

State: Arkansas **Filing Company:** North American Company for Life and Health Insurance
TOI/Sub-TOI: L08 Life - Other/L08.000 Life - Other
Product Name: Form 82-52, 82-5, 82-37, 82-47
Project Name/Number: Form 82-52, 82-5, 82-37, 82-47/Form 82-52, 82-5, 82-37, 82-47

Filing at a Glance

Company: North American Company for Life and Health Insurance
Product Name: Form 82-52, 82-5, 82-37, 82-47
State: Arkansas
TOI: L08 Life - Other
Sub-TOI: L08.000 Life - Other
Filing Type: Form
Date Submitted: 11/01/2012
SERFF Tr Num: NALH-128752337
SERFF Status: Closed-Approved-Closed
State Tr Num:
State Status: Approved-Closed
Co Tr Num: FORM 82-52, 82-5, 82-37, 82-47

Implementation: 01/01/2013
Date Requested:
Author(s): Sherry M. Olson
Reviewer(s): Linda Bird (primary)
Disposition Date: 11/09/2012
Disposition Status: Approved-Closed
Implementation Date:

State Filing Description:

State: Arkansas **Filing Company:** North American Company for Life and Health Insurance
TOI/Sub-TOI: L08 Life - Other/L08.000 Life - Other
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General Information

Project Name: Form 82-52, 82-5, 82-37, 82-47 Status of Filing in Domicile: Pending
Project Number: Form 82-52, 82-5, 82-37, 82-47 Date Approved in Domicile:
Requested Filing Mode: Review & Approval Domicile Status Comments: North American's domicile state of Iowa is a member of the Interstate Compact; these forms are being submitted to the Compact.
Explanation for Combination/Other: Market Type: Individual
Submission Type: New Submission Individual Market Type:
Overall Rate Impact: Filing Status Changed: 11/09/2012
State Status Changed: 11/09/2012
Deemer Date: Created By: Sherry M. Olson
Submitted By: Sherry M. Olson Corresponding Filing Tracking Number:

Filing Description:

RE: North American Company for Life and Health Insurance
NAIC # 66794 FEIN # 36-2428931
Form 82-52 (10-12), Regular Issue Application for Life Insurance
Form 82-5 (10-12), Application for Life Insurance Part 2/Medical Examiner's Report
Form 82-47 (10-12), Application for Policy Reinstatement or Change
Form 82-37 (10-12), Guaranteed Issue Application for Individual Life Insurance

NOTE: This filing is identical to SERFF Tr #: NALH-128750146, submitted for review and approval for our sister company Midland National Life Insurance Company on 10/30/2012. Except for the company names and form numbers, the forms are identical.

We are filing the above forms for review and approval. These are new forms that will replace the previously approved forms listed below. The forms are laser printed and we reserve the right to change logos, company address, fonts and layouts. We certify the font size will never be less than the minimum 10 point required.

1. Form 82-52 (10-12) replaces Form 82-52 (8-08), which was approved 12/17/2008 (SERFF Tr#: NALH-125885595). This form will be used to apply for individual life policy forms when the application is submitted on a fully underwritten basis.

In addition to minor language changes, the primary differences to the previously approved version of the form are:

Page 1:

- Added brackets to the company logo at the top of page 1 and to the contact information at the bottom of page 1.
- Added 2a for Secondary Addressee Designation
- Added instruction "If Trust, Name and Date of Trust"
- Added the instruction "Name of Product" to question 6a.
- Added blank for existing North American policy number to question 7.

Page 2:

- Changed the order of questions 12-20 and specifically revised language in:
- Question 15, to ask whether the applicant currently engages in or within the next two years intends to engage in the listed activities
- Question 16, to ask whether the applicant is currently a pilot, student pilot or crew member in any type of aircraft or within the next two years intends to become one.
- Question 17, to ask whether the proposed insured has pled guilty to a felony or misdemeanor (excluding traffic violations).

State: Arkansas **Filing Company:** North American Company for Life and Health Insurance

TOI/Sub-TOI: L08 Life - Other/L08.000 Life - Other

Product Name: Form 82-52, 82-5, 82-37, 82-47

Project Name/Number: Form 82-52, 82-5, 82-37, 82-47/Form 82-52, 82-5, 82-37, 82-47

- Questions 18 and 19 are now separate questions and were previously sub-parts of the same question.
- Created a grid format with columns for Question Number, Date and Details for yes answers to questions 12-20.
- Question 21, revised to specify whether the applicant's parent or siblings have a history of the listed items.
- Deleted the Home Office Endorsements box

Page 3:

- Added question 1e to list any currently prescribed medications
- Revised the introduction to question 2 to include whether the applicant has been diagnosed or been given advice by a medical professional for the listed items.
- Question 2c, removed the reference to immune system and added new question 2d to ask about immune system disease or disorders.
- Revised disorders listed in questions 2f, 2g, 2h and 2i
- Deleted previous question 2j regarding any injury, disease or illness not indicated above.
- Revised the introduction to question 3 to add "Excluding minor illnesses or minor injuries not requiring treatment"
- Question 3a, added a reference to diagnostic test
- Question 3c, limited question to within the last five years and added injury to list of items.
- Question 4, revised HIV question based on Interstate Compact standards.

Page 4:

- 1st paragraph – added "to the best of their knowledge and belief".
- 2nd paragraph – removed references to Home Office Endorsement; added "gender or benefits" to list of changes that require Owner's written consent.
- 4th paragraph – corrected Medical Information Bureau Inc to MIB Inc; added authorization to make a report of personal health information to MIB; added statement that no sales representative is authorized to accept risk, pass on insurability etc.
- Added TIN certification regarding backup withholding
- Fraud Statement, revised to use Interstate Compact standard fraud statement.
- Added statement regarding individuals who are authorized to signed on behalf of entities.
- Deleted previous page 5, Agent's Report and previous page 6, containing Fair Credit Reporting Act Notification, Notice of Insurance Information Practices and the Medical Information Bureau Notification. These notices will be provided to the applicant on a separate form that is not part of the application

2. Form 82-5 (10-12) is a new form that will replaces Form 82-5 (7-04), which was approved on 9/24/2004. This form will be used in conjunction with Form 82-52 (10-12) when a paramedical exam is performed as part of the underwriting process.

