

SERFF Tracking Number: NAWS-127957821 State: Arkansas  
Filing Company: National Western Life Insurance Company State Tracking Number:  
Company Tracking Number: 01-3146-11, 01-3147-11, 01-3148-11, 01-9064-11, 01-9065-11 ACCELERATED BENEFIT RIDERS AND LIFE APPLICATIONS  
FOR TERM POLICIES  
TOI: L08 Life - Other Sub-TOI: L08.000 Life - Other  
Product Name: 01-3146-11, 01-3147-11, 01-3148-11, 01-9064-11, 01-9065-11 ACCELERATED BENEFIT RIDERS AND LIFE APPLICATIONS  
FOR TERM POLICIES  
Project Name/Number: 01-3146-11, 01-3147-11, 01-3148-11, 01-9064-11, 01-9065-11 ACCELERATED BENEFIT RIDERS AND LIFE APPLICATIONS  
FOR TERM POLICIES/01-3146-11, 01-3147-11, 01-3148-11, 01-9064-11, 01-9065-11

## Filing at a Glance

Company: National Western Life Insurance Company

Product Name: 01-3146-11, 01-3147-11, 01-3148-11, 01-9064-11, 01-9065-11  
ACCELERATED BENEFIT RIDERS AND LIFE APPLICATIONS FOR TERM POLICIES

TOI: L08 Life - Other

SERFF Status: Closed-  
Disapproved

State Tr Num:

Sub-TOI: L08.000 Life - Other

Co Tr Num: 01-3146-11, 01-3147-11, 01-3148-11, 01-9064-11, 01-9065-11 ACCELERATED BENEFIT RIDERS AND LIFE APPLICATIONS FOR TERM POLICIES

State Status: Disapproved-Closed

Filing Type: Form

Authors: Stephanie Foskitt, Kitty Kennedy

Reviewer(s): Linda Bird

Disposition Date: 06/27/2012

Date Submitted: 01/06/2012

Disposition Status: Disapproved

Implementation Date Requested: On Approval

Implementation Date:

State Filing Description:

## General Information

Project Name: 01-3146-11, 01-3147-11, 01-3148-11, 01-9064-11, 01-9065-11 ACCELERATED BENEFIT RIDERS AND LIFE APPLICATIONS FOR TERM POLICIES

Status of Filing in Domicile: Authorized

Project Number: 01-3146-11, 01-3147-11, 01-3148-11, 01-9064-11, 01-9065-11

Date Approved in Domicile:

Requested Filing Mode: Review & Approval

Domicile Status Comments: These forms are deemed exempt by our state of domicile, Colorado.

Explanation for Combination/Other:

Market Type: Individual

SERFF Tracking Number: NAWS-127957821 State: Arkansas  
Filing Company: National Western Life Insurance Company State Tracking Number:  
Company Tracking Number: 01-3146-11, 01-3147-11, 01-3148-11, 01-9064-11, 01-9065-11 ACCELERATED BENEFIT RIDERS AND LIFE APPLICATIONS  
FOR TERM POLICIES  
TOI: L08 Life - Other Sub-TOI: L08.000 Life - Other  
Product Name: 01-3146-11, 01-3147-11, 01-3148-11, 01-9064-11, 01-9065-11 ACCELERATED BENEFIT RIDERS AND LIFE APPLICATIONS  
FOR TERM POLICIES  
Project Name/Number: 01-3146-11, 01-3147-11, 01-3148-11, 01-9064-11, 01-9065-11 ACCELERATED BENEFIT RIDERS AND LIFE APPLICATIONS  
FOR TERM POLICIES/01-3146-11, 01-3147-11, 01-3148-11, 01-9064-11, 01-9065-11

Submission Type: New Submission

Individual Market Type:

Overall Rate Impact:

Filing Status Changed: 06/27/2012

State Status Changed: 06/27/2012

Deemer Date:

Created By: Stephanie Foskitt

Submitted By: Stephanie Foskitt

Corresponding Filing Tracking Number:

Filing Description:

Re: Accelerated Death Benefit for Chronic Illness Rider, Form 01-3146-11  
Accelerated Death Benefit for Critical Illness Rider, Form 01-3147-11  
Accelerated Death Benefit for Terminal Illness Rider, Form 01-3148-11  
Application for Individual Life Insurance, Form 01-9064-11  
Application for Other Insured Rider, Form 01-9065-11  
National Western Life Insurance Company, NAIC 66850, FEIN 84-0467208

To Whom It May Concern:

Please find attached the above captioned forms submitted for review and approval. These forms are new and will not replace any previously approved forms. This filing contains no unusual or possibly controversial items from normal industry standards. The forms will be used with previously approved term life policy form 01-1157-09-AR approved for use on November 9, 2009; and level term life policy form 01-1123L-01-AR approved for use on October 28, 2011.

These three accelerated benefit riders are added to the above mentioned term life policies at no charge and with no premium. These three riders cover both the primary insured and any other insureds on the policy. Each insured may accelerate up to 90% of their coverage (primary insured Face Amount, or other insured Insurance Benefit) with additional stipulations.

Form 01-3146-11 is a Chronic Illness Rider and will pay an accelerated benefit for illnesses which cause the insured or other insured to be confined to an institution, or causes them to be unable to perform some activities of daily living.

Form 01-3147-11 is a Critical Illness Rider and will pay an accelerated benefit for illnesses for which the insured or other insured requires extreme medical intervention, or for which their life expectancy may be shortened.

Form 01-3148-11 is a Terminal Illness Rider and will pay an accelerated benefit for illnesses for with the insured or other insured is not expected to live beyond twenty-four months.

SERFF Tracking Number: NAWS-127957821 State: Arkansas  
Filing Company: National Western Life Insurance Company State Tracking Number:  
Company Tracking Number: 01-3146-11, 01-3147-11, 01-3148-11, 01-9064-11, 01-9065-11 ACCELERATED BENEFIT RIDERS AND LIFE APPLICATIONS  
FOR TERM POLICIES  
TOI: L08 Life - Other Sub-TOI: L08.000 Life - Other  
Product Name: 01-3146-11, 01-3147-11, 01-3148-11, 01-9064-11, 01-9065-11 ACCELERATED BENEFIT RIDERS AND LIFE APPLICATIONS  
FOR TERM POLICIES  
Project Name/Number: 01-3146-11, 01-3147-11, 01-3148-11, 01-9064-11, 01-9065-11 ACCELERATED BENEFIT RIDERS AND LIFE APPLICATIONS  
FOR TERM POLICIES/01-3146-11, 01-3147-11, 01-3148-11, 01-9064-11, 01-9065-11

Thank you for your time and consideration in this matter. If you have any questions or need more information, please feel free to contact me by email at SFoskitt@NationalWesternLife.com or by phone at 512-719-1563.

Sincerely,  
Stephanie Foskitt  
Contract Compliance Analyst

We reserve the right to change the format of this form without changing any of the language. Printing standards will never be less than those required.

State Narrative:

## Company and Contact

### Filing Contact Information

Stephanie Foskitt, Contract Compliance Analyst SFoskitt@NationalWesternLife.com

National Western Life Insurance Company 512-719-1563 [Phone]  
850 East Anderson Lane 512-719-8522 [FAX]  
Austin, TX 78752

### Filing Company Information

National Western Life Insurance Company CoCode: 66850 State of Domicile: Colorado  
850 East Anderson Lane Group Code: Company Type:  
Austin, TX 78752-1602 Group Name: State ID Number:  
(512) 836-1010 ext. [Phone] FEIN Number: 84-0467208

## Filing Fees

Fee Required? Yes  
Fee Amount: \$250.00  
Retaliatory? No  
Fee Explanation: \$50 per form x 5 forms = \$250 total  
Per Company: No

SERFF Tracking Number: NAWS-127957821 State: Arkansas  
Filing Company: National Western Life Insurance Company State Tracking Number:  
Company Tracking Number: 01-3146-11, 01-3147-11, 01-3148-11, 01-9064-11, 01-9065-11 ACCELERATED BENEFIT RIDERS AND LIFE APPLICATIONS  
FOR TERM POLICIES  
TOI: L08 Life - Other Sub-TOI: L08.000 Life - Other  
Product Name: 01-3146-11, 01-3147-11, 01-3148-11, 01-9064-11, 01-9065-11 ACCELERATED BENEFIT RIDERS AND LIFE APPLICATIONS  
FOR TERM POLICIES  
Project Name/Number: 01-3146-11, 01-3147-11, 01-3148-11, 01-9064-11, 01-9065-11 ACCELERATED BENEFIT RIDERS AND LIFE APPLICATIONS  
FOR TERM POLICIES/01-3146-11, 01-3147-11, 01-3148-11, 01-9064-11, 01-9065-11

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
National Western Life Insurance Company	\$250.00	01/06/2012	55086168

SERFF Tracking Number: NAWS-127957821 State: Arkansas  
 Filing Company: National Western Life Insurance Company State Tracking Number:  
 Company Tracking Number: 01-3146-11, 01-3147-11, 01-3148-11, 01-9064-11, 01-9065-11 ACCELERATED BENEFIT RIDERS AND LIFE APPLICATIONS  
 FOR TERM POLICIES  
 TOI: L08 Life - Other Sub-TOI: L08.000 Life - Other  
 Product Name: 01-3146-11, 01-3147-11, 01-3148-11, 01-9064-11, 01-9065-11 ACCELERATED BENEFIT RIDERS AND LIFE APPLICATIONS  
 FOR TERM POLICIES  
 Project Name/Number: 01-3146-11, 01-3147-11, 01-3148-11, 01-9064-11, 01-9065-11 ACCELERATED BENEFIT RIDERS AND LIFE APPLICATIONS  
 FOR TERM POLICIES/01-3146-11, 01-3147-11, 01-3148-11, 01-9064-11, 01-9065-11

## Correspondence Summary

### Dispositions

Status	Created By	Created On	Date Submitted
Disapproved	Linda Bird	06/27/2012	06/27/2012

**Objection Letters and Response Letters**

Objection Letters				Response Letters		
Status	Created By	Created On	Date Submitted	Responded By	Created On	Date Submitted
Pending	Linda Bird	04/25/2012	04/25/2012			
Industry Response						
Pending	Linda Bird	03/15/2012	03/15/2012			
Industry Response						
Pending	Linda Bird	01/09/2012	01/09/2012			
Industry Response						

SERFF Tracking Number: NAWS-127957821 State: Arkansas  
Filing Company: National Western Life Insurance Company State Tracking Number:  
Company Tracking Number: 01-3146-11, 01-3147-11, 01-3148-11, 01-9064-11, 01-9065-11 ACCELERATED BENEFIT RIDERS AND LIFE APPLICATIONS  
FOR TERM POLICIES  
TOI: L08 Life - Other Sub-TOI: L08.000 Life - Other  
Product Name: 01-3146-11, 01-3147-11, 01-3148-11, 01-9064-11, 01-9065-11 ACCELERATED BENEFIT RIDERS AND LIFE APPLICATIONS  
FOR TERM POLICIES  
Project Name/Number: 01-3146-11, 01-3147-11, 01-3148-11, 01-9064-11, 01-9065-11 ACCELERATED BENEFIT RIDERS AND LIFE APPLICATIONS  
FOR TERM POLICIES/01-3146-11, 01-3147-11, 01-3148-11, 01-9064-11, 01-9065-11

## Disposition

Disposition Date: 06/27/2012

Implementation Date:

Status: Disapproved

Comment: Our records indicate that we have been holding these filings in a pending status since January 9, 2012. It is Department policy to close a submission after such a long time has lapsed without resolution of the problems. Therefore, we are disapproving your submission today.

Rate data does NOT apply to filing.

