_\_\_  
Date

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## Supporting Document Schedules

**Item Status:** **Status Date:**

**Satisfied - Item:** Flesch Certification

**Comments:**

Rule & Regulation 19 certification attached.  
 Rule & Regulation 49 does not apply to application forms.  
 Flesch Certification attached.  
 Bulletin 15-2009 replaces Bulletin 11-88 and does not apply to application forms.

**Attachments:**

4580 5-11 readability.pdf  
 4580 5-11 AR Cert.pdf

**Item Status:** **Status Date:**

**Satisfied - Item:** Application

**Comments:**

This form will be used with current and future approved application forms. Currently approved application forms include:  
 Form 82-52 (8-08), approved 12/17/2008

**Attachment:**

82-52-CM0808.pdf

**Item Status:** **Status Date:**

**Satisfied - Item:** Statement of Variability

**Comments:**

**Attachment:**

4580 5-11 Stmt of Variability.pdf

## READABILITY CERTIFICATE

Name and Address of Insurer      North American Company for Life and Health Insurance  
Corporate Markets Center  
2000 44<sup>th</sup> Street South, Ste. 300 Fargo, ND 58103

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

<u>FORM NUMBER</u>	<u>DESCRIPTION</u>	<u>SCORE</u>
Form 4580 5-11	Amendment of Application/ Verification of Medical Exam	53.72

*Carmen R. Walter*

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Signature

Carmen Walter  
Typed Name

Assistant Vice President – Corporate Markets Product Development  
Title

May 26, 2011  
Date

TO: Arkansas Department of Insurance  
FROM: North American Company for Life and Health Insurance  
DATE: May 27, 2011  
RE: Form 4580 5-11

Midland National Life Insurance Company certifies that the referenced form complies with Arkansas Regulation 19 § 10B regarding unfair sex discrimination in insurance.



Carmen R. Walter  
Assistant Vice President – Corporate Markets Product Development  
Corporate Markets  
North American Company for Life and Health Insurance

Date: May 27, 2011



**Regular Issue**

**Application for Life Insurance -- Part 1**

1. Name of Proposed Insured (First, Middle and Last)		Birth date	Birthplace	Sex	Marital Status
2. Residence Address (Street, City, State, Zip)			Social Security No.	Height ft. in.	Weight Lbs.
3. Occupation (Title and Duties)		Gross Annual Compensation \$		Telephone Numbers (Home) (Bus)	
4. Owner Name			Social Security or Tax ID No.		
Owner Address (Street, City, State, Zip)			Relationship to proposed Insured		
5a. Beneficiary			5b. Relationship		
6a. Plan Applied for			6b. Sub-account where applicable		
6c. Amount Applied for \$		6d. Death Benefit Option: <input type="checkbox"/> 1 Level <input type="checkbox"/> 2 Increasing <input type="checkbox"/> Other _____			
7. Changes to an existing policy		8. Additional Benefits:			
9a. Planned Periodic Premium \$		9b. Premium Mode <input type="checkbox"/> Single <input type="checkbox"/> Annual <input type="checkbox"/> Other			
10. Are you a U.S. citizen? <input type="checkbox"/> Yes <input type="checkbox"/> No (complete appropriate questionnaire)					
11a. Do you have existing annuity contracts or life insurance policies? <input type="checkbox"/> No <input type="checkbox"/> Yes (If "Yes," complete 11b.)					

**11b. Policies in Force:**

Company	Amount	Indicate		Intention of Replacement or Change	
		Personal	Business	Yes	No
		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Yes	<input type="checkbox"/> No
		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Yes	<input type="checkbox"/> No
		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Yes	<input type="checkbox"/> No
		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Yes	<input type="checkbox"/> No
		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Yes	<input type="checkbox"/> No

**11c. Policies Applied for:**     None

Company	Amount	Net Amount at Risk	Indicate	
			Personal	Business
			<input type="checkbox"/>	<input type="checkbox"/>
			<input type="checkbox"/>	<input type="checkbox"/>
			<input type="checkbox"/>	<input type="checkbox"/>
			<input type="checkbox"/>	<input type="checkbox"/>
			<input type="checkbox"/>	<input type="checkbox"/>