We completely reformatted this form compared to the previous version. The questions have been reformatted and expanded to two pages to improve the form's usability. We added a supplemental page 3 to record additional information that exceeds the space allowed on the first two pages. We also reformatted the Medical Examiner's Report page.

3. Form 82-37 (10-12) replaces Form 82-37 (11-12), which was approved on 01/05/2012 (SERFF Tr#: NALH-127938913). This form will be used to apply for individual life policy forms when the application is submitted on a guaranteed issue basis.

The primary differences to the previously approved version of the form are:

Page 1:

- Agreement section – added "to the best of their knowledge and belief"; removed references to Home Office Endorsement; added "gender or benefits" to list of changes that require Owner's written consent; added statement that no sales representative is authorized to accept risk, pass on insurability etc.
- Added statement regarding individuals who are authorized to signed on behalf of entities.
- Deleted the Home Office Changes box

Page 2:

State: Arkansas **Filing Company:** North American Company for Life and Health Insurance

TOI/Sub-TOI: L08 Life - Other/L08.000 Life - Other

Product Name: Form 82-52, 82-5, 82-37, 82-47

Project Name/Number: Form 82-52, 82-5, 82-37, 82-47/Form 82-52, 82-5, 82-37, 82-47

- Revised Premium column to specify "Life Policy Premium"
- Added column for "Annuity Rider Premium".

4. Form 82-47 (10-12) will replace Form 82-47 (10-09), which was approved on 01/13/2010 (SERFF Tr#: NALH-126442970). This form will be used to apply for changes to or reinstatements of existing North American policies.

In addition to minor language changes, the primary differences to the previously approved version of the form are:

Page 1:

- Added brackets to the company logo at the top of page 1 and to the contact information at the bottom of page 1.
- Changed the order of questions 8-16 and specifically revised language in:
- Question 12, to ask whether the applicant currently engages in or within the next two years intends to engage in the listed activities
- Question 13, to ask whether the applicant is currently a pilot, student pilot or crew member in any type of aircraft or within the next two years intends to become one.
- Question 14, to ask whether the proposed insured has pled guilty to a felony or misdemeanor (excluding traffic violations).
- Questions 15 and 16 are now separate questions and were previously sub-parts of the same question.

Page 2:

- Revised the introduction to question 2 to include whether the applicant has been diagnosed or been given advice by a medical professional for the listed items.
- Question 2c, removed the reference to immune system and added new question 2d to ask about immune system disease or disorders.
- Deleted previous question 2j regarding any injury, disease or illness not indicated above.
- Revised the introduction to question 3 to add "Excluding minor illnesses or minor injuries not requiring treatment"
- Question 3a, added a reference to diagnostic test
- Question 3c, limited question to within the last five years and added injury to list of items.
- Question 4, revised HIV question based on Interstate Compact standards.

Page 3:

- 1st paragraph – added "to the best of their knowledge and belief".
- 2nd paragraph – removed references to Home Office Endorsement; added "gender or benefits" to list of changes that require Owner's written consent.
- 4th paragraph – corrected Medical Information Bureau Inc to MIB Inc; added authorization to make a report of personal health information to MIB; added statement that no sales representative is authorized to accept risk, pass on insurability etc.
- Revised fraud statement to use Interstate Compact standard fraud statement.
- Added statement regarding individuals who are authorized to signed on behalf of entities.
- Deleted the Home Office Endorsements box

Generally, these forms will be used to apply for individual life insurance policy forms available in the bank-, credit union- or corporate-owned life insurance market where they are designed for purchase in connection with non-qualified deferred compensation plans (employee compensation and benefit plans, key person insurance and insurance to cover the costs of providing pre- and post-retirement employee benefits). The employer/corporation is the owner, beneficiary and pays the premiums on policies covering employee/insureds.

For informational purposes, a Statement of Variability that provides the variable ranges and variable text for the bracketed information is attached to the Supporting Documents tab.

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These application forms may be used to apply for current and future approved North American individual life insurance policy forms.

We reserve the right to have the forms completed electronically, including the use of electronic signatures, in compliance with the Uniform Electronic Transactions Act and/or the Federal ESIGN Act.

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

Sincerely,

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

Company and Contact

Filing Contact Information

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

Filing Company Information

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

Filing Fees

Fee Required? Yes
 Fee Amount: \$200.00
 Retaliatory? No
 Fee Explanation: \$50 per form x 4 forms
 Per Company: No

Company	Amount	Date Processed	Transaction #
North American Company for Life and Health Insurance	\$200.00	11/01/2012	64471567

SERFF Tracking #:

NALH-128752337

State Tracking #:

Company Tracking #:

FORM 82-52, 82-5, 82-37, 82-47

State:

Arkansas

Filing Company:

North American Company for Life and Health Insurance

TOI/Sub-TOI:

L08 Life - Other/L08.000 Life - Other

Product Name:

Form 82-52, 82-5, 82-37, 82-47

Project Name/Number:

Form 82-52, 82-5, 82-37, 82-47/Form 82-52, 82-5, 82-37, 82-47

Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Linda Bird	11/09/2012	11/09/2012

Amendments

Schedule	Schedule Item Name	Created By	Created On	Date Submitted
Supporting Document	Statement of Variability	Sherry M. Olson	11/01/2012	11/01/2012

State: Arkansas
TOI/Sub-TOI: L08 Life - Other/L08.000 Life - Other
Product Name: Form 82-52, 82-5, 82-37, 82-47
Project Name/Number: Form 82-52, 82-5, 82-37, 82-47/Form 82-52, 82-5, 82-37, 82-47