SERFF Tracking Number: NAWS-127957821 State: Arkansas

Filing Company: National Western Life Insurance Company State Tracking Number:

Company Tracking Number: 01-3146-11, 01-3147-11, 01-3148-11, 01-9064-11, 01-9065-11 ACCELERATED BENEFIT RIDERS AND LIFE APPLICATIONS  
FOR TERM POLICIES

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

Product Name: 01-3146-11, 01-3147-11, 01-3148-11, 01-9064-11, 01-9065-11 ACCELERATED BENEFIT RIDERS AND LIFE APPLICATIONS  
FOR TERM POLICIES

Project Name/Number: 01-3146-11, 01-3147-11, 01-3148-11, 01-9064-11, 01-9065-11 ACCELERATED BENEFIT RIDERS AND LIFE APPLICATIONS  
FOR TERM POLICIES/01-3146-11, 01-3147-11, 01-3148-11, 01-9064-11, 01-9065-11

Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification		Yes
Supporting Document	Application		Yes
Supporting Document	Cover Letter		Yes
Supporting Document	Accelerated Death Benefit Riders - Actuarial Material		No
Form	Accelerated Death Benefit for Chronic Illness Rider		Yes
Form	Accelerated Death Benefit for Critical Illness Rider		Yes
Form	Accelerated Death Benefit for Terminal Illness Rider		Yes
Form	Application for Individual Life Insurance		Yes
Form	Application for Other Insured Rider		Yes

SERFF Tracking Number: NAWS-127957821 State: Arkansas  
Filing Company: National Western Life Insurance Company State Tracking Number:  
Company Tracking Number: 01-3146-11, 01-3147-11, 01-3148-11, 01-9064-11, 01-9065-11 ACCELERATED BENEFIT RIDERS AND LIFE APPLICATIONS  
FOR TERM POLICIES  
TOI: L08 Life - Other Sub-TOI: L08.000 Life - Other  
Product Name: 01-3146-11, 01-3147-11, 01-3148-11, 01-9064-11, 01-9065-11 ACCELERATED BENEFIT RIDERS AND LIFE APPLICATIONS  
FOR TERM POLICIES  
Project Name/Number: 01-3146-11, 01-3147-11, 01-3148-11, 01-9064-11, 01-9065-11 ACCELERATED BENEFIT RIDERS AND LIFE APPLICATIONS  
FOR TERM POLICIES/01-3146-11, 01-3147-11, 01-3148-11, 01-9064-11, 01-9065-11

## Objection Letter

Objection Letter Status Pending Industry Response  
Objection Letter Date 04/25/2012  
Submitted Date 04/25/2012  
Respond By Date 05/25/2012

Dear Stephanie Foskitt,

This will acknowledge receipt of the captioned filing.

### Objection 1

#### Comment:

It has come to our attention that you have not responded to our 01/09/2012 Objection Letter regarding this filing.

Please advise the Department if the company would like to withdraw the filing or if additional time is needed to comply?

A.C.A. 23-79-109(1)-(5) sets forth the procedure by which filings may be deemed approved upon the expiration of certain time periods with no affirmative action by the commissioner. If the commissioner determines that additional information is needed to make a decision regarding approval, such request for information will be made to the company. The filing will not be considered complete until said additional information is received. The time periods set forth in this statute will not begin to run until the filing is complete.

Please feel free to contact me if you have questions.

Sincerely,  
Linda Bird

SERFF Tracking Number: NAWS-127957821 State: Arkansas  
Filing Company: National Western Life Insurance Company State Tracking Number:  
Company Tracking Number: 01-3146-11, 01-3147-11, 01-3148-11, 01-9064-11, 01-9065-11 ACCELERATED BENEFIT RIDERS AND LIFE APPLICATIONS  
FOR TERM POLICIES  
TOI: L08 Life - Other Sub-TOI: L08.000 Life - Other  
Product Name: 01-3146-11, 01-3147-11, 01-3148-11, 01-9064-11, 01-9065-11 ACCELERATED BENEFIT RIDERS AND LIFE APPLICATIONS  
FOR TERM POLICIES  
Project Name/Number: 01-3146-11, 01-3147-11, 01-3148-11, 01-9064-11, 01-9065-11 ACCELERATED BENEFIT RIDERS AND LIFE APPLICATIONS  
FOR TERM POLICIES/01-3146-11, 01-3147-11, 01-3148-11, 01-9064-11, 01-9065-11

## Objection Letter

Objection Letter Status	Pending Industry Response
Objection Letter Date	03/15/2012
Submitted Date	03/15/2012
Respond By Date	04/16/2012

Dear Stephanie Foskitt,

This will acknowledge receipt of the captioned filing.

A.C.A. 23-79-109(1)-(5) sets forth the procedure by which filings may be deemed approved upon the expiration of certain time periods with no affirmative action by the commissioner. If the commissioner determines that additional information is needed to make a decision regarding approval, such request for information will be made to the company. The filing will not be considered complete until said additional information is received. The time periods set forth in this statute will not begin to run until the filing is complete.

Please feel free to contact me if you have questions.

Sincerely,  
Linda Bird

SERFF Tracking Number: NAWS-127957821 State: Arkansas  
Filing Company: National Western Life Insurance Company State Tracking Number:  
Company Tracking Number: 01-3146-11, 01-3147-11, 01-3148-11, 01-9064-11, 01-9065-11 ACCELERATED BENEFIT RIDERS AND LIFE APPLICATIONS  
FOR TERM POLICIES  
TOI: L08 Life - Other Sub-TOI: L08.000 Life - Other  
Product Name: 01-3146-11, 01-3147-11, 01-3148-11, 01-9064-11, 01-9065-11 ACCELERATED BENEFIT RIDERS AND LIFE APPLICATIONS  
FOR TERM POLICIES  
Project Name/Number: 01-3146-11, 01-3147-11, 01-3148-11, 01-9064-11, 01-9065-11 ACCELERATED BENEFIT RIDERS AND LIFE APPLICATIONS  
FOR TERM POLICIES/01-3146-11, 01-3147-11, 01-3148-11, 01-9064-11, 01-9065-11

## Objection Letter

Objection Letter Status	Pending Industry Response
Objection Letter Date	01/09/2012
Submitted Date	01/09/2012
Respond By Date	02/09/2012

Dear Stephanie Foskitt,

This will acknowledge receipt of the captioned filing.

### Objection 1

#### Comment:

The Accelerated Benefit Rider issued with life insurance policies require a disclosure statement as outlined in Rule and Regulation 60s8.

A.C.A. 23-79-109(1)-(5) sets forth the procedure by which filings may be deemed approved upon the expiration of certain time periods with no affirmative action by the commissioner. If the commissioner determines that additional information is needed to make a decision regarding approval, such request for information will be made to the company. The filing will not be considered complete until said additional information is received. The time periods set forth in this statute will not begin to run until the filing is complete.

Please feel free to contact me if you have questions.

Sincerely,  
Linda Bird

SERFF Tracking Number: NAWS-127957821 State: Arkansas  
 Filing Company: National Western Life Insurance Company State Tracking Number:  
 Company Tracking Number: 01-3146-11, 01-3147-11, 01-3148-11, 01-9064-11, 01-9065-11 ACCELERATED BENEFIT RIDERS AND LIFE APPLICATIONS  
 FOR TERM POLICIES  
 TOI: L08 Life - Other Sub-TOI: L08.000 Life - Other  
 Product Name: 01-3146-11, 01-3147-11, 01-3148-11, 01-9064-11, 01-9065-11 ACCELERATED BENEFIT RIDERS AND LIFE APPLICATIONS  
 FOR TERM POLICIES  
 Project Name/Number: 01-3146-11, 01-3147-11, 01-3148-11, 01-9064-11, 01-9065-11 ACCELERATED BENEFIT RIDERS AND LIFE APPLICATIONS  
 FOR TERM POLICIES/01-3146-11, 01-3147-11, 01-3148-11, 01-9064-11, 01-9065-11

## Form Schedule

### Lead Form Number: 01-3146-11

Schedule Item Status	Form Number	Form Type Form Name	Action	Action Specific Data	Readability	Attachment
	01-3146-11	Policy/Cont Accelerated Death ract/Fratern Benefit for Chronic al Illness Rider Certificate: Amendmen t, Insert Page, Endorseme nt or Rider	Initial		50.000	01-3146-11 Chronic - Accel Death Ben Rider.pdf
	01-3147-11	Policy/Cont Accelerated Death ract/Fratern Benefit for Critical al Illness Rider Certificate: Amendmen t, Insert Page, Endorseme nt or Rider	Initial		55.000	01-3147-11 Critical - Accel Death Ben Rider.pdf
	01-3148-11	Policy/Cont Accelerated Death ract/Fratern Benefit for Terminal al Illness Rider Certificate: Amendmen t, Insert Page, Endorseme nt or Rider	Initial		52.000	01-3148-11 Terminal - Accel Death Ben Rider.pdf
	01-9064-11	Application/ Application for	Initial		0.000	01-9064-11

SERFF Tracking Number: NAWS-127957821 State: Arkansas  
 Filing Company: National Western Life Insurance Company State Tracking Number:  
 Company Tracking Number: 01-3146-11, 01-3147-11, 01-3148-11, 01-9064-11, 01-9065-11 ACCELERATED BENEFIT RIDERS AND LIFE APPLICATIONS  
 FOR TERM POLICIES  
 TOI: L08 Life - Other Sub-TOI: L08.000 Life - Other  
 Product Name: 01-3146-11, 01-3147-11, 01-3148-11, 01-9064-11, 01-9065-11 ACCELERATED BENEFIT RIDERS AND LIFE APPLICATIONS  
 FOR TERM POLICIES  
 Project Name/Number: 01-3146-11, 01-3147-11, 01-3148-11, 01-9064-11, 01-9065-11 ACCELERATED BENEFIT RIDERS AND LIFE APPLICATIONS  
 FOR TERM POLICIES/01-3146-11, 01-3147-11, 01-3148-11, 01-9064-11, 01-9065-11  
 Enrollment Individual Life Application for  
 Form Insurance Insurance.pdf  
 01-9065-11 Application/ Application for Other Initial 0.000 01-9065-11  
 Enrollment Insured Rider Application for  
 Form Other Insured  
 Rider.pdf

**NATIONAL WESTERN LIFE INSURANCE COMPANY**  
**ACCELERATED DEATH BENEFIT FOR CHRONIC ILLNESS**

**NOTICE TO POLICYOWNER**

**Policy benefits and premiums will be reduced if an Accelerated Benefit payment is made. Benefits paid under this rider may be taxable. If they are, then some or all of your actual expenses may be deductible. You may wish to consult your personal tax advisor for current information.**

**Prior to the payment of the Accelerated Benefit we are required to obtain from an assignee or irrevocable beneficiary a signed acknowledgment of agreement for payout.**

**Receipt of payment under this rider will result in reduction of benefits under the policy and any affected riders. Upon acceleration, you will not receive the full Death Benefit under the policy or rider, but a reduced amount as described below.**

This rider is made a part of the policy to which it is attached in consideration of the application. The terms of the policy apply to this rider except as changed by the terms of this rider.

This rider is issued on the life of the Insured and any Other Insureds while coverage for the Insured or Other Insured is in force. The benefit is payable one time per Insured upon whom the benefit is determined under Accelerated Benefit, unless paid under another accelerated benefit rider attached to this policy. The use of the word "Insured" in this rider means "Insured or Other Insured". The use of the phrase "Face Amount" means "Face Amount of the Policy" for the Insured or "Other Insured Rider Insurance Benefit" for any Other Insureds. The use of the word policy in this rider means "Policy or Other Insured Rider".

