

State: Arkansas Filing Company: EMC National Life Company
TOI/Sub-TOI: L08 Life - Other/L08.000 Life - Other
Product Name: 6 Life Applications
Project Name/Number: /

Filing at a Glance

Company: EMC National Life Company
Product Name: 6 Life Applications
State: Arkansas
TOI: L08 Life - Other
Sub-TOI: L08.000 Life - Other
Filing Type: Form
Date Submitted: 09/30/2012
SERFF Tr Num: EMCN-128708304
SERFF Status: Closed-Approved-Closed
State Tr Num:
State Status: Approved-Closed
Co Tr Num: 6 LIFE APPLICATIONS

Implementation: On Approval
Date Requested:
Author(s): Mark Rowley
Reviewer(s): Linda Bird (primary)
Disposition Date: 10/04/2012
Disposition Status: Approved-Closed
Implementation Date:

State Filing Description:

State: Arkansas
TOI/Sub-TOI: L08 Life - Other/L08.000 Life - Other
Product Name: 6 Life Applications
Project Name/Number: /

Filing Company: EMC National Life Company

General Information

Project Name: Status of Filing in Domicile: Pending
Project Number: Date Approved in Domicile:
Requested Filing Mode: Domicile Status Comments:
Explanation for Combination/Other: Market Type: Individual
Submission Type: New Submission Individual Market Type:
Overall Rate Impact: Filing Status Changed: 10/04/2012
State Status Changed: 10/04/2012
Deemer Date: Created By: Mark Rowley
Submitted By: Mark Rowley Corresponding Filing Tracking Number:

Filing Description:

The following applications are being filed for approval:

EAP050 (7-12) – Application for Individual Life Insurance
EAP051 (7-12) – Tele-Underwriting Application
EAP052 (7-12) – Application for Individual Life Insurance Reinstatement
EAP053 (7-12) -- Application for Individual Life Insurance for Youth Products
EAP054 (8-12) – Individual Life Insurance Application
EAP056 (9-12) – Workplace Application for Individual Life Insurance Products

These are new forms and will not replace any existing forms. Our licensed representatives will utilize applications EAP050, EAP051, EAP054, and EAP056 when meeting with clients applying for our term, whole life, and universal life products. Application EAP052 will be used for reinstatement of any term, whole life, or universal life product. Application EAP053 will be used when meeting clients applying for any of our life insurance products used in the youth market. We plan to also use these applications with future individual whole life, term and universal life products as they are developed.

This submission contains no unusual or possibly controversial items from normal company or industry standards.

These applications were written to be readable and easily understood by insureds. The forms achieved the following flesch scores:

EAP050 (7-12) – 52.6
EAP051 (7-12) – 54.2
EAP052 (7-12) – 50.0
EAP053 (7-12) – 58.9
EAP054 (8-12) – 50.9
EAP056 (9-12) – 51.2

Bracketed matter shown in the applications is subject to change. The accompanying Statements of Variability provide an explanation of the variable items applicable to these forms.

These applications may be used in both paper and electronic format.

Our electronic application process complies with the Uniform Electronic Transaction Act. The applicant can review and/or correct any information entered into the application screens before signing the application. Appropriate encryption standards have been implemented to prohibit alteration of the application after the applicant has signed it. Once completed, the information is transmitted to the home office via a secured web protocol. At the end of the process the completed application

State: Arkansas **Filing Company:** EMC National Life Company
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will be printed and be formatted the same as the application submitted in this filing. Both internal and external safeguards for electronic information have been implemented by our Technical Services Department.

Should you have any questions, please contact me at 515-237-2147, or via electronic mail at mrowley@emcnl.com. Thank you.

Company and Contact

Filing Contact Information

Mark Rowley, VP, Managing Actuary mrowley@emcnl.com
 PO Box 9202 515-237-2147 [Phone]
 Des Moines, IA 50306-9202

Filing Company Information

EMC National Life Company	CoCode: 62928	State of Domicile: Iowa
PO Box 9202	Group Code:	Company Type: L and Health
Des Moines, IA 50306-9202	Group Name:	State ID Number:
(515) 237-2147 ext. [Phone]	FEIN Number: 42-0868851	

Filing Fees

Fee Required? Yes
 Fee Amount: \$300.00
 Retaliatory? No
 Fee Explanation: 6 applications
 Per Company: No

Company	Amount	Date Processed	Transaction #
EMC National Life Company	\$300.00	09/30/2012	63247642

SERFF Tracking #:

EMCN-128708304

State Tracking #:

Company Tracking #:

6 LIFE APPLICATIONS

State:

Arkansas

Filing Company:

EMC National Life Company

TOI/Sub-TOI:

L08 Life - Other/L08.000 Life - Other

Product Name:

6 Life Applications

Project Name/Number:

/

Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Linda Bird	10/04/2012	10/04/2012

State: Arkansas
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Product Name: 6 Life Applications
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Disposition

Disposition Date: 10/04/2012

Implementation Date:

Status: Approved-Closed

Comment:

Rate data does NOT apply to filing.

Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification		Yes
Supporting Document	Application		No
Supporting Document	Statements of Variability		Yes
Form	Application for Individual Life Insurance		Yes
Form	Tele-Underwriting Application		Yes
Form	Application for Individual Life Insurance Reinstatement		Yes
Form	Application for Individual Life Insurance for Youth Products		Yes
Form	Individual Life Insurance Application		Yes
Form	Workplace Application for Individual Life Insurance Products		Yes

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Form Schedule

Lead Form Number: EAP050 (7-12)							
Item No.	Schedule Item Status	Form Number	Form Type	Form Name	Action/ Action Specific Data	Readability Score	Attachments
1		EAP050 (7-12)	AEF	Application for Individual Life Insurance	Initial:	52.600	EAP050(7-12).pdf
2		EAP051 (7-12)	AEF	Tele-Underwriting Application	Initial:	54.200	EAP051(7-12).pdf
3		EAP052 (7-12)	AEF	Application for Individual Life Insurance Reinstatement	Initial:	50.000	EAP052(7-12).pdf
4		EAP053 (7-12)	AEF	Application for Individual Life Insurance for Youth Products	Initial:	58.900	EAP053(7-12).pdf
5		EAP054 (8-12)	AEF	Individual Life Insurance Application	Initial:	50.900	EAP054(8-12).pdf
6		EAP056 (9-12)	AEF	Workplace Application for Individual Life Insurance Products	Initial:	51.200	EAP056(9-12).pdf

Form Type Legend:

ADV	Advertising	AEF	Application/Enrollment Form
CER	Certificate	CERA	Certificate Amendment, Insert Page, Endorsement or Rider
DDP	Data/Declaration Pages	FND	Funding Agreement (Annuity, Individual and Group)
MTX	Matrix	NOC	Notice of Coverage
OTH	Other	OUT	Outline of Coverage
PJK	Policy Jacket	POL	Policy/Contract/Fraternal Certificate
POLA	Policy/Contract/Fraternal Certificate: Amendment, Insert Page, Endorsement or Rider	SCH	Schedule Pages



National Life Company

[P.O. Box 9144 ■ Des Moines, IA 50306-9144
1.800.232.5818 ■ www.EMCNationalLife.com]

Application *for* **Individual Life** **Insurance**

**Use for all fully
underwritten life products**

Do not use for Workplace products

EMC, flag design and *Count on EMC* Reg. U.S. Pat. & Tm. Off.

ALWAYS DETACH AND GIVE TO APPLICANT

FAIR CREDIT REPORTING ACT

In compliance with 15 USC 1681 et. seq., this notice is to inform you that:

In making this application for insurance it is understood that an investigative consumer report may be made whereby information is obtained through personal interviews with third parties, such as family members, business associates, financial sources, friends, neighbors or others with whom you are acquainted. This inquiry includes information as to your character, general reputation, personal characteristics and mode of living, whichever may be applicable. You have the right to make a written request to EMC National Life Company, [P.O. Box 9144, Des Moines, IA 50306-9144], within a reasonable period of time for a complete and accurate disclosure of additional information concerning the nature and scope of the investigation.

NOTIFICATION REGARDING THE MIB, INC.

Information regarding your insurability will be treated as confidential. EMC National Life Company or its reinsurer(s) may, however, make a brief report thereon to MIB, Inc., 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]. 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 federal Fair Credit Reporting Act. The address of MIB's information office is [50 Braintree Hill Park, Suite 400, Braintree, Massachusetts 02184-8734].

EMC National Life Company or its reinsurer(s) 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.]

COMPLETE, DETACH AND GIVE TO APPLICANT ONLY WHEN FULL FIRST PREMIUM IS PAID WITH APPLICATION

CONDITIONAL COVERAGE RECEIPT

RECEIVED FROM _____, this _____ day of _____ the sum of \$ _____, subject to the terms and conditions of the policy, as full (check one) annual semiannual quarterly check plan premium, along with the application bearing the date of this Receipt, for coverage on _____, the Proposed Insured(s).

TERMS AND CONDITIONS

"Effective Date" as used herein means the later of a) the date the application is signed; b) the date of completion of all medical examinations, if required; or c) the requested Effective Date shown on the application.

Coverage may become effective prior to the policy delivery if and when all of the following conditions are met:

1. The amount of the payment is equal to the first full premium selected and the payment is taken with the application;
2. The Proposed Insured(s) must be, on the Effective Date as defined above, a risk acceptable to EMC National Life Company under its rules, standards and practices for the exact contract of insurance and premium applied for, without any modifications; and
3. The contract is issued exactly as applied for within 60 days from the date of the application. If the application is declined or disapproved or if the contract is not issued within 60 days from the date of application, then this condition has not been fulfilled, no coverage is or has been provided under the terms of this Conditional Receipt, and any premium paid will be returned.
4. The maximum amount of coverage which may become effective under this Conditional Receipt, including any Riders applied for, cannot exceed [\$250,000].

If any of the above conditions are not met, there shall be no liability on the part of EMC National Life Company except to return the premiums collected with the application.

This Receipt shall be rendered void if it is modified or altered, or if a check or draft given in payment is not honored. No agent or broker of EMC National Life Company, [P.O. Box 9144, Des Moines, IA 50306-9144], is authorized to waive or alter any of the above conditions.

X _____	X _____	X _____
Applicant's Signature	Agent's Signature	Date

**ALL PREMIUM CHECKS OR DRAFTS MUST BE MADE PAYABLE TO EMC NATIONAL LIFE COMPANY.
DO NOT MAKE CHECKS PAYABLE TO THE AGENT. DO NOT LEAVE THE PAYEE BLANK.**

EMC NATIONAL LIFE COMPANY
[P.O. BOX 9144 • DES MOINES, IA 50306-9144]

INDIVIDUAL LIFE INSURANCE APPLICATION

PRINT IN BLACK INK

1. Proposed Insured Name (First, M.I., Last)	Age	Birthdate Mo-Day-Yr	Birth State	Social Security / TIN # Driver's License #	Sex	Height	Weight
				SS#: DL#:			

COMPLETE FOR FAMILY / BUSINESS COVERAGE

Spouse / Other Insured Name				SS#: DL#:			
Child / Other Insured Name				SS#: DL#:			
Child / Other Insured Name				SS#: DL#:			

Mailing Address: _____

Address _____ City _____ State _____ Zip _____

Proposed Insured's phone numbers (include area codes): Home (____) _____ Business / Cell (____) _____

If we need to contact you, we should call: Home Business / Cell Time _____ A.M. P.M.

Are all Proposed Insureds U.S. citizens? Yes No If no, provide details in Section 7 and send copy of permanent resident visa.