Filing Company: North American Company for Life and Health Insurance

Disposition

Disposition Date: 11/09/2012

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		Yes
Supporting Document (revised)	Statement of Variability		Yes
Supporting Document	Statement of Variability	Replaced	Yes
Form	Regular Issue Application for Life Insurance		Yes
Form	Application Part 2/Medical Examiner's Report		Yes
Form	Guaranteed Issue Application		Yes
Form	Application for Policy Reinstatement or Change		Yes

SERFF Tracking #:

NALH-128752337

State Tracking #:

Company Tracking #:

FORM 82-52, 82-5, 82-37, 82-47

State:

Arkansas

Filing Company:

North American Company for Life and Health Insurance

TOI/Sub-TOI:

L08 Life - Other/L08.000 Life - Other

Product Name:

Form 82-52, 82-5, 82-37, 82-47

Project Name/Number:

Form 82-52, 82-5, 82-37, 82-47/Form 82-52, 82-5, 82-37, 82-47

Amendment Letter

Submitted Date: 11/01/2012

Comments:

A corrected Statement of Variability was added to the filing.

Changed Items:

No Form Schedule Items Changed.

No Rate Schedule Items Changed.

Supporting Document Schedule Item Changes

Satisfied - Item:	Statement of Variability
Comments:	
Attachment(s):	
Form 82-52, 82-5, 82-37, 82-47 _10-12_ Statement of Variability.pdf	
<i>Previous Version</i>	
<i>Satisfied - Item:</i>	<i>Statement of Variability</i>
<i>Comments:</i>	
<i>Attachment(s):</i>	
<i>Form 82-52, 82-5, 82-37, 82-47_ 10-12_ Statement of Variability.pdf</i>	

State: Arkansas

Filing Company:

North American Company for Life and Health Insurance

TOI/Sub-TOI: L08 Life - Other/L08.000 Life - Other

Product Name: Form 82-52, 82-5, 82-37, 82-47

Project Name/Number: Form 82-52, 82-5, 82-37, 82-47/Form 82-52, 82-5, 82-37, 82-47

Form Schedule

Lead Form Number:

Item No.	Schedule Item Status	Form Name	Form Number	Form Type	Form Action	Action Specific Data	Readability Score	Attachments
1		Regular Issue Application for Life Insurance	Form 82-52 (10-12)	AEF	Initial		50.800	Form 82-52 _10-12_.pdf
2		Application Part 2/Medical Examiner's Report	Form 82-5 (10-12)	AEF	Initial		56.100	Form 82-5 10-12 combined.pdf
3		Guaranteed Issue Application	Form 82-37 (10-12)	AEF	Initial		50.300	Form 82-37 _10-12_app & census.pdf
4		Application for Policy Reinstatement or Change	Form 82-47 (10-12)	AEF	Initial		50.900	Form 82-47 _10-12_rev 10-22-12.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



North American Company
for Life and Health Insurance
Since 1886

Regular Issue
Application for Life Insurance -- Part 1

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

11b. Policies in Force:

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

11c. Policies Applied for / Indicate Below or None:

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

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

**Application for Life Insurance -- Part 1,
Evidence of Insurability**

Provide details for all "Yes" answers to questions 12-20 below.

<table style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 10%; text-align: center;">Yes</td> <td style="width: 10%; text-align: center;">No</td> <td style="padding-left: 20px;">12. Have you ever used:</td> </tr> <tr> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="padding-left: 20px;">a) Cigarettes? Date last used: _____</td> </tr> <tr> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="padding-left: 20px;">b) Other nicotine products? Date last used: _____</td> </tr> <tr> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td>13. Have you ever had an application for insurance declined, postponed or rated?</td> </tr> <tr> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td>14. Do you intend to travel outside the U.S. or Canada within the next 2 years? (If "Yes", complete appropriate questionnaire.)</td> </tr> <tr> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td>15. Do you currently engage in or within the next two years do you intend to engage in aviation related sports, powered or competitive vehicle racing, sky or scuba diving, mountain climbing, or any other hazardous sport or activity? (If "Yes", complete appropriate questionnaire.)</td> </tr> </table>	Yes	No	12. Have you ever used:	<input type="checkbox"/>	<input type="checkbox"/>	a) Cigarettes? Date last used: _____	<input type="checkbox"/>	<input type="checkbox"/>	b) Other nicotine products? Date last used: _____	<input type="checkbox"/>	<input type="checkbox"/>	13. Have you ever had an application for insurance declined, postponed or rated?	<input type="checkbox"/>	<input type="checkbox"/>	14. Do you intend to travel outside the U.S. or Canada within the next 2 years? (If "Yes", complete appropriate questionnaire.)	<input type="checkbox"/>	<input type="checkbox"/>	15. Do you currently engage in or within the next two years do you intend to engage in aviation related sports, powered or competitive vehicle racing, sky or scuba diving, mountain climbing, or any other hazardous sport or activity? (If "Yes", complete appropriate questionnaire.)	<table style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 10%; text-align: center;">Yes</td> <td style="width: 10%; text-align: center;">No</td> <td style="padding-left: 20px;">16. Are you currently a pilot, student pilot or crew member in any type of aircraft or within the next two years do you intend to become a pilot, student pilot, or crew member in any type of aircraft? (If "Yes", complete appropriate questionnaire.)</td> </tr> <tr> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="padding-left: 20px;">17. Except for traffic violations, have you ever pled guilty to or been convicted of a felony or misdemeanor?</td> </tr> <tr> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td>18. Within the past five years, have you been convicted of or pled guilty to any moving violations?</td> </tr> <tr> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td>19. Have you ever pled guilty to or been convicted of driving while under the influence of alcohol or drugs?</td> </tr> <tr> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td>20. Your driver's license #: _____ State: _____</td> </tr> </table>	Yes	No	16. Are you currently a pilot, student pilot or crew member in any type of aircraft or within the next two years do you intend to become a pilot, student pilot, or crew member in any type of aircraft? (If "Yes", complete appropriate questionnaire.)	<input type="checkbox"/>	<input type="checkbox"/>	17. Except for traffic violations, have you ever pled guilty to or been convicted of a felony or misdemeanor?	<input type="checkbox"/>	<input type="checkbox"/>	18. Within the past five years, have you been convicted of or pled guilty to any moving violations?	<input type="checkbox"/>	<input type="checkbox"/>	19. Have you ever pled guilty to or been convicted of driving while under the influence of alcohol or drugs?	<input type="checkbox"/>	<input type="checkbox"/>	20. Your driver's license #: _____ State: _____
Yes	No	12. Have you ever used:																																
<input type="checkbox"/>	<input type="checkbox"/>	a) Cigarettes? Date last used: _____																																
<input type="checkbox"/>	<input type="checkbox"/>	b) Other nicotine products? Date last used: _____																																
<input type="checkbox"/>	<input type="checkbox"/>	13. Have you ever had an application for insurance declined, postponed or rated?																																
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<input type="checkbox"/>	<input type="checkbox"/>	19. Have you ever pled guilty to or been convicted of driving while under the influence of alcohol or drugs?																																
<input type="checkbox"/>	<input type="checkbox"/>	20. Your driver's license #: _____ State: _____																																

