Clear Form Clear Kit

North American Company
for Life and Health Insurance
Since 1886

L3187ALAR

Application for Policy Conversion, Change, or Reinstatement

1. Instructions/Information
   - Answer Medical/Insurability questions if: (a) reinstating; (b) increasing face amount; (c) adding benefits or riders; (d) requesting change to non smoker status (or if original plan did not distinguish between smokers and non-smokers and non-smoker rates are desired.); (e) Death Benefit Option; (f) rating reduction/removal; and (g) Exchanging.
   - Must remit full modal premium or EFT authorization to complete the change.
   - Be certain to obtain Owner's signature.

Section A - To be completed for ALL requests. Check appropriate box.

☐ **Change** ☐ **Review Rating** ☐ **Reinstatement** ☐ **Conversion** ☐ **Class Change**
☐ **Increase** ☐ **Add Rider** ☐ **Decrease** ☐ **Option Change** ☐ **Exchange**

EXISTING COVERAGE: ☐ UNIVERSAL LIFE ☐ INDEX UNIVERSAL LIFE ☐ WHOLE LIFE ☐ TERM ☐ RIDER

Policy Number

PRIMARY PROPOSED INSURED

2. Last Name | First Name | Middle Initial

2a. Are you a U.S. Citizen or do you have a permanent Visa? ☐ Yes ☐ No

Sex: ☐ Male ☐ Female	Date of Birth	Age	Place of Birth – State / Country	Height (FT. IN)	Weight (LBS.)	Marital Status

Social Security Number	Driver's License Number	Expiration Date	State

3. RESIDENCE ADDRESS Street City State Zip Code

3 a. How long at this address? (If less than 2 years, provide previous address.)

_____ Years _____ Months

3b. BILLING ADDRESS (If other than residence) Street City State Zip Code

3c. SECONDARY ADDRESS Street City State Zip Code

4. Employer (Company Name and Address)

Occupation (Title and Duties)	Net Income $	Annual Income $	Net Worth $

5. CONTACT THE PROPOSED INSURED AT:
☐ RESIDENCE
_____ (CST) ☐ AM ☐ PM
☐ BUSINESS

RESIDENCE TELEPHONE NUMBER
Primary Insured ( ) _____
Additional Insured ( ) _____
Cell Phone ( ) _____

BUSINESS TELEPHONE NUMBER
Primary Insured ( ) _____
Additional Insured ( ) _____
Cell Phone ( ) _____

Section B – To be completed for Changes and Conversions

6. Death Benefit Option
☐ Level ☐ Increasing ☐ Return of Premium

For Conversions, the balance of the Plan or Rider is to be:
☐ continued in force ☐ terminated ☐ decreased

Telemed: ☐ Yes ☐ No

Name of New Plan	New Policy Date	$ Amount of Insurance
	_____ Mo. _____ Yr.	

For Applicable Products Only:
☐ Guideline Level Premium Test
☐ Cash Value Accumulation Test

☐ Non-Smoker ☐ Preferred Smoker ☐ Preferred Tobacco ☐ Preferred Non-Tobacco
☐ Standard Non-Tobacco ☐ Smoker ☐ Standard Tobacco ☐ Super Preferred Non-Tobacco
☐ Preferred Plus Non-Tobacco

Exchange Commission Option: ☐ A ☐ B

6a. In the boxes below, enter the amount of changes only. NOTE: The Total Amount/Units column should reflect the new TOTAL after the change.

RIDER/BENEFIT	ADD	DELETE	TRANSFER	INCREASE BY	DECREASE BY	CONVERT	OTHER	Total Amount
Base Plan *								
CTR								
Chronic Illness Rider								
AIR								
WP								
WoSC								
ADB								
WMD								
PGR								
GIR/OPAI								
ABE								
AIO (Term Only)								
Other								

(CTR) Childrens Rider
(AIR) Add'l Insured Rider
(WP) Waiver of Premium
(WoSC) Waiver of Surrender Charge
(ADB) Accidental Death Benefit
(WMD) Waiver of Monthly Deduction
(PGR) Premium Guarantee Rider
(GIR) Guaranteed Insurability Rider / (OPAI) Option to Purchase Add'l Insurance
(ABE) Accelerated Benefit Endorsement
(AIO) Additional Insurance Option

* Please review your policy contract as a decrease may result in a surrender charge being assessed.