Employment	Employer Name	Occupation (Duties)	# of Years	Total of Annual Earned & Unearned Income
Insured				\$
Spouse (if applying)				\$
Other Insured (if applying)				\$

2. Beneficiary: Primary Applicant (If a trust is the beneficiary, record name and date of the trust.)

	Name (First, M.I., Last)	Birthdate	Social Security / TIN #	Relationship	%
Primary					
Contingent					

Beneficiary: Spouse / Other Insureds (If a trust is the beneficiary, record name and date of the trust.)

	Name (First, M.I., Last)	Birthdate	Social Security / TIN #	Relationship	%
Primary					
Contingent					

3. Owner (Complete only if Owner is other than Proposed Insured. If Joint Ownership, specify details in Section 7. If a trust is the owner, provide a copy of the trust.)

	Name (First, M.I., Last)	Mailing Address	Birthdate	Soc. Sec. / TIN #	Relationship
First Owner					
Contingent					



4. **Payor** (specify one): Insured Owner Other

If Other, provide: Full Name Address / City / State / Zip Relationship

5. **Additional Person to Receive Lapse Notification** (if desired):

Full Name Address / City / State / Zip Relationship

6. **Life Insurance / Annuities In Force** (List below, including any existing EMCNL policies.) Check if none in force

Person Insured	Company	Policy #	Life Amount	ADB	To Be Replaced
					<input type="checkbox"/> Yes <input type="checkbox"/> No
					<input type="checkbox"/> Yes <input type="checkbox"/> No
					<input type="checkbox"/> Yes <input type="checkbox"/> No

Is this policy being purchased to replace any existing life insurance policy or annuity contract? Yes No
 If yes, complete any replacement form required by your state and send with the application.

7. **Special Requests:** _____

8. **Life Plan:** _____ **Amount of Primary Coverage:** \$ _____
 Please use marketing name. See agent website or product guide for product options and rider specifications.

Term Life Options and Riders

- Primary Insured Level Term for _____ Years]
- Spouse / Other Insured Term Rider Amt. \$ _____ / _____ Years]
- Disability Income Rider (must complete Section 14)]
- Primary Insured Critical Illness Life Rider Amt. \$ _____ (must complete disclosure form)]
- Spouse / Other Insured Critical Illness Life Rider Amt. \$ _____ (must complete disclosure form)]
- Waiver of Premium]
- Children's Term # Units _____ or Amt. \$ _____]
- Accidental Death Benefit Amt. \$ _____]
- Other _____]

Universal Life Options and Riders

- Option 1 – Level Death Benefit]
- Option 2 – Increasing Death Benefit]
- Primary Insured Term Rider Amt. \$ _____ / _____ Years]
- Spouse / Other Insured Term Rider Amt. \$ _____ / _____ Years]
- Disability Income Rider (must complete Section 14)]
- Primary Insured Critical Illness Life Rider Amt. \$ _____ (must complete disclosure form)]
- Spouse / Other Insured Critical Illness Life Rider Amt. \$ _____ (must complete disclosure form)]
- Waiver: (specify one) Monthly Deductions Stipulated Amt. \$ _____ Minimum Premium]
- Children's Term # Units _____ or Amt. \$ _____]
- Accidental Death Benefit Amt. \$ _____]
- GPO / GIO Amt. \$ _____]
- Other _____]

Whole Life Options and Riders [(Plan 3 - Fully Underwritten Only. Complete Simplified Issue Application LA101 for Plans 1 & 2.)]

- Primary Insured Term Rider Amt. \$ _____ / _____ Years (continuous pay only)]
- Primary Insured Disability Income Rider - (must complete Section 14) (continuous pay only)]
- Primary Insured Critical Illness Life Rider Amt. \$ _____ (must complete disclosure form) (continuous pay only)]
- Waiver of Premium (continuous pay only)]
- Additional Premium Rider Amt. \$ _____]
- Children's Term # Units _____ or Amt. \$ _____ (continuous pay only)]
- Other _____]

9. Premium Options

Mode: <input type="checkbox"/> Annual <input type="checkbox"/> Semiannual <input type="checkbox"/> Quarterly <input type="checkbox"/> Monthly (not available on Direct Bill)
Form: <input type="checkbox"/> Check Plan <input type="checkbox"/> Direct Bill <input type="checkbox"/> List Bill <input type="checkbox"/> ABS# _____]
Premium: [Planned Periodic \$ _____ Extra Single / Lump Sum \$ _____ Estimated 1035 / Lump Sum \$ _____]
Amount Paid with Application \$ _____

10. Has any person proposed for coverage:

Yes No

- A. Have any other application for personal insurance pending?
 - B. Applied for life, health, or disability insurance or reinstatement which was declined, postponed, rated, restricted or modified?
 - C. Engaged in aviation activity other than as a passenger? (If yes, complete 1,2, 3, 4, 5 and 6.)
 - (1) Number of hours flown last 12 months _____
 - (2) Number of hours contemplated over next 12 months _____
 - (3) Total number of hours flown _____
 - (4) License type _____
 - (5) Type of flying _____
 - (6) Instrument Flight Rating (IFR)?
 - D. Engaged in ballooning, sky diving, hang gliding, rock or mountain climbing, rodeo competition, SCUBA diving (max. depth _____) or any form of organized motorized racing? Intentions to engage in such activities over next 12 months: activity _____ frequency _____
 - E. Within the past 5 years, had a driver's license suspended or revoked for any reason, or been charged with or convicted of driving while intoxicated or under the influence of a controlled substance or with any moving violation involving a motor vehicle? (If yes, list below the name(s), date(s) and details.)
 - F. Have any charges pending, plead guilty or been convicted of or are awaiting trial for any crime other than a misdemeanor, including currently being on parole or probation?
 - G. Currently a member of the military, military reserve or National Guard, whether active or inactive, or has the Proposed Insured entered into a written agreement to enter the armed services? (If yes, list below name, branch, rank and duties.)
 - H. Do you intend to travel outside the U.S. or Canada or change your country of residence in the next 24 months? (If yes, list countries, cities, duration and purpose of travel in the details section below.)
 - I. (1) Now use tobacco or any nicotine substitute?
 - (2) Ever used tobacco or any nicotine substitute? (If yes, provide date when stopped.) _____
- If yes to I. (1) or (2), indicate below name of person and type of tobacco or nicotine substitute used (cigarettes, pipe, cigar, chew, patch, gum, other).

Specify person's name and give details to all yes answers. Also, use this area to provide any other information.

11. Family History: Has any person proposed for coverage had a parent / sibling who was diagnosed with or died of heart disease, kidney disease, diabetes, cancer, stroke or other hereditary disease?

	Proposed Insured		Spouse / Other Insured	
	Age if Living	Age at Death / Cause or if Living, Age at Diagnosis / Cause	Age if Living	Age at Death / Cause or if Living, Age at Diagnosis / Cause
Father				
Mother				
Sibling				

12. IMPORTANT! GIVE COMPLETE DETAILS ON NEXT PAGE FOR EACH "YES" ANSWER SPECIFYING TO WHOM MEDICAL HISTORY APPLIES, DATES AND RESULTS OF TREATMENT, DOCTORS AND COMPLETE ADDRESSES.

- A. Has any person proposed for coverage had any diagnosis or treatment for: **Yes No**
 - (1) High blood pressure, elevated cholesterol, chest pain or angina, heart attack, disease or disorder of the heart or heart valves, blood clot, blood vessels, stroke, Transient Ischemic Attack (mini stroke), speech defect or paralysis?
 - (2) Cancer, tumor, melanoma, basal or squamous cell carcinoma, abnormal moles or lesions, polyps, dysplastic nevi, leukemia or blood disorder?

Required Agent's Report

Yes No

- A. Have you seen all persons proposed for coverage?
If not, please explain. _____
- B. Have you accurately recorded information given to you by all persons proposed for coverage?.....
- C. To the best of your knowledge, will the insurance applied for replace any existing annuity/life policy(ies)?
- D. As applicable, have you given disclosure/replacement notices as required by your state?
- E. As applicable, have you given the Conditional Coverage Receipt?
- F. Were the notices regarding MIB, Inc. and the Fair Credit Reporting Act given?
- G. **Illustration Certification.** Applicable to a policy with non-guaranteed elements where required by law:
I understand and agree that if a sales illustration was not provided by me to the Proposed Insured, a fully compliant illustration conforming to the policy as issued will be provided no later than at the time of policy delivery.
- H. Purpose of Insurance: Personal Business - (circle one) Keyman, Buy-Sell, Creditor
- I. **Please choose only one if medical exam is required:** Exam ordered by agent: Date Ordered _____
(see EMCNL Underwriting Guide LB138) Exam to be ordered by the Home Office

I certify to the best of my knowledge that all persons proposed for coverage or any person or entity are not being paid cash or promised services as an inducement to enter into this insurance transaction and that this insurance transaction will not be sold or assigned for any type of viatical settlement, senior settlement, life settlement or other secondary market.

Additional certification when Agent *did* see all persons proposed for coverage: I certify that I have verified the personal information of the applicant(s) by viewing state issued driver's license, state issued I.D. card, military I.D. card, Permanent U.S. Resident Card (Green Card), passport or other government issued picture I.D. card. I further certify that all persons proposed for coverage appeared to me to be lucid and able to fully understand all of the questions on this application.

Agent's Printed Name

X

Agent's Signature (witness)

Agent's Contract # Commission % Date

Commission Split, if applicable:

Agent's Name Agent's Contract # Commission %

REQUIRED: Complete Page 7 – Authorization and Page 8 (if applicable) – Check Plan

**AUTHORIZATION TO OBTAIN AND DISCLOSE INFORMATION
Life Insurance Application
This Authorization Complies with the HIPAA Privacy Rule.**

I (person(s) signed below) understand EMC National Life Company (EMCNL), its reinsurers, insurance support organizations (such as MIB, Inc. or any of its members or affiliates) and their authorized representative, may obtain medical and other information in order to evaluate my application for insurance. I authorize any Medical Providers, as described below, to disclose or release Protected Health Information, as described below, to EMC National Life Company, [P.O. Box 9144, Des Moines, Iowa 50306-9144], or its authorized representative.

- Medical Providers: All physicians, medical or dental practitioners, hospitals, clinics, pharmacies, pharmacy benefit managers, other medical care facilities and all other providers of medical or dental services who have provided treatment or other health care services to me or on my behalf.
- Protected Health Information: Any and all records and health information within such Medical Person’s possession, such as medical history, entire medical records, mental, psychiatric (excluding psychotherapy notes) and physical condition, prescription drug records, tobacco, drug and alcohol use and any other protected health information concerning me. This includes information which may be considered to be a communicable or a sexually transmitted disease, which may include, but are not limited to diseases such as hepatitis, syphilis, gonorrhea, the Human Immunodeficiency Virus (HIV) and the Acquired Immune Deficiency Syndrome (AIDS).

In addition, I authorize the Veterans Administration, the MIB, Inc., my employer, consumer reporting agency, insurance company or other organization who possesses information, records or knowledge of me including information about drugs, alcoholism or mental illness, my health, other insurance coverage, employment, age, general character, finances or participation in hazardous activities to furnish such information to EMCNL, its reinsurers and their authorized representative upon presenting this authorization.

By my signature below, I acknowledge that any agreements I have made to restrict my Protected Health Information do not apply to this authorization and I instruct any Medical Provider to release and disclose my entire medical record without restriction.

The purpose of the release of the above information is for EMCNL to evaluate and underwrite an application for insurance coverage, to determine the rates and terms that apply to such insurance coverage, and/or to resolve any issues of incomplete, incorrect or misrepresented information on the application which may arise during the processing of the application.