Details for questions 12-20 (include dates):

Question Number	Date	Details

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

Relationship to Proposed Insured	Condition	Current Age	Age at Death

**Application for Life Insurance – Part 1,
Evidence of Insurability**

1a. Name and address of Personal Physician:

1b. Date and reason last consulted:

1c. Name and Address of physician **most recently** consulted if different than above:

1d. Date and reason for most recent consultation:

1e. List any currently prescribed medications:

2. Have you ever had or been treated, diagnosed or been given advice by a medical professional for:

Yes No

 a. Elevated cholesterol, high blood pressure, transient ischemic attack (TIA), stroke or circulation disorder?

 b. Chest pain, heart attack, heart murmur, irregular heart rate, or other disease or disorder of the heart?

 c. Cancer, tumor, polyp or blood disease or disorder?

 d. Immune system disease or disorder, except those related to the Human Immunodeficiency Virus (AIDS virus)?

 e. Diabetes, kidney, or urinary disease or disorder?

 f. Crohn's disease, colitis, ulcer, diverticulitis, hepatitis, or any disease of the esophagus or liver?

 g. Sleep apnea, asthma, emphysema, lung or respiratory disease or disorder?

 h. Depression, mental illness, anxiety or seizure disorder?

 i. Breast, uterus, ovaries, testicles or prostate disease or disorder, or sexually transmitted diseases?

 j. Arthritis, lupus, fibromyalgia or other skin, bone, joint or muscle disease or disorder?

3. Excluding minor illnesses or minor injuries not requiring treatment, other than above, have you ever:

 a. Within the last five years, consulted any other physician or medical practitioner, or had a diagnostic test, such as an electrocardiogram (EKG), chest X-ray, laboratory test or other study?

 b. Within the last five years, received medical treatment or advice, including medication, or been hospitalized or had surgery?

 c. Within the last five years, applied for, or received benefits, because of injury, accident, sickness, or disability?

 d. Sought or received treatment for, or been arrested for, the use of alcohol, marijuana, or drugs?

 e. Used narcotics, cocaine, LSD, marijuana, amphetamines, or barbiturates, unless administered on the advice of a physician?

4. Have you ever:

 Been diagnosed by a member of the medical profession or tested positive for Human Immunodeficiency Virus (AIDS virus) or Acquired Immune Deficiency Syndrome (AIDS)?

5. Details for questions 2-4. Give details for each YES answer.

Question Number	Condition/Diagnosis	Approximate Dates/Duration	Treatment	Physician Name & Address



Proposed Insured _____ **Birth Date** _____
 First name Middle initial Last name Month Day Year

1a. Do you have a personal physician or belong to an HMO or clinic? Yes No If so, please provide information below:

Name: _____

Address: _____

Date last seen: _____ Reason: _____

Treatment: _____

b. Physician most recently consulted, if different than above:

Name: _____

Address: _____

Date last seen: _____ Reason: _____

Treatment: _____

2. Have you ever used:

Yes No

a. Cigarettes?

b. Date last used: _____

c. Other nicotine products?

d. Date last used: _____

If your answer is "yes" to any of the following questions, circle applicable item and explain in area provided (#10).

3. Have you ever been treated, diagnosed or been given advice by a medical professional for:

Yes No

a. Depression, stress disorders, anxiety disorders, or any other brain, nervous, mental or emotional disorder?

b. Disorder of eyes, ears, nose, or throat?

c. Dizziness, fainting, seizures, headache, narcolepsy, paralysis or stroke?

d. Sleep apnea, shortness of breath, persistent hoarseness or cough, blood spitting, bronchitis, pleurisy, asthma, emphysema, tuberculosis or chronic respiratory disorder?

e. Chest pain, palpitation, high blood pressure, irregular heartbeat, rheumatic fever, heart murmur, heart attack or other disorder of the heart or blood vessels?

f. Abdominal pain, ulcer, colitis, cirrhosis, hepatitis, recurrent diarrhea, intestinal bleeding, or any other disease of the liver, gallbladder, pancreas, stomach, or intestines?

g. Sugar, albumin, blood or pus in urine, venereal disease, stone or other disorder of kidney, bladder, prostate or reproductive organs?

h. Diabetes, thyroid disorder, or disorder or any other glands?

i. Neuritis, arthritis, lupus, fibromyalgia, or any disorder of the muscles bones, or spine?

j. Disorder of the skin or lymph glands?

k. Cyst, tumor or cancer, or polyp?

l. Anemia, leukemia, disorder of the blood, or other immune system disorder not related to HIV?