**THE FACE AMOUNT OF THE POLICY WILL BE REDUCED BY THE ELECTED FACE AMOUNT IF A PAYMENT IS MADE UNDER THIS RIDER**

**ACCELERATED BENEFIT**

We will pay an Accelerated Benefit to you:

1. during the lifetime of the Insured; and
2. upon receipt by us of written proof of loss, received while this rider is in force; and
3. upon determination of a Qualifying Event of the Insured; and
4. upon your election of payment; and
5. in lieu of the Elected Face Amount.

The Accelerated Benefit will be determined by us when you submit written proof of loss. The Accelerated Benefit will be equal to the Elected Face Amount less:

1. the actuarial discount, determined by us; and
2. an administrative fee not to exceed \$500.

The following factors may be used by us in the determination of the actuarial discount:

1. the Elected Face Amount; and
2. future premiums payable under the policy for the Elected Face Amount; and
3. our assessment of the future expected mortality of the Insured; and
4. the Accelerated Benefit Interest Rate in effect.

The total of all Face Amounts we will accelerate under this and any other accelerated benefit riders on the life of any Insured is \$500,000. The Accelerated Benefit provided by this rider is payable only once per Insured

regardless of the subsequent occurrence of the same or a different Qualifying Event which would otherwise be covered.

Accelerated Benefits will not be available under this rider if you elect accelerated benefits under another rider. However, if you elect partial benefits under this or another accelerated benefits rider, you will remain eligible for benefits under any accelerated death benefit for terminal illness rider.

### **ACCELERATED BENEFIT INTEREST RATE**

We will declare the Accelerated Benefit Interest Rate. It will be determined on the date we receive your written proof of loss and will not exceed the greater of:

1. the yield on 90-day U.S. Treasury Bills on that date; or
2. the maximum adjustable policy loan interest rate allowed by law on that date.

### **DEFINITION OF CHRONIC ILLNESS QUALIFYING EVENT**

**Activities of Daily Living** mean bathing, continence, dressing, eating, toileting, and transferring.

1. Bathing is washing oneself by sponge bath or in either a tub or shower, including the task of getting into and out of the tub or shower.
2. Continence is maintaining control of bowel and bladder function; or when unable to maintain control of bowel or bladder function, performing associated personal hygiene (including caring for catheter or colostomy bag).
3. Dressing is putting on and taking off all items of clothing and any necessary braces, fasteners, or artificial limbs.
4. Eating is feeding oneself by getting food into the body from a receptacle, such as a plate, cup, or table, or by a feeding tube or intravenously.
5. Toileting is getting to and from the toilet, getting on and off the toilet, and performing associated personal hygiene.
6. Transferring is sufficient mobility to move into and out of a bed, chair, or wheelchair or to move from place to place, either by walking, a wheelchair, or other means.

**Assisted Living Facility** is a facility that is primarily engaged in providing ongoing care and related services to inpatients in one location and meets all of the following criteria:

1. It is licensed by the appropriate licensing agency, if the state in which it operates licenses; and
2. It provides 24 hour-a-day care and services sufficient to support needs resulting from Severe Cognitive Impairment or the inability to perform Activities of Daily Living; and
3. It has a trained and ready-to-respond employee on duty at all times to provide care; and
4. It provides three meals a day and accommodates special dietary needs; and
5. It has formal arrangements with a Physician or a registered nurse (RN) or a licensed practical nurse (LPN) to furnish medical care in case of an emergency; and
6. It has appropriate methods and procedures for handling and administering drugs and biologicals.

**Home Health Care Provider** is an agency, organization, or individual that meets all of the following criteria:

1. It specializes in giving nursing care, therapeutic services, or assistance with the Activities of Daily Living in the home; and
2. It is licensed or certified to provide such care or services by the appropriate state licensing agency or authority where the service is performed or is Medicare-certified as a Home Health Care Provider; and
3. It maintains a complete medical record and Plan of Care for each patient; and
4. It is operating within the scope of the provider's license or certification; and
5. It presents a charge for care or services that the Insured is legally responsible to pay; and
6. If an individual, the individual is not the Owner, the Insured, or a member of the Immediate Family.

**Immediate Family** means spouse, parents, step-parents, grandparents, domestic partner, siblings, children (natural, adopted, or step), grandchildren, and in-laws of the Owner or any Insured under the policy.

**Nursing Home Facility** is a facility that meets all of the following criteria:

1. It is licensed as a nursing home by the state where it is located; and
2. It is a separate facility or a distinct part of another facility physically separated from the rest of such facility; and
3. It provides nursing care to individuals who are not able to care for themselves and who require confinement; and
4. Its primary function is to provide continuous 24 hour-a-day nursing care, room and board, and it charges for these services. The care must be performed under the direction of a Physician, a registered nurse (RN), or a licensed practical nurse (LPN).

**Physician** is a doctor of medicine or osteopathy practicing within the scope of their license as issued by the jurisdiction in the United States of America in which the services are rendered. A Physician cannot be the Owner, any Insured under the policy, or any member of the Owner or any Insured's Immediate Family.

**Plan of Care** means a written individualized plan of Qualified Care Services that specifies the type and frequency of all services required to maintain the Insured with the Qualified Care Services, the cost of such services, and the service provider.

**Qualified Care Services** means necessary diagnostic, preventive, therapeutic, curing, treating, mitigating, or rehabilitative services provided by a facility that:

1. Is licensed by the state where it is located as a Nursing Home Facility, Home Health Care Provider, or Assisted Living Facility; and
2. Is operated pursuant to state and federal law.

**Qualifying Event** means that two or more years after the Policy Date the Insured has received Qualified Care Services for a period of at least 90 consecutive days and continues to receive Qualified Care Services:

1. Due to the inability to perform, without Substantial Assistance, at least two (2) Activities of Daily Living ; or
2. Requiring Substantial Supervision to protect the Insured from threats to health and safety due to Severe Cognitive Impairment.

**Substantial Assistance** means:

1. The physical assistance of another person without which the Insured would not be able to perform an Activity of Daily Living; and
2. The presence of another person within arm's reach of the Insured that is necessary to prevent, by physical intervention, injury to the Insured while the Insured is performing an Activity of Daily Living.

**Severe Cognitive Impairment** means the deterioration or loss of intellectual capacity requiring Substantial Supervision for protection of self and others, as established by the clinical diagnosis of a Physician who is authorized, in the state where the Qualified Care Services are provided, to make such a diagnosis. Such diagnosis shall include the patient's history and neurological, psychological, and/or psychiatric evaluations and laboratory findings.

**Substantial Supervision** means continual supervision, which may include cueing by verbal prompting, gestures, or other demonstrations, by another person that is necessary to protect the Insured from threats to his or her health or safety, such as may result from wandering.

## **PROOF OF LOSS AND ACCELERATED BENEFIT PAYMENT**

Written proof of a loss must be given to the Company within 365 days of a Qualifying Event. This must be sent to our Executive Office at 850 East Anderson Lane, Austin, TX 78752. You must provide written proof that the Insured has experienced a Qualifying Event. Written proof must include at least the following:

1. certification from a Physician that the Insured has experienced a Qualifying Event; and
2. complete records of the Insured's medical history, diagnoses, and treatments.

A Physician must furnish us a written diagnosis of a Qualifying Event. The written diagnosis must include documentation supported by clinical, radiological, histological, and/or laboratory evidence of the Qualifying Event.

We reserve the right to require a second opinion or examination of the Insured by a Physician of our choice to determine the Qualifying Event. If a difference of opinion occurs between the Insured's Physician and ours, a third opinion, agreeable to both the Owner and us will be obtained and will be the basis for approving or disapproving the request. The cost of any second or third opinion or examination will be at our expense.

We will not evaluate a claim less than 30 days following the date of a Qualifying Event.

If the claim is determined to be eligible for payment, we will send to you, to any irrevocable beneficiary, and to any assignee of record a benefit offer and an Effect of Benefit Statement. The Effect of Benefit Statement will demonstrate the impact the Elected Face Amount will have on the policy Face Amount and premium. You may choose the Elected Face Amount within the following conditions and limitations. The Elected Face Amount:

1. must be less than 90% of the Face Amount; and
2. must be greater than \$5,000.00; and
3. must be \$500,000.00 or less; and
4. must leave a remaining Face Amount of not less than \$12,500.00.

If the Elected Face Amount is less than the maximum amount allowed above, then you have elected partial benefits. If the Elected Face Amount is equal to the maximum amount allowed above, then you have elected full benefits. Any excess between full benefits and partial benefits will be available under any terminal illness rider attached to this policy.

If you choose to accept the offer, we must receive the offer verifying your Elected Face Amount, signed by you, and signed by any irrevocable beneficiaries and assignees of record. The offer for Accelerated Benefit must be accepted within 60 days of receipt or the offer is void. If the Insured dies prior to the Accelerated Benefit payment being mailed or deposited, then the offer is void and the policy Death Benefit will be payable in accordance with the terms of the policy.

The Accelerated Benefit will be paid to you in a lump sum. If periodic payments are elected, you may apply the Accelerated Benefit to any non-life contingent settlement option pursuant to the Settlement Options provision of the policy.

Upon payment of the Accelerated Benefit, we will send you an updated Effect of Benefit Statement showing the requested Elected Face Amount and the Accelerated Benefit payment and their impact on the policy Face Amount and premium.

### **LIMITATIONS AND EXCLUSIONS**

**Exclusions.** No Accelerated Benefit will be payable for a Qualifying Event if a claim results from any of the following:

1. the abuse of alcohol or taking of drugs (other than under the direction of a Physician); or
2. attempted suicide or injuries intentionally self-inflicted, whether sane or insane; or
3. injury received during voluntary participation in a riot, strike, or civil commotion; or
4. injury received during insurrection, war or invasion, or any act incidental thereto; or
5. participating or attempting to participate in an illegal activity.

**Legal Notice.** This rider provides for the acceleration of the payment of the Face Amount of the policy. This is not meant to cause you to involuntarily access the benefits of the policy ultimately payable to the Beneficiary. Therefore, no Accelerated Benefit will be payable if:

1. you are required by law to use the Accelerated Benefit to meet the claims of creditors, whether in bankruptcy or otherwise; or
2. you are required by a government agency to use the Accelerated Benefit in order to apply for, obtain, or otherwise keep a government benefit or entitlement.

### OTHER TERMS OF THIS RIDER

**Other Riders.** Payment of accelerated benefits will have no effect upon any accidental death benefit riders or children's term life insurance riders.

**Reinstatement.** If the policy terminates for non-payment of premium, the rider may be reinstated under the same conditions as the policy. This rider may not be reinstated unless the policy is in force or is being reinstated at the same time.

The reinstated rider will cover a Qualifying Event which is first diagnosed after the date reinstatement is approved by us. Upon the date of reinstatement, the Insured's and our rights will be those that were in effect before the rider terminated.

**Termination.** This rider will terminate on the earliest of:

1. your written request for cancellation of this rider; or
2. the date the policy terminates; or
3. the election of benefits under this or any other accelerated benefit rider on this policy.

**Effective Date.** The effective date of this rider is the Policy Date.



**President**

# NATIONAL WESTERN LIFE INSURANCE COMPANY

## ACCELERATED DEATH BENEFIT FOR CRITICAL ILLNESS

### NOTICE TO POLICYOWNER

**Policy benefits and premiums will be reduced if an Accelerated Benefit payment is made. Benefits paid under this rider may be taxable. If they are, then some or all of your actual expenses may be deductible. You may wish to consult your personal tax advisor for current information.**

**Prior to the payment of the Accelerated Benefit we are required to obtain from an assignee or irrevocable beneficiary a signed acknowledgment of agreement for payout.**

**Receipt of payment under this rider will result in reduction of benefits under the policy and any affected riders. Upon acceleration, the full Death Benefit under the policy or rider will not be payable.**

This rider is made a part of the policy to which it is attached in consideration of the application. The terms of the policy apply to this rider except as changed by the terms of this rider.