I authorize EMCNL or its reinsurers to make a brief report of my Protected Health Information to MIB, Inc. EMCNL or its reinsurers may make a brief report regarding me or my children to other insurance companies to whom I have applied or may apply.

This authorization will remain in effect from the date signed below for a period of 24 months, and a copy of this authorization is as valid as the original. I understand that this authorization may be revoked at any time by sending written notice of such to EMCNL at the address above. The right to revoke this authorization is limited to the extent that EMCNL has taken action in reliance on the authorization or the law provides the Company with the right to contest a claim under the policy for which I have applied or to contest the policy itself. I understand that any information that is disclosed pursuant to this authorization may no longer be covered by federal rules governing privacy and confidentiality of health information, but it will not be redisclosed by the recipient except as authorized by me or as allowed by law.

I understand that my Medical Providers may not refuse to provide treatment or payment for health care services if I refuse to sign this authorization. I further understand that if I refuse to sign this authorization, EMCNL may not issue the insurance coverage for which I am applying or if coverage has been issued may not be able to make any benefit payments. I understand that any Personal Representative or I will receive a copy of this authorization upon request.

I authorize EMCNL to obtain an investigative consumer report on me, if required.

I elect to be interviewed if any investigative consumer report is prepared in connection with this application.

X _____
Signature of Proposed Insured or Personal Representative Printed Name Date

X _____
Signature of Spouse (if applying) or Personal Representative Printed Name Date

X _____
Signature of Other Applicant (other than Proposed Insured or Spouse – if applying) or Personal Representative Printed Name Date

Note: If the authorization is signed by a Personal Representative of an individual, a description of the Representative’s authority and relationship must be provided below.

Description of Personal Representative’s Authority and Relationship to the Individual



National Life Company

[P.O. Box 9144 ■ Des Moines, IA 50306-9144
1.800.232.5818 ■ www.EMCNationalLife.com]

Teleunderwriting Application *for* Individual Life Insurance

for Medically Underwritten Amounts of Coverage

Fax application to ESP at [1-866-931-8242]

AND

Fax to Home Office at [1-800-439-9526] or

Mail original application to Home Office.

See page 6 for further instructions

ALWAYS DETACH AND GIVE TO APPLICANT

FAIR CREDIT REPORTING ACT

In compliance with 15 USC 1681 et. seq., this notice is to inform you that:

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COMPLETE, DETACH AND GIVE TO APPLICANT ONLY WHEN FULL FIRST PREMIUM IS PAID WITH APPLICATION

CONDITIONAL COVERAGE RECEIPT

RECEIVED FROM _____, this _____ day of _____ the sum of \$ _____, subject to the terms and conditions of the policy, as full (check one) annual semiannual quarterly check plan premium, along with the application bearing the date of this Receipt, for coverage on _____, the Proposed Insured(s).

TERMS AND CONDITIONS

"Effective Date" as used herein means the later of a) the date the application is signed; b) the date of completion of all medical examinations, if required; or c) the requested Effective Date shown on the application.

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3. The contract is issued exactly as applied for within 60 days from the date of the application. If the application is declined or disapproved or if the contract is not issued within 60 days from the date of application, then this condition has not been fulfilled, no coverage is or has been provided under the terms of this Conditional Receipt, and any premium paid will be returned.
4. The maximum amount of coverage which may become effective under this Conditional Receipt, including any Riders applied for, cannot exceed [\$250,000].

If any of the above conditions are not met, there shall be no liability on the part of EMC National Life Company except to return the premiums collected with the application.

This Receipt shall be rendered void if it is modified or altered, or if a check or draft given in payment is not honored. No agent or broker of EMC National Life Company, [P.O. Box 9144, Des Moines, IA 50306-9144], is authorized to waive or alter any of the above conditions.

X

Applicant's Signature

X

Agent's Signature

X

Date

**ALL PREMIUM CHECKS OR DRAFTS MUST BE MADE PAYABLE TO EMC NATIONAL LIFE COMPANY.
DO NOT MAKE CHECKS PAYABLE TO THE AGENT. DO NOT LEAVE THE PAYEE BLANK.**

EMC NATIONAL LIFE COMPANY
 [P.O. BOX 9144 • DES MOINES, IA 50306-9144]

TELEUNDERWRITING INDIVIDUAL LIFE INSURANCE APPLICATION

PRINT IN BLACK INK

1. Proposed Insured Name (First, M.I., Last)	Age	Birthdate Mo-Day-Yr	Birth State	Social Security / TIN # Driver's License #	Sex	Height	Weight
				SS#: DL#:			
COMPLETE FOR FAMILY / BUSINESS COVERAGE							
Spouse / Other Insured Name				SS#: DL#:			
Child / Other Insured Name				SS#: DL#:			
Child / Other Insured Name				SS#: DL#:			

Mailing Address: _____
 Address City State Zip
 Proposed Insured's phone numbers (include area codes): Home (____) _____ Business / Cell (____) _____
 If we need to contact you, we should call: Home Business / Cell Time _____ A.M. P.M.
 Are all Proposed Insureds U.S. citizens? Yes No If no, provide details in Section 7 and send copy of permanent resident visa.

Employment	Employer Name	Occupation (Duties)	# of Years	Total of Annual Earned & Unearned Income
Insured				\$
Spouse (if applying)				\$
Other Insured (if applying)				\$

2. Beneficiary: Primary Applicant (If a trust is the beneficiary, record name and date of the trust.)

	Name (First, M.I., Last)	Birthdate	Social Security / TIN #	Relationship	%
Primary					
Contingent					

Beneficiary: Spouse / Other Insureds (If a trust is the beneficiary, record name and date of the trust.)

	Name (First, M.I., Last)	Birthdate	Social Security / TIN #	Relationship	%
Primary					
Contingent					

3. Owner (Complete only if Owner is other than Proposed Insured. If Joint Ownership, specify details in Section 7. If a trust is the owner, provide a copy of the trust.)

	Name (First, M.I., Last)	Mailing Address	Birthdate	Soc. Sec. / TIN #	Relationship
First Owner					
Contingent					



4. **Payor** (specify one): Insured Owner Other

If Other, provide: Full Name Address / City / State / Zip Relationship

5. **Additional Person to Receive Lapse Notification** (if desired):

Full Name Address / City / State / Zip Relationship

6. **Life Insurance / Annuities In Force** (List below, including any existing EMCNL policies.) **Check if none in force**

Person Insured	Company	Policy #	Life Amount	ADB	To Be Replaced
					<input type="checkbox"/> Yes <input type="checkbox"/> No
					<input type="checkbox"/> Yes <input type="checkbox"/> No
					<input type="checkbox"/> Yes <input type="checkbox"/> No

Is this policy being purchased to replace any existing life insurance policy or annuity contract? Yes No
 If yes, complete any replacement form required by your state and send with the application.

7. **Special Requests** _____

8. **Life Plan:** _____ **Amount of Primary Coverage:** \$ _____
 Please use marketing name. See agent website or product guide for product options and rider specifications.

Term Life Options and Riders

- Primary Insured Level Term for _____ Years]
- Spouse / Other Insured Term Rider Amt. \$ _____ / _____ Years]
- Disability Income Rider (must complete Section 12)]
- Primary Insured Critical Illness Life Rider Amt. \$ _____ (must complete disclosure form)]
- Spouse / Other Insured Critical Illness Life Rider Amt. \$ _____ (must complete disclosure form)]
- Waiver of Premium]
- Children's Term # Units _____ or Amt. \$ _____ (must complete Section 11)]
- Accidental Death Benefit Amt. \$ _____]
- Other _____]

Universal Life Options and Riders

- Option 1 – Level Death Benefit]
- Option 2 – Increasing Death Benefit]
- Primary Insured Term Rider Amt. \$ _____ / _____ Years]
- Spouse / Other Insured Term Rider Amt. \$ _____ / _____ Years]
- Disability Income Rider (must complete Section 12)]
- Primary Insured Critical Illness Life Rider Amt. \$ _____ (must complete disclosure form)]
- Spouse / Other Insured Critical Illness Life Rider Amt. \$ _____ (must complete disclosure form)]
- [Waiver: (specify one) Monthly Deductions Stipulated Amt. \$ _____ Minimum Premium]
- Children's Term # Units _____ or Amt. \$ _____ (must complete Section 11)]
- Accidental Death Benefit Amt. \$ _____]
- GPO / GIO Amt. \$ _____]
- Other _____]

Whole Life Options and Riders [(Plan 3 - Fully Underwritten Only. Complete Simplified Issue Application LA101 for Plans 1 & 2.)]

- Primary Insured Term Rider Amt. \$ _____ / _____ Years (continuous pay only)]
- Primary Insured Disability Income Rider - (must complete Section 12) (continuous pay only)]
- Primary Insured Critical Illness Life Rider Amt. \$ _____ (must complete disclosure form) (continuous pay only)]
- Waiver of Premium (continuous pay only)]
- Additional Premium Rider Amt. \$ _____]
- Children's Term # Units _____ or Amt. \$ _____ (continuous pay only)(must complete Section 11)]
- Other _____]

9. Premium Options

Mode: <input type="checkbox"/> Annual <input type="checkbox"/> Semiannual <input type="checkbox"/> Quarterly <input type="checkbox"/> Monthly (not available on Direct Bill)
Form: <input type="checkbox"/> Check Plan <input type="checkbox"/> Direct Bill <input type="checkbox"/> List Bill <input type="checkbox"/> ABS# _____]
Premium: [Planned Periodic \$ _____ Extra Single / Lump Sum \$ _____ Estimated 1035 / Lump Sum \$ _____]
Amount Paid with Application \$ _____

10. Has any person proposed for coverage:

- | | Yes | No |
|---|--------------------------|--------------------------|
| A. Have any other application for personal insurance pending? | <input type="checkbox"/> | <input type="checkbox"/> |
| B. Applied for life, health, or disability insurance or reinstatement which was declined, postponed, rated, restricted or modified?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| C. Engaged in aviation activity other than as a passenger? (If yes, complete 1,2, 3, 4, 5 and 6.) | <input type="checkbox"/> | <input type="checkbox"/> |
| (1) Number of hours flown last 12 months _____ | | |
| (2) Number of hours contemplated over next 12 months _____ | | |
| (3) Total number of hours flown _____ | | |
| (4) License type _____ | | |
| (5) Type of flying _____ | | |
| (6) Instrument Flight Rating (IFR)?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| D. Engaged in ballooning, sky diving, hang gliding, rock or mountain climbing, rodeo competition, SCUBA diving (max. depth _____) or any form of organized motorized racing? Intentions to engage in such activities over next 12 months: activity _____ frequency _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| E. Within the past 5 years, had a driver's license suspended or revoked for any reason, or been charged with or convicted of driving while intoxicated or under the influence of a controlled substance or with any moving violation involving a motor vehicle? (If yes, list below name(s), date(s) and details.)..... | <input type="checkbox"/> | <input type="checkbox"/> |
| F. Have any charges pending, plead guilty or been convicted of or are awaiting trial for any crime other than a misdemeanor, including currently being on parole or probation?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| G. Currently a member of the military, military reserve or National Guard, whether active or inactive, or has the Proposed Insured entered into a written agreement to enter the armed services? (If yes, list below name, branch, rank and duties.)..... | <input type="checkbox"/> | <input type="checkbox"/> |
| H. Do you intend to travel outside the U.S. or Canada or change your country of residence in the next 24 months? (If yes, list countries, cities, duration and purpose of travel in the details section below.) | <input type="checkbox"/> | <input type="checkbox"/> |
| I. (1) Now use tobacco or any nicotine substitute?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| (2) Ever used tobacco or any nicotine substitute? (If yes, provide date when stopped.) _____ .. | <input type="checkbox"/> | <input type="checkbox"/> |
| If yes to I. (1) or (2), indicate below name of person and type of tobacco or nicotine substitute used (cigarettes, pipe, cigar, chew, patch, gum, other). | | |

Specify person's name and give details to all yes answers. Also, use this area to provide any other information.