ADDITIONAL INSURED PROPOSED FOR INSURANCE (Complete Separate Application for Business Associates and Multiple/Additional Insureds)

7. Last Name | First Name | Middle Initial

7a. Are you a U.S. Citizen or do you have a permanent Visa? ☐ Yes ☐ No

Sex: ☐ Male ☐ Female	Date of Birth	Age	Place of Birth – State / Country	Height (FT. IN)	Weight (LBS.)	Relationship to Insured

Social Security Number	Driver's License Number	Expiration Date	State

8. Employer (Company Name and Address)

Occupation (Title and Duties)	Annual Income $

9. DEPENDENT CHILDREN PROPOSED FOR INSURANCE

Name	Date of Birth	Place of Birth State/Country	Age	Sex	Social Security Number	Height (FT. IN)	Weight (LBS.)	Relationship To Proposed Insured

10. OWNER INFORMATION (Complete only if other than Primary Insured)

NAME OF OWNER(S) If Trust, list all Trustees as well as Name and Date of Trust and complete Trust Form.

OWNER ADDRESS Street | City | State | Zip Code

Relationship to Primary Insured	Owner's Social Security Number or Tax ID #

11. PRIMARY BENEFICIARY If percentage shares are not listed below, they will be divided equally among the beneficiaries. Provide Beneficiary(ies) Full Name(s). (If Trust, list Name and Date of Trust and complete Trust Form.)

Name	Percent	Relationship to Primary Insured	Social Security Number or Tax ID #
Total	100		

NOTE: PRIMARY BENEFICIARY designations do not apply to others covered under Family/Children's insurance riders.

12. CONTINGENT BENEFICIARY If percentage shares are not listed below, they will be divided equally among the beneficiaries. Provide Beneficiary(ies) Full Name(s). (If Trust, list Name and Date of Trust and complete Trust Form.)

Name	Percent	Relationship to Primary Insured	Social Security Number or Tax ID #
Total	100		

13. Has anyone proposed for insurance ever smoked cigarettes, cigars, pipes, or used tobacco in any form, including smokeless tobacco, nicotine patch, gum, or other substitutes?

13a. Primary Insured: ☐ Yes ☐ No If "yes", provide: Type of product(s) used: _____
Amount Used: _____ How Often: Daily ___ Weekly ___ Monthly ___ Date of last use: mm/yy _____

13b. Additional Insured Rider: ☐ Yes ☐ No If "yes", provide: Type of product(s) used: _____
Amount Used: _____ How Often: Daily ___ Weekly ___ Monthly ___ Date of last use: mm/yy _____

PREMIUM INFORMATION

14. Premium Frequency: ☐ Annual ☐ Semi-Annual ☐ Quarterly ☐ Monthly ☐ Single Pay ☐ Lump Sum $_____
Premium Mode: ☐ EFT ☐ List Billing ☐ Direct Billing (A, SA, Q) Only ☐ Civil Service Allotment ☐ Military Government Allotment
Other _____ List Bill Code _____

For term and whole life policies, if you elect to pay premium on a basis other than annual, you may pay more premium than would be required if you paid premium on an annual basis.

Amount of Modal Premium $ Amount Paid with Application $

Make all checks payable to: NORTH AMERICAN COMPANY FOR LIFE AND HEALTH INSURANCE

15. FOR EFT ONLY: DRAW DATE ____ ____ (1ST –28TH) Month Day	ACCOUNT TYPE ☐ Checking (attach voided check)	AUTHORIZED SIGNATURE(S) OF ACCOUNT HOLDER(S) X
15a. Initial Draft ☐ Yes ☐ No	☐ Savings (must completed 15b)	X
15b. Routing Transit Number	Account Number	Financial Institution Name and Address

REPLACEMENT INFORMATION

16. Does any person proposed for coverage have any life insurance or annuities currently in force or pending? ☐ Yes ☐ No If Yes, list below and complete applicable replacement form and submit with application.
(This includes policies that have or will be sold, assigned or otherwise placed via life settlement, viatical or other agreements, or that you intend to replace, cancel, or sell.)