4. Other than above, have you within the past 5 years:

- | | | |
|--------------------------|--------------------------|---|
| Yes | No | |
| <input type="checkbox"/> | <input type="checkbox"/> | a. Consulted or been advised to consult a physician, psychiatrist, psychologist, therapist, counselor or other health care practitioner (include regular checkups)? |
| <input type="checkbox"/> | <input type="checkbox"/> | b. Had any illness, surgery, or been treated or evaluated at a hospital, emergency room or any other health care facility? |
| <input type="checkbox"/> | <input type="checkbox"/> | c. Had an EKG, x-ray, stress test, CT scan, MRI, echocardiogram, angiography, blood studies or any other diagnostic test? |
| <input type="checkbox"/> | <input type="checkbox"/> | d. Been advised to have any test, hospitalization, or surgery that was not completed? |
| <input type="checkbox"/> | <input type="checkbox"/> | e. Had military service deferment, rejection or discharge because of an injury, sickness or disability? |
| <input type="checkbox"/> | <input type="checkbox"/> | f. Requested or received a pension, benefits, or payments because of an injury, accident, sickness or disability? |

- | | | |
|---|--------------------------|--------------------------|
| | Yes | No |
| 5. Do your parents or natural siblings have a history of tuberculosis, congenital disorder, diabetes, cancer, high blood pressure, heart or kidney disease, mental illness or suicide? | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Have you ever been treated or counseled for use of alcohol or drugs? | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. Are you now under observation or treatment, or taking any prescribed or non-prescribed medication or supplement?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. Have you had any change in weight in the past year?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 9. Have you ever been diagnosed by a member of the medical profession or tested positive for Human Immunodeficiency Virus (AIDS virus) or Acquired Immune Deficiency Syndrome (AIDS)?..... | <input type="checkbox"/> | <input type="checkbox"/> |

10. Details for questions 2-9: (Include names of medical professionals, addresses, dates, diagnosis & treatment. Attach Supplement A if necessary.)

Question Number	Date	Details

Family History

Relative	Health History	Age if Living	Age at Death	Cause of Death
Father				
Mother				
Sibling(s)				

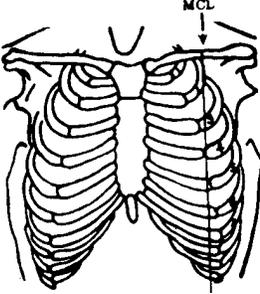
I have read the statements and answers recorded on this Application Part 2. They are to the best of my knowledge and belief, true complete, and correctly recorded. I agree they will become part of this application and any policy issued on it.

Signed at _____ Date: _____
City State

Witness Signature Proposed Insured Signature

11a. Height (In shoes)	Weight (Clothed)	Chest (Full Inspiration)	Chest (Forced Expiration)	Abdomen, at Umbilicus	b. Did you weigh? c. Did you measure? d. Is appearance unhealthy or older than stated age?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
ft. in.	lbs.	in.	in.	in.		<input type="checkbox"/>	<input type="checkbox"/>

12. Blood Pressure (Record ALL readings)	1 st	2 nd	3 rd	13. Pulse	At Rest	After Exercise	3 Minutes Later
Systolic				Rate			
Diastolic 5 th phase				Irregularities per min			

<p>14. Heart: Is there any: Enlargement <input type="checkbox"/> Yes <input type="checkbox"/> No Dyspnea <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Murmur(s) <input type="checkbox"/> Yes <input type="checkbox"/> No Edema <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>1st Murmur 2nd Murmur</p> <p>Location </p> <p>Indicate:</p> <p>Constant <input type="checkbox"/> <input type="checkbox"/></p> <p>Inconstant <input type="checkbox"/> <input type="checkbox"/></p> <p>Transmitted <input type="checkbox"/> <input type="checkbox"/></p> <p>Localized <input type="checkbox"/> <input type="checkbox"/></p> <p>Systolic <input type="checkbox"/> <input type="checkbox"/></p> <p>Presystolic <input type="checkbox"/> <input type="checkbox"/></p> <p>Diastolic <input type="checkbox"/> <input type="checkbox"/></p> <p>Soft (Gr. 1-2) <input type="checkbox"/> <input type="checkbox"/></p> <p>Mod. (Gr. 3-4) <input type="checkbox"/> <input type="checkbox"/></p> <p>Loud (Gr. 5-6) <input type="checkbox"/> <input type="checkbox"/></p> <p>After exercise: <input type="checkbox"/> <input type="checkbox"/></p> <p>Increased <input type="checkbox"/> <input type="checkbox"/></p> <p>Absent <input type="checkbox"/> <input type="checkbox"/></p> <p>Unchanged <input type="checkbox"/> <input type="checkbox"/></p> <p>Decreased <input type="checkbox"/> <input type="checkbox"/></p> <p>Apex by <input type="checkbox"/> X</p> <p>Murmur area by <input type="checkbox"/> ○</p> <p>Point of greatest intensity by <input type="checkbox"/> ○</p> <p>Transmission by <input type="checkbox"/> ↓</p> 	<p>Comments or explanations:</p>
---	----------------------------------

15. Is there on examination any abnormality of the following: (Circle applicable items and give details.)	Yes No
a. Eyes, ears, nose, mouth, pharynx?.....	<input type="checkbox"/> <input type="checkbox"/>
(If vision or hearing markedly impaired, indicate degree and correction).	
b. Skin (incl. scars); lymph nodes; varicose veins or peripheral arteries?	<input type="checkbox"/> <input type="checkbox"/>
c. Nervous system (include reflexes, gait, paralysis)?.....	<input type="checkbox"/> <input type="checkbox"/>
d. Respiratory system?.....	<input type="checkbox"/> <input type="checkbox"/>
e. Abdomen (include scars)?.....	<input type="checkbox"/> <input type="checkbox"/>
f. Genitourinary system (include prostate)?.....	<input type="checkbox"/> <input type="checkbox"/>
g. Endocrine system (include thyroid and breasts)?.....	<input type="checkbox"/> <input type="checkbox"/>

To be completed by either the medical or paramedical examiner.