11. Child Rider Supplement (Answer questions A-F if applying for a Children's Term Rider.)

- | | Yes | No |
|--|--------------------------|--------------------------|
| Have any of the children listed in section 1 had any diagnosis or treatment for:
(If yes, give details in box on page 4 and specify which child.) | | |
| A. Cancer in any form? | <input type="checkbox"/> | <input type="checkbox"/> |
| B. Heart disorder, defect, coronary disease or rheumatic fever? | <input type="checkbox"/> | <input type="checkbox"/> |
| C. Diabetes, disorder of the lung, kidney, stomach, liver or intestine, epilepsy, brain or nervous system disorder, or mental condition or disorder?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| D. Acquired Immune Deficiency Syndrome (AIDS)? | <input type="checkbox"/> | <input type="checkbox"/> |
| E. Within the past 5 years: | | |
| (1) Has any child proposed for coverage been treated, examined or advised by a member of the medical profession? | <input type="checkbox"/> | <input type="checkbox"/> |
| (2) Been advised by a member of the medical profession to get specified medical care which was not completed, such as any hospitalization, surgery or diagnostic tests, except those tests related to the Human Immunodeficiency Virus (AIDS Virus)? | <input type="checkbox"/> | <input type="checkbox"/> |
| F. Within the past 5 years, has any child proposed for coverage had diagnostic tests such as an electrocardiogram (EKG), x-ray or other diagnostic tests, except those tests related to the Human Immunodeficiency Virus (AIDS Virus)? | <input type="checkbox"/> | <input type="checkbox"/> |

Required Agent's Report

Yes No

- A. Have you seen all persons proposed for coverage?
If not, please explain. _____
- B. Have you accurately recorded information given to you by all persons proposed for coverage?
- C. To the best of your knowledge, will the insurance applied for replace any existing annuity/life policy(ies)?
- D. As applicable, have you given disclosure/replacement notices as required by your state?
- E. As applicable, have you given the Conditional Coverage Receipt?
- F. Were the notices regarding MIB, Inc. and the Fair Credit Reporting Act given?
- G. **Illustration Certification.** Applicable to a policy with non-guaranteed elements where required by law:
I understand and agree that if a sales illustration was not provided by me to the Proposed Insured, a fully compliant illustration conforming to the policy as issued will be provided no later than at the time of policy delivery.
- H. Purpose of Insurance: Personal Business - (circle one) Keyman, Buy-Sell, Creditor
- I. **Please choose only one:** **Exam ordered by agent: Date Ordered** _____
 Exam to be ordered by the Home Office, or
 For quicker service, FAX a copy of this application to the fax numbers on the front of the application.

I certify to the best of my knowledge that all persons proposed for coverage or any person or entity are not being paid cash or promised services as an inducement to enter into this insurance transaction and that this insurance transaction will not be sold or assigned for any type of viatical settlement, senior settlement, life settlement or other secondary market.

Additional certification when Agent did see all persons proposed for coverage: I certify that I have verified the personal information of the applicant(s) by viewing state issued driver's license, state issued I.D. card, military I.D. card, Permanent U.S. Resident Card (Green Card), passport or other government issued picture I.D. card. I further certify that all persons proposed for coverage appeared to me to be lucid and able to fully understand all of the questions on this application.

Agent's Printed Name

X

Agent's Signature (witness)

Agent's Contract # Commission % Date

Commission Split, if applicable:

Agent's Name Agent's Contract # Commission %

REQUIRED: Complete Page 7 – Authorization and Page 8 (if applicable) – Check Plan

INSTRUCTIONS FOR USE OF THIS APPLICATION

1. This application is only to be used when Teleunderwriting is desired.
2. **This application is to be used only for amounts of insurance that require a medical examination based on the EMCNL Underwriting Guide (LB138).**
3. All non-medical amounts applied for based on the EMCNL Underwriting Guide (LB138) require state approved Application for Life Insurance.
4. You will need to obtain all state mandated replacement forms, blood consent forms and proposal illustrations. These forms will not be obtained by the paramedical representative.
5. The Part II medical questionnaire portion of this application will be completed by requiring a telephone interview with the applicant. Verification of this information and the applicant's signature must be obtained by a paramedical representative.

**AUTHORIZATION TO OBTAIN AND DISCLOSE INFORMATION
Life Insurance Application
This Authorization Complies with the HIPAA Privacy Rule.**

I (person(s) signed below) understand EMC National Life Company (EMCNL), its reinsurers, insurance support organizations (such as MIB, Inc. or any of its members or affiliates) and their authorized representative, may obtain medical and other information in order to evaluate my application for insurance. I authorize any Medical Providers, as described below, to disclose or release Protected Health Information, as described below, to EMC National Life Company, [P.O. Box 9144, Des Moines, Iowa 50306-9144], or its authorized representative.

- Medical Providers: All physicians, medical or dental practitioners, hospitals, clinics, pharmacies, pharmacy benefit managers, other medical care facilities and all other providers of medical or dental services who have provided treatment or other health care services to me or on my behalf.
- Protected Health Information: Any and all records and health information within such Medical Person's possession, such as medical history, entire medical records, mental, psychiatric (excluding psychotherapy notes) and physical condition, prescription drug records, tobacco, drug and alcohol use and any other protected health information concerning me. This includes information which may be considered to be a communicable or a sexually transmitted disease, which may include, but are not limited to diseases such as hepatitis, syphilis, gonorrhea, the Human Immunodeficiency Virus (HIV) and the Acquired Immune Deficiency Syndrome (AIDS).

In addition, I authorize the Veterans Administration, the MIB, Inc., my employer, consumer reporting agency, insurance company or other organization who possesses information, records or knowledge of me including information about drugs, alcoholism or mental illness, my health, other insurance coverage, employment, age, general character, finances or participation in hazardous activities to furnish such information to EMCNL, its reinsurers and their authorized representative upon presenting this authorization.

By my signature below, I acknowledge that any agreements I have made to restrict my Protected Health Information do not apply to this authorization and I instruct any Medical Provider to release and disclose my entire medical record without restriction.

The purpose of the release of the above information is for EMCNL to evaluate and underwrite an application for insurance coverage, to determine the rates and terms that apply to such insurance coverage, and/or to resolve any issues of incomplete, incorrect or misrepresented information on the application which may arise during the processing of the application.

I authorize EMCNL or its reinsurers to make a brief report of my Protected Health Information to MIB, Inc. EMCNL or its reinsurers may make a brief report regarding me or my children to other insurance companies to whom I have applied or may apply.

This authorization will remain in effect from the date signed below for a period of 24 months, and a copy of this authorization is as valid as the original. I understand that this authorization may be revoked at any time by sending written notice of such to EMCNL at the address above. The right to revoke this authorization is limited to the extent that EMCNL has taken action in reliance on the authorization or the law provides the Company with the right to contest a claim under the policy for which I have applied or to contest the policy itself. I understand that any information that is disclosed pursuant to this authorization may no longer be covered by federal rules governing privacy and confidentiality of health information, but it will not be redisclosed by the recipient except as authorized by me or as allowed by law.

I understand that my Medical Providers may not refuse to provide treatment or payment for health care services if I refuse to sign this authorization. I further understand that if I refuse to sign this authorization, EMCNL may not issue the insurance coverage for which I am applying or if coverage has been issued may not be able to make any benefit payments. I understand that any Personal Representative or I will receive a copy of this authorization upon request.

I authorize EMCNL to obtain an investigative consumer report on me, if required.

I elect to be interviewed if any investigative consumer report is prepared in connection with this application.

X _____
Signature of Proposed Insured or Personal Representative Printed Name Date

X _____
Signature of Spouse (if applying) or Personal Representative Printed Name Date

X _____
Signature of Other Applicant (other than Proposed Insured or Spouse – if applying) or Personal Representative Printed Name Date

Note: If the authorization is signed by a Personal Representative of an individual, a description of the Representative's authority and relationship must be provided below.

Description of Personal Representative's Authority and Relationship to the Individual



National Life Company

[P.O. Box 9144 ■ Des Moines, IA 50306-9144
1.800.232.5818 ■ www.EMCNationalLife.com]

Application
for
Life
Insurance
Reinstatement

ALWAYS DETACH AND GIVE TO APPLICANT

FAIR CREDIT REPORTING ACT

In compliance with 15 USC 1681 et. seq. 1, this notice is to inform you that:

In making this application for insurance it is understood that an investigative consumer report may be made whereby information is obtained through personal interviews with third parties, such as family members, business associates, financial sources, friends, neighbors or others with whom you are acquainted. This inquiry includes information as to your character, general reputation, personal characteristics and mode of living, whichever may be applicable. You have the right to make a written request to EMC National Life Company, [P.O. Box 9144, Des Moines, IA 50306-9144], within a reasonable period of time for a complete and accurate disclosure of additional information concerning the nature and scope of the investigation.

NOTIFICATION REGARDING THE MIB, INC.

Information regarding your insurability will be treated as confidential. EMC National Life Company or its reinsurer(s) may, however, make a brief report thereon to MIB Inc., 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]. 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 federal Fair Credit Reporting Act. The address of MIB's information office is [50 Braintree Hill Park, Suite 400, Braintree, Massachusetts 02184-8734].

EMC National Life Company or its reinsurer(s) 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)

EMC NATIONAL LIFE COMPANY
[P.O. BOX 9144 • DES MOINES, IA 50306-9144]
LIFE INSURANCE REINSTATEMENT APPLICATION

I HEREBY APPLY FOR REINSTATEMENT OF POLICY # _____ .

