National Life Group®

Application

Our Vision

To Bring Peace of Mind To Everyone We Touch.

Our Mission

Keeping Our Promises.

Life Insurance Products Issued by
Life Insurance Company of the Southwest®

Experience Life®

Centralized Mailing Address: One National Life Drive, Montpelier, VT 05604 | Home Office: Addison, TX
800-732-8939 | www.NationalLife.com

8121TX(0521)K LSW
Cat. No. 46557

Basic Kit Instructions

- e-mail scanned images to nbapplicationimages@nationallife.com or retirementservices@nationallife.com for qualified pension or profit sharing plan applications.
- Form 8121, Individual Life Insurance Application, is to be used for single life products.
- Issue Age calculation for FlexLife, PeakLife, LSW Term, and all NL products should be age as of nearest birthday. All other products use age last birthday.
- For survivorship products the 8121 along with form 8122, Second Proposed Insured/Other Insured Life Insurance Application, must be used.
- If you need additional room for Remarks, you may use the 8123 form, Supplemental Information to the Application for Life Insurance.
- Any alterations or corrections on the application must be initialed by the applicant including corrections made using white out.
- Dates, agents and participation percentages must NOT be whited out or altered on applications and agent reports.
- An election box in Part L (Sales Illustration Certification) must be checked in order to say if an illustration was used or not. If the illustration was viewed on a computer screen, the Computer View Illustration Certification form must be signed, if available in your state.
- **Signatures -** Make sure that you the Agent, the Proposed Insured and the Applicant/Owner sign and date the Signatures section. If the Proposed Insured is a minor between ages 0 - 17, a parent or legal guardian must sign the application and the HIPAA form. Proposed Insureds age 18 and up need to sign the application as the Proposed Insured, also the HIPAA form and the HIV consent form.
- **Agent's Report** - 8121G must be completed and signed by you, the Agent. Be sure to include the class quoted for both insureds.
- **Premium/Bank Draft Information** - Complete Part F on form 8121.
- **ABR Disclosure** - Send one signed copy with the application and leave the other signed copy with the Applicant.
- **HIPAA Authorization** - Form must include the Proposed Insured's printed name and date of birth, then signed and dated by the Proposed Insured. If under age 18, the parent or legal guardian needs to sign and enter relationship to the Proposed Insured below signature. One signed copy is sent with the application. The other signed copy of the HIPAA form remains with the Applicant. HIPAA forms are required for all CTR Insureds.
- **HIV Consent** - Send one copy with the application. The other signed copy of the consent form should remain with the Applicant. The HIV consent form is required when blood or oral fluids are collected.
- **Interest Crediting Strategies form 8613 (LSW) / 8411 (NL)** - Required for all Indexed Universal Life products.
- **Qualified Pension or Profit Sharing Plan** - complete applications as follows:
  - **For Full Underwriting:** On form 8121 complete all Parts except Parts B, C, E, and G.
  - **For Grandfathered Simplified Underwriting or Guaranteed Issue Plans:** Use Instructions for Full Underwriting except in Part J, only complete question 4 and do no complete Part I.
  - **For Automatic Issue:** Use instructions for Full Underwriting except in Part J, only complete question 4 and do not complete Part I.
  - **For specific qualified plan forms**: Refer to separate Pension Kit, Form 20713.
- **Military Sales Disclosure form 8643** - This form is to be completed at the time of application when selling any life insurance product to any active duty member of the Armed Forces and if applicable their spouse or dependent.
- **Additional forms required when applicable:**
  - Replacement form 8027 & 1035 Exchange forms (states that have adopted the NAIC Model Regulation, the 8027 is required when there is insurance inforce, even if not replacing)
  - Employer Owned Notification & Consent form 8453
  - Avocation, Aviation & Foreign Travel Supplemental Application form 1480