This rider is issued on the life of the Insured and any Other Insureds while coverage for the Insured or Other Insured is in force. The benefit is payable one time per Insured upon whom the benefit is determined under Accelerated Benefit, unless paid under another accelerated benefit rider attached to this policy. The use of the word "Insured" in this rider means "Insured or Other Insured". The use of the phrase "Face Amount" means "Face Amount of the Policy" for the Insured or "Other Insured Rider Insurance Benefit" for any Other Insureds. The use of the word policy in this rider means "Policy or Other Insured Rider".

### **THE FACE AMOUNT OF THE POLICY WILL BE REDUCED BY THE ELECTED FACE AMOUNT IF A PAYMENT IS MADE UNDER THIS RIDER**

#### ACCELERATED BENEFIT

We will pay an Accelerated Benefit to you:

1. during the lifetime of the Insured; and
2. upon receipt by us of written proof of loss, received while this rider is in force; and
3. upon determination of a Qualifying Event of the Insured; and
4. upon your election of payment; and
5. in lieu of the Elected Face Amount.

The Accelerated Benefit will be determined by us when you submit written proof of loss. The Accelerated Benefit will be equal to the Elected Face Amount less:

1. the actuarial discount, determined by us; and
2. an administrative fee not to exceed \$500.

The following factors may be used by us in the determination of the actuarial discount:

1. the Elected Face Amount; and
2. future premiums payable under the policy for the Elected Face Amount; and
3. our assessment of the future expected mortality of the Insured; and
4. the Accelerated Benefit Interest Rate in effect.

The total of all Face Amounts we will accelerate under this and any other accelerated benefit riders on the life of any Insured is \$500,000. The Accelerated Benefit provided by this rider is payable only once per Insured regardless of the subsequent occurrence of the same or a different Qualifying Event which would otherwise be covered.

Accelerated Benefits will not be available under this rider if you elect accelerated benefits under another rider. However, if you elect partial benefits under this or another accelerated benefits rider, you will remain eligible for benefits under any accelerated death benefit for terminal illness rider.

### **ACCELERATED BENEFIT INTEREST RATE**

We will declare the Accelerated Benefit Interest Rate. It will be determined on the date we receive your written proof of loss and will not exceed the greater of:

1. the yield on 90-day U.S. Treasury Bills on that date; or
2. the maximum adjustable policy loan interest rate allowed by law on that date.

### **DEFINITION OF A CRITICAL ILLNESS QUALIFYING EVENT**

You may submit proof of loss for Accelerated Benefit if the Insured has experienced a Qualifying Event while the policy and this rider are in force. A Qualifying Event must first be diagnosed at least 30 days following the Policy Date in the case of illness, or after the Policy Date in the case of accidental injuries.

A Qualifying Event is defined as one of the following:

**Heart Attack (Myocardial Infarction).** The death of a portion of heart muscle (myocardium) resulting from a blockage of one or more coronary arteries. The heart attack must have been severe enough to require an inpatient hospital stay. Heart Attack does not include angina or the chance finding of electrocardiographic (EKG) changes indicative of a previous heart attack. This diagnosis must be supported by:

1. a clinical picture of a myocardial infarction; and
2. new electrocardiographic and echocardiographic findings consistent with myocardial infarction; and
3. elevation of CPK-MB, Troponin, and other cardiac enzymes above standard laboratory levels of normal.

**Stroke (Cerebrovascular Accident).** Damage to the brain tissue caused by hemorrhage, thrombosis or embolus resulting in paralysis or other measurable neurological deficit persisting for at least 60 days following the date of the cerebrovascular accident. Excluded are Transient Ischemia Attacks and Vertebrobasilar Ischemia.

**Life Threatening Cancer.** Only those types of cancer manifested by the presence of a malignant tumor characterized by the uncontrolled growth and spread of malignant cells and the invasion of tissue. As used herein, Leukemia and Hodgkins Disease (except Stage 1 Hodgkins Disease) shall be considered cancer.

Diagnosis of Life Threatening Cancer must be established according to the criteria of malignancy established by The American Board of Pathology after a study of the histocytologic architecture or pattern of the suspect tumor, tissue, or specimen.

Cancer does not include pre-malignant tumors or polyps, cancer in situ, intraductal non-invasive carcinoma of the breast, Kaposi's Sarcoma, carcinoid of the appendix, Stage I transitional cell carcinoma of the urinary bladder, Stage A prostate cancer, or any skin cancers other than malignant melanoma that extends into the dermis or deeper.

**Kidney Failure.** The end stage of chronic, irreversible failure of both kidneys to function, necessitating renal dialysis expected to continue for a period of at least 6 months or resulting in renal transplantation.

**Major Organ Transplant.** Medically necessary surgery to transplant into the Insured from another human being, any of the following organs: heart, lung or lungs, liver, bone marrow, or pancreas.

**Diagnosis of ALS (Amyotrophic Lateral Sclerosis)** by a qualified Physician.

**Paralysis** – The complete and permanent loss of use of two or more limbs through neurological injury for a continuous period of at least 180 days. Paralysis must be confirmed by a Physician board certified in Neurology.

**Major Multi-System Trauma** – Any major accident or injury resulting in significant alteration of any three (3) body systems which requires hospitalization and extended rehabilitation, results in permanent impairment of the function and/or altered ability to perform three or more Activities of Daily Living, and significantly alters the Insured's life expectancy. The Activities of Daily Living are:

- Bathing – including washing oneself by sponge bath, or in a tub or shower, including the task of getting into and out of the tub or shower.
- Contenance – the ability to maintain control of bowel and bladder function, or when unable to maintain control of bowel or bladder function, the ability to perform associated person hygiene, including caring for a catheter or colostomy bag.
- Dressing – the ability to put on and take off all items of clothing and any necessary braces, fasteners, or artificial limbs.
- Eating – the ability to feed oneself by getting food into the body from a receptacle, such as a plate, cup, or table, or by a feeding tube or intravenously.
- Toileting – the ability to get to and from the toilet, getting on and off the toilet, and performing associated personal hygiene.
- Transferring – the ability to move into and out of a bed, chair, or wheelchair.

**Auto-Immune Deficiency Syndrome (AIDS)** – Advanced HIV infection that is associated with an AIDS-defining condition (P. carinii pneumonia, esophageal candidiasis, wasting, Kaposi's sarcoma, disseminated mycobacterium avium infection, tuberculosis, cytomegalovirus disease, HIV-associated dementia, recurrent bacterial pneumonia, toxoplasmosis, immunoblastic lymphoma, chronic cryptosporidiosis, Burkitt lymphoma, disseminated histoplasmosis, invasive cervical cancer, and chronic herpes simplex) and has been diagnosed by a Physician.

**Severe Central Nervous System Disease** – Severe disease of the central nervous system, brain, and/or spinal cord, as diagnosed by a Physician, that is life threatening and significantly alters the Insured's life expectancy, as diagnosed by a Physician. Severe Central Nervous System Disease includes, but is not limited to, progressive multiple sclerosis, Parkinson's Disease, and Huntington's chorea which permanently alters a portion of the cerebrum.

**Loss of Limbs** – The complete and permanent severance of two or more limbs through or above the elbow or knee joint due to trauma or accident and that results in a reduced life expectancy.

**Alzheimers** – A degenerative brain process that produces, usually slowly over time, dementia or senility (also known as senile dementia) resulting in the inability of the insured to perform independently three or more activities of daily living (bathing, continence, dressing, toileting, eating, transferring, and taking medications). A clinically established diagnosis is required from a Physician who is a psychiatrist or neurologist.

**Dementia** – A progressive brain dysfunction, which results in a restriction of daily activities and in most cases leads in the long term to the need for care. Dementia is a collection of symptoms including memory loss, personality change, and impaired intellectual functions resulting from disease or trauma to the brain. These changes are not part of the normal aging and are severe enough to impact daily living, independence, and relationships. A clinically established diagnosis is required from a Physician who is a psychiatrist or neurologist. Alcohol and drug induced dementia are excluded.

## Heart Surgery –

- **Coronary Artery Bypass Surgery:** The undergoing of heart surgery to correct narrowing or blockage of one or more coronary arteries with bypass grafting using either the saphenous vein or internal mammary artery graft, excluding any non surgical or trans-catheter techniques such as balloon angioplasty, stent placement, or laser relief of an obstruction. The surgery must be determined to be medically necessary by a cardiologist.
- **Coronary Angioplasty:** The undergoing of an interventional procedure such as angioplasty, stent placement, endarterectomy or laser treatment to unblock or widen a coronary artery that supplies blood to the heart to allow an uninterrupted flow of blood (70% or greater artery stenosis that cannot be controlled by medication). Diagnosis must include all of the following: cardiologist reports indicating prior treatment using appropriate medication; EKG showing significant changes (ST depression of two millimeters or more); angiographic evidence of the underlying disease; and unequivocal recommendation for the procedure from a cardiologist.
- **Heart Valve Replacement:** The undergoing of open heart surgery to replace any heart valve with either a natural or mechanical valve. The surgery must be determined to be medically necessary by a cardiologist. Exclusion: No benefit will be payable under this condition for heart valve repair.
- **Aorta Surgery:** The undergoing of open heart surgery for the excision and surgical replacement of the diseased thoracic, abdominal, or ascending aorta with a graft (traumatic injury of the aorta is excluded).

**Physician** is a doctor of medicine or osteopathy practicing within the scope of their license as issued by the jurisdiction in the United States of America in which the services are rendered. A Physician cannot be the Owner, any Insured under the policy, or any member of the Owner or any Insured's Immediate Family. (Immediate Family includes spouse, parents, step-parents, grandparents, domestic partner, siblings, children (natural, adopted, or step), grandchildren, and in-laws.)

### PROOF OF LOSS AND ACCELERATED BENEFIT PAYMENT

Written proof of a loss must be given to the Company within 365 days of a Qualifying Event. This must be sent to our Executive Office at 850 East Anderson Lane, Austin, TX 78752. You must provide written proof that the Insured has experienced a Qualifying Event. Written proof must include at least the following:

1. certification from a Physician that the Insured has experienced a Qualifying Event; and
2. complete records of the Insured's medical history, diagnoses, and treatments.

A Physician must furnish us a written diagnosis of a Qualifying Event. The written diagnosis must include documentation supported by clinical, radiological, histological, and/or laboratory evidence of the Qualifying Event.

We reserve the right to require a second opinion or examination of the Insured by a Physician of our choice to determine the Qualifying Event. If a difference of opinion occurs between the Insured's Physician and ours, a third opinion, agreeable to both the Owner and us will be obtained and will be the basis for approving or disapproving the request. The cost of any second or third opinion or examination will be at our expense.

We will not evaluate a claim less than 30 days following the date of a Qualifying Event.

If the claim is determined to be eligible for payment, we will send to you, to any irrevocable beneficiary, and to any assignee of record a benefit offer and an Effect of Benefit Statement. The Effect of Benefit Statement will demonstrate the impact the Elected Face Amount will have on the policy Face Amount and premium. You may choose the Elected Face Amount within the following conditions and limitations.

The Elected Face Amount:

1. must be less than 90% of the Face Amount; and
2. must be greater than \$5,000.00; and
3. must be \$500,000.00 or less; and
4. must leave a remaining Face Amount of not less than \$12,500.00.

If the Elected Face Amount is less than the maximum amount allowed above, then you have elected partial benefits. If the Elected Face Amount is equal to the maximum amount allowed above, then you have elected full benefits. Any excess between full benefits and partial benefits will be available under any terminal illness rider attached to this policy.

If you choose to accept the offer, we must receive the offer verifying your Elected Face Amount, signed by you, and signed by any irrevocable beneficiaries and assignees of record. The offer for Accelerated Benefit must be accepted within 60 days of receipt or the offer is void. If the Insured dies prior to the Accelerated Benefit payment being mailed or deposited, then the offer is void and the policy Death Benefit will be payable in accordance with the terms of the policy.