1. Has the Proposed Insured ever consulted you professionally?.....	Yes No
2. Are you related in any way to Proposed Insured or Agent?.....	<input type="checkbox"/> <input type="checkbox"/>
3. Are you a business associate of the Proposed Insured or Agent?.....	<input type="checkbox"/> <input type="checkbox"/>
If yes, which one and how associated?.....	<input type="checkbox"/> <input type="checkbox"/>
4. Are you aware of any additional information which might have a bearing upon the Proposed Insured's insurability?.....	<input type="checkbox"/> <input type="checkbox"/>

Send Urine Specimen to Laboratory in Container Provided. If Blood Specimen is Required, Send to Laboratory in Kit Provided.

Other Services Performed With This Examination:	Is urine specimen being sent to laboratory? <input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Resting EKG <input type="checkbox"/> Chest X-ray <input type="checkbox"/> Venipuncture	Is person examined menstruating? <input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Treadmill EKG <input type="checkbox"/> DBS <input type="checkbox"/> Other _____	

I certify that I made this examination at _____ A.M. _____ P.M. on the _____ day of _____.	Examination made at <input type="checkbox"/> my office <input type="checkbox"/> Individual's Place of Business <input type="checkbox"/> Individual's Residence <input type="checkbox"/> Other
--	---

Examiner's Signature	Tax ID or SSN (IMPORTANT: Payment cannot be made without number):
----------------------	---

Examiner's Name (Print Full Name)	Examination Authorized By (Name of Agent – Please Print)
-----------------------------------	--

Examiner's Address (Street, City, State, Zip)	Examiner's Telephone Number ()
---	------------------------------------

Owner: _____

Date of Hire or Appointment (mm/dd/yyyy)	Proposed Insured (Last, First, Middle)	Sex	Date of Birth (mm/dd/yyyy)	SSN#	Nicotine use in past 12 months*	Amount Applied For	Life Policy Premium	Death Benefit Option	Annuity Rider Premium	Title If Director, provide occupation	Salary If Director, provide fee compensation	U.S. Citizen (Y or N)
---	---	-----	-------------------------------	------	---------------------------------	--------------------	---------------------	----------------------	-----------------------	--	---	--------------------------

*In the past 12 months, has the proposed Insured smoked one or more cigarettes or used any other tobacco/nicotine products? Indicate Y or N.

I represent that, to the best of my knowledge and belief:

1. In the past 90 days each Proposed Insured has worked at least 30 hours per week for the sponsoring employer, at the usual place of business with the customary duties, except as disclosed in the Details section.
2. Each Proposed Insured while employed by the sponsoring employer has not missed more than five consecutive days of work due to illness or injury in the past 90 days, except as disclosed in the Details section.
- 3a. The sponsoring employer keeps employment records and can certify the accuracy of statements #1 and #2.
- 3b. The sponsoring employer agrees that these employment records will be made available to North American Company for Life and Health Insurance upon request either now or at any time in the future.
4. No other application for life insurance is pending or contemplated for any Proposed Insured by the sponsoring employer and owner with this or any other company, except as disclosed in the Details section.

Details:

I have reviewed the census information and statements #1 through #4 and agree this information is accurate.

Signature of Owner

Title

Date



**Application for
Policy Reinstatement or Change**

1. Name of Insured (First, Middle and Last)		Birth date	Birthplace	Sex	Marital Status			
2. Residence Address (Street, City, State, Zip)			Social Security No.	Height ft. in.	Weight lbs.			
3. Policy Number	4. Occupation / Title and Gross Annual Compensation \$			Telephone # (home): (business):				
5a. Owner Name and Address		5b. Social Security or Tax ID No.						
		5c. Relationship to Proposed Insured						
6. Policy Change requested: <input type="checkbox"/> Reconsideration of Rate Class <input type="checkbox"/> Reinstatement <input type="checkbox"/> Other: _____								
7. Life Insurance and annuities in force and pending: If None, check here: <input type="checkbox"/>								
Company	Policy #	Personal or Business	Pending	Issue Year	Benefit Amount	ADB Amount	WP Amount	Intention of Replacement or Change
			<input type="checkbox"/>					<input type="checkbox"/> Y <input type="checkbox"/> N
			<input type="checkbox"/>					<input type="checkbox"/> Y <input type="checkbox"/> N
			<input type="checkbox"/>					<input type="checkbox"/> Y <input type="checkbox"/> N
			<input type="checkbox"/>					<input type="checkbox"/> Y <input type="checkbox"/> N
			<input type="checkbox"/>					<input type="checkbox"/> Y <input type="checkbox"/> N
			<input type="checkbox"/>					<input type="checkbox"/> Y <input type="checkbox"/> N

Provide details for all "Yes" answers to questions 8-18 below.

<table style="width:100%; border-collapse: collapse;"> <tr> <td style="width:10%; text-align: center;">Yes</td> <td style="width:10%; text-align: center;">No</td> <td></td> </tr> <tr> <td align="center"><input type="checkbox"/></td> <td align="center"><input type="checkbox"/></td> <td>8. Are you a U.S. citizen? (If "No", complete appropriate questionnaire.)</td> </tr> <tr> <td></td> <td></td> <td>9. Have you ever used:</td> </tr> <tr> <td align="center"><input type="checkbox"/></td> <td align="center"><input type="checkbox"/></td> <td>a) Cigarettes? Date last used: _____</td> </tr> <tr> <td align="center"><input type="checkbox"/></td> <td align="center"><input type="checkbox"/></td> <td>b) Other nicotine products? Date last used: _____</td> </tr> <tr> <td align="center"><input type="checkbox"/></td> <td align="center"><input type="checkbox"/></td> <td>10. Have you ever had an application for insurance declined, postponed or rated?</td> </tr> <tr> <td align="center"><input type="checkbox"/></td> <td align="center"><input type="checkbox"/></td> <td>11. Do you intend to travel outside the U.S. or Canada within the next 2 years? (If "Yes", complete appropriate questionnaire.)</td> </tr> <tr> <td align="center"><input type="checkbox"/></td> <td align="center"><input type="checkbox"/></td> <td>12. Do you currently engage in or within the next two years do you intend to engage in aviation related sports, powered or competitive vehicle racing, sky or scuba diving, mountain climbing, or any other hazardous sport or activity? (If "Yes", complete appropriate questionnaire.)</td> </tr> </table>	Yes	No		<input type="checkbox"/>	<input type="checkbox"/>	8. Are you a U.S. citizen? (If "No", complete appropriate questionnaire.)			9. Have you ever used:	<input type="checkbox"/>	<input type="checkbox"/>	a) Cigarettes? 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Within the past five years, have you been convicted of or pled guilty to any moving violations?</td> </tr> <tr> <td align="center"><input type="checkbox"/></td> <td align="center"><input type="checkbox"/></td> <td>16. Have you ever pled guilty to or been convicted of driving while under the influence of alcohol or drugs?</td> </tr> <tr> <td align="center"><input type="checkbox"/></td> <td align="center"><input type="checkbox"/></td> <td>17. Your driver's license #: _____ State: _____</td> </tr> <tr> <td align="center"><input type="checkbox"/></td> <td align="center"><input type="checkbox"/></td> <td>18. Do your parents or siblings have a history of heart disease, cancer, high blood pressure, diabetes, hemophilia, Huntington's chorea, polycystic kidney disease, or any congenital disorder?</td> </tr> </table>	Yes	No		<input type="checkbox"/>	<input type="checkbox"/>	13. 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Yes	No																																													
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Details for questions 8-18:

**Application for Policy Reinstatement or Change
Evidence of Insurability**

1a. Name and address of Personal Physician:

1b. Date and reason last consulted:

1c. Name and Address of physician **most recently** consulted if different than above:

1d. Date and reason for most recent consultation:

1e. List any currently prescribed medications:

2. Have you ever had or been treated, diagnosed or been given advice by a medical professional for:

Yes No

 a. Elevated cholesterol, high blood pressure, transient ischemic attack (TIA), stroke or circulation disorder?

 b. Chest pain, heart attack, heart murmur, irregular heart rate, or other disease or disorder of the heart?

 c. Cancer, tumor, polyp or blood disease or disorder?

 d. Immune system disease or disorder, except those related to the Human Immunodeficiency Virus (AIDS virus)?

 e. Diabetes, kidney, or urinary disease or disorder?

 f. Crohn's disease, colitis, ulcer, diverticulitis, hepatitis, or any disease of the esophagus or liver?

 g. Sleep apnea, asthma, emphysema, lung or respiratory disease or disorder?

 h. Depression, mental illness, anxiety or seizure disorder?

 i. Breast, uterus, ovaries, testicles or prostate disease or disorder, or sexually transmitted diseases?

 j. Arthritis, lupus, fibromyalgia or other skin, bone, joint or muscle disease or disorder?

3. Excluding minor illnesses and minor injuries not requiring treatment, other than above, have you ever:

 a. Within the last five years, consulted any other physician or medical practitioner, or had a diagnostic test, such as an electrocardiogram (EKG), chest X-ray, laboratory test or other study?

 b. Within the last five years, received medical treatment or advice, including medication, or been hospitalized or had surgery?

 c. Within the last five years, applied for, or received benefits, because of injury, accident, sickness, or disability?

 d. Sought or received treatment for, or been arrested for, the use of alcohol, marijuana, or drugs?

 e. Used narcotics, cocaine, LSD, marijuana, amphetamines, or barbiturates, unless administered on the advice of a physician?

4. Have you ever:

 Been diagnosed by a member of the medical profession or tested positive for Human Immunodeficiency Virus (AIDS virus) or Acquired Immune Deficiency Syndrome (AIDS)?

5. Details for questions 2-4. Give details for each YES answer.

Question Number	Condition/Diagnosis	Approximate Dates/Duration	Treatment	Physician Name & Address

Agreement and Authorization

Each person who signs below represents and agrees that the statements and answers recorded on this application are given to obtain this insurance and are to the best of their knowledge and belief, true, complete, and correctly recorded. Fraud or material misrepresentation in the application will make this agreement invalid, and North American Company for Life and Health Insurance's (the "Company") only liability shall be to refund any advance payment made.

It is agreed that the Policy will not be reinstated or a change will not be effected, and the Company will have no liability until: (a) this application is approved; and (b) all money required for reinstatement and/or change has been paid. This must be during the lifetime of any person proposed for insurance; also, his or her eligibility and health must remain as described in this application. If these requirements are met, insurance will be in effect on the effective date of the reinstatement or change. By accepting the reinstated policy or changed policy, the Owner consents to any changes or corrections made by the Company, except that changes in the insurance amount, the risk class, the insurance plan, gender or benefits will be made only with the Owner's written consent. Each person who signs below acknowledges that he or she has read and understands this application and has received copies of the Fair Credit Reporting Act Notification, Notice of Insurance Information Practices, and the Medical Information Bureau Notification.

I authorize any physician, medical practitioner, hospital, clinic, other medical or medically related facility, insurance or reinsuring company, MIB, Inc (MIB), consumer reporting agency, or employer having information available as to diagnosis, treatment, and prognosis with respect to any physical or mental condition and/or treatment of me and any information as to employment, other insurance coverage, or other non-medical information about me to give to the Company or its reinsurers, any and all such information. I authorize North American, or its reinsurers, to make a brief report of my personal health information to MIB. I authorize all of these sources, except MIB, to give records or knowledge to any agency that the Company employs to collect and transmit such information. The Company will not release any information to any person or organization **except** to reinsuring companies, MIB, or other persons or organizations performing business or legal services in connection with my application or claim, or as may be otherwise lawfully required or as I may authorize later. I understand that I may request to be interviewed in connection with the preparation of an investigative consumer report. I understand that I am entitled to receive a copy of the investigative consumer report upon request. I understand that I may request a copy of this authorization and that a photographic copy will be as valid as the original, and either shall remain in effect for a period of two years from the date signed. I have the right to revoke this authorization by notifying the Company in writing. The Company may rely on my authorization prior to receiving my notice of revocation. I understand that no sales representative has the Company's authority to accept risk, pass on insurability, or make or void, save or change any conditions or provisions of the application, policy or receipt, as applicable.

