

SERFF Tracking Number: NALH-127383084 State: Arkansas
Filing Company: North American Company for Life and Health Insurance State Tracking Number: 49646
Company Tracking Number: 15099Z
TOI: L07I Individual Life - Whole Sub-TOI: L07I.511 External Index - Single Premium
Product Name: 15099Z & 15100Z SPWL Applications
Project Name/Number: 15099Z & 15100Z SPWL Applications/15099Z & 15100Z SPWL Applications

Filing at a Glance

Company: North American Company for Life and Health Insurance

Product Name: 15099Z & 15100Z SPWL Applications SERFF Tr Num: NALH-127383084 State: Arkansas

TOI: L07I Individual Life - Whole SERFF Status: Closed-Approved-Closed State Tr Num: 49646

Sub-TOI: L07I.511 External Index - Single Premium Co Tr Num: 15099Z State Status: Approved-Closed

Filing Type: Form

Reviewer(s): Linda Bird

Authors: Deanna Hoffman, Chris Cairns Disposition Date: 08/31/2011

Date Submitted: 08/26/2011 Disposition Status: Approved-Closed

Implementation Date Requested: On Approval

Implementation Date:

State Filing Description:

General Information

Project Name: 15099Z & 15100Z SPWL Applications
Project Number: 15099Z & 15100Z SPWL Applications
Requested Filing Mode: Review & Approval

Status of Filing in Domicile: Pending

Date Approved in Domicile:

Domicile Status Comments: These forms are being filed concurrently with our state of domicile, Iowa.

Explanation for Combination/Other:

Market Type: Individual

Submission Type: New Submission

Individual Market Type:

Overall Rate Impact:

Filing Status Changed: 08/31/2011

State Status Changed: 08/31/2011

Deemer Date:

Created By: Deanna Hoffman

Submitted By: Deanna Hoffman

Corresponding Filing Tracking Number:

Filing Description:

RE: NORTH AMERICAN COMPANY FOR LIFE AND HEALTH

NAIC #431-66974 FEIN #36-2428931

New Submission Product Description

SERFF Tracking Number: NALH-127383084 State: Arkansas
Filing Company: North American Company for Life and Health State Tracking Number: 49646
Insurance
Company Tracking Number: 15099Z
TOI: L07I Individual Life - Whole Sub-TOI: L07I.511 External Index - Single Premium
Product Name: 15099Z & 15100Z SPWL Applications
Project Name/Number: 15099Z & 15100Z SPWL Applications/15099Z & 15100Z SPWL Applications
15099Z Single Premium Life Application
15100Z Application for Reinstatement of Single Premium Life Insurance

We are filing the above referenced forms for your review and approval. These are new individual life forms and do not replace any forms currently on file with your Department. These forms will be used on a general basis. No part of this filing contains any unusual or possibly controversial items from normal Company or industry standards. These forms will be filed concurrently in Iowa, our state of domicile. Furthermore, Midland National Life assures you that this filing meets the provisions of Rule & Regulation 19, Regulation 49, and Arkansas Code Ann.23-79-138.

This form 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.

Form 15099Z is identical to previously approved form 13465Z (approved by your Department on 03-17-2010). The differences between forms 15099Z and 13465Z are listed below:

The addition of the following text in the AGREEMENT/AUTHORIZATION TO OBTAIN AND DISCLOSE INFORMATION section on page 4 of 5 of the Single Premium Life Application

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 my authorized representative will receive a copy of this authorization upon request.

The statement, "Annuities at their Best" on the cover page has been removed.

On page 5 of 5, the signature line, "Additional Agent Name (Please Print)", has been added.

Due to formatting changes, on page 4 of 5 the sections titled, Certification: Accelerated Death Benefit and the insured signature section have moved to the top of page 5 of 5.