The Accelerated Benefit will be paid to you in a lump sum. If periodic payments are elected, you may apply the Accelerated Benefit to any non-life contingent settlement option pursuant to the Settlement Options provision of the policy.

Upon payment of the Accelerated Benefit, we will send you an updated Effect of Benefit Statement showing the requested Elected Face Amount and the Accelerated Benefit payment and their impact on the policy Face Amount and premium.

### **LIMITATIONS AND EXCLUSIONS**

**Exclusions.** No Accelerated Benefit will be payable for a Qualifying Event if a claim results from any of the following:

1. the abuse of alcohol or taking of drugs (other than under the direction of a Physician); or
2. attempted suicide or injuries intentionally self-inflicted, whether sane or insane; or
3. injury received during voluntary participation in a riot, strike, or civil commotion; or
4. injury received during insurrection, war or invasion, or any act incidental thereto; or
5. participating or attempting to participate in an illegal activity.

**Legal Notice.** This rider provides for the acceleration of the payment of the Face Amount of the policy. This is not meant to cause you to involuntarily access the benefits of the policy ultimately payable to the Beneficiary. Therefore, no Accelerated Benefit will be payable if:

1. you are required by law to use the Accelerated Benefit to meet the claims of creditors, whether in bankruptcy or otherwise; or
2. you are required by a government agency to use the Accelerated Benefit in order to apply for, obtain, or otherwise keep a government benefit or entitlement.

### **OTHER TERMS OF THIS RIDER**

**Other Riders.** Payment of accelerated benefits will have no effect upon any accidental death benefit riders or children's term life insurance riders.

**Reinstatement.** If the policy terminates for non-payment of premium, the rider may be reinstated under the same conditions as the policy. This rider may not be reinstated unless the policy is in force or is being reinstated at the same time.

The reinstated rider will cover a Qualifying Event which is first diagnosed after the date reinstatement is approved by us. Upon the date of reinstatement, the Insured's and our rights will be those that were in effect before the rider terminated.

**Termination.** This rider will terminate on the earliest of:

1. your written request for cancellation of this rider; or
2. the date the policy terminates; or
3. the election of benefits under this or any other accelerated benefit rider on this policy.

**Effective Date.** The effective date of this rider is the Policy Date.

A handwritten signature in black ink, appearing to read "Ross L. Hoody". The signature is written in a cursive, flowing style.

**President**

**NATIONAL WESTERN LIFE INSURANCE COMPANY**  
**ACCELERATED DEATH BENEFIT FOR TERMINAL ILLNESS**

**NOTICE TO POLICYOWNER**

**Policy benefits and premiums will be reduced if an Accelerated Benefit payment is made. Benefits paid under this rider may be taxable. If they are, then some or all of your actual expenses may be deductible. You may wish to consult your personal tax advisor for current information.**

**Prior to the payment of the Accelerated Benefit we are required to obtain from an assignee or irrevocable beneficiary a signed acknowledgment of agreement for payout.**

**Receipt of payment under this rider will result in reduction of benefits under the policy and any affected riders. Upon acceleration, you will not receive the full Death Benefit under the policy or rider, but a reduced amount as described below.**

This rider is made a part of the policy to which it is attached in consideration of the application. The terms of the policy apply to this rider except as changed by the terms of this rider.

This rider is issued on the life of the Insured and any Other Insureds while coverage for the Insured or Other Insured is in force. The benefit is payable one time per Insured upon whom the benefit is determined under Accelerated Benefit, unless paid under another accelerated benefit rider attached to this policy. The use of the word "Insured" in this rider means "Insured or Other Insured". The use of the phrase "Face Amount" means "Face Amount of the Policy" for the Insured or "Other Insured Rider Insurance Benefit" for any Other Insureds. The use of the word policy in this rider means "Policy or Other Insured Rider".

**THE FACE AMOUNT OF THE POLICY WILL BE REDUCED BY THE ELECTED FACE AMOUNT IF A PAYMENT IS MADE UNDER THIS RIDER**

**ACCELERATED BENEFIT**

We will pay an Accelerated Benefit to you:

1. during the lifetime of the Insured; and
2. upon receipt by us of written proof of loss, received while this rider is in force; and
3. upon determination of a Qualifying Event of the Insured; and
4. upon your election of payment; and
5. in lieu of the Elected Face Amount.

The Accelerated Benefit will be determined by us when you submit written proof of loss. The Accelerated Benefit will be equal to the Elected Face Amount less:

1. the actuarial discount, determined by us; and
2. an administrative fee not to exceed \$500.

The following factors may be used by us in the determination of the actuarial discount:

1. the Elected Face Amount; and
2. future premiums payable under the policy for the Elected Face Amount; and
3. our assessment of the future expected mortality of the Insured; and
4. the Accelerated Benefit Interest Rate in effect.

The total of all Face Amounts we will accelerate under this and any other accelerated benefit riders on the life of any Insured is \$500,000. The Accelerated Benefit provided by this rider is payable only once per Insured

regardless of the subsequent occurrence of the same or a different Qualifying Event which would otherwise be covered. If you elect partial benefits under another accelerated benefits rider, you will remain eligible for remaining benefits under this rider.

### **ACCELERATED BENEFIT INTEREST RATE**

We will declare the Accelerated Benefit Interest Rate. It will be determined on the date we receive your written proof of loss and will not exceed the greater of:

1. the yield on 90-day U.S. Treasury Bills on that date; or
2. the maximum adjustable policy loan interest rate allowed by law on that date.

### **DEFINITION OF A TERMINAL ILLNESS QUALIFYING EVENT**

A Qualifying Event is a diagnosis of Terminal Illness.

A Terminal Illness is an illness:

1. From which the Insured is not expected to recover; and
2. From which the insured is expected to live less than twenty-four months after the date you request payment of the accelerated benefit in writing.

### **PROOF OF LOSS AND ACCELERATED BENEFIT PAYMENT**

Written proof of a loss must be given to the Company within 365 days of a Qualifying Event. This must be sent to our Executive Office at 850 East Anderson Lane, Austin, TX 78752. You must provide written proof that the Insured has experienced a Qualifying Event. Written proof must include at least the following:

1. certification from a Physician that the Insured has experienced a Qualifying Event; and
2. complete records of the Insured's medical history, diagnoses, and treatments.

A Physician must furnish us a written diagnosis of a Qualifying Event. The written diagnosis must include documentation supported by clinical, radiological, histological, and/or laboratory evidence of the Qualifying Event.

A Physician is a doctor of medicine or osteopathy practicing within the scope of their license as issued by the jurisdiction in the United States of America in which the services are rendered. A Physician cannot be the Owner, any Insured under the policy, or any member of the Owner or any Insured's Immediate Family. (Immediate Family includes spouse, parents, step-parents, grandparents, domestic partner, siblings, children (natural, adopted, or step), grandchildren, and in-laws.)

We reserve the right to require a second opinion or examination of the Insured by a Physician of our choice to determine the Qualifying Event. If a difference of opinion occurs between the Insured's Physician and ours, a third opinion, agreeable to both the Owner and us will be obtained and will be the basis for approving or disapproving the request. The cost of any second or third opinion or examination will be at our expense.

We will not evaluate a claim less than 30 days following the date of a Qualifying Event.

If the claim is determined to be eligible for payment, we will send to you, to any irrevocable beneficiary, and to any assignee of record a benefit offer and an Effect of Benefit Statement. The Effect of Benefit Statement will demonstrate the impact the Elected Face Amount will have on the policy Face Amount and premium. You may choose the Elected Face Amount within the following conditions and limitations.

The Elected Face Amount:

1. must be less than 90% of the Face Amount; and
2. must be greater than \$5,000.00; and
3. must be \$500,000.00 or less; and
4. must leave a remaining Face Amount of not less than \$12,500.00; and
5. must be no greater than the difference between the full benefit and the Elected Face Amount in any prior accelerated benefit rider election, if any.

If you choose to accept the offer, we must receive the offer verifying your Elected Face Amount, signed by you, and signed by any irrevocable beneficiaries and assignees of record. The offer for Accelerated Benefit must be accepted within 60 days of receipt or the offer is void. If the Insured dies prior to the Accelerated Benefit payment being mailed or deposited, then the offer is void and the policy Death Benefit will be payable in accordance with the terms of the policy.

The Accelerated Benefit will be paid to you in a lump sum. If periodic payments are elected, you may apply the Accelerated Benefit to any non-life contingent settlement option pursuant to the Settlement Options provision of the policy.

Upon payment of the Accelerated Benefit, we will send you an updated Effect of Benefit Statement showing the requested Elected Face Amount and the Accelerated Benefit payment and their impact on the policy Face Amount and premium.

#### **LIMITATIONS AND EXCLUSIONS**

**Exclusions.** No Accelerated Benefit will be payable for a Qualifying Event if a claim results from any of the following:

1. the abuse of alcohol or taking of drugs (other than under the direction of a Physician); or
2. attempted suicide or injuries intentionally self-inflicted, whether sane or insane; or
3. injury received during voluntary participation in a riot, strike, or civil commotion; or
4. injury received during insurrection, war or invasion, or any act incidental thereto; or
5. participating or attempting to participate in an illegal activity.

**Legal Notice.** This rider provides for the acceleration of the payment of the Face Amount of the policy. This is not meant to cause you to involuntarily access the benefits of the policy ultimately payable to the Beneficiary. Therefore, no Accelerated Benefit will be payable if:

1. you are required by law to use the Accelerated Benefit to meet the claims of creditors, whether in bankruptcy or otherwise; or
2. you are required by a government agency to use the Accelerated Benefit in order to apply for, obtain, or otherwise keep a government benefit or entitlement.

#### **OTHER TERMS OF THIS RIDER**

**Other Riders.** Payment of accelerated benefits will have no effect upon any accidental death benefit riders or children's term life insurance riders.

**Reinstatement.** If the policy terminates for non-payment of premium, the rider may be reinstated under the same conditions as the policy. This rider may not be reinstated unless the policy is in force or is being reinstated at the same time.

The reinstated rider will cover a Qualifying Event which is first diagnosed after the date reinstatement is approved by us. Upon the date of reinstatement, the Insured's and our rights will be those that were in effect before the rider terminated.

**Termination.** This rider will terminate on the earliest of:

1. your written request for cancellation of this rider; or
2. the date the policy terminates; or
3. the election of full benefits under any other accelerated benefit rider on this policy; or
4. the election of any benefits under this rider.

**Effective Date.** The effective date of this rider is the Policy Date.

A handwritten signature in black ink, reading "Ross L. Hoody". The signature is written in a cursive style with a large, sweeping initial "R".