**NORTH AMERICAN COMPANY FOR LIFE AND HEALTH INSURANCE**  
 PRINCIPAL OFFICE • WEST DES MOINES, IA 50266  
 CORPORATE MARKETS CENTER • 2000 44<sup>TH</sup> STREET SOUTH, STE. 300 • FARGO, ND 58103  
 PHONE (800) 283-5433 • FAX: (701) 433-8596

**Application for Life Insurance -- Part 1, Continued**

Provide details for all "Yes" answers to questions 12-19 below.

<table style="width:100%; border-collapse: collapse;"> <tr> <td style="width:10%; text-align: center;">Yes</td> <td style="width:10%; text-align: center;">No</td> <td></td> </tr> <tr> <td style="text-align: center;">12. <input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td>Do you intend to travel outside the U.S. or Canada within the next 2 years? <b>(If "Yes," complete appropriate questionnaire.)</b></td> </tr> <tr> <td style="text-align: center;">13. <input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td>Do you participate in or do you contemplate participating in aviation related sports, powered or competitive vehicle racing, sky or scuba diving, mountain climbing, or any other hazardous sport or activity? <b>(If "Yes," complete appropriate questionnaire.)</b></td> </tr> <tr> <td style="text-align: center;">14. <input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td>Have you ever been convicted of, or are you awaiting trial for a felony?</td> </tr> <tr> <td style="text-align: center;">15. <input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td>Have you ever had an application for insurance declined, postponed, rated, or modified?</td> </tr> </table>	Yes	No		12. <input type="checkbox"/>	<input type="checkbox"/>	Do you intend to travel outside the U.S. or Canada within the next 2 years? <b>(If "Yes," complete appropriate questionnaire.)</b>	13. <input type="checkbox"/>	<input type="checkbox"/>	Do you participate in or do you contemplate participating in aviation related sports, powered or competitive vehicle racing, sky or scuba diving, mountain climbing, or any other hazardous sport or activity? <b>(If "Yes," complete appropriate questionnaire.)</b>	14. <input type="checkbox"/>	<input type="checkbox"/>	Have you ever been convicted of, or are you awaiting trial for a felony?	15. <input type="checkbox"/>	<input type="checkbox"/>	Have you ever had an application for insurance declined, postponed, rated, or modified?	<p>16. Your driver's license #: _____ State: _____</p> <p>17. Within the past 10 years, have you been convicted of or pled guilty to:</p> <table style="width:100%; border-collapse: collapse;"> <tr> <td style="width:10%; text-align: center;">Yes</td> <td style="width:10%; text-align: center;">No</td> <td></td> </tr> <tr> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td>a. Moving violations?</td> </tr> <tr> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td>b. Driving under the influence of alcohol and/or other drugs?</td> </tr> </table> <p>18. <input type="checkbox"/> <input type="checkbox"/> Have you been a pilot or crew member during the past 3 years or have any intention of becoming a pilot, student pilot, or crew member in any type of aircraft? <b>(If "Yes," complete appropriate questionnaire.)</b></p> <p>19. Have you ever used:</p> <table style="width:100%; border-collapse: collapse;"> <tr> <td style="width:10%; text-align: center;"><input type="checkbox"/></td> <td style="width:10%; text-align: center;"><input type="checkbox"/></td> <td>a. Cigarettes? Date Last Used: _____</td> </tr> <tr> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td>b. Other nicotine products? Date Last Used: _____</td> </tr> </table>	Yes	No		<input type="checkbox"/>	<input type="checkbox"/>	a. Moving violations?	<input type="checkbox"/>	<input type="checkbox"/>	b. Driving under the influence of alcohol and/or other drugs?	<input type="checkbox"/>	<input type="checkbox"/>	a. Cigarettes? Date Last Used: _____	<input type="checkbox"/>	<input type="checkbox"/>	b. Other nicotine products? Date Last Used: _____
Yes	No																														
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<input type="checkbox"/>	<input type="checkbox"/>	b. Other nicotine products? Date Last Used: _____																													

**Details for questions 12-19 (include dates):**

20.  Yes  No Do you have any family history of heart disease, cancer, high blood pressure, diabetes, hemophilia, Huntington's chorea, polycystic kidney disease, or any congenital disorder? If "Yes," give details, including relationship, condition, current age, or age at death.