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

TAXPAYER IDENTIFICATION NUMBER CERTIFICATION – Under penalties of perjury, I certify that the number shown on this form is my correct taxpayer identification number (or I am waiting for a number to be issued to me), and I am not subject to back up withholding because (a) I am exempt from backup withholding, or (b) I have not been notified by the Internal Revenue Service that I am subject to backup withholding as a result of failure to report all interest or dividends, or (c) the IRS has notified me that I am no longer subject to backup withholding.

FRAUD STATEMENT – Any person who knowingly presents a false statement in an application for insurance may be guilty of a criminal offense and subject to penalties under state law.

Authorized individuals are signing on behalf of the entity purchasing the life insurance and each individual is authorized and empowered to individually or collectively enter into contracts and financial transactions including the purchase of life insurance. The entity is duly organized and existing in compliance with all laws and regulations. The entity shall notify the Company in writing of a change in or revocation of authorized individuals. The authorized individuals and the entity agree to indemnify the Company for liability of any kind arising out of any acts or omissions taken by the Company upon their instructions and in reliance on their representations to the Company in connection with the policy.

Signed at _____ Date _____
City State

Signature of Proposed Insured

Signature of Owner (If Owner is corporation, trust or other entity, include title of signee.)

Agent certification

(1) To the best of my knowledge and belief, the answers given to the questions in this application are full, complete, and true, and there is nothing adversely affecting the insurability of any person proposed for insurance, except as stated in this application; (2) that I gave the Medical Information Bureau Notification, Notice of Insurance Information Practices and Fair Credit Reporting Act Notification to the Proposed Insured; (3) to the best of my knowledge and belief, the applicant **does** **does not** have any existing life insurance or annuities; and, the insurance applied for **does** **does not** replace existing insurance.

Signature of Agent Date Agent's No.

SERFF Tracking #:

NALH-128752337

State Tracking #:**Company Tracking #:**

FORM 82-52, 82-5, 82-37, 82-47

State:

Arkansas

Filing Company:

North American Company for Life and Health Insurance

TOI/Sub-TOI:

L08 Life - Other/L08.000 Life - Other

Product Name:

Form 82-52, 82-5, 82-37, 82-47

Project Name/Number:

Form 82-52, 82-5, 82-37, 82-47/Form 82-52, 82-5, 82-37, 82-47

Supporting Document Schedules

		Item Status:	Status Date:
Satisfied - Item:	Flesch Certification		
Comments:	Rule & Regulation 19 certification attached. Rule & Regulation 49 does not apply to application forms. Flesch Certification attached. Bulletin 15-2009 replaces Bulletin 11-88 and does not apply to application forms.		
Attachment(s):			
Form 82-52, 82-5, 82-37, 82-47 _10-12_ readability.pdf			
Form 82-52, 82-5, 82-37, 82-47 _10-12_ AR Cert.pdf			

		Item Status:	Status Date:
Satisfied - Item:	Application		
Comments:	Applications are submitted for approval on the Form Schedule		

		Item Status:	Status Date:
Satisfied - Item:	Statement of Variability		
Comments:			
Attachment(s):			
Form 82-52, 82-5, 82-37, 82-47 _10-12_ Statement of Variability.pdf			

READABILITY CERTIFICATE

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

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

<u>FORM NUMBER</u>	<u>DESCRIPTION</u>	<u>SCORE</u>
Form 82-52 (10-12)	Regular Issue Application for Life Insurance	50.8
Form 82-5 (10-12)	Application Part 2/Medical Examiner's Report	56.1
Form 82-37 (10-12)	Guaranteed Issue Application	50.3
Form 82-47 (10-12)	Application for Policy Reinstatement or Change	50.9

Carmen R. Walter

Signature

Carmen Walter

Typed Name

Assistant Vice President – Corporate Markets Product Development

Title

November 1, 2012

Date

TO: Arkansas Department of Insurance

FROM: North American Company for Life and Health Insurance

DATE: November 1, 2012

RE: Form 82-52 (10-12), Regular Issue Application for Life Insurance
Form 82-5 (10-12), Application for Life Insurance Part 2/Medical Examiner's Report
Form 82-47 (10-12), Application for Policy Reinstatement or Change
Form 82-37 (10-12), Guaranteed Issue Application for Individual Life Insurance

North American Company certifies that the referenced forms comply with Arkansas Regulation 19 § 10B regarding unfair sex discrimination in insurance.



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

Date: November 1, 2012

STATEMENT OF VARIABILITY

Application Form Series Form 82-51 (10-12); Form 82-5 (10-12); Form 82-37 (10-12); Form 82-47 (10-12)

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

Bracketed Item	Variable Text/Range
Logo, Principal Office location and Corporate Markets Center Office location and contact information	Have been bracketed to reserve the right to change or delete addresses and contact information without re-filing this application for approval. Any change to the Company name and logo will be filed on an informational basis.

State: Arkansas**Filing Company:**

North American Company for Life and Health Insurance

TOI/Sub-TOI: L08 Life - Other/L08.000 Life - Other**Product Name:** Form 82-52, 82-5, 82-37, 82-47**Project Name/Number:** Form 82-52, 82-5, 82-37, 82-47/Form 82-52, 82-5, 82-37, 82-47

Superseded Schedule Items

Please note that all items on the following pages are items, which have been replaced by a newer version. The newest version is located with the appropriate schedule on previous pages. These items are in date order with most recent first.

Creation Date	Schedule Item Status	Schedule	Schedule Item Name	Replacement Creation Date	Attached Document(s)
11/01/2012	Replaced 11/09/2012	Supporting Document	Statement of Variability	11/01/2012	Form 82-52, 82-5, 82-37, 82-47_10-12_Statement of Variability.pdf (Superseded)

STATEMENT OF VARIABILITY

Application Form Series Form 82-51 (10-12); Form 82-5 (10-12); Form 82-37 (10-12); Form 82-47 (10-12)

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