

SERFF Tracking Number: EMCN-128335842 State: Arkansas  
Filing Company: EMC National Life Company State Tracking Number:  
Company Tracking Number: EGR023 MIB  
TOI: L04G Group Life - Term Sub-TOI: L04G.103 Renewable - Single Life -  
Fixed/Indeterminate Premium  
Product Name: Evidence of Insurability Form - MIB Change  
Project Name/Number: /

## Filing at a Glance

Company: EMC National Life Company

Product Name: Evidence of Insurability Form - SERFF Tr Num: EMCN-128335842 State: Arkansas  
MIB Change

TOI: L04G Group Life - Term

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

Sub-TOI: L04G.103 Renewable - Single Life -  
Fixed/Indeterminate Premium

Co Tr Num: EGR023 MIB

State Status: Approved-Closed

Filing Type: Form

Reviewer(s): Linda Bird

Author: Mark Rowley

Disposition Date: 05/14/2012

Date Submitted: 05/10/2012

Disposition Status: Approved-  
Closed

Implementation Date Requested: On Approval

Implementation Date:

State Filing Description:

## 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: Group

Submission Type: New Submission

Group Market Size: Small and Large

Group Market Type: Employer, Association

Overall Rate Impact:

Filing Status Changed: 05/14/2012

State Status Changed: 05/14/2012

Deemer Date:

Created By: Mark Rowley

Submitted By: Mark Rowley

Corresponding Filing Tracking Number:

Filing Description:

No part of this filing contains any unusual or possibly controversial items from normal company or industry standards.

In 2012 various insurance departments approved an evidence of insurability form that was part of our filing for our new group term life policy form. We have now become aware of a new MIB requirement to add some language to the authorization section of this form. This filing requests approval for a modified evidence of insurability form that has the MIB requested changes, plus we made one other small change. Included in this filing are the new form, and a redlined

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version that highlights the changes. The previous filing or filings where the evidence of insurability form was referenced were:

SERFF Tracking Numbers: FRCS-127938926 & FRCS-127939699

Approval Date: 1/4/2012

State Narrative:

## Company and Contact

### Filing Contact Information

Mark Rowley, VP, Managing Actuary mrowley@emcni.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

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## Filing Fees

Fee Required? Yes  
 Fee Amount: \$50.00  
 Retaliatory? No  
 Fee Explanation: One form  
 Per Company: No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
EMC National Life Company	\$50.00	05/10/2012	59093470

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## Correspondence Summary

### Dispositions

Status	Created By	Created On	Date Submitted
Approved- Closed	Linda Bird	05/14/2012	05/14/2012

*SERFF Tracking Number:*      *EMCN-128335842*                      *State:*                      *Arkansas*  
*Filing Company:*              *EMC National Life Company*                      *State Tracking Number:*  
*Company Tracking Number:*      *EGR023 MIB*  
*TOI:*                      *L04G Group Life - Term*                      *Sub-TOI:*                      *L04G.103 Renewable - Single Life -*  
*Fixed/Indeterminate Premium*  
  
*Product Name:*              *Evidence of Insurability Form - MIB Change*  
*Project Name/Number:*      /

## **Disposition**

Disposition Date: 05/14/2012

Implementation Date:

Status: Approved-Closed

Comment:

Rate data does NOT apply to filing.

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Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification		Yes
Supporting Document	Application		No
Supporting Document	Redline Version of Evidence of Insurability		Yes
Form	Evidence of Insurability		Yes

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## Form Schedule

### Lead Form Number: EGR023 (4-12)

Schedule Item Status	Form Number	Form Type Form Name	Action	Action Specific Data	Readability	Attachment
	EGR023 (4-12)	Application/ Evidence of Enrollment Insurability Form	Revised	Replaced Form #: EGR023 (4-12) Previous Filing #: EGR023	50.000	EGR023_412 - GroupEol_brackets.pdf



# National Life Company

[699 Walnut Street ■ Suite 1100 ■ Des Moines, IA 50309]  
[1.800.232.5818 ■ www.EMCNationalLife.com]

Fax Completed Forms  
To: [515-237-2288]

## Group Term Life Insurance Evidence of Insurability Form

Group Policy Number \_\_\_\_\_ Group Name \_\_\_\_\_

Employee/Member Name \_\_\_\_\_

APPLICANT NAME (Employee, Member, Spouse or Child)		SEX	DATE OF BIRTH
APPLICANT'S HOME ADDRESS (Street, City, State, Zip)		HEIGHT	WEIGHT
APPLICANT'S OCCUPATIONAL DUTIES	HOME PHONE #	STATE OF BIRTH	SOCIAL SECURITY #

**PLEASE ANSWER THE FOLLOWING QUESTIONS:**

**Yes No**

- A. Are you a full-time employee working 30 hours or more a week? .....
- B. In the past ten years, have you been diagnosed or treated by a member of the medical profession for:
  - 1. Cancer in any form? .....
  - 2. Heart or coronary disease, stroke, disorder of blood vessels including high blood pressure? .....
  - 3. Diabetes, disorder of lung, kidney, stomach, intestine, liver, alcoholism, drug addiction or mental condition?..
  - 4. Human Immunodeficiency Virus (HIV), Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC)? .....
- C. Within the past 5 years, have you been diagnosed or treated by a member of the medical profession for any disease or condition not stated above?.....
- D. Within the past 5 years, been told by a medical professional you had any abnormal diagnostic or screening tests?.....
- E. Are you currently or have you taken prescription medication within the last year? .....