Name	Company	Policy Number	Pending	Issue Yr.	Basic Amount	ADB Amount	WP Amount	Intention of Replacement Or Change *
16a.			☐					17a. ☐ Yes ☐ No
16b.			☐					17b. ☐ Yes ☐ No
16c.			☐					17c. ☐ Yes ☐ No
16d.			☐					17d. ☐ Yes ☐ No

* Replacement means that the insurance applied for may replace, change or use any value of an existing or pending life insurance policy or annuity. Also complete Section 18. below. If this is a 1035 Exchange, also complete 1035 Exchange paperwork and submit with application.

18. I(We) originally purchased the above insurance on or around (date):	Please print the name of the Agent that you bought the original insurance from, if known.	
Approximate net value to be received from exchange product: $ _____	Surrender charge that may be incurred on This transaction: $ _____	Front End Load (if any) at time of original product purchase: $ _____ or _____ %
It is my (Our) intention to reinvest the net value Received from this transaction into: ☐ Universal Life ☐ Indexed Life ☐ Other	Will this transaction result in a taxable event? ☐ Yes ☐ No	Does this transaction qualify as a non-taxable exchange under IRS Section 1035 rules? ☐ Yes ☐ No If yes, complete 1035 Exchange paperwork.

The reason for changing the product MUST be provided! Please be specific and clearly show the advantages of this transaction to the policyholder.

I (We) have discussed and understand the option of transferring my (Our) contract fund. I (We) understand, I (We) may pay a surrender charge on my (Our) original purchase and that, when I (We) purchase a new product that the surrender charge and other applicable product provisions will start anew. In the event the new policy is not accepted during the free look period, all value will be returned to the original policy and treated in accordance with its provisions.

19. Are any of the above policies being used to fund this policy? ..... ☐ Yes ☐ No
20. Has, or will, any person proposed for insurance, or owner of this policy, been compensated in any way to purchase this policy? ..... ☐ Yes ☐ No
21. Is the proposed insured(s), or owner of this policy, paying for this policy with his/her own funds? ..... ☐ Yes ☐ No
22. Have you entered into any other agreement in regard to this policy which arranges a settlement agreement with a particular investor or lender? ..... ☐ Yes ☐ No

If the answer is 'Yes' to questions 19, 20, or 22 provide details below. If answer to question 21 is 'No' provide details below. In addition to providing details, complete the applicable Disclosure and Acknowledgement Form and submit with the application.

TO BE COMPLETED BY SOLICITING AGENT

Does any person covered under this application have any existing life insurance or annuities? ..... ☐ Yes ☐ No
Is any insurance applied for in this application intended to replace any existing life insurance or annuity? ..... ☐ Yes ☐ No
If the policy being applied for includes an accelerated death benefit(s), the agent provided the Proposed Primary Insured the Accelerated Benefit Summary and Disclosure Statement(s) prior to or concurrent with this application? ..... ☐ Yes ☐ No
Complete the applicable Replacement Notice and submit with the application.

23. SPECIAL REQUESTS OR DETAILS

TO BE COMPLETED FOR MILITARY PERSONNEL (Including National Guard and Reserves)

24. Permanent Home of Record — Street — City — State — Zip Code

25. Military Address — Street — City — State — Zip Code

26. Job Duties

27. Are you currently drawing extra duty or hazard pay? ☐ Yes ☐ No

28. Military Information ☐ USA ☐ USN ☐ USAF ☐ Other (Specify) _____ Military ID _____
Pay Grade _____ Rotation Date _____ Expected Discharge Date _____

29. Has the Proposed Insured, applied to be a member of, or been a member of a special forces, special or hazardous duty organization? ☐ Yes ☐ No
If Yes, provide specific details.

30. Has the Proposed Insured been alerted to, volunteered for, or received formal orders to a hazardous area or overseas assignment? ☐ Yes ☐ No
If Yes, provide specific details.