Form 15100Z is identical to previously approved form 13734Z (approved by your Department on 03-17-2010). The only difference between form 15100Z and 13734Z is the addition of the following text in the AGREEMENT/AUTHORIZATION TO OBTAIN AND DISCLOSE INFORMATION section on page 2 of 3 of the Application for Reinstatement of Single Premium Life Insurance.

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 my authorized representative will receive a copy of this authorization upon request.

SERFF Tracking Number: NALH-127383084 State: Arkansas
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 Project Name/Number: 15099Z & 15100Z SPWL Applications/15099Z & 15100Z SPWL Applications

No other changes other than those mentioned above have been made to forms 15099Z and 15100Z.

If you have further questions concerning this filing, please contact me at 1-877-586-0240 x 35881.

Company and Contact

Filing Contact Information

Dee Hoffman, Product Compliance Analyst dhoffman@mnlife.com
 4601 Westown Parkway 877-586-0240 [Phone] 35881 [Ext]
 Suite 300 800-225-1682 [FAX]
 West Des Moines, IA 50266

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: 5. Filing or review of life and health policy/contracts, endorsements, certificate, riders, applications or annuity forms, per form...\$50.00.

Per Company: No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
North American Company for Life and Health Insurance	\$100.00	08/26/2011	51000828

SERFF Tracking Number: NALH-127383084 State: Arkansas
Filing Company: North American Company for Life and Health State Tracking Number: 49646
Insurance
Company Tracking Number: 15099Z
TOI: L071 Individual Life - Whole Sub-TOI: L071.511 External Index - Single Premium
Product Name: 15099Z & 15100Z SPWL Applications
Project Name/Number: 15099Z & 15100Z SPWL Applications/15099Z & 15100Z SPWL Applications

Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved- Closed	Linda Bird	08/31/2011	08/31/2011

SERFF Tracking Number: NALH-127383084 State: Arkansas
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Insurance
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Project Name/Number: 15099Z & 15100Z SPWL Applications/15099Z & 15100Z SPWL Applications

Disposition

Disposition Date: 08/31/2011

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		No
Supporting Document	Life & Annuity - Acturial Memo		No
Supporting Document	Statement of Variability		Yes
Supporting Document	Readability Certification		Yes
Form	Single Premium Life Application		Yes
Form	Application for Reinstatement for Single Premium Life Insurance		Yes

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Form Schedule

Lead Form Number: 15099Z

Schedule Item Status	Form Number	Form Type Form Name	Action	Action Specific Data	Readability	Attachment
	15009Z	Application/ Single Premium Life Enrollment Application Form	Initial		50.000	15099Z PRT 08-11_FINAL_w brackets_08-23-2011.pdf
	15100Z	Application/ Application for Enrollment Reinstatement for Form Single Premium Life Insurance	Initial		50.000	15100Z PRT 08-11_FINAL_w brackets_08-23-11.pdf



**NORTH AMERICAN SINGLE PREMIUM WHOLE LIFE
SINGLE PREMIUM LIFE APPLICATION**

Beneficiary Designation*

Check One: Primary Contingent

First Name MI Last Name Birth Date (mm/dd/yyyy) - -

Social Security Number - - Relationship Percentage %

Check One: Primary Contingent

First Name MI Last Name Birth Date (mm/dd/yyyy) - -

Social Security Number - - Relationship Percentage %

Check One: Primary Contingent | Check One: Trust Corporation Estate Other

Full Name Trust Date (mm/dd/yyyy) - -

Tax ID Number - - Percentage %

*** For multiple beneficiaries use the Beneficiary Designation Form (11617Z)**

Product Selection:

Premium Policy funded by:

Check – amount \$. 1035 Exchange – amount \$.

Must be payable to North American Company for Life and Health Insurance

If 1035 Exchange from what company? _____

For multiple transfers, I understand that, this policy is being funded with more than one premium. I understand that if final funds are received within 60 days of receipt of first funds, that my interest will be credited from the date the policy becomes effective, **such date being the date the last premium is received in the Home Office.** If additional funds are not received within 60 days of receipt of first funds, then the policy will be issued effective the date the most recent funds were received within 60 days of application receipt. If the policy is index linked, the initial index will be set on the effective date of the policy.