**GIVE DETAILS BELOW FOR ANY YES ANSWERS. ATTACH ADDITIONAL SHEET, IF NECESSARY.**

Name(s) & Address(es) of Doctors/Hospitals	Date & Diagnosis/Treatment/Medication
_____	_____
_____	_____
_____	_____
_____	_____

**IMPORTANT!  
YOU MUST COMPLETE, SIGN AND RETURN PAGES 1 AND 2.**



**ACKNOWLEDGMENT AND AUTHORIZATION**

I acknowledge receipt of a notice titled "Notice Regarding the Medical Information Bureau" regarding the filing and distribution of medical information concerning the Proposed Insured and receipt of notice of the "Fair Credit Reporting Act."

It is represented that all statements and answers to questions in this application are complete and true to the best of my knowledge and belief. I agree that no obligation shall exist against EMC National Life Company unless the insurance applied for is issued and the first premium paid while the Proposed Insured is alive and the health of the Proposed Insured remains the same as represented in this application, and then the liability of Company shall be only as is specified in the policy. I fully understand and agree that if any material information is willfully false or intentionally misleading, it could, subject to the Incontestability Provision and legal proceedings, provide the basis for the Company to refuse or rescind coverage and to refund all my premium as though my coverage had never been in force. No changes or corrections in the application will be effective unless agreed to in writing by the Proposed Insured and Owner.

**FRAUD STATEMENT/WARNING**

I acknowledge that I have read the applicable fraud warning and other provisions on page 3.

**AUTHORIZATION TO OBTAIN AND DISCLOSE INFORMATION**

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, 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. 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.

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 EMC National Life Company 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.

Signed at \_\_\_\_\_ on \_\_\_\_\_ **X** \_\_\_\_\_  
City and State Month/Day/Year Signature of Employee/Member

**X** \_\_\_\_\_ **X** \_\_\_\_\_  
Children if age 18 or over if proposed for insurance Signature of Spouse, If Proposed For Insurance

## – To Be Retained By Applicant –

**FRAUD INFORMATION:** The following states require insurance applicants to acknowledge a fraud warning statement specific to that state. Your signature and date on this application indicates that you have read and acknowledge the fraud warning statement applicable in your state of residence and, if applicable, the state in which this application is signed.

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

**DISTRICT OF COLUMBIA WARNING** - It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer, may deny insurance benefits if false information materially related to a claim was provided by the applicant.

**FLORIDA** - Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

**KENTUCKY** - Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime.

**MAINE** - It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance benefits.

**NEW MEXICO** - Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to civil fines and criminal penalties.

**OHIO** - Any person who, with the intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

**OKLAHOMA - WARNING:** Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

**OREGON** - Willfully falsifying material facts on an application or claim may subject you to criminal penalties.

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

**VIRGINIA** - Any person who, with the intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement may have violated state law.

**TENNESSEE and WASHINGTON** - It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

**If your state is not separately listed, refer to the fraud statement that follows:**

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

**– To Be Retained By 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 MEDICAL INFORMATION BUREAU**

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 the MIB, Inc., formerly known as Medical Information Bureau, a not-for-profit membership organization of insurance companies, which operates an information exchange on behalf of its Members. If you apply to another MIB Member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, MIB, upon request, will supply such company with the information about you in its file.

Upon receipt of a request from you, MIB will arrange disclosure of any information in your file. Please contact MIB at [866-692-6901 (TTY 866-346-3642)]. If you question the accuracy of the information in MIB's file, you may contact MIB and seek a correction in accordance with the procedures set forth in the 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.]

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## Supporting Document Schedules

	<b>Item Status:</b>	<b>Status Date:</b>
<b>Satisfied - Item:</b> Flesch Certification <b>Comments:</b> <b>Attachment:</b> AR Read Cert.pdf		

	<b>Item Status:</b>	<b>Status Date:</b>
<b>Bypassed - Item:</b> Application <b>Bypass Reason:</b> N/A <b>Comments:</b>		

	<b>Item Status:</b>	<b>Status Date:</b>
<b>Satisfied - Item:</b> Redline Version of Evidence of Insurability <b>Comments:</b> <b>Attachment:</b> EGR023_412-GroupEol_brackets_red.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>
EGR023 (4-12)	50.0



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Mark C. Rowley, FSA, MAAA  
Vice President, Managing Actuary  
May 10, 2012



# National Life Company

[699 Walnut Street ■ Suite 1100 ■ Des Moines, IA 50309]  
[1.800.232.5818 ■ www.EMCNationalLife.com]