PRINT IN BLACK INK

1. Complete for Proposed Insured Who Was Covered by the Above Policy

Proposed Insured Name (First, M.I., Last)	Height	Weight	Social Security / TIN # Driver's License #	Current occupation or if not currently working why
			SS#:	
			DL#:	
Proposed Insured's phone numbers (include area codes): Home (____) _____ Business / Cell (____) _____				
If we need to contact you, we should call: <input type="checkbox"/> Home <input type="checkbox"/> Business / Cell Time _____ <input type="checkbox"/> A.M. <input type="checkbox"/> P.M.				
Do you use tobacco or any nicotine substitute? <input type="checkbox"/> Never <input type="checkbox"/> Current <input type="checkbox"/> Past				
If current or past, indicate type and date last used: <input type="checkbox"/> Cigarettes <input type="checkbox"/> Pipe / Cigar <input type="checkbox"/> Chew <input type="checkbox"/> Nicotine Patch / Gum				
Date last used: _____				

2. Complete for Spouse or Other Insured if Covered by the Above Policy

Spouse / Other Insured Name	Height	Weight	Social Security / TIN # Driver's License #	Current occupation or if not currently working why
			SS#:	
			DL#:	
Do you use tobacco or any nicotine substitute? <input type="checkbox"/> Never <input type="checkbox"/> Current <input type="checkbox"/> Past				
If current or past, indicate type and date last used: <input type="checkbox"/> Cigarettes <input type="checkbox"/> Pipe / Cigar <input type="checkbox"/> Chew <input type="checkbox"/> Nicotine Patch / Gum				
Date last used: _____				

3. Has any person applying for reinstatement under the policy:

Yes No

- A. Have any other application for personal insurance pending?
- B. Within the past 3 years, applied for life, health, disability insurance or reinstatement which was declined, postponed, rated, restricted or modified?
- C. Within the past 5 years, engaged in aviation activity other than as a passenger? (If yes, complete 1,2, 3, 4, 5, 6.).....
 - (1) Number of hours flown last 12 months _____
 - (2) Number of hours contemplated over next 12 months _____
 - (3) Total number of hours flown _____
 - (4) License type _____
 - (5) Type of flying _____
 - (6) Instrument Flight Rating (IFR)?
- D. Within the past 5 years, engaged in ballooning, sky diving, hang gliding, rock or mountain climbing, rodeo competition, SCUBA diving (max. depth _____) or any form of organized motorized racing? Intentions to engage in such activities over next 12 months: activity _____ frequency _____
- E. Within the past 5 years, had a driver's license suspended or revoked for any reason, or been charged with or convicted of driving while intoxicated or under the influence of a controlled substance or with any moving violation involving a motor vehicle? (If yes, list below the name(s), date(s) and details.).....
- F. Have any charges pending, plead guilty or been convicted of or are awaiting trial for any crime other than a misdemeanor, including currently being on parole or probation?
- G. Currently a member of the military, military reserve or National Guard, whether active or inactive, or has the Proposed Insured entered into a written agreement to enter the armed services? (If yes, list below name, branch, rank and duties.)
- H. Do you intend to travel outside the U.S. or Canada or change your country of residence in the next 24 months? (If yes, list below countries, cities, duration and purpose of travel.).....

Specify person's name and give details to all yes answers. Also, use this area to provide any other information.



4. IMPORTANT! FOR ANY PERSON APPLYING FOR REINSTATEMENT, GIVE COMPLETE DETAILS BELOW FOR EACH “YES” ANSWER SPECIFYING TO WHOM MEDICAL HISTORY APPLIES, DATES AND RESULTS OF TREATMENT, DOCTORS AND COMPLETE ADDRESSES.

- A. Since the date of application of the lapsed policy, has any person applying for reinstatement had any diagnosis or treatment for:
- | | | |
|--|------------|-----------|
| | Yes | No |
|--|------------|-----------|
- (1) High blood pressure, elevated cholesterol, chest pain or angina, heart attack, disease or disorder of the heart or heart valves, blood clot, blood vessels, stroke, Transient Ischemic Attack (mini stroke), speech defect or paralysis?.....
 - (2) Cancer, tumor, melanoma, basal or squamous cell carcinoma, abnormal moles or lesions, polyps, dysplastic nevi, leukemia or blood disorder?.....
 - (3) Nervous, emotional or mental disorder, dementia or Alzheimer’s?.....
 - (4) Diabetes, disease or disorder of the pancreas, thyroid or other endocrine disorder?.....
 - (5) Stomach or intestines, hepatitis, liver, kidney, bladder, genito-urinary organs or breast?
 - (6) Asthma, sleep apnea, emphysema, chronic bronchitis, Chronic Obstructive Pulmonary Disease (COPD) or other lung disorder?
 - (7) Epilepsy, brain or nervous system disorder?.....
 - (8) Been diagnosed as having or been treated for Human Immunodeficiency Virus (HIV), Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC) by a member of the medical profession?.....
 - (9) Been diagnosed as having or been treated for any immune deficiency disorder, autoimmune disorder, or muscle or connective tissue disease or disorder (not HIV related)?.....
 - (10) Except as prescribed by a physician, ever used marijuana, heroin, cocaine, barbiturates or other illegal drugs, joined any organization, received or had treatment or counseling for drug or alcohol abuse?
- B. Is any person applying for reinstatement taking prescription medication?
- C. Within the past 5 years, has any person applying for reinstatement:
- (1) Been treated, examined or advised by a member of the medical profession?
 - (2) Been advised by a member of the medical profession to get specified medical care which was not completed, such as any hospitalization, surgery or diagnostic tests, except those tests related to the Human Immunodeficiency Virus (AIDS Virus)?.....
 - (3) Had diagnostic tests such as an electrocardiogram (EKG), x-ray or other diagnostic tests, except those tests related to the Human Immunodeficiency Virus (AIDS Virus)?
 - (4) Been a patient in a hospital, clinic or other medical facility?

Give complete details below to all yes answers. Use box on page 1 if additional space is needed.

Ques. #	Person’s Name	Dates	Symptom(s), Condition(s), Diagnosis	Treatment / Medication	Complete Name(s) & Address(es) of Doctors, Hospitals or Clinics

5. For each person applying for reinstatement, please provide:

	Individual Insured	Other Insured	Children
Name and Address of Personal Physician			
Date and Reason Last Seen			

6. Disability Income Rider (Complete the following questions only if a person applying for reinstatement has Disability Income Rider coverage under this policy.)

A. Name of each person with Disability Income Rider coverage: _____
Primary Other

- B. Has any person applying for reinstatement:
- | | Yes | No |
|---|--------------------------|--------------------------|
| (1) Within the past 5 years, received Disability, Workers' Comp. or Pension Benefits? | <input type="checkbox"/> | <input type="checkbox"/> |
| (2) Within the past 5 years, received medical care for the muscles, bones, joints, including but not limited to the neck, back, spine, feet or nerve disorder or treatment of muscular or neuromuscular disorders?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| (3) Within the past 5 years, received treatment or been diagnosed with arthritis, gout, bursitis or rheumatism? | <input type="checkbox"/> | <input type="checkbox"/> |
| (4) Had any physical or occupational therapy or had therapy recommended? | <input type="checkbox"/> | <input type="checkbox"/> |
| (5) Had any prior complications of pregnancy or currently pregnant? | <input type="checkbox"/> | <input type="checkbox"/> |

C. Describe employment duties below for each person applying for reinstatement (what you do, types of machines used).

Specify person's name and give details to all yes answers. Specify employment duties.

7. Statements and Agreements of All Applicants Undersigned Below

I understand all of the questions that I have read on this reinstatement application. I am not currently taking and I am not under the influence of any medications or drugs that would affect my ability to fully understand and to fully and accurately complete this application. All of the statements and answers in this application for reinstatement of my coverage are true and complete to the best of my knowledge and belief. I agree that this application will be the basis for, and will become part of, any policy that is reinstated by EMC National Life Company (the Company) and that no information about me will be considered to have been given to the Company unless it is stated in the application. I understand that the agent has no authority to approve the application, change the policy or waive any policy provisions. I understand no insurance will be effective unless or until approved for reinstatement and the full reinstatement premium for the policy has been paid. I am not being paid cash and have not been promised services as an inducement to enter into this application. The purpose of this reinstatement application is not to sell or assign it to any type of viatical settlement, senior settlement or life settlement company. I acknowledge receipt of a copy of the Fair Credit Reporting Act and MIB, Inc. notices.

WARNING

Fraud Notice

Any person who knowingly submits a false statement in an application or files a claim containing false or deceptive statements may be guilty of insurance fraud and subject to penalties under state law.

I understand and acknowledge this Fraud Notice.

Misrepresentation Notice

If your answers to the questions in the reinstatement application are incorrect or untrue, EMC National Life Company may deny coverage by voiding or canceling your policy and returning your premium payments to you or your estate from the date of reinstatement. Be aware that voiding or canceling your policy may have an adverse impact to your intended beneficiary(ies).

I understand and acknowledge this Misrepresentation Notice. I agree that the information on this application will be relied on to determine insurability and that incorrect or untrue information may result in coverage being voided, subject to the Incontestability provision in the policy.

X _____
 Proposed Insured's Signature Signed at City / State Date

X _____ **X** _____ **X** _____
 Owner's Signature Spouse's / Other Insured's Signature Signature of Witness
 (if other than Proposed Insured) (if applying for coverage)

AUTHORIZATION TO OBTAIN AND DISCLOSE INFORMATION
Life Insurance Application
This Authorization Complies with the HIPAA Privacy Rule.

I (person(s) signed below) understand EMC National Life Company (EMCNL), its reinsurers, insurance support organizations (such as MIB, Inc. or any of its members or affiliates) and their authorized representative, may obtain medical and other information in order to evaluate my application for insurance. I authorize any Medical Providers, as described below, to disclose or release Protected Health Information, as described below, to EMC National Life Company, [P.O. Box 9144, Des Moines, Iowa 50306-9144], or its authorized representative.

- Medical Providers: All physicians, medical or dental practitioners, hospitals, clinics, pharmacies, pharmacy benefit managers, other medical care facilities and all other providers of medical or dental services who have provided treatment or other health care services to me or on my behalf.
- Protected Health Information: Any and all records and health information within such Medical Person's possession, such as medical history, entire medical records, mental, psychiatric (excluding psychotherapy notes) and physical condition, prescription drug records, tobacco, drug and alcohol use and any other protected health information concerning me. This includes information which may be considered to be a communicable or a sexually transmitted disease, which may include, but are not limited to diseases such as hepatitis, syphilis, gonorrhea, the Human Immunodeficiency Virus (HIV) and the Acquired Immune Deficiency Syndrome (AIDS).

In addition, I authorize the Veterans Administration, the MIB, Inc., my employer, consumer reporting agency, insurance company or other organization who possesses information, records or knowledge of me including information about drugs, alcoholism or mental illness, my health, other insurance coverage, employment, age, general character, finances or participation in hazardous activities to furnish such information to EMCNL, its reinsurers and their authorized representative upon presenting this authorization.

By my signature below, I acknowledge that any agreements I have made to restrict my Protected Health Information do not apply to this authorization and I instruct any Medical Provider to release and disclose my entire medical record without restriction.

The purpose of the release of the above information is for EMCNL to evaluate and underwrite an application for insurance coverage, to determine the rates and terms that apply to such insurance coverage, and/or to resolve any issues of incomplete, incorrect or misrepresented information on the application which may arise during the processing of the application.

I authorize EMCNL or its reinsurers to make a brief report of my Protected Health Information to MIB, Inc. EMCNL or its reinsurers may make a brief report regarding me or my children to other insurance companies to whom I have applied or may apply.

This authorization will remain in effect from the date signed below for a period of 24 months, and a copy of this authorization is as valid as the original. I understand that this authorization may be revoked at any time by sending written notice of such to EMCNL at the address above. The right to revoke this authorization is limited to the extent that EMCNL has taken action in reliance on the authorization or the law provides the Company with the right to contest a claim under the policy for which I have applied or to contest the policy itself. I understand that any information that is disclosed pursuant to this authorization may no longer be covered by federal rules governing privacy and confidentiality of health information, but it will not be redisclosed by the recipient except as authorized by me or as allowed by law.

I understand that my Medical Providers may not refuse to provide treatment or payment for health care services if I refuse to sign this authorization. I further understand that if I refuse to sign this authorization, EMCNL may not issue the insurance coverage for which I am applying or if coverage has been issued may not be able to make any benefit payments. I understand that any Personal Representative or I will receive a copy of this authorization upon request.

I authorize EMCNL to obtain an investigative consumer report on me, if required.

I elect to be interviewed if any investigative consumer report is prepared in connection with this application.

X _____
 Signature of Proposed Insured or Personal Representative Printed Name Date

X _____
 Signature of Spouse (if applying) or Personal Representative Printed Name Date

X _____
 Signature of Other Applicant (other than Proposed Insured or Spouse – if applying) or Personal Representative Printed Name Date

Note: If the authorization is signed by a Personal Representative of an individual, a description of the Representative's authority and relationship must be provided below.