Replacement (must be completed)

Is there any insurance in force or application pending on the life of the proposed insured?..... Y N

If yes, provide the Company Name: _____ Issue Date: _____ Amt: _____ Type: _____

Will the coverage applied for replace or change any existing or applied for life insurance or annuity? Y N

If yes, provide the Company Name: _____ Issue Date: _____ Amt: _____ Type: _____



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Questions (must be completed)

1. Height ' " Weight

2. Do you need assistance with the normal activities of daily living (bathing, continence, dressing, eating, toileting, or transferring), or are you currently hospitalized, disabled due to illness, confined to a bed or nursing facility, using oxygen equipment to assist in breathing, been medically diagnosed as having a terminal illness or life expectancy of 12 months or less, or receiving hospice care? Yes No
3. Have you ever been medically diagnosed, treated for, medically advised to have treatment for, or taken medication for: Congestive Heart Failure (CHF), Cardiomyopathy, Organ transplant, Renal (kidney) failure, Chronic Kidney Disease, Renal insufficiency, Liver failure, Alzheimer's, Dementia, Schizophrenia, Manic depression, Bipolar disorder, Mental incapacity, Lou Gehrig's disease (ALS), Huntington's disease, Amputation of a body part caused by cancer or any disease, Diabetic Insulin shock, Diabetic Coma, diagnosed with Diabetes prior to age 20 or taken insulin injections prior to age 40. Yes No
4. Have you ever been medically treated or diagnosed by a medical professional as having Acquired Immune Deficiency Syndrome (AIDS), AIDS related complex (ARC), or any immune deficiency related disorder or tested positive for the human immunodeficiency virus (HIV)? Yes No
5. Is any person proposed for insurance currently receiving or have an application pending for any illness or disability benefits or compensation? Yes No
6. Within the past 24 months have you:
- (a) Been confined two (2) times or more to a hospital, nursing facility, convalescent care facility, assisted living facility, mental facility or hospice care? Yes No
 - (b) Been diagnosed with internal cancer, leukemia, lymphoma, or melanoma or had more than one occurrence of any cancer in your life time (excluding basal or squamous cell skin cancer), had a recurrence of any cancer, or currently being treated for cancer? Yes No
 - (c) Been declined for life or health insurance? Yes No
7. Within the past 36 months have you:
- (a) Been medically diagnosed, treated or taken medication for: Cirrhosis, Liver disease, Chronic Hepatitis, Angina, Chronic Bronchitis, Emphysema, Chronic Obstructive Lung or Pulmonary disease (COLD/COPD), Stroke, or transient ischemic attack (TIA/mini-stroke), Hodgkin's disease, neuromuscular or brain disease (including cerebral palsy, muscular dystrophy, multiple sclerosis, grand mal epilepsy, cystic fibrosis or Parkinson's disease) systemic lupus (SLE), respiratory failure, or have paralysis of two or more extremities? Yes No
 - (b) Been diagnosed as having, been treated for or hospitalized for: Heart disease, heart attack, uncontrolled high blood pressure, or heart or circulatory vascular surgery (including coronary artery bypass, pacemaker or replacement pacemaker, heart valve replacement, abdominal aortic aneurysm, angioplasty, or cardiac or vascular stent placement), or any procedure to improve circulation to the heart, brain or extremities? Yes No
8. Within the past 48 months have you been convicted of a felony or are you currently incarcerated, on parole or probation, been treated for or been advised to have treatment for alcohol or any illegal or prescription drugs, attempted suicide, or been convicted of operating a vehicle while intoxicated, reckless driving or impaired? Yes No

Additional Questions (must be completed)