Fax Completed Forms  
To: [515-237-2288]

## Group Term Life Insurance Evidence of Insurability Form

Group Policy Number \_\_\_\_\_ Group Name \_\_\_\_\_

Employee/Member Name \_\_\_\_\_

APPLICANT NAME (Employee, Member, Spouse or Child)		SEX	DATE OF BIRTH
APPLICANT'S HOME ADDRESS (Street, City, State, Zip)		HEIGHT	WEIGHT
APPLICANT'S OCCUPATIONAL DUTIES	HOME PHONE #	STATE OF BIRTH	SOCIAL SECURITY #

### PLEASE ANSWER THE FOLLOWING QUESTIONS:

**Yes No**

- A. Are you a full-time employee working 30 hours or more a week? .....
- B. In the past ten years, have you been diagnosed or treated by a member of the medical profession for:
  - 1. Cancer in any form? .....
  - 2. Heart or coronary disease, stroke, disorder of blood vessels including high blood pressure? .....
  - 3. Diabetes, disorder of lung, kidney, stomach, intestine, liver, alcoholism, drug addiction or mental condition?..
  - 4. Human Immunodeficiency Virus (HIV), Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC)? .....
- C. Within the past 5 years, have you been diagnosed or treated by a member of the medical profession for any disease or condition not stated above?.....
- D. Within the past 5 years, been told by a medical professional you had any abnormal diagnostic or screening tests?.....
- E. Are you currently or have you taken prescription medication within the last year? .....

### GIVE DETAILS BELOW FOR ANY YES ANSWERS. ATTACH ADDITIONAL SHEET, IF NECESSARY.

Name(s) & Address(es) of Doctors/Hospitals

Date & Diagnosis/Treatment/Medication

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**IMPORTANT!**  
**YOU MUST COMPLETE, SIGN AND RETURN PAGES 1 AND 2.**



**ACKNOWLEDGMENT AND AUTHORIZATION**

I acknowledge receipt of a notice titled "Notice Regarding the Medical Information Bureau" regarding the filing and distribution of medical information concerning the Proposed Insured and receipt of notice of the "Fair Credit Reporting Act."

It is represented that all statements and answers to questions in this application are complete and true to the best of my knowledge and belief. I agree that no obligation shall exist against EMC National Life Company unless the insurance applied for is issued and the first premium paid while the Proposed Insured is alive and the health of the Proposed Insured remains the same as represented in this application, and then the liability of Company shall be only as is specified in the policy. I fully understand and agree that if any material information is willfully false or intentionally misleading, it could, subject to the Incontestability Provision and legal proceedings, provide the basis for the Company to refuse or rescind coverage and to refund all my premium as though my coverage had never been in force. No changes or corrections in the application will be effective unless agreed to in writing by the Proposed Insured and Owner.

**FRAUD STATEMENT/WARNING**

I acknowledge that I have read the applicable fraud warning and other provisions on page 3.

**AUTHORIZATION TO OBTAIN AND DISCLOSE INFORMATION**

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, 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. 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.

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 EMC National Life Company 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.

Signed at \_\_\_\_\_ on \_\_\_\_\_ X  
City and State Month/Day/Year Signature of Employee/Member

X \_\_\_\_\_ X  
Children if age 18 or over if proposed for insurance Signature of Spouse, If Proposed For Insurance

## – To Be Retained By Applicant –

**FRAUD INFORMATION:** The following states require insurance applicants to acknowledge a fraud warning statement specific to that state. Your signature and date on this application indicates that you have read and acknowledge the fraud warning statement applicable in your state of residence and, if applicable, the state in which this application is signed.

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

**DISTRICT OF COLUMBIA WARNING** - It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer, may deny insurance benefits if false information materially related to a claim was provided by the applicant.

**FLORIDA** - Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

**KENTUCKY** - Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime.

**MAINE** - It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance benefits.

**NEW MEXICO** - Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to civil fines and criminal penalties.

**OHIO** - Any person who, with the intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

**OKLAHOMA - WARNING:** Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

**OREGON** - Willfully falsifying material facts on an application or claim may subject you to criminal penalties.

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

**VIRGINIA** - Any person who, with the intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement may have violated state law.

**TENNESSEE and WASHINGTON** - It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

**If your state is not separately listed, refer to the fraud statement that follows:**

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

**– To Be Retained By 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 MEDICAL INFORMATION BUREAU**

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 the MIB, Inc., formerly known as Medical Information Bureau, a not-for-profit membership organization of insurance companies, which operates an information exchange on behalf of its Members. If you apply to another MIB Member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, MIB, upon request, will supply such company with the information about you in its file.

Upon receipt of a request from you, MIB will arrange disclosure of any information in your file. Please contact MIB at [866-692-6901 (TTY 866-346-3642)]. If you question the accuracy of the information in MIB's file, you may contact MIB and seek a correction in accordance with the procedures set forth in the 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.]