**President**

**I. PRIMARY INSURED (Please Print Clearly Using Black Ink)**

Name of Proposed Insured (First, Middle, Last)		Date of Birth (mm/dd/yyyy)	Age	Place of Birth (State and Country)
<input type="checkbox"/> Male <input type="checkbox"/> Female	Marital Status <input type="checkbox"/> Married <input type="checkbox"/> Single <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced	<input type="checkbox"/> Tobacco Use <input type="checkbox"/> Tobacco Free		
Home Address (number and street)	City	State	Zip	
Social Security Number or Tax ID	Drivers License Number and State	Home Phone Number	Best time and place to call <input type="checkbox"/> Home <input type="checkbox"/> AM <input type="checkbox"/> PM <input type="checkbox"/> Work <input type="checkbox"/> AM <input type="checkbox"/> PM	
Citizenship <input type="checkbox"/> U.S. Citizen <input type="checkbox"/> Other		If Non US Citizen: Type of Visa _____ Exp date _____ Country of Citizenship _____		
Current Employer	Occupation and Duties	Work Phone Number		
Employer Address (number and street)	City	State	Zip	

**II. COVERAGE APPLIED FOR**

Plan of Insurance (Name of Product) _____	Face Amount \$ _____
<b>Riders: (Not all riders are available in all plans or in all states)</b>	
<input type="checkbox"/> Accidental Death Benefit _____	
<input type="checkbox"/> Waiver of Cost of Insurance <input type="checkbox"/> Critical Illness Rider <input type="checkbox"/> Chronic Illness Rider <input type="checkbox"/> Terminal Illness Rider	
<input type="checkbox"/> Other Insured Rider: (complete Other Insured Rider Application) Face Amount \$ (cannot exceed coverage on Primary insured)	
<input type="checkbox"/> Child Rider: _____ # of units (Complete section XII for Children)	

**III. PREMIUMS AND FINANCES**

Annual Premium \$ _____	Planned Modal Premium \$ _____	Cash with app \$ _____
Mode:	<input type="checkbox"/> Annual <input type="checkbox"/> Semi-annual <input type="checkbox"/> Quarterly <input type="checkbox"/> Monthly <input type="checkbox"/> Single pay <input type="checkbox"/> Other _____	
Method:	<input type="checkbox"/> Direct Billing <input type="checkbox"/> Bank Draft <input type="checkbox"/> Allotment <input type="checkbox"/> Salary Deduction <input type="checkbox"/> Other _____	
Source of Premium: <input type="checkbox"/> Salary <input type="checkbox"/> Savings <input type="checkbox"/> Investments <input type="checkbox"/> 1035 Exchange <input type="checkbox"/> Loan (premium financing) <input type="checkbox"/> Other (specify) _____		
Who will pay the premium? _____ Relationship to Proposed Insured _____		

**IV. OWNERSHIP INFORMATION (Complete only if Owner is other than the Proposed Insured)**

Owner / Applicant / Trust Name	Date of Birth (mm/dd/yyyy)	SSN / TIN
Phone Number	Relationship to Proposed Insured	
Address (number and street)	City	State Zip Code
If the owner is a trust, please submit the Trust Information Form.		

**V. BENEFICIARY INFORMATION (If percentages are not given, the shares will be divided equally)**

<b>Primary Beneficiaries</b>		
Full Name	Relationship	% Share
1. _____	_____	_____
2. _____	_____	_____
3. _____	_____	_____
<b>Contingent Beneficiaries</b>		
Full Name	Relationship	% Share
1. _____	_____	_____
2. _____	_____	_____
3. _____	_____	_____

**VI. OTHER COVERAGE AND REPLACEMENT**

1. Does the Proposed Insured have any existing life insurance or annuity policies with this company or any other company? (If yes provide details in #4) .....  Yes  No
2. Is this policy intended to replace any existing life insurance or annuity? .....  Yes  No  
(If yes, please submit appropriate state replacement forms)
3. Is the Proposed Owner or Proposed Insured considering using funds from an existing policy or contract to pay premiums on the Policy being applied for? (If Yes, complete the appropriate state replacement forms) .....  Yes  No
4. Company Policy Number Type of Coverage Amt of Coverage To be Replaced 1035 Exchange  

				<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
				<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
				<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
				<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

**VII. HEIGHT AND WEIGHT**

What is your height? \_\_\_\_\_ ft \_\_\_\_\_ in: What is your weight? \_\_\_\_\_ Lbs

**VIII. MEDICAL HISTORY QUESTIONS** (If any question in Section VIII is answered yes, or height and weight is not within product guidelines, no coverage can be issued.)

1. 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)? .....  Yes  No
2. Do you have any impairment, whether physical or mental, for which you need or receive assistance or supervision in performing normal activities of daily living such as bathing, continence, dressing, eating, toileting, transferring or taking medications? .....  Yes  No
3. Do you use a walker, wheelchair, motorized scooter or any medical appliance such as oxygen, respirator, or dialysis machine, or have a defibrillator implanted? .....  Yes  No
4. Have you had or been advised by a member of the medical profession to have, an organ transplant, or have you been medically diagnosed as having a terminal illness or life expectancy of 12 months or less? .....  Yes  No
5. Are you currently hospitalized, confined to a bed or nursing facility, residing in an assisted living facility or receiving hospice care? .....  Yes  No
6. Have you ever been diagnosed, treated, tested positive for, or been given medical advice by a member of the medical profession for a disease or disorder such as:
  - a. Congestive heart failure, cardiomyopathy, cirrhosis of the liver, liver failure, kidney (renal) failure, end stage kidney disease, chronic kidney disease or renal insufficiency? .....  Yes  No
  - b. Alzheimer’s disease, dementia, memory loss, mental incapacity, schizophrenia, manic depression, bipolar disorder, brain disease, Lou Gehrig’s disease (ALS), Huntington’s disease, muscular dystrophy, cystic fibrosis, multiple sclerosis or multiple myeloma? .....  Yes  No
7. Have you:
  - a. Been diagnosed, treated, tested positive for, or been given medical advice by a member of the medical profession for diabetes prior to age 20? .....  Yes  No
  - b. Taken insulin prior to age 40? .....  Yes  No
  - c. Ever been treated for insulin shock or diabetic coma? .....  Yes  No
  - d. Been hospitalized two or more times for any diabetic complications within the last 2 years? .....  Yes  No
8. Within the past 3 years have you been diagnosed by a member of the medical profession with leukemia, lymphoma, melanoma or any internal cancer, or received chemotherapy, radiation or had surgery for any cancer (other than basal or squamous cell cancer of the skin)? .....  Yes  No
9. Other than basal cell or squamous cell cancer of the skin, have you ever had more than one occurrence of any cancer, a recurrence of any cancer, or an amputation caused by cancer or any other disease, or are you currently being treated for cancer? .....  Yes  No

VIII. MEDICAL HISTORY QUESTIONS CONTINUED (If any question in Section VIII is answered yes, no coverage can be issued.)

- 10. Within the past 2 years have you:
  - a. Been diagnosed or treated by a member of medical profession for, been hospitalized for, or taken or been prescribed medication for: Chronic Obstructive Pulmonary or Lung Disease (COPD/COLD), emphysema, chronic bronchitis, respiratory failure, chronic hepatitis, liver disease, angina, stroke, transient ischemic attack (TIA), Hodgkin's disease, cerebral palsy, Parkinson's disease, grand mal epilepsy, systemic lupus (SLE) disease, or do you have paralysis of 2 or more extremities? .....  Yes  No
  - b. Been diagnosed or treated by a member of the medical profession for, or been hospitalized for: Heart disease, heart attack, uncontrolled high blood pressure, heart or circulatory surgery, including coronary artery bypass, angioplasty, cardiac or vascular stent placement, pacemaker or pacemaker replacement, heart valve replacement, aneurysm, or any cardiac or vascular surgery or procedure to improve the circulation to the heart, brain or extremities?.....  Yes  No
  - c. Been confined three or more times to a hospital, nursing facility, convalescent care facility, assisted living facility, or mental care facility? .....  Yes  No
  - d. Been declined for life, health or long term care insurance? .....  Yes  No

IX. NON MEDICAL HISTORY QUESTIONS (IF ANY QUESTION IN SECTION IX IS ANSWERED YES, OR HEIGHT AND WEIGHT IS NOT WITHIN PRODUCT GUIDELINES, NO COVERAGE CAN BE ISSUED.)

- 11. Is household income under \$20,000? .....  Yes  No
- 12. Is proposed insured currently undergoing Chapter 7 bankruptcy or is bankruptcy not yet discharged? .....  Yes  No
- 13. Within the last 5 years have you:
  - a. Been convicted of a felony or are you currently incarcerated, on parole or probation? .....  Yes  No
  - b. Been treated for or been advised to have treatment for alcohol or any drugs of abuse, or attempted suicide?.....  Yes  No
- 14. Within the last 3 years have you been convicted of operating a vehicle while intoxicated, impaired, or under the influence or for reckless driving? .....  Yes  No
- 15. Within the past 2 years did you, or in the near future do you intend to:
  - a. Participate as a student aviation pilot? .....  Yes  No
  - b. Fly less than 50 hours solo or over 300 hours (excluding commercial airline pilot)? .....  Yes  No
  - c. Have any aviation related accident or violation?.....  Yes  No
  - d. Fly as a crop duster, aerobatic pilot, Search and Rescue or flown experimental aircraft?.....  Yes  No
  - e. Participate in hang gliding, parasailing, ultra light activity more than 10 times a year, stunt activity or over 3,000 feet in altitude? .....  Yes  No
  - f. Do mountain climbing excluding recreational or less than 1 day of duration or outside of contiguous (lower 48) United States? .....  Yes  No
  - g. Participate in scuba diving greater than 75 ft or more than 10 dives per year? .....  Yes  No
  - h. Participate in auto racing, motorboat or motorcycle racing? .....  Yes  No
- 16. If applicant is active duty Military; Military Reserve or National Guard:
  - a. Are you currently serving, have orders for, or anticipate orders for, any hazardous job duties or war zone territory?.....  Yes  No
- 17. Have both of your parents died prior to age 45 from complications of heart disease, cerebral vascular accidents (strokes), cancer or chronic kidney disease? .....  Yes  No

X. ADDITIONAL INFORMATION

- 18. Are you taking any medication for any impairment or disease listed in Section VIII? .....  Yes  No
- 19. In the last 12 months, have you used any tobacco or nicotine products such as smoking cigarettes, pipes or cigars, using snuff or chewing tobacco, or a nicotine delivery device such as a patch, gum or lozenge? .....  Yes  No
- 20. Have you applied for life insurance with any other insurance companies in the last 2 years? .....  Yes  No
- 21. Do you believe that this life insurance policy is appropriate for your financial situation based on your income, net worth, funds, and retirement considerations? .....  Yes  No

**XI. COMPLETE SECTION IF ANY INSURED IS UNDER 18 AND CHILD RIDER IS APPLIED FOR. IF ANY QUESTION IS ANSWERED YES, NO CHILD COVERAGE CAN BE ISSUED.**

Name of Child (First, Middle, Last)	<input type="checkbox"/> Male <input type="checkbox"/> Female	Date of Birth (mm/dd/yyyy)	Age	Place of Birth (State and Country)
Name of Child (First, Middle, Last)	<input type="checkbox"/> Male <input type="checkbox"/> Female	Date of Birth (mm/dd/yyyy)	Age	Place of Birth (State and Country)

1. Has any child 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) .....  Yes  No
2. Has any child ever been diagnosed by a member of the medical profession or taken medication for any neuromuscular disease, cerebral palsy, multiple sclerosis, muscular dystrophy, internal cancer, diabetes, cardio-vascular disease, kidney disease? .....  Yes  No
3. Does any child have paralysis of 2 or more extremities, or any heredity or congenital defects? .....  Yes  No

Each of the undersigned: Declares that all answers in this application are true and complete to the best of their knowledge and belief, and understands that: (a) all statements and answers in this application will be relied upon by the Company to determine insurability and to issue the policy; (b) no information will be considered given to the Company unless it is stated in the application; (c) the agent does not have the Company's authorization to accept risk, pass on insurability, or make, void, waive, or change any conditions or provisions in the application, policy or receipt, as applicable; and (d) a material misrepresentation may void the policy during the contestable period. This policy will take effect when: (1) the application is approved at National Western's Office in Austin, Texas; (2) National Western delivers the policy; (3) the initial premium has been paid; and (4) each of the prior three conditions is satisfied while the proposed insureds are alive and their health and insurability are as described herein.