1. Are you taking medication for any impairment outlined in the questions listed above? Yes No
2. Have you used nicotine based products in the past 12 months? Yes No
3. Have you applied for Life Insurance in the last two years? Yes No



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Agreement/Authorization to Obtain and Disclose Information:

I have read all the questions and answers on this application. All responses are true and complete to the best of my knowledge and belief. A copy of this application will be attached to and made a part of the insurance policy. Coverage issued on this application will be effective once the application is received in good order, underwritten and premium is paid and received by the Company and a policy has been issued and delivered to the Owner during the Proposed Insured's lifetime. I have received and or have had read to me and understand the MIB Disclosure and Fair Credit Reporting Acts notices. For use in determining insurability, I authorize any licensed physician, medical practitioner, the Medical Information Bureau, Pharmacy Benefit Manager, or other institution or entity that has any records or knowledge of the Proposed Insured's medical or prescription history to give any such information to the Company, its representatives, or reinsurers. This authorization is valid for 24 months 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 my authorized representative will receive a copy of this authorization upon request. A photocopy or facsimile of this authorization will be as valid as the original. 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.

Effective Date: Any insurance issued as a result of this application will either: (1) not take effect until the premium is received and the policy is delivered to and accepted by the Owner during the lifetime of any person applying 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 – 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.

Fraud Warnings and Other Disclosures

AR, DC, KY, LA, ME, NM, OH, OK, PA, RI and TN

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 policy 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.

WA Residents: It's a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purposes of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits. **NJ Residents:** Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties. **FL Residents:** Any person who knowingly, and with intent to injure, defraud or deceive any insurer, files a statement of claim or an application containing any false, incomplete or misleading information is guilty of a felony of the third degree. **VA Residents:** Any person who, with the intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement may have violated the state law.

Financial Institution Disclosure: Insurance policies 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.



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APPLICATION FOR REINSTATEMENT OF SINGLE PREMIUM LIFE INSURANCE

Mail to: North American Company for Life and Health Insurance

P.O. Box 79905, Des Moines, IA 50325-0905

Overnight to: 4350 Westown Pkwy, West Des Moines, IA 50266

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

Name of Proposed Insured(s)

Policy or Certificate Number

If the above referenced Policy or Certificate is to be reinstated, please answer the following questions:

1. Height ' " Weight
2. Do you need assistance with the normal activities of daily living (bathing, continence, dressing, eating, toileting, or transferring), or are you currently hospitalized, disabled due to illness, confined to a bed or nursing facility, using oxygen equipment to assist in breathing, been medically diagnosed as having a terminal illness or life expectancy of 12 months or less, or receiving hospice care? Yes No
3. Have you ever been medically diagnosed, treated for, medically advised to have treatment for, or taken medication for: Congestive Heart Failure (CHF), Cardiomyopathy, Organ transplant, Renal (kidney) failure, Chronic Kidney Disease, Renal insufficiency, Liver failure, Alzheimer's, Dementia, Schizophrenia, Manic depression, Bipolar disorder, Mental incapacity, Lou Gehrig's disease (ALS), Huntington's disease, Amputation of a body part caused by cancer or any disease, Diabetic Insulin shock, Diabetic Coma, diagnosed with Diabetes prior to age 20 or taken insulin injections prior to age 40. Yes No
4. Have you ever been medically treated or diagnosed by a medical professional as having Acquired Immune Deficiency Syndrome (AIDS), AIDS related complex (ARC), or any immune deficiency related disorder or tested positive for the human immunodeficiency virus (HIV)? Yes No
5. Is any person proposed for insurance currently receiving or have an application pending for any illness or disability benefits or compensation? Yes No
6. Within the past 24 months have you:
 - (a) Been confined two (2) times or more to a hospital, nursing facility, convalescent care facility, assisted living facility, mental facility or hospice care? Yes No
 - (b) Been diagnosed with internal cancer, leukemia, lymphoma, or melanoma or had more than one occurrence of any cancer in your life time (excluding basal or squamous cell skin cancer), had a recurrence of any cancer, or currently being treated for cancer? Yes No
 - (c) Been declined for life or health insurance? Yes No