UNDERWRITING QUESTIONS

Questions for 31 must be completed for ALL Proposed Insureds, including CTR. Details to "Yes" answers are to be provided in the Details Section below.

31. Has any person proposed for insurance:	Yes	No
(a) In the past 10 years used barbiturates, hallucinatory drugs, narcotics including crack, ecstasy, opium derivatives, marijuana, LSD, PCP, or any derivatives of these drugs, or been advised by a licensed medical professional to get, or undergone any treatment, counseling or hospitalization for drug abuse?	☐	☐
(b) In the past 10 years been advised by a licensed medical professional to limit your alcohol use or been advised to get, or undergone any treatment or counseling or hospitalization for alcoholism, excessive alcohol use or abuse? Or, have you subsequently consumed alcohol after receiving counseling or treatment for alcohol use? Or, drink on average more than 3 alcoholic drinks per day?	☐	☐
(c) In the past 10 years had their driver's license revoked or suspended or been convicted of reckless driving, driving without a valid license, or for driving while under the influence of alcohol or drugs (DWI, DUI)?	☐	☐
(d) Had more than one speeding violation, or any motor vehicle moving violations or accidents or been arrested for driving under the influence of alcohol within the past five years?	☐	☐
(e) In the past 10 years been convicted of any criminal activity, or been held or served time in any type of incarceration, jail, penitentiary, prison, probation, or parole program? Or, have any criminal charges pending against them at this time?	☐	☐
(f) Flown a plane in the past 24 months or plan to fly in the next 12 months as a pilot, copilot, student pilot, military pilot, engineer or in any other capacity except as a regularly scheduled commercial airline pilot or fare-paying passenger?	☐	☐
(g) In the past 12 months or in the next 12 months, engaged in or plan to engage in activities including: hang gliding, skydiving, motor vehicle/cycle racing, rock climbing, ballooning, bungee jumping, mountain climbing, motor boat racing, snowmobile racing, ultra light aircraft flying, scuba diving to more than 50 feet in depth, or in caves, ship wrecks or deep seas or other extreme sports?	☐	☐
(h) In the past 10 years been refused for life insurance or charged an extra premium for life insurance?	☐	☐
(i) Traveled to or resided for more than 30 days outside of the U.S., U.S. territories, Canada, or Japan within the past 12 months or plan to travel to or reside outside of the U.S., U.S. territories, Canada, or Japan in the next 12 months?	☐	☐
(j) Have any bankruptcy pending or expect to file bankruptcy in the next 12 months?	☐	☐

DETAILS TO 'YES' ANSWERS FOR QUESTIONS FROM SECTION 31(a) THROUGH 31(j)

Question #	Proposed Insured's Name	Dates and Details

Questions 32 through 35 must be completed for ALL Proposed Insureds, including CTR, not subject to a full paramedical exam. Details to "Yes" answers are to be provided in the Details Section below.