Relationship to Proposed Insured	Condition	Current Age	Age at Death

**Home Office Endorsements**





**AGENT'S REPORT**

Name of Business Contact: \_\_\_\_\_

<p>1. Proposed Insured's Gross Annual Compensation:</p> <p>Salary: _____</p> <p>Benefits/Bonuses: _____</p> <p>2. Additional Income: _____</p> <p>Source: _____</p> <p>3. Case Manager Name: _____</p>	<p>What is the purpose of this Insurance? (Please check all that apply)</p> <ul style="list-style-type: none"><li><input type="checkbox"/> Benefit Expense Recovery</li><li><input type="checkbox"/> Salary Continuation</li><li><input type="checkbox"/> Deferred Compensation</li><li><input type="checkbox"/> Incentive Compensation</li><li><input type="checkbox"/> Split Dollar</li><li><input type="checkbox"/> Survivor Income</li><li><input type="checkbox"/> Key Person</li><li><input type="checkbox"/> Other (Please Describe) _____</li></ul>
--	---

**Agents Entitled to Commission**

Name	Agent Number	% Commission
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

**Special Instructions**

## **Leave with Proposed Insured**

### **Fair Credit Reporting Act Notification**

As part of North American Company for Life and Health Insurance's normal procedure of processing applications, we may obtain an investigative consumer report concerning such information as to your character, general reputation, and personal characteristics, except as may be related directly or indirectly to your sexual orientation. We will obtain this information through interviews with your friends, neighbors, and associates. You may make a written request to be personally interviewed when such a report is being prepared. You have the right to make a written request to receive a copy of the investigative consumer report. Further information on the nature and scope of the report, if one is made, is available upon request from North American Company for Life and Health Insurance.

### **Notice of Insurance Information Practices**

You are our most important source of information, but personal information may also be collected from other persons. Such information, as well as other personal or privileged information our agent or we subsequently collect, may, in certain circumstances, be disclosed to third parties without your authorization.

We have established procedures to give you access to all personal information collected. You may request correction of such information in our files that you believe to be inaccurate.

We will provide a more complete description of the information practices of North American Company for Life and Health Insurance upon your request, in accordance with the requirements of the Insurance Information and Privacy Protection Law in effect in your state of residence.

### **Medical Information Bureau Notification**

Information regarding your insurability will be treated as confidential. North American Company for Life and Health Insurance, or its reinsurers may, however, make a brief report thereon to the MIB, Inc., formerly known as Medical Information Bureau, a not-for-profit membership organization of insurance companies, which operates an information exchange on behalf of its members. If you apply to another MIB member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, MIB, upon request, will supply such company with the information about you in its file. Upon receipt of a request from you, MIB will arrange disclosure of any information in your file. Please contact MIB at 866-692-6901 (TTY 866-346-3642). If you question the accuracy of the information in MIB's file, you may contact MIB and seek a correction in accordance with the procedures set forth in the Fair Credit Reporting Act. The address of MIB's information office is [50 Braintree Hill Park, Suite 400, Braintree, Massachusetts 02184-8734]. North American Company for Life and Health Insurance or its reinsurers may also release information from its file to other insurance companies to whom you may apply for life or health insurance, or to whom a claim for benefits may be submitted. Information for consumers about MIB may be obtained on its website at [www.mib.com](http://www.mib.com).

STATEMENT OF VARIABILITY - Form 4580

The following is a list of bracketed items and the corresponding range of text and/or values.

<u>Bracketed Item</u>	<u>Explanation</u>
Company Principal Office location and Corporate Markets Center Office location and contact information	Have been bracketed to reserve the right to change or delete addresses and contact information without re-filing this application