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7. Within the past 36 months have you:

- (a) Been medically diagnosed, treated or taken medication for: Cirrhosis, Liver disease, Chronic Hepatitis, Angina, Chronic Bronchitis, Emphysema, Chronic Obstructive Lung or Pulmonary disease (COLD/COPD), Stroke, or transient ischemic attack (TIA/mini-stroke), Hodgkin's disease, neuromuscular or brain disease (including cerebral palsy, muscular dystrophy, multiple sclerosis, grand mal epilepsy, cystic fibrosis or Parkinson's disease) systemic lupus (SLE), respiratory failure, or have paralysis of two or more extremities? Yes No
- (b) Been diagnosed as having, been treated for or hospitalized for: Heart disease, heart attack, uncontrolled high blood pressure, or heart or circulatory vascular surgery (including coronary artery bypass, pacemaker or replacement pacemaker, heart valve replacement, abdominal aortic aneurysm, angioplasty, or cardiac or vascular stent placement), or any procedure to improve circulation to the heart, brain or extremities? Yes No
8. Within the past 48 months have you been convicted of a felony or are you currently incarcerated, on parole or probation, been treated for or been advised to have treatment for alcohol or any illegal or prescription drugs, attempted suicide, or been convicted of operating a vehicle while intoxicated, reckless driving or impaired? Yes No

Additional Questions (must be completed)

1. Are you taking medication for any impairment outlined in the questions listed above? Yes No
2. Have you used nicotine based products in the past 12 months? Yes No
3. Have you applied for Life Insurance in the last two years? Yes No

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

Agreement/Authorization To Obtain and Disclose Information:

I have read all the questions and answers on this application. All responses are true and complete to the best of my knowledge and belief. A copy of this application will be attached to and made a part of the insurance policy. Coverage issued on this application will be effective once the application is received in good order, underwritten and the required loan interest or policy debt is paid and received by the Company during the Proposed Insured's lifetime. I have received and/or have had read to me and understand the MIB Disclosure and Fair Credit Reporting Acts notices. For use in determining insurability, I authorize any licensed physician, medical practitioner, the Medical Information Bureau, Pharmacy Benefit Manager, or other institution or entity that has any records or knowledge of the Proposed Insured's medical or prescription history to give any such information to the Company, its representatives, or reinsurers. This authorization is valid for 24 months 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 my authorized representative will receive a copy of this authorization upon request. A photocopy or facsimile of this authorization will be as valid as the original.

\$1018110



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SERFF Tracking Number: NALH-127383084 State: Arkansas
 Filing Company: North American Company for Life and Health State Tracking Number: 49646
 Insurance
 Company Tracking Number: 15099Z
 TOI: L07I Individual Life - Whole Sub-TOI: L07I.511 External Index - Single Premium
 Product Name: 15099Z & 15100Z SPWL Applications
 Project Name/Number: 15099Z & 15100Z SPWL Applications/15099Z & 15100Z SPWL Applications

Supporting Document Schedules

Item Status: **Status Date:**

Satisfied - Item: Flesch Certification

Comments:

Please find the Readability Certification added below as an imported component. Other certifications can be found in the Filing Description under the General Information Tab.