		Yes	No
32.	In the past 10 years, has any person proposed for insurance been diagnosed by a licensed medical professional, treated or advised to get treatment from a licensed medical professional, hospitalized, or presently taking prescription(s) or medication(s) for any of the following disease(s) or disorder(s):		
	(a) Angina, chest pain, heart attack, heart failure, heart surgery, irregular heartbeat, abnormal EKG, coronary artery bypass, angioplasty, stents, peripheral vascular disease, poor circulation, valvular heart disease, cardiomyopathy or heart murmur?....	☐	☐
	(b) High blood pressure, hypertension or abnormal cholesterol levels?	☐	☐
	(c) Stroke, seizures, epilepsy, dizziness, fainting, memory disorder or any other neurological or brain disorder?	☐	☐
	(d) Multiple Sclerosis, neuritis, neuropathy, paralysis, muscular dystrophy, Parkinson's disease or any other disorder of the muscles?	☐	☐
	(e) Arthritis, chronic pain, fibromyalgia, connective tissue disease, lupus or scleroderma?	☐	☐
	(f) Cancer, malignancy, tumor, melanoma, lymphoma, Hodgkin's disease or leukemia?	☐	☐
	(g) Chronic obstructive pulmonary or lung disease, chronic bronchitis, emphysema, sarcoidosis, asthma, shortness of breath, tuberculosis or sleep apnea?	☐	☐
	(h) Diabetes, abnormal blood sugar, sugar in the urine, disease or disorders of the adrenal, parathyroid, pituitary or thyroid glands?	☐	☐
	(i) Disorder of the kidney, bladder or urinary system, abnormal PSA, abnormal pap smear without subsequent normal pap smear or protein or blood in the urine?	☐	☐
	(j) Anemia, hemophilia, clotting disorder or any other disorder of the blood?	☐	☐
	(k) Immune Deficiency disorder (Acquired Immune Deficiency Syndrome (AIDS)), AIDS related complex (ARC) or been told test results indicate exposure to the AIDS virus?	☐	☐
	(l) Colitis, ulcerative colitis, Crohn's, esophageal varices, peptic or gastric ulcer, intestinal or rectal bleeding, diverticulitis, colon polyps, cirrhosis, hepatitis, liver failure, liver impairment, loss of bowel function or other disease or disorder of the liver or pancreas?	☐	☐
	(m) Depression, anxiety, stress, eating disorder or any other nervous, mental or emotional condition?	☐	☐
	(n) Any mental or physical disorder or medically or surgically treated condition not listed above?	☐	☐
33.	Other than indicated above, has any person proposed for insurance:		
	(a) Had a parent or sibling who before age 60 was diagnosed with or died from cardiovascular disease, stroke, cancer (except basal or squamous cell cancer of the skin), Huntington's Chorea, familial polyposis or polycystic kidney disease? ..... If yes, provide age at onset and current age if living. If deceased, age at death.	☐	☐
	(b) Had a weight gain or loss of 10 or more pounds within the past 12 months for any reason other than pregnancy?	☐	☐
	(c) In the past 12 months been advised by a licensed medical professional to have a check up, EKG, X-ray, blood or urine test or any other diagnostic test or are you now planning to seek medical advise or treatment for any reason?	☐	☐
	(d) In the past 12 months been advised by a licensed medical professional to be admitted to a hospital, medical facility, nursing home or assisted living facility?	☐	☐
34.	Is any person proposed for insurance currently taking any prescription medications, herbal remedies or non-prescription medications for any disease or disorder not listed above? ..... If yes, list the medications and remedies and the reasons for which they are taken.	☐	☐
35.	Is any person proposed for insurance currently receiving or have an application pending for any illness or disability benefits or compensation?	☐	☐

DETAILS TO 'YES' ANSWERS FOR QUESTIONS 32 THROUGH 35

Question #	Proposed Insured's Name	Date, Diagnosis, Treatment, Results and Duration	Name, Address and Phone # of Attending Physician and Hospital

36. If not listed above, please provide full name, address and phone numbers of licensed medical professional(s) consulted in the past five years for each person proposed for coverage.

(a) Date and findings of last visit:

(b) Tests performed and treatment received:

CUSTOMER IDENTIFICATION			
Indicate the form of ID presented and used to verify this owner's identity:			
A. Owner #1			
Natural Person/Trust Accounts (info on trustee)			
☐ Driver's License	State:	Number:	Expiration Date:
☐ State Issued ID	State:	Number:	Expiration Date:
☐ Military ID		Number:	Expiration Date
☐ Passport	Country:	Number:	Expiration Date:
☐ Alien Registration Card	Country:	Number:	Expiration Date:
Non-Natural/Business or Corporation			
☐ Partner or Trust Agreement		Date:	
☐ Certificate of Incorporation	State:	Date:	
☐ Business License	State:	Number:	
B. Owner #2			
Natural Person/Trust Accounts (info on trustee)			
☐ Driver's License	State:	Number:	Expiration Date:
☐ State Issued ID	State:	Number:	Expiration Date:
☐ Military ID		Number:	Expiration Date
☐ Passport	Country:	Number:	Expiration Date:
☐ Alien Registration Card	Country:	Number:	Expiration Date:
Non-Natural/Business or Corporation			
☐ Partner or Trust Agreement		Date:	
☐ Certificate of Incorporation	State:	Date:	
☐ Business License	State:	Number:	