 Description of Personal Representative's Authority and Relationship to the Individual

APPLICATION FOR INDIVIDUAL LIFE INSURANCE FOR YOUTH PRODUCTS
EMC NATIONAL LIFE COMPANY • [P.O. Box 9144 Des Moines, Iowa 50306-9144]

1. PROPOSED INSURED

PRINT IN BLACK INK

FIRST NAME	MIDDLE NAME	LAST NAME	SOCIAL SECURITY #	
MAILING ADDRESS			<input type="checkbox"/> FEMALE <input type="checkbox"/> MALE	DATE OF BIRTH
			AGE	
CITY	STATE	ZIP + 4 DIGIT	TELEPHONE # ()	
Is the Proposed Insured a U.S. citizen? <input type="checkbox"/> YES <input type="checkbox"/> NO If no, provide details on a separate sheet and send copy of permanent resident visa card.				

2. PRIMARY BENEFICIARY

NAME (First, M.I., Last)	DATE OF BIRTH	SOCIAL SECURITY #	RELATIONSHIP	%

CONTINGENT BENEFICIARY

NAME (First, M.I., Last)	DATE OF BIRTH	SOCIAL SECURITY #	RELATIONSHIP	%

3. OWNER

FIRST NAME	MIDDLE NAME	LAST NAME	SOCIAL SECURITY #
MAILING ADDRESS			DATE OF BIRTH
CITY	STATE	ZIP + 4 DIGIT	RELATIONSHIP TO INSURED

4. AMOUNT OF INSURANCE [Youth Plus Term: \$5,000 \$7,500 \$10,000 \$20,000]
 [Young American Increasing Whole Life: \$ _____ (\$2,000 - \$35,000)]
 [Additional Premium Rider (Young American Only): \$ _____]
 [Future Youth Product]

5. PREMIUM OPTIONS [Youth Plus Term: Single Premium 2-Year Payment Plan]
 [Young American Increasing Whole Life: Single Premium 5 Pay 10 Pay 20 Pay Continuous]
 [Future Youth Product]

6. MODE Single Premium \$ _____]
 Planned Premium \$ _____ Annual Semiannual Quarterly Monthly (not available on Direct Bill)]
 Form: Check Plan Direct Bill List Bill ABS# _____]
 [Additional Premium Rider / Single Premium (Young American only): \$ _____]

7. LIFE INSURANCE / ANNUITIES IN FORCE (List below, including any existing EMCNL policies.) Check if none in force

Person Insured	Company	Policy #	Life Amount	ADB	To Be Replaced
					<input type="checkbox"/> Yes <input type="checkbox"/> No
					<input type="checkbox"/> Yes <input type="checkbox"/> No
					<input type="checkbox"/> Yes <input type="checkbox"/> No

Is this policy being purchased to replace any existing life insurance policy or annuity contract? Yes No
 If yes, complete any replacement form required by your state and send with the application.



8. **PAYOR** (specify one) Insured Owner Other

If Other, provide: Full Name Address / City / State / Zip Relationship

9. **ADDITIONAL PERSON TO RECEIVE LAPSE NOTIFICATION** (if desired)

Full Name Address / City / State / Zip Relationship

10. IMPORTANT! GIVE COMPLETE DETAILS BELOW FOR EACH "YES" ANSWER SPECIFYING DATES AND RESULTS OF TREATMENT, DOCTORS AND COMPLETE ADDRESSES.

- A. Within the past 10 years, has the Proposed Insured been diagnosed or treated by a medical practitioner for: **Yes** **No**
- (1) Cancer in any form?
 - (2) Heart disorder or defect, coronary disease, rheumatic fever, stroke or disorder of blood vessels?.....
 - (3) Mental illness requiring hospitalization or inpatient treatment, diabetes, disorder of the lung, kidney, stomach, liver, intestine, epilepsy or brain or nervous system disorder?
 - (4) Tested positive for exposure to the Human Immunodeficiency Virus (HIV) or been diagnosed as having Acquired Immune Deficiency Syndrome (AIDS)?
- B. Within the past 5 years, has the Proposed Insured:
- (1) Been hospitalized?
 - (2) Been advised by a member of the medical profession to get specified medical care which was not completed, such as any hospitalization, surgery or diagnostic tests, except those tests related to the Human Immunodeficiency Virus (AIDS Virus)?.....

Give complete details below to all Yes answers. Use Section 12 if additional space is needed.

Ques. #	Dates	Symptom(s), Condition(s), Diagnosis	Treatment / Medication	Complete Name(s) & Address(es) of Doctors, Hospitals or Clinics

11. FOR THE PROPOSED INSURED, PLEASE PROVIDE:

Name and Address of Personal Physician	Date and Reason Last Seen

12. **PROVIDE DETAILS OR SPECIAL REQUESTS:** _____

**AUTHORIZATION TO OBTAIN AND DISCLOSE INFORMATION
Life Insurance Application**

This Authorization Complies with the HIPAA Privacy Rule.

I, the undersigned, understand EMC National Life Company (EMCNL), its reinsurers, insurance support organizations (such as MIB, Inc. or any of its members or affiliates) and their authorized representative, may obtain medical and other information in order to evaluate my application for insurance. I authorize any Medical Providers, as described below, to disclose or release Protected Health Information, as described below, to EMC National Life Company, [P.O. Box 9144, Des Moines, Iowa 50306-9144], or its authorized representative.

- Medical Providers: All physicians, medical or dental practitioners, hospitals, clinics, pharmacies, pharmacy benefit managers, other medical care facilities and all other providers of medical or dental services who have provided treatment or other health care services to me or on my behalf.
- Protected Health Information: Any and all records and health information within such Medical Person's possession, such as medical history, entire medical records, mental, psychiatric (excluding psychotherapy notes) and physical condition, prescription drug records, tobacco, drug and alcohol use and any other protected health information concerning me. This includes information which may be considered to be a communicable or a sexually transmitted disease, which may include, but are not limited to diseases such as hepatitis, syphilis, gonorrhea, the Human Immunodeficiency Virus (HIV) and the Acquired Immune Deficiency Syndrome (AIDS).

In addition, I authorize the Veterans Administration, the MIB, Inc., my employer, consumer reporting agency, insurance company or other organization who possesses information, records or knowledge of me including information about drugs, alcoholism or mental illness, my health, other insurance coverage, employment, age, general character, finances or participation in hazardous activities to furnish such information to EMCNL, its reinsurers and their authorized representative upon presenting this authorization.

By my signature below, I acknowledge that any agreements I have made to restrict my Protected Health Information do not apply to this authorization and I instruct any Medical Provider to release and disclose my entire medical record without restriction.

The purpose of the release of the above information is for EMCNL to evaluate and underwrite an application for insurance coverage, to determine the rates and terms that apply to such insurance coverage, and/or to resolve any issues of incomplete, incorrect or misrepresented information on the application which may arise during the processing of the application.

I authorize EMCNL or its reinsurers to make a brief report of my Protected Health Information to MIB, Inc. EMCNL or its reinsurers may make a brief report regarding me or my children to other insurance companies to whom I have applied or may apply.

This authorization will remain in effect from the date signed below for a period of 24 months, and a copy of this authorization is as valid as the original. I understand that this authorization may be revoked at any time by sending written notice of such to EMCNL at the address above. The right to revoke this authorization is limited to the extent that EMCNL has taken action in reliance on the authorization or the law provides the Company with the right to contest a claim under the policy for which I have applied or to contest the policy itself. I understand that any information that is disclosed pursuant to this authorization may no longer be covered by federal rules governing privacy and confidentiality of health information, but it will not be redisclosed by the recipient except as authorized by me or as allowed by law.

I understand that my Medical Providers may not refuse to provide treatment or payment for health care services if I refuse to sign this authorization. I further understand that if I refuse to sign this authorization, EMCNL may not issue the insurance coverage for which I am applying or if coverage has been issued may not be able to make any benefit payments. I understand that any Personal Representative or I will receive a copy of this authorization upon request.

I authorize EMCNL to obtain an investigative consumer report on me, if required.

I elect to be interviewed if any investigative consumer report is prepared in connection with this application.

X _____
Signature of Parent or Guardian or Personal Representative Printed Name Date

X _____
Proposed Insured's (age 18 and over) Signature Printed Name Date

Note: If the authorization is signed by a Personal Representative of an individual, a description of the Representative's authority and relationship must be provided below.

Description of Personal Representative's Authority and Relationship to the Individual

ALWAYS DETACH AND GIVE TO APPLICANT

FAIR CREDIT REPORTING ACT

In compliance with 15 USC 1681 et. seq., this notice is to inform you that:

In making this application for insurance it is understood that an investigative consumer report may be made whereby information is obtained through personal interviews with third parties, such as family members, business associates, financial sources, friends, neighbors or others with whom you are acquainted. This inquiry includes information as to your character, general reputation, personal characteristics and mode of living, whichever may be applicable. You have the right to make a written request to EMC National Life Company, [P.O. Box 9144, Des Moines, IA 50306-9144], within a reasonable period of time for a complete and accurate disclosure of additional information concerning the nature and scope of the investigation.

NOTIFICATION REGARDING THE MIB, INC.

Information regarding your insurability will be treated as confidential. EMC National Life Company or its reinsurer(s) may, however, make a brief report thereon to MIB, Inc., 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]. 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 federal Fair Credit Reporting Act. The address of MIB's information office is [50 Braintree Hill Park, Suite 400, Braintree, Massachusetts 02184-8734].

EMC National Life Company or its reinsurer(s) 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.]

COMPLETE, DETACH AND GIVE TO APPLICANT ONLY WHEN FULL FIRST PREMIUM IS PAID WITH APPLICATION

CONDITIONAL COVERAGE RECEIPT

RECEIVED FROM _____, this _____ day of _____ the sum of \$ _____, subject to the terms and conditions of the policy, as full (check one) annual semiannual quarterly check plan premium, along with the application bearing the date of this Receipt, for coverage on _____, the Proposed Insured(s).

TERMS AND CONDITIONS

"Effective Date" as used herein means the later of a) the date the application is signed; b) the date of completion of all medical examinations, if required; or c) the requested Effective Date shown on the application.

Coverage may become effective prior to the policy delivery if and when all of the following conditions are met:

- 1. The amount of the payment is equal to the first full premium selected and the payment is taken with the application;
- 2. The Proposed Insured(s) must be, on the Effective Date as defined above, a risk acceptable to EMC National Life Company under its rules, standards and practices for the exact contract of insurance and premium applied for, without any modifications; and
- 3. The contract is issued exactly as applied for within 60 days from the date of the application. If the application is declined or disapproved or if the contract is not issued within 60 days from the date of application, then this condition has not been fulfilled, no coverage is or has been provided under the terms of this Conditional Receipt, and any premium paid will be returned.

If any of the above conditions are not met, there shall be no liability on the part of EMC National Life Company except to return the premiums collected with the application.

This Receipt shall be rendered void if it is modified or altered, or if a check or draft given in payment is not honored. No agent or broker of EMC National Life Company, [P.O. Box 9144, Des Moines, IA 50306-9144], is authorized to waive or alter any of the above conditions.

X _____ **X** _____ **X** _____
 Applicant's Signature Agent's Signature Date

ALL PREMIUM CHECKS OR DRAFTS MUST BE MADE PAYABLE TO EMC NATIONAL LIFE COMPANY. DO NOT MAKE CHECKS PAYABLE TO THE AGENT. DO NOT LEAVE THE PAYEE BLANK.