Proposed Insured: I authorize any licensed physician, medical practitioner, hospital, other health care provider, veterans administration, pharmacy benefit manager, pharmacy, consumer reporting agency, insurance support organization, laboratory, insurance company, reinsuring company or the MIB, Inc., formerly known as Medical Information Bureau, or other organization or person to give any information about me or my mental or physical health to the Company and/or its authorized agents to determine my eligibility for life insurance coverage. The Company may disclose such information to its reinsurers and the MIB, Inc. National Western or its reinsurers may also release such information to other life or health insurance companies to whom an application for insurance or to whom a claim for benefits is submitted. This authorization also applies to any member of my family proposed for coverage in the application and is valid for 2 years after the date shown below. A photocopy of this form is as valid as the original. I may have a copy of this form upon request.

Each of the undersigned acknowledges receipt of the Notice under the Fair Credit Reporting Act (Consumer Report Notice), MIB Disclosure Notice, and Notice of Information Practices (if applicable).

**FRAUD WARNING: 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.**

Signed at \_\_\_\_\_ Date \_\_\_\_\_  
City and State

\_\_\_\_\_  
 Signature of Proposed Insured (parent if age 17 or less)

\_\_\_\_\_  
 Signature of Owner if other than Proposed Insured  
 (If a Trust, signature of trustee)  
 (If business or corporation, officer, other than Proposed insured, and Title)

\_\_\_\_\_  
 Agent Name (please print) License No.

\_\_\_\_\_  
 Signature of Agent

**AGENT REPORT**

1. How long have you known the Proposed Insured? \_\_\_\_\_ Are you related?  Yes  No If yes, How? \_\_\_\_\_
2. Did you personally see the Proposed Insured(s) and complete the application in his and/or her presence? .....  Yes  No  
If No, please explain: \_\_\_\_\_
3. Are you aware of any information about any of the Proposed Insured(s) that might affect his/her insurability? .....  Yes  No  
If Yes, give details: \_\_\_\_\_
4. Will the policy applied for replace or change any existing life insurance or annuity? .....  Yes  No
5. Do you have any knowledge or reason to believe:
  - a. that the Proposed Insured or Owner is considering assigning or transferring any rights or interest in this policy to an unrelated third party such as a Life Settlement company, Viatical, Investor, trust, bank, lending institution or other third party? .....  Yes  No
  - b. that any of the initial or future premiums will be borrowed, loaned or otherwise financed? .....  Yes  No
  - c. that the Proposed Insured or Owner has taken or been offered any incentive, financial or other, or been offered free insurance as an inducement to purchase this policy? .....  Yes  No

I certify that:

- a. the insurance being applied for is suitable for the Proposed Insured's needs and financial objectives
- b. the consumer notices were delivered to the Proposed Insured or Owner;
- c. all questions on the application were asked of each Proposed Insured, and the answers were recorded as given, prior to the application being signed;
- d. the temporary insurance agreement was explained fully and (if applicable), the receipt was given.
- e. the answers given in this application and Agent's Report are complete and accurate to the best of my knowledge and belief

Date \_\_\_\_\_ Agent Signature \_\_\_\_\_ Print Agent Name \_\_\_\_\_

**Licensed agent(s) to receive commissions (please print)**

Name of Agent	Agent No.	Percent of commission	Agent phone #	Agent Email address
1. _____	_____	_____	_____	_____
2. _____	_____	_____	_____	_____
3. _____	_____	_____	_____	_____

**TEMPORARY INSURANCE AGREEMENT & RECEIPT**

This agreement shall be void if altered or modified. • Premium checks must be made payable to National Western Life.

Proposed Insured \_\_\_\_\_ Amount Paid \$ \_\_\_\_\_ Application Date \_\_\_\_\_

Subject to all terms and conditions of the insurance policy applied for in this application, this Temporary Insurance Agreement & Receipt (TIA) provides Temporary Insurance in the amount of the lesser of: (a) the amount of insurance applied for; or (b) \$50,000 on each proposed insured; or (c) \$250,000 in the aggregate for all insureds listed on the application. This Temporary Insurance will take effect and end as defined below.

I have read this Temporary Insurance Agreement & Receipt and it has been explained to me by the agent. I understand and agree to all conditions and limitations. Proposed owner's signature \_\_\_\_\_ Date \_\_\_\_\_

I explained and witnessed the signing of this Agreement.

01-9064-11 Receipt Agent's signature \_\_\_\_\_ Date \_\_\_\_\_

Temporary Insurance will take effect on the date that the following four requirements are met: (1) the application is fully completed, including any amendments required by National Western; (2) the initial premium has been paid; and (3) all medical exams or tests required by National Western are completed; and (4) as of the date of this Agreement, the proposed insured must be insurable at standard rates for the type and amount of insurance applied for.

Temporary Insurance will end on the earliest of the following dates: (1) the date insurance begins under the policy applied for; (2) the date this application is cancelled or declined; or (3) 60 days have passed since the date of this application.

**DETACH AND LEAVE WITH APPLICANT  
(DO NOT SEND TO NATIONAL WESTERN)**

Date \_\_\_\_\_

NOTICE UNDER THE FAIR CREDIT REPORTING ACT. This is to inform you that, as part of our procedure for processing your application for insurance, an investigative consumer report may be prepared whereby information is obtained through personal interviews with your neighbors, friends, or others with whom you are acquainted. This inquiry includes information as to your character, general reputation, personal characteristics and mode of living. None of the information described in this paragraph will be used to establish, or aid in establishing, the proposed insured's sexual orientation. You have the right to make a written request within a reasonable period of time to receive additional, detailed information about the nature and scope of this investigation.

MIB DISCLOSURE NOTICE. Information regarding your insurability will be treated as confidential; however, we or our reinsurers may make a brief report thereon to the MIB, Inc., formerly known as Medical Information Bureau, a not-for-profit membership 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 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 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. We or our reinsurers may also release information to other life or health insurance companies to whom you may (1) apply for life or health insurance, or (2) submit a claim for benefits. Information for consumers about MIB may be obtained on its website at [www.mib.com](http://www.mib.com).

NOTICE OF INFORMATION PRACTICES. Residents of Arizona, California, Connecticut, Georgia, Illinois, Maine, Massachusetts, Minnesota, Montana, New Mexico, Nevada, New Jersey, North Carolina, Ohio, Oregon and Virginia must be given and sign an Authorization to Obtain and Disclose Information and Notice of Information Practices [SU-6412(current version)]. New Mexico residents are to use SU-6412-NM(current version).

**Proposed Primary Insured** \_\_\_\_\_

**I. OTHER INSURED (Please Print Clearly Using Black Ink)**

Name (First, Middle, Last)	Date of Birth (mm/dd/yyyy)	Age	Place of Birth (State and Country)	SSN
<input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Tobacco Use <input type="checkbox"/> Tobacco Free				
Residence Address (street and number)	City	State	Zip	Home Phone
Business Phone				
Face Amount	Relationship to Primary Insured			
Occupation and Duties _____				
Citizenship <input type="checkbox"/> U.S. Citizen <input type="checkbox"/> Other				
If Non US Citizen: Type of Visa _____		Exp date _____	Country of Citizenship _____	
Drivers License # and State _____				

**II. BENEFICIARY INFORMATION (If percentages are not given, the shares will be divided equally)**

<b>Primary Beneficiaries</b>		
Full Name	Relationship	% Share
1. _____		
2. _____		
<b>Contingent Beneficiaries</b>		
Full Name	Relationship	% Share
1. _____		
2. _____		

**III. OTHER COVERAGE AND REPLACEMENT**

1. Does the Proposed Insured have any existing life insurance or annuity policies with this company or any other company? (If yes provide details in #4).....						<input type="checkbox"/> Yes	<input type="checkbox"/> No
2. Is this policy intended to replace any existing life insurance or annuity? ..... (If yes, please submit appropriate state replacement forms)						<input type="checkbox"/> Yes	<input type="checkbox"/> No
3. Is the Proposed Owner or Proposed Insured considering using funds from an existing policy or contract to pay premiums on the Policy being applied for? (If Yes, complete the appropriate state replacement forms) .....						<input type="checkbox"/> Yes	<input type="checkbox"/> No
4. Company	Policy Number	Type of Coverage	Amt of Coverage	To be Replaced	1035 Exchange		
_____	_____	_____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No		
_____	_____	_____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No		
_____	_____	_____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No		
_____	_____	_____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No		

**IV. HEIGHT AND WEIGHT**

What is your height? \_\_\_\_\_ ft \_\_\_\_\_ in: What is your weight? \_\_\_\_\_ Lbs

**V. MEDICAL HISTORY QUESTIONS (IF ANY QUESTION IN SECTION VIII IS ANSWERED YES, NO COVERAGE CAN BE ISSUED.)**

If any question in Section V is answered yes, or height and weight is not within product guidelines, no coverage can be issued.

1. 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)? .....  Yes  No
2. Do you have any impairment, whether physical or mental, for which you need or receive assistance or supervision in performing normal activities of daily living such as bathing, continence, dressing, eating, toileting, transferring or taking medications? .....  Yes  No
3. Do you use a walker, wheelchair, motorized scooter or any medical appliance such as oxygen, respirator, or dialysis machine, or have a defibrillator implanted? .....  Yes  No
4. Have you had or been advised by a member of the medical profession to have, an organ transplant, or have you been medically diagnosed as having a terminal illness or life expectancy of 12 months or less? .....  Yes  No
5. Are you currently hospitalized, confined to a bed or nursing facility, residing in an assisted living facility or receiving hospice care? .....  Yes  No
6. Have you ever been diagnosed, treated, tested positive for, or been given medical advice by a member of the medical profession for a disease or disorder such as:
  - a. Congestive heart failure, cardiomyopathy, cirrhosis of the liver, liver failure, kidney (renal) failure, end stage kidney disease, chronic kidney disease or renal insufficiency? .....  Yes  No
  - b. Alzheimer’s disease, dementia, memory loss, mental incapacity, schizophrenia, manic depression, bipolar disorder, brain disease, Lou Gehrig’s disease (ALS), Huntington’s disease, muscular dystrophy, cystic fibrosis, multiple sclerosis or multiple myeloma? .....  Yes  No
7. Have you:
  - a. Been diagnosed, treated, tested positive for, or been given medical advice by a member of the medical profession for diabetes prior to age 20? .....  Yes  No
  - b. Taken insulin prior to age 40? .....  Yes  No
  - c. Ever been treated for insulin shock or diabetic coma? .....  Yes  No
  - d. Been hospitalized two or more times for any diabetic complications within the last 2 years? .....  Yes  No
8. Within the past 3 years have you been diagnosed by a member of the medical profession with leukemia, lymphoma, melanoma or any internal cancer, or received chemotherapy, radiation or had surgery for any cancer (other than basal or squamous cell cancer of the skin)? .....  Yes  No
9. Other than basal cell or squamous cell cancer of the skin, have you ever had more than one occurrence of any cancer, a recurrence of any cancer, or an amputation caused by cancer or any other disease, or are you currently being treated for cancer? .....  Yes  No
10. Within the past 2 years have you:
  - a. Been diagnosed or treated by a member of medical profession for, been hospitalized for, or taken or been prescribed medication for: Chronic Obstructive Pulmonary or Lung Disease (COPD/COLD), emphysema, chronic bronchitis, respiratory failure, chronic hepatitis, liver disease, angina, stroke, transient ischemic attack (TIA), Hodgkin’s disease, cerebral palsy, Parkinson’s disease, grand mal epilepsy, systemic lupus (SLE) disease, or do you have paralysis of 2 or more extremities? .....  Yes  No
  - b. Been diagnosed or treated by a member of the medical profession for, or been hospitalized for: Heart disease, heart attack, uncontrolled high blood pressure, heart or circulatory surgery, including coronary artery bypass, angioplasty, cardiac or vascular stent placement, pacemaker or pacemaker replacement, heart valve replacement, aneurysm, or any cardiac or vascular surgery, or procedure to improve the circulation to the heart, brain or extremities? .....  Yes  No
  - c. Been confined three or more times to a hospital, nursing facility, convalescent care facility, assisted living facility, or mental care facility? .....  Yes  No
  - d. Been declined for life, health or long term care insurance? .....  Yes  No