IT IS DECLARED that statements and answers in this application, including statements by the Proposed Insured(s) in any medical questionnaire or supplement that become part of this application, are complete and true to the best knowledge and belief of the undersigned. IT IS AGREED THAT: (1) any waiver or modification of this application will not be effective unless in writing and signed by the President, or the Secretary; (2) the acceptance of any policy or policy change issued on this application shall constitute a ratification of any correction or amendment made by the Company. No change in amount, classification, plan of insurance, or benefits shall be effective unless agreed to in writing by the applicant(s).The undersigned FURTHER AGREES to immediately advise the Company of any change to any of the responses contained in the application, including any change in the health or habits of any Proposed Insured(s), that arises or is discovered after completing this application, but before the Policy or policy change is effective, as defined herein.

Effective Date - Any insurance issued as a result of this application will not take effect until approved by the Company and the full first premium is paid and the contract is delivered to and accepted by the Owner during the lifetime of any person proposed for insurance and while such person is in the state of health described in all parts of this application.

The undersigned applicant(s) acknowledges receipt of the Fair Credit Reporting Act notice/MIB, Inc., Notice and Notice of Insurance of Information Practices.

TAX PAYER IDENTIFICATION NUMBER CERTIFICATION - Under penalties of perjury, I certify that:

1. The number shown on this form is my correct taxpayer identification number (or I am waiting for a number to be issued to me), and
2. I am not subject to backup withholding because: (a) ☐ I am exempt from backup withholding, or (b) ☐ I have not been notified by the Internal Revenue Service that I am subject to backup withholding as a result of a failure to report all interest or dividends, or (c) ☐ the IRS has notified me that I am no longer subject to backup withholding. (Please check appropriate response.)

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

AUTHORIZATION: To determine eligibility for insurance, the undersigned applicant(s) authorize any licensed physician, medical practitioner, health care professional, hospital, clinic, or other medically related facility, laboratory, pharmacy or pharmacy benefit manager, insurance or reinsuring company, viatical company, viatical broker or provider, the Medical Information Bureau, Inc., consumer reporting agency, insurance support organization, independent administrator, or other organization, institution, or person, or employer having information available as to diagnosis, prescription history, medications prescribed, treatment and prognosis with respect to information regarding alcoholism, drug abuse, and psychiatric care or any physical or mental condition and/or treatment of me or my minor children and any other nonmedical information of me or my minor children to give to North American Company for Life and Health Insurance (the Company) or its legal representative, any and all such information. I also authorize the Company to conduct a personal telephone interview in connection with my application; and to release any such data to its reinsurers, the Medical Information Bureau, or other persons or organizations performing business or legal services in connection with my application, or as required by law when given a copy of this authorization. I understand that I may request to be interviewed in connection with the preparation of an investigative consumer report. I understand that I am entitled to receive a copy of the investigative consumer report upon request. This authorization is valid for 30 months from the date signed. I may revoke this authorization for information not then obtained by notifying the Company in writing. Such revocation will not be effective until received by the Company. I understand that I or any authorized representative will receive a copy of this authorization upon request.

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

Accelerated Death Benefit: If the policy being applied for includes an accelerated death benefit(s), the undersigned applicant(s) understands and acknowledges: (1) Receipt of such benefits may affect eligibility for public assistance programs and benefits may be taxable; (2) Payment of this benefit will reduce the Insured's death benefit; (3) There is no additional premium for this benefit; and (4) The agent or I, the applicant was provided the Accelerated Benefit Summary and Disclosure Statement(s) prior to or concurrent with this application.

SIGNATURES					
Signed At (City, State)				Date	
Signature of Proposed Primary Insured (If 15 Years or Older), or Legal Guardian (If Primary Proposed Insured is a Minor) X		Signature of Proposed Additional Insured X			
Signature of Owner(s) (If other than Proposed Primary Insured) (If Owner is Corporation, Trust, or other Entity, include Title of Signee.) X		Spouse Consent X			
Signature of Soliciting Agent X	Print Agent's Last Name		Agent Code	Telephone Number ( ) Cell Phone Number ( )	
Other Agent (Print)	% Credit	Agent Code	General Agent (Print)		Agent Code