- 8. Has the person proposed for coverage:** **Yes** **No**
- A. Have any other application for personal insurance pending?
- B. Within the last 10 years, applied for life, health, or disability insurance or reinstatement which was declined, postponed, rated, restricted or modified?.....
- C. Within the last 2 years, have you engaged in aviation activity other than as a passenger?
- D. Within the last 2 years, have you engaged in ballooning, sky diving, hang gliding, rock or mountain climbing, rodeo competition, SCUBA diving, or any form of organized motorized racing or do you intend to engage in such activities over the next 12 months?
- E. Within the last 3 years, had a driver's license suspended or revoked for any reason, or been charged with or convicted of driving while intoxicated or under the influence of a controlled substance or had more than 2 moving (traffic) violations?.....
- F. Within the last 10 years, have you been convicted of a felony or are you currently on parole or probation?
- G. (1) Have you ever used tobacco in any form?.....
- (2) If yes, have you used any tobacco products within the last 12 months?

- 9. A. Within the last 10 years, has the person proposed for coverage:** **Yes** **No**
- (1) Had any diagnosis or treatment for: high blood pressure not controlled by medication, chest pain or angina, heart attack, stroke, or disease or disorder of the heart, heart valves, blood or blood vessels?
- (2) Had any diagnosis or treatment for: cancer (except for basal cell or squamous cell skin cancer), tumor, leukemia, epilepsy, diabetes, hepatitis, disease or disorder of the pancreas, stomach or intestines, brain or nervous system, kidney or liver?.....
- (3) Had any diagnosis or treatment for: lung disorders including emphysema, chronic obstructive pulmonary disease (COPD), chronic bronchitis, tuberculosis or asthma (except for mild or exercise induced)?.....
- (4) Been diagnosed as having or been treated for Human Immunodeficiency Virus (HIV), Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC) by a member of the medical profession?
- (5) Been diagnosed as having or been treated for any immune deficiency disorder or autoimmune or muscle or connective tissue disease or disorder (not HIV related)?
- (6) Had mental illness, including depression or anxiety requiring inpatient treatment or hospitalization, bipolar disorder or history of suicide attempt?
- (7) Except as prescribed by a physician, ever used marijuana, heroin, cocaine, barbiturates or other illegal drugs, joined any organization, received or had treatment or counseling for drug or alcohol abuse?

- B. Within the last 5 years, has the person proposed for coverage:**
- (1) Been hospitalized, treated, examined or advised by a member of the medical profession excluding for colds, minor viruses or minor injuries which prevented normal activities for less than 5 days?.....
- (2) Been advised by a member of the medical profession to get specified medical care which was not completed, such as any hospitalization, surgery or diagnostic tests except those tests related to the Human Immunodeficiency Virus (AIDS Virus)?

10. Taxpayer Identification Certification. Per Internal Revenue Service guidelines, use this area to report and certify the taxpayer identification number (typically this is your social security number or an employer identification number) of the owner of the policy. Under penalties of perjury, by my signature on this form on page 3, I certify that:

1. The number shown on this form on page 1 is my correct taxpayer identification number; **and**
2. I am not subject to backup withholding either because: **(a)** I am exempt from backup withholding, or **(b)** I have not been notified by the Internal Revenue Service (IRS) 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; **and**
3. I am a U.S. person (including a U.S. resident alien).

Note: You must cross out item 2 above if you have been notified by the IRS that you are currently subject to backup withholding because you have failed to report all interest and dividends on your tax return.

AUTHORIZATION TO OBTAIN AND DISCLOSE INFORMATION
Life Insurance Application
This Authorization Complies with the HIPAA Privacy Rule.

I (person(s) signed below) understand EMC National Life Company (EMCNL), its reinsurers, insurance support organizations (such as MIB, Inc. or any of its members or affiliates) and their authorized representative, may obtain medical and other information in order to evaluate my application for insurance. I authorize any Medical Providers, as described below, to disclose or release Protected Health Information, as described below, to EMC National Life Company, [P.O. Box 9144, Des Moines, Iowa 50306-9144], or its authorized representative.

- Medical Providers: All physicians, medical or dental practitioners, hospitals, clinics, pharmacies, pharmacy benefit managers, other medical care facilities and all other providers of medical or dental services who have provided treatment or other health care services to me or on my behalf.
- Protected Health Information: Any and all records and health information within such Medical Person's possession, such as medical history, entire medical records, mental, psychiatric (excluding psychotherapy notes) and physical condition, prescription drug records, tobacco, drug and alcohol use and any other protected health information concerning me. This includes information which may be considered to be a communicable or a sexually transmitted disease, which may include, but are not limited to diseases such as hepatitis, syphilis, gonorrhea, the Human Immunodeficiency Virus (HIV) and the Acquired Immune Deficiency Syndrome (AIDS).

In addition, I authorize the Veterans Administration, the MIB, Inc., my employer, consumer reporting agency, insurance company or other organization who possesses information, records or knowledge of me including information about drugs, alcoholism or mental illness, my health, other insurance coverage, employment, age, general character, finances or participation in hazardous activities to furnish such information to EMCNL, its reinsurers and their authorized representative upon presenting this authorization.

By my signature below, I acknowledge that any agreements I have made to restrict my Protected Health Information do not apply to this authorization and I instruct any Medical Provider to release and disclose my entire medical record without restriction.

The purpose of the release of the above information is for EMCNL to evaluate and underwrite an application for insurance coverage, to determine the rates and terms that apply to such insurance coverage, and/or to resolve any issues of incomplete, incorrect or misrepresented information on the application which may arise during the processing of the application.

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I understand that my Medical Providers may not refuse to provide treatment or payment for health care services if I refuse to sign this authorization. I further understand that if I refuse to sign this authorization, EMCNL may not issue the insurance coverage for which I am applying or if coverage has been issued may not be able to make any benefit payments. I understand that any Personal Representative or I will receive a copy of this authorization upon request.

I authorize EMCNL to obtain an investigative consumer report on me, if required.

I elect to be interviewed if any investigative consumer report is prepared in connection with this application.

X _____
Signature of Proposed Insured or Personal Representative Printed Name Date

Note: If the authorization is signed by a Personal Representative of an individual, a description of the Representative's authority and relationship must be provided below.

Description of Personal Representative's Authority and Relationship to the Individual

ALWAYS DETACH AND GIVE TO APPLICANT

FAIR CREDIT REPORTING ACT

In compliance with 15 USC 1681 et. seq., this notice is to inform you that:

In making this application for insurance it is understood that an investigative consumer report may be made whereby information is obtained through personal interviews with third parties, such as family members, business associates, financial sources, friends, neighbors or others with whom you are acquainted. This inquiry includes information as to your character, general reputation, personal characteristics and mode of living, whichever may be applicable. You have the right to make a written request to EMC National Life Company, [P.O. Box 9144, Des Moines, IA 50306-9144], within a reasonable period of time for a complete and accurate disclosure of additional information concerning the nature and scope of the investigation.

NOTIFICATION REGARDING THE MIB, INC.

Information regarding your insurability will be treated as confidential. EMC National Life Company or its reinsurer(s) may, however, make a brief report thereon to MIB, Inc., 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]. 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 federal Fair Credit Reporting Act. The address of MIB's information office is [50 Braintree Hill Park, Suite 400, Braintree, Massachusetts 02184-8734].

EMC National Life Company or its reinsurer(s) 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.

WORKPLACE APPLICATION FOR INDIVIDUAL LIFE INSURANCE PRODUCTS

PRINT IN BLACK INK

1. Employee / Association Member Information

First Name			M.I.	Last		Social Security Number		Employee Number	
Address				City		State	Zip	Telephone Number (home) (work)	
<input type="checkbox"/> Employee	<input type="checkbox"/> Male	Height	Weight	Date of Birth	Birth State	Occupation			
<input type="checkbox"/> Association Member	<input type="checkbox"/> Female								
Are you Actively-at-Work?* <input type="checkbox"/> Yes <input type="checkbox"/> No For Association Member only, if you answered "no" above, have you been disabled or hospitalized, except for normal pregnancy, in the last 6 months? <input type="checkbox"/> Yes <input type="checkbox"/> No									

* Actively-at-Work means that you are actively at work now for wage or profit and have worked at least [20 hours] each week performing all duties at your regular occupation at your regular place of employment for the last 3 months except for minor illness or injury of 1 week or less or normal pregnancy.

2. Dependent Coverage

Spouse's First Name		M.I.	Last		Social Security Number		Date of Birth	Birth State	Height	Weight
Children (Children's Term Rider is only available on 1 policy.)										
Name				Date of Birth		Name			Date of Birth	
1.						3.				
2.						4.				
Has the spouse or any child been disabled or hospitalized, except for normal pregnancy, in the last 6 months? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, list name(s). _____ Person(s) named will be excluded from coverage.										

3. Tobacco Use

Within the last 12 months, has any person to be insured used tobacco in any form? Yes No
If yes, list name(s). _____

4. Beneficiary Designation

Beneficiary - Full Name & Relationship	If spouse or children's coverage is applied for, the primary beneficiary of the spouse or children's coverage is the Employee / Member. The contingent beneficiary is the estate of the insured spouse or child.
Contingent Beneficiary - Full Name & Relationship	

5. Owner (Complete only if Owner is other than the Employee / Member.)

Name (First, M.I., Last)	Address	Soc. Sec. Number	Relationship

6. Life Insurance / Annuities In Force

A. Do any of the applicants have any life insurance policies or annuity contracts in force with EMC National Life Company or any other company? Yes No

B. Is this policy being purchased to replace any existing life insurance policy or annuity contract? Yes No
Replacement forms may need to be completed as required by your state.

7. Premium Options

Rates: 48 Week 52 Week Monthly]

Billing: List Bill Pre-Authorized Check Plan (PAC)]

Proposed Effective Date: _____ / _____ / _____

Special Billing Instructions: _____



10. **Additional Information**

Empty form box for additional information.

11. **Interim Coverage – Applies Only to Payroll Deduction**

Is interim coverage being applied for? If "yes," effective immediately, interim coverage will be provided as applied for either until the date the policy becomes effective, or until the Owner is notified that no insurance policy will be issued. Interim coverage applies to the death benefit only. In no event will interim coverage be provided for more than 60 days from the date of this application. Yes No

12. **Statements and Agreements of All Applicants Signed Below**

I have read, or had read to me, the above questions and my answers to them. My answers are true and complete to the best of my knowledge and belief. I agree that this application will be the basis for, and will become part of, any policy that is issued by EMC National Life Company (EMCNL) and that no information about me will be considered to have been given to EMCNL unless it is stated in the application. I understand that the agent has no authority to approve the application, change the policy or waive any policy provisions. I understand no insurance will be effective until the date stated in the policy and all eligibility requirements are met or the date elected in Section 7. I acknowledge receipt of a copy of the "Important Notice."

AUTHORIZATION: I understand EMCNL, its reinsurers, insurance support organizations and their authorized representatives may obtain medical and other information in order to evaluate my application for insurance. Any physician, practitioner, hospital, clinic, pharmacies, pharmacy benefit managers, other medical or medically related facility, the Veterans Administration, the MIB, Inc., my employer and consumer reporting agency or insurance company who possesses information of care, treatment or advice of me may furnish such information to EMCNL or its reinsurers upon presenting this authorization. I understand this authorization includes information about drugs, alcoholism or mental illness. This information will not be released to others except as allowed by law or as I further authorize. I understand that any information that is disclosed pursuant to this authorization may no longer be covered by federal rules governing privacy and confidentiality of health information, but it will not be redisclosed by the recipient except as authorized by me or as allowed by law. This authorization will remain in effect from the date signed below for a period of 24 months, and a copy is as valid as the original. I understand that I may revoke this authorization at any time in writing and that I or my personal representative may receive a copy upon request.