Item Status: **Status Date:**

Bypassed - Item: Application
Bypass Reason: Not Applicable

Comments:

Item Status: **Status Date:**

Bypassed - Item: Life & Annuity - Acturial Memo
Bypass Reason: Not Applicable

Comments:

Item Status: **Status Date:**

Satisfied - Item: Statement of Variability

Comments:

Attachments:

STATEMENT OF VARIABILITY_15099Z_8-23-2011.pdf
 STATEMENT OF VARIABILITY_15100Z_8-23-2011.pdf

Item Status: **Status Date:**

Satisfied - Item: Readability Certification

Comments:

SERFF Tracking Number: NALH-127383084 *State:* Arkansas
Filing Company: North American Company for Life and Health *State Tracking Number:* 49646
Insurance
Company Tracking Number: 15099Z
TOI: L07I Individual Life - Whole *Sub-TOI:* L07I.511 External Index - Single Premium
Product Name: 15099Z & 15100Z SPWL Applications
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Attachment:

NAC Readability Cert_ 08-08-2011.pdf

STATEMENT OF VARIABILITY
SINGLE PREMIUM LIFE APPLICATION
FORM 15099Z

The following sections of the Single Premium Life Application, form 15099Z, have been bracketed. Please see explanations for each section below.

PAGE 1 of 3:

Company address – This information is bracketed to allow for flexibility in address changes in the future.

Overnight to: This information is bracketed to allow for flexibility in address changes in the future.

PAGE 3 of 3:

Fraud Warnings and Other Disclosures,- This section is bracketed to allow for future change in state fraud notices. This allows flexibility to add new states, as required in the future, to this section as well as revising the existing state notices as applicable.

PAGE 5 of 5:

Commission Options for this Application - The brackets in this section allows the agent to select their applicable commission schedule and also allows for added commission schedules as needed.

STATEMENT OF VARIABILITY
APPLICATION FOR REINSTATEMENT OF SINGLE PREMIUM LIFE
FORM 15100Z

The following sections of the Application for Reinstatement of Single Premium Life, form 15100Z, have been bracketed. Please see explanations for each section below.

PAGE 1 of 3:

Company address – This information is bracketed to allow for flexibility in address changes in the future.

Overnight to: This information is bracketed to allow for flexibility in address changes in the future.

PAGE 3 of 3:

Fraud Warnings and Other Disclosures.- This section is bracketed to allow for future change in state fraud notices. This allows flexibility to add new states, as required in the future, to this section as well as revising the existing state notices as applicable.

CERTIFICATE OF READABILITY
North American Company for Life and Health

Name of Company

This is to certify that the forms listed below are in compliance with Public Act 79-300.

A. Option Selected

- 1. Policy and its related forms are scored for the Flesch reading ease test as one unit and the combined score is listed below.
- 2. Policy and its related forms are scored separately for the Flesch reading ease test. Scores for the policy and each form are indicated below:
- 3. Form and Form Numbers to which Certification is Applicable:

<u>Form</u>	<u>Form Number</u>	<u>Flesch Score</u>
Single Premium Life Application	15099Z	50.0
Application for Reinstatement of Single Premium Life Insurance	15100Z	50.0

Test Option Selected

- 1. Test was applied to entire policy form(s).
- 2. Test was applied on sample basis. Form(s) contain(s) more than 10,000 words. Copy of form(s) enclosed indicating word samples tested.

C. Standards for Certification

A checked block indicates the standard has been achieved:

- 1. The policy text achieves a minimum score of 45 on the Flesch reading ease test in accordance with the option chosen in Section A above.
- 2. It is printed in not less than ten point type, one point leaded. (This does not apply to specification pages, schedules and tables.)
- 3. The layout and spacing of the policy separate the paragraphs from each other and from the border of the paper.
- 4. The section titles are captioned in bold face type or otherwise stand out significantly from the text.
- 5. Unnecessarily long, complicated or obscure words, sentences, paragraphs or constructions are not used in the policy.
- 6. The style, arrangement and overall appearance of the policy give no undue prominence to any portion of the policy or to any endorsements or riders.
- 7. A table of contents or an index of the principle sections is included in the policy. (This applies only if the policy has more than 3,000 words or consists of more than 3 pages.)

This certification must be signed by an officer of the insurer.



Signature _____

Date 08-08-2011

Mike Yanacheak
Officer's Name

Second Vice President, Product Development
Officer's Title