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Agent's Report

Part 1 - Proposed Primary Insured Information - Please PRINT

1. Proposed Insured's Name _____
2. Did you meet with the Proposed Insured in person during the sales and application process? ☐ Yes ☐ No
3. How long have you known the Proposed Insured(s)? _____
4. Are you related? ☐ Yes ☐ No
   (If 'Yes', relationship?) _____
5. Proposed Primary Insured's
   Net Worth $ _____
   Household Income $ _____
   Household Net Worth $ _____
6. Are there existing life, disability or annuity contracts? ☐ Yes ☐ No
7. To the best of your knowledge, is this insurance intended to replace any existing coverage? ☐ Yes ☐ No
8. List any sales materials, including illustrations, used relating to the new application _____
9. Which rate class was quoted?
   Proposed Primary Insured _____
   Proposed 2nd/Other Insured _____
10. Indicate underwriting requirement(s)

PI	2nd/OIR	
☐	☐	Jump In / Term Out *(If available)* Policy Spec Pages Attached
☐	☐	No Fluid
☐	☐	Blood / Urine and Vitals (Mini-Exam)
☐	☐	Blood, Urine, Paramed Exam
☐	☐	Blood, Urine, Paramed Exam, EKG
☐	☐	Blood, Urine, Paramed Exam, EKG, Mature Assessment

   Note - Mature assessment needed at age 70 or older.
   Exam service ordered from _____
11. What is the purpose of this insurance? _____
12. How was the face amount determined? _____
13. If business insurance, please complete Business Insurance Questionnaire Form 20098.

Part 2 - Proposed Insured / Owner Information

1. To your knowledge is any Proposed Insured or the Owner receiving any loans, cash, promises of future benefit, free insurance, or other valuable consideration as an inducement to apply for or become an insured under this life insurance policy? ☐ Yes ☐ No
2. Are you aware that any Proposed Insured or the Owner has been involved in any discussions regarding transfer of ownership of the policy being applied for to a third party, such as (but not limited to) a life settlement company or investor group? ☐ Yes ☐ No

Part 3 - Owner's Information

1. Annual Income $ _____
   Net Worth $ _____
2. If Owner is a **Corporation**, what % of stock is owned by Proposed Primary Insured? _____ %
3. If Owner is a **Limited** Partnership, give name of **all** general partners *(Print names)*
   _____
   _____

Part 4 - Notes

Companion Application Name _____ Are you a Home Office Employee, Spouse or Child? ☐ Yes ☐ No

If your Agent Number is pending, please provide your email address.

Part 5 - Agent's Signature

Licensed Agent	Licensed Agent's Name *(Print)*	Percent	Agent No./Suffix	Phone & Email
Additional Agent	Name of Additional Agent *(Print)*	Percent	Agent No./Suffix	Phone & Email
Additional Agent	Name of Additional Agent *(Print)*	Percent	Agent No./Suffix	Phone & Email

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Individual Life Insurance Application

Part A - Proposed Insured Information

1. Name *(print first, middle, last)*	2. Place of Birth - State/Country	3. Sex ☐ M ☐ F

4. Home Address *(Street, City, State & Zip. If mailing address different, provide in Remarks)*	5. Date of Birth	6. Issue at Age	7. SS No.

8. Home Phone ( )	Mobile Phone ( )	Work Phone ( )	9. E-Mail Address	10a. Driver's License #	10b. State

11. Are you a citizen of ☐ USA ☐ Other Country _____	11a. Perm. Res. Card # *(include copy)*	11b. Type of VISA *(include copy)*

12. Employer & time employed	13. Occupation *(w/specific duties)*	14a. Annual Income	14b. Net Worth

Part B - Owner Information (*If a business include form 8453. If a trust include form 5213.)*

Owner is: ☐ Proposed Insured ☐ Individual ☐ Business *(LLC, LP)* ☐ Partnership ☐ Trust

1. Full Name of Owner *(if trust - provide trustees, grantor(s), date of trust agreement and trust name)*

2. Date of Birth	3. SSN or Tax ID	4. Relationship

5. Mailing Address *(Street, City, State & Zip)*	6. E-Mail Address	7. Telephone # ( )

8. Full Name of ☐ Joint Owner or ☐ Contingent Owner *(if applicable)*

8a. Date of Birth	8b. SSN or Tax ID	8c. Relationship

Survivorship Language for Ownership, unless otherwise provided: Individual owner, while living; thereafter the Proposed Insured. Joint Owners, the survivors or survivor, while living; thereafter the Proposed Insured. Business Entity, while existent; thereafter the Proposed Insured. While Trust is existent; thereafter the Proposed Insured.