I authorize EMCNL or its reinsurers to make a brief report of my personal health information to MIB, Inc. EMCNL or its reinsurers may make a brief report regarding me or my children to other insurance companies to whom I have applied or may apply.

FRAUD NOTICE/ WARNING: Any person who knowingly submits a false statement in an application or files a claim containing false or deceptive statements may be guilty of insurance fraud and subject to penalties under state law.

Signed at City / State

Date

X
Employee's / Member's Signature

X
Owner's Signature (if other than Employee / Member)

X
Spouse's Signature (if required for coverage)

X
Owner's Signature (if other than Spouse)

13. **Required Agent's Report**

- | | Yes | No |
|---|--------------------------|--------------------------|
| A. Have you accurately recorded information given to you by all persons proposed for coverage?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| B. To the best of your knowledge, will the insurance applied for replace any existing annuity / life policy(ies)? | <input type="checkbox"/> | <input type="checkbox"/> |
| C. As applicable, have you given to the applicant disclosure / replacement notices as required by your state? | <input type="checkbox"/> | <input type="checkbox"/> |
| D. Were the notices in the "Important Notice" given to the applicant? | <input type="checkbox"/> | <input type="checkbox"/> |

X
Agent's Signature (witness)

Agent's Printed Name

Agent's Contract Number Date

State: Arkansas
 TOI/Sub-TOI: L08 Life - Other/L08.000 Life - Other
 Product Name: 6 Life Applications
 Project Name/Number: /

Filing Company: EMC National Life Company

Supporting Document Schedules

		Item Status:	Status Date:
Satisfied - Item:	Flesch Certification		
Comments:			
Attachment(s):			
AR Read Cert.pdf			

		Item Status:	Status Date:
Satisfied - Item:	Statements of Variability		
Comments:			
Attachment(s):			
Stmt of Variability EAP050.pdf Stmt of Variability EAP051.pdf Stmt of Variability EAP054.pdf Stmt of Variability EAP056.pdf Stmt of Variability EAP052.pdf Stmt of Variability EAP053.pdf			

READABILITY

CERTIFICATION

I certify to the best of my knowledge that these forms are readable based on the factors specified in Sections 66-3251 to 66-3258 of the Arkansas Statutes. The Flesch Scores are as follows:

<u>Form Number</u>	<u>Flesch Score</u>
EAP050 (7-12)	52.6
EAP051 (7-12)	54.2
EAP052 (7-12)	50.0
EAP053 (7-12)	58.9
EAP054 (8-12)	50.9
EAP056 (9-12)	51.2



Mark C. Rowley, FSA, MAAA
Vice President, Managing Actuary
September 30, 2012

EMC National Life Company
Statement of Variability

Application for Individual Life Insurance EAP050 (7-12)

1. **Company Address –
Cover Page, Fair Credit Reporting/MIB/Conditional Receipt Page, Page 1, and Page 7**
In the event of a change in the company address, the new information will be shown.
2. **Company Phone Number .**
Cover Page
In the event of a change in the company phone number, the new information will be shown.
3. **Company Website Address .**
Cover Page
In the event of a change in the company website address, the new information will be shown.
4. **MIB, Inc. Address –
Fair Credit Reporting/MIB/Conditional Receipt Page**
In the event of a change in address for MIB, Inc. the new information will be shown.
5. **MIB, Inc. Phone Number–
Fair Credit Reporting/MIB/Conditional Receipt Page**
In the event of a change in phone number for MIB, Inc. the new information will be shown.
6. **MIB, Inc. Website Address–
Fair Credit Reporting/MIB/Conditional Receipt Page**
In the event of a change in website address for MIB, Inc. the new information will be shown.
7. **Maximum Amount under Conditional Receipt
Fair Credit Reporting/MIB/Conditional Receipt Page**
This amount could vary from \$100,000 to \$1,000,000.
8. **Plan of Insurance –
Page 2 – Section 8**
This section contains a box with each of the products currently being sold and the riders available for each product. As the products available in our portfolio change (new ones added or current ones discontinued) the boxes will reflect these changes. Also, the riders available under each product will change for the same reasons.
9. **Mode –
Page 3 – Question 9**
We currently offer payment modes of annual, semiannual, quarterly and monthly. We would like the option to change the modes that are offered in the future.
10. **Form –
Page 3 – Question 9**
We currently offer check plan, direct bill, list bill, and ABS. We would like the option to change the forms that are offered in the future.
11. **Planned Premium Amounts -
Page 3 – Question 9**
Currently with our products there are the options of paying a planned periodic or lump sum payment, or both. We would like the option in the future to offer other planned payment periods, such as a 10 year pay or Paid Up at 65.

Mark Rowley _____

Mark C. Rowley, FSA, MAAA
Vice President, Managing Actuary

September 30, 2012 _____

Date

EMC National Life Company
Statement of Variability

Application for Individual Life Insurance EAP051 (7-12)

1. **Company Address –
Cover Page, Fair Credit Reporting/MIB/Conditional Receipt Page, Page 1, and Page 7**
In the event of a change in the company address, the new information will be shown.
2. **Company Phone Number .
Cover Page**
In the event of a change in the company phone number, the new information will be shown.
3. **Company Website Address .
Cover Page**
In the event of a change in the company website address, the new information will be shown.
4. **MIB, Inc. Address –
Fair Credit Reporting/MIB/Conditional Receipt Page**
In the event of a change in address for MIB, Inc. the new information will be shown.
5. **MIB, Inc. Phone Number–
Fair Credit Reporting/MIB/Conditional Receipt Page**
In the event of a change in phone number for MIB, Inc. the new information will be shown.
6. **MIB, Inc. Website Address–
Fair Credit Reporting/MIB/Conditional Receipt Page**
In the event of a change in website address for MIB, Inc. the new information will be shown.
7. **Maximum Amount under Conditional Receipt
Fair Credit Reporting/MIB/Conditional Receipt Page**
This amount could vary from \$100,000 to \$1,000,000.
8. **Plan of Insurance –
Page 2 – Section 8**
This section contains a box with each of the products currently being sold and the riders available for each product. As the products available in our portfolio change (new ones added or current ones discontinued) the boxes will reflect these changes. Also, the riders available under each product will change for the same reasons.
9. **Mode –
Page 3 – Question 9**
We currently offer payment modes of annual, semiannual, quarterly and monthly. We would like the option to change the modes that are offered in the future.
10. **Form –
Page 3 – Question 9**
We currently offer check plan, direct bill, list bill, and ABS. We would like the option to change the forms that are offered in the future.
11. **Planned Premium Amounts -
Page 3 – Question 9**
Currently with our products there are the options of paying a planned periodic or lump sum payment, or both. We would like the option in the future to offer other planned payment periods, such as a 10 year pay or Paid Up at 65.

Mark Rowley

Mark C. Rowley, FSA, MAAA
Vice President, Managing Actuary

September 30, 2012
Date

EMC National Life Company
Statement of Variability

Application for Individual Life Insurance EAP054 (8-12)

**1. Company Address –
Pages 1, 4 and 5**

In the event of a change in the company address, the new information will be shown.

**2. Plan of Insurance –
Page 1 – Section 6**

This section contains a box with each of the products currently being sold. As the products available in our portfolio change (new ones added or current ones discontinued) the boxes will reflect these changes.

**3. Mode –
Page 1 – Question 7**

We currently offer payment modes of annual, semiannual, quarterly and monthly. We would like the option to change the modes that are offered in the future.

**4. Form –
Page 1 – Question 7**

We currently offer check plan and credit card. We would like the option to change the forms that are offered in the future.

**5. MIB Phone Number, Address, and Website -
Page 5**

In the event of a change, the new information will be shown.



Mark C. Rowley, FSA, MAAA
Vice President, Managing Actuary

September 30, 2012

Date

EMC National Life Company
Statement of Variability

Application for Individual Life Insurance EAP056 (9-12)

**1. Company Address –
Page 1**

In the event of a change in the company address, the new information will be shown.

**2. Actively-at-Work hours –
Page 1 – Section 1**

The hours could vary from 10 to 30 depending on the case.

**3. Rates –
Page 1 – Section 7**

We currently rate options of 48 week, 52 week, and monthly. We would like the option to change the rate options that are offered in the future.

**4. Billing –
Page 1 – Section 7**

We currently offer billing options of List Bill and PAC. We would like the option to change the billing options that are offered in the future.

**5. Plan of Insurance –
Page 2 – Section 8**

This section contains a box with each of the products currently being sold and the riders available for each product. As the products available in our portfolio change (new ones added or current ones discontinued) the boxes will reflect these changes. Also, the riders available under each product will change for the same reasons.



Mark C. Rowley, FSA, MAAA
Vice President, Managing Actuary

September 30, 2012

Date

EMC National Life Company
Statement of Variability

Application for Individual Life Insurance Reinstatement EAP052 (7-12)

1. **Company Address –
Cover Page, Fair Credit Reporting/MIB/Conditional Receipt Page, Page 1, and Page 4**
In the event of a change in the company address, the new information will be shown.
2. **Company Phone Number .
Cover Page**
In the event of a change in the company phone number, the new information will be shown.
3. **Company Website Address .
Cover Page**
In the event of a change in the company website address, the new information will be shown.
4. **MIB, Inc. Address –
Fair Credit Reporting/MIB/Conditional Receipt Page**
In the event of a change in address for MIB, Inc. the new information will be shown.
5. **MIB, Inc. Phone Number–
Fair Credit Reporting/MIB/Conditional Receipt Page**
In the event of a change in phone number for MIB, Inc. the new information will be shown.
6. **MIB, Inc. Website Address–
Fair Credit Reporting/MIB/Conditional Receipt Page**
In the event of a change in website address for MIB, Inc. the new information will be shown.



Mark C. Rowley, FSA, MAAA
Vice President, Managing Actuary

September 30, 2012
Date

EMC National Life Company
Statement of Variability

Application for Individual Life Insurance for Youth Products EAP053 (7-12)

**1. Company Address –
Page 1 and Page 4**

In the event of a change in the company address, the new information will be shown.

**2. Amount of Insurance .
Page 1 – Question 4**

This section contains a box with each of the products currently being sold and the riders available for each product. As the products available in our portfolio change (new ones added or current ones discontinued) the boxes will reflect these changes. Also, the riders available under each product will change for the same reasons. Also, the face amounts offered under each plan can change.

**3. Premium Options .
Page 1 – Question 5**

This section contains a box with each of the products currently being sold. As the products available in our portfolio change (new ones added or current ones discontinued) the boxes will reflect these changes. Also, the premium options available under each product can change.

**4. Mode –
Page 1 – Question 6**

We currently offer payment modes of single premium, annual, semiannual, quarterly and monthly. We would like the option to change the modes that are offered in the future.

**5. Form –
Page 1 – Question 6**

We currently offer check plan, direct bill, list bill, and ABS. We would like the option to change the forms that are offered in the future.

**6. MIB, Inc. Address –
Page 5**

In the event of a change in address for MIB, Inc. the new information will be shown.

**7. MIB, Inc. Phone Number–
Page 5**

In the event of a change in phone number for MIB, Inc. the new information will be shown.

**8. MIB, Inc. Website Address–
Page 5**

In the event of a change in website address for MIB, Inc. the new information will be shown.



Mark C. Rowley, FSA, MAAA
Vice President, Managing Actuary

September 30, 2012

Date