VI. NON MEDICAL HISTORY QUESTIONS (IF ANY QUESTION IN SECTION IX IS ANSWERED YES, NO COVERAGE CAN BE ISSUED.)

- 11. Is household income under \$20,000?
12. Is proposed insured currently undergoing Chapter 7 bankruptcy or is bankruptcy not yet discharged?
13. Within the last 5 years have you:
a. Been convicted of a felony or are you currently incarcerated, on parole or probation?
b. Been treated for or been advised to have treatment for alcohol or any drugs of abuse, or attempted suicide?
14. Within the last 3 years have you been convicted of operating a vehicle while intoxicated, impaired, or under the influence or for reckless driving?
15. Within the past 2 years did you, or in the near future do you intend to:
a. Participate as a student aviation pilot?
b. Fly less than 50 hours solo or over 300 hours (excluding commercial airline pilot)?
c. Have any aviation related accident or violation?
d. Fly as a crop duster, aerobatic pilot, Search and Rescue or flown experimental aircraft?
e. Participate in hang gliding, parasailing, ultra light activity more than 10 times a year, stunt activity or over 3,000 feet in altitude?
f. Do mountain climbing excluding recreational or less than 1 day of duration or outside of contiguous (lower 48) United States?
g. Participate in scuba diving greater than 75 ft or more than 10 dives per year?
h. Participate in auto racing, motorboat or motorcycle racing?
16. If applicant is active duty Military; Military Reserve or National Guard:
a. Are you currently serving, have orders for, or anticipate orders for, any hazardous job duties or war zone territory?
17. Have both of your parents died prior to age 45 from complications of heart disease, cerebral vascular accidents (strokes), cancer or chronic kidney disease?

VI. ADDITIONAL INFORMATION

- 18. Are you taking any medication for any impairment or disease listed in Section V?
19. In the last 12 months, have you used any tobacco or nicotine products such as smoking cigarettes, pipes or cigars, using snuff or chewing tobacco, or a nicotine delivery device such as a patch, gum or lozenge?
20. Have you applied for life insurance with any other insurance companies in the last 2 years?
21. Do you believe that this life insurance policy is appropriate for your financial situation based on your income, net worth, funds, and retirement considerations?

Each of the undersigned: Declares that all answers in this application are true and complete to the best of their knowledge and belief, and understands that: (a) all statements and answers in this application will be relied upon by the Company to determine insurability and to issue the policy; (b) no information will be considered given to the company unless it is stated in an application; (c) the Company's agent does not have the Company's authorization to accept risk, pass on insurability, or make, void, waive, or change any conditions or provisions in the application, policy or receipt, as applicable; and (d) a material misrepresentation may void the policy during the contestable period. This policy will take effect when: (1) the application is approved at National Western's Office in Austin, Texas; (2) National Western delivers the policy; (3) the initial premium has been paid; and (4) each of the prior three conditions is satisfied while the proposed insureds are alive and their health and insurability are as described herein.

I authorize any licensed physician, medical practitioner, hospital, other health care provider, veterans administration, pharmacy benefit manager, pharmacy, consumer reporting agency, insurance support organization, laboratory, insurance company, reinsuring company or the MIB, Inc., formerly known as Medical Information Bureau, or other organization or person to give any information about me or my mental or physical health to the Company and/or its authorized agents to determine my eligibility for life insurance coverage. The Company may disclose such information to its reinsurers and the MIB, Inc. National Western or its reinsurers may also release such information to other life or health insurance companies to whom an application for insurance or to whom a claim for benefits is submitted. This authorization also applies to any member of my family proposed for coverage in the application and is valid for 2 years after the date shown below. A photocopy of this form is as valid as the original. I may have a copy of this form upon request.

Each of the undersigned acknowledges receipt of the Notice under the Fair Credit Reporting Act (Consumer Report Notice), MIB Disclosure Notice, and Notice of Information Practices (if applicable).

FRAUD WARNING: 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.

Signed at \_\_\_\_\_ Date \_\_\_\_\_
City and State

Signature of Proposed Other Insured

Signature of Owner

Agent Name (please print)

License No.

Signature of Agent



**TEMPORARY INSURANCE AGREEMENT & RECEIPT**

This agreement shall be void if altered or modified. • Premium checks must be made payable to National Western Life.

Proposed Insured \_\_\_\_\_ Amount Paid \$ \_\_\_\_\_ Application Date \_\_\_\_\_

Subject to all terms and conditions of the insurance policy applied for in this application, this Temporary Insurance Agreement & Receipt (TIA) provides Temporary Insurance in the amount of the lesser of: (a) the amount of insurance applied for; or (b) \$50,000 on each proposed insured; or (c) \$250,000 in the aggregate for all insureds listed on the application. This Temporary Insurance will take effect and end as defined below.

I have read this Temporary Insurance Agreement & Receipt and it has been explained to me by the agent. I understand and agree to all conditions and limitations. Proposed owner's signature \_\_\_\_\_ Date \_\_\_\_\_

I explained and witnessed the signing of this Agreement.

01-9065-11 Receipt Agent's signature \_\_\_\_\_ Date \_\_\_\_\_

Temporary Insurance will take effect on the date that the following four requirements are met: (1) the application is fully completed, including any amendments required by National Western; (2) the initial premium has been paid; and (3) all medical exams or tests required by National Western are completed; and (4) as of the date of this Agreement, the proposed insured must be insurable at standard rates for the type and amount of insurance applied for.

Temporary Insurance will end on the earliest of the following dates: (1) the date insurance begins under the policy applied for; (2) the date this application is cancelled or declined; or (3) 60 days have passed since the date of this application.

**DETACH AND LEAVE WITH APPLICANT  
(DO NOT SEND TO NATIONAL WESTERN)**

Date \_\_\_\_\_

NOTICE UNDER THE FAIR CREDIT REPORTING ACT. This is to inform you that, as part of our procedure for processing your application for insurance, an investigative consumer report may be prepared whereby information is obtained through personal interviews with your neighbors, friends, or others with whom you are acquainted. This inquiry includes information as to your character, general reputation, personal characteristics and mode of living. None of the information described in this paragraph will be used to establish, or aid in establishing, the proposed insured's sexual orientation. You have the right to make a written request within a reasonable period of time to receive additional, detailed information about the nature and scope of this investigation.

MIB DISCLOSURE NOTICE. Information regarding your insurability will be treated as confidential; however, we or our reinsurers may make a brief report thereon to the MIB, Inc., formerly known as Medical Information Bureau, a not-for-profit membership 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 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 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. We or our reinsurers may also release information to other life or health insurance companies to whom you may (1) apply for life or health insurance, or (2) submit a claim for benefits. Information for consumers about MIB may be obtained on its website at [www.mib.com](http://www.mib.com).

NOTICE OF INFORMATION PRACTICES. Residents of Arizona, California, Connecticut, Georgia, Illinois, Maine, Massachusetts, Minnesota, Montana, New Mexico, Nevada, New Jersey, North Carolina, Ohio, Oregon and Virginia must be given and sign an Authorization to Obtain and Disclose Information and Notice of Information Practices [SU-6412(current version)]. New Mexico residents are to use SU-6412-NM(current version).



SERFF Tracking Number: NAWS-127957821 State: Arkansas  
Filing Company: National Western Life Insurance Company State Tracking Number:  
Company Tracking Number: 01-3146-11, 01-3147-11, 01-3148-11, 01-9064-11, 01-9065-11 ACCELERATED BENEFIT RIDERS AND LIFE APPLICATIONS  
FOR TERM POLICIES  
TOI: L08 Life - Other Sub-TOI: L08.000 Life - Other  
Product Name: 01-3146-11, 01-3147-11, 01-3148-11, 01-9064-11, 01-9065-11 ACCELERATED BENEFIT RIDERS AND LIFE APPLICATIONS  
FOR TERM POLICIES  
Project Name/Number: 01-3146-11, 01-3147-11, 01-3148-11, 01-9064-11, 01-9065-11 ACCELERATED BENEFIT RIDERS AND LIFE APPLICATIONS  
FOR TERM POLICIES/01-3146-11, 01-3147-11, 01-3148-11, 01-9064-11, 01-9065-11

ActDescrSample 01-3147-11.pdf

ActDescrSample 01-3148-11.pdf

Chronic Sample.pdf

Critical Sample.pdf

Terminal Sample.pdf

**NATIONAL WESTERN LIFE INSURANCE COMPANY**  
**NAIC COMPANY NUMBER 66850**  
**FLESCH READING EASE TEST SCORE CERTIFICATE**  
Accelerated Death Benefit for Chronic Illness Rider, Form 01-3146-11  
Accelerated Death Benefit for Critical Illness Rider, Form 01-3147-11  
Accelerated Death Benefit for Terminal Illness Rider, Form 01-3148-11

I hereby certify the following:

1. The Flesch Reading Ease Test score is as indicated below.
2. The form is printed, except for specifications pages, schedules and tables, in not less than ten point type.
3. The number of words contained in the text is as indicated below.
4. The entire form was analyzed.

<b><u>Form No.</u></b>	<b><u>Flesch Score</u></b>	<b><u>Words</u></b>
01-3146-11 (scored with 01-1157-09)	50	5,472
01-3147-11 (scored with 01-1157-09)	55	6,253
01-3148-11 (scored with 01-1157-09)	52	4,533



Paul D. Facey, FSA, MAAA  
Senior Vice President – Chief Actuary



January 6, 2012

Mr. Jay Bradford  
Arkansas Department of Insurance Insurance Commissioner  
1200 West Third Street  
Little Rock, Arkansas 72201-1904

Re: Accelerated Death Benefit for Chronic Illness Rider, Form 01-3146-11  
Accelerated Death Benefit for Critical Illness Rider, Form 01-3147-11  
Accelerated Death Benefit for Terminal Illness Rider, Form 01-3148-11  
Application for Individual Life Insurance, Form 01-9064-11  
Application for Other Insured Rider, Form 01-9065-11  
National Western Life Insurance Company, NAIC 66850, FEIN 84-0467208

To Whom It May Concern:

Please find attached the above captioned forms submitted for review and approval. These forms are new and will not replace any previously approved forms. This filing contains no unusual or possibly controversial items from normal industry standards. The forms will be used with previously approved term life policy form 01-1157-09-AR approved for use on November 9, 2009; and level term life policy form 01-1123L-01-AR approved for use on October 28, 2011.

These three accelerated benefit riders are added to the above mentioned term life policies at no charge and with no premium. These three riders cover both the primary insured and any other insureds on the policy. Each insured may accelerate up to 90% of their coverage (primary insured Face Amount, or other insured Insurance Benefit) with additional stipulations.

Form 01-3146-11 is a Chronic Illness Rider and will pay an accelerated benefit for illnesses which cause the insured or other insured to be confined to an institution, or causes them to be unable to perform some activities of daily living.

Form 01-3147-11 is a Critical Illness Rider and will pay an accelerated benefit for illnesses for which the insured or other insured requires extreme medical intervention, or for which their life expectancy may be shortened.

Form 01-3148-11 is a Terminal Illness Rider and will pay an accelerated benefit for illnesses for with the insured or other insured is not expected to live beyond twenty-four months.

Thank you for your time and consideration in this matter. If you have any questions or need more information, please feel free to contact me by email at [SFoskitt@NationalWesternLife.com](mailto:SFoskitt@NationalWesternLife.com) or by phone at 512-719-1563.

Sincerely,

A handwritten signature in black ink that reads "SFoskitt". The signature is written in a cursive, flowing style.

Stephanie Foskitt  
Contract Compliance Analyst

We reserve the right to change the format of this form without changing any of the language. Printing standards will never be less than those required.