Part C - Beneficiary Information *(If a trust - include trustees, trustor, date and tax ID#.)*

Primary: The beneficiary is the Owner, unless otherwise provided. *(Name, Relationship, Address, Telephone #, E-mail, DOB & SSN)*

Contingent: *(Name, Relationship, Address, Telephone #, E-mail, DOB & SSN)*

If a charitable organization, is this part of the Charitable Matching Gift Death Benefit Rider? *(FlexLife II only.)* ☐ Yes ☐ No

A deceased beneficiary's share shall be paid equally to the surviving beneficiaries of the same class, unless otherwise provided.

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NLIC: One National Life Drive, Montpelier, VT 05604 | **LSW:** 15455 Dallas Parkway, Suite 800, Addison, TX 75001

Part D - Policy Information

1a. Product Name:

1b. Company: *(Must match issuing company on Page 1.)*
☐ NLIC ☐ LSW

2. Face Amount:

3. Term Rider Plan: *(Whole Life)*

4. Term Rider Amount:
$

5. Death Benefit Option:
☐ A - Level ☐ B - Increasing

6. Definition of Life Insurance Test: *(Applies to IUL & UL only.)*
☐ Guideline Premium Test (GPT) ☐ Cash Value Accumulation Test (CVAT)

7. Use of Dividends: *(Whole Life) (Choose **only** one.)*
☐ Cash ☐ Additions ☐ Applied *(N/A with EFT)*
☐ Deposits ☐ Internal Paid-Up Insurance

☐ Flex Term Rider ***(A premium will be charged for this rider.)***
One Yr. Term + Adds = $ _____

8. Riders and Amounts:

☐ Accelerated Benefits (ABR) *(Complete ABR Disclosure form)*
☐ Accidental Death Benefit (ADB) $ _____
☐ Additional Paid Up
Rider Modal Premium (APAR) $ _____
Rider Single Premium (SPAR) $ _____
☐ Additional Protection Benefit (APB) $ _____
☐ Balance Sheet Benefit (BSB) *(% Waived)* _____ %
☐ Beneficiary Insurance Option (BIO) *(Complete 1445)*
☐ Benefit Distribution Option (BDO) *(Read the BDO Disclosure Statements in Part M.)*
1. Benefit Distribution Percentage _____ %
2. Duration of Benefit Payments _____ Years
☐ Children's Term (CTR) $ _____

☐ Guaranteed Insurability (GIO, GIR) $ _____
☐ Disability Income (DIR) ☐ 2 Yr ☐ 5 Yr $ _____
a. Do you have any disability insurance, including employer sponsored short or long-term coverage? ☐ Yes ☐ No
(If yes, give details in Remarks)
☐ Waiver of Monthly Deductions (WMD)
☐ Waiver of Premiums (WP) $ _____
(Annual Premium Waived if applicable)
☐ Other _____ $ _____
The Death Benefit Protection Rider is automatically added, if eligible.
☐ Please check this box if you do NOT want this rider. Otherwise, it will be added. There is a minimum premium associated with this rider, and the AssurePlus Protector or the IncomeBuilder product will have a monthly charge if issue age is over 50.

Part E - Children's Term Rider (CTR) - Applicable for ages 0-16 only *(Complete HIPAA for each child.)*

1. Complete the following questions for Children's Term Rider only. *(Provide Names, Dates of Birth, and SS Numbers of all Children to be covered.)*

Name:	Date of Birth	Social Security No.

2. To the best of your knowledge: *(If 'Yes', give details, including the name and address of any physician in Remarks)*

a. Has a licensed member of the medical profession diagnosed any Child as having Attention Deficit Disorder, dyslexia, autism, mental retardation, or any psychiatric disease? ☐ Yes ☐ No

b. Has a licensed member of the medical profession diagnosed or treated any Child for seizures, juvenile diabetes, scoliosis, hemophilia, cancer, or a heart, lung, or respiratory disease? ☐ Yes ☐ No

c. Does the Proposed Insured/child live with parent? ☐ Yes ☐ No

d. Does any Child take medication prescribed by a doctor? ☐ Yes ☐ No

Part F - Premium Information

1. Initial Premium Payment Method

☐ Draft Initial Premium via Electronic Funds Transfer *(EFT) (One-time payment for the planned premium amount from the bank account listed in #4.)*

Draft Day 1st - 31st _____ *(Advanced dating will occur to align the requested draft date with the effective date of your policy.)*

☐ Check with application *(Cash equivalent form 7953 is needed for cashier's checks and money orders.)*

☐ Collect payment on delivery *(No conditional coverage offered.)*

☐ Check ☐ Delayed bank draft *(pending communication from agent; using banking information from #4)*

2. Billing Information

a. Planned Periodic/Modal Premium $ _____

b. Premium Frequency ☐ Annual ☐ Semi-Annual ☐ Quarterly ☐ Monthly

c. Billing Type ☐ Automatic Payments via EFT *(From bank account listed in #4.)* Draft Day 1st - 31st _____

☐ Send Paper Bills to ☐ Owner ☐ Proposed Insured ☐ Group Bill No. _____

☐ Other *(name, street, city, state & zip)* _____

☐ Single Premium *(no bill)*

d. Source of Funds for Premium Payment

☐ Income/Savings ☐ Home Equity ☐ Payment by Third Party ☐ Loan/Premium Finance

☐ Other _____

3. Automatic Payment of Premium *(Whole life only, also known as APL. Uses loan value to pay premium.)* ☐ Yes ☐ No

4. Bank Information *(Complete if EFT is selected in Initial Premium and/or Billing Information section.)*

I authorize the National Life Group to draft payments from my account ☐ Checking ☐ Savings

Name of Bank _____ Name on Bank Account _____

Bank Routing No. *(9 digits)*

Bank Account No. *(Do not include check number.)*

☐ Please check this box if you agree that premiums may continue to be drafted if the premium amount increases by $25 or less. You will be given prior notification for any premium increases that exceed $25.

I understand that recurring premiums will be initiated on my chosen draft date, however, funds may take several days to clear my account.

Depositor's Mailing Address _____

Depositor's Email Address _____ Depositor's Phone No. _____

Depositor Signature *(If not Applicant/Owner.) (Exactly as it appears on bank records.)* _____

Part G - Juvenile Coverage - *Applicable for Ages 0-17 only* *(Complete HIPAA for each child. The entire application must be completed for minor age applicants.)*

Complete the following questions for Juvenile Coverage only:

1. Does the Proposed Insured/child live with parent? ☐ Yes ☐ No
   (*If 'No', explain in Remarks. Give name & relationship of person with whom the PI lives.)*

2. Amount of Insurance in force on Proposed Insured, the Applicant and other members of Proposed Insured's family:

	Age	Company	Amount In-Force	Amount Applied for
Applicant			$	$
Proposed Insured's father			$	$
Proposed Insured's mother			$	$
Brothers and sisters of Proposed Insured *(If none, so state)*			$	$
			$	$
			$	$

Part H - Recent Applications, Inforce Coverage, and Replacement Information *(All questions must be answered.)*

1. Do you have any inforce life insurance or annuity contracts including long term care insurance, disability income insurance or riders? *(If yes, provide details)* ☐ Yes ☐ No

Company	Policy Number	Date Issued	Amount of Coverage	ADB Coverage	To be Replaced	1035 Exchange
					☐ Yes ☐ No	☐
					☐ Yes ☐ No	☐
					☐ Yes ☐ No	☐
					☐ Yes ☐ No	☐

2. Have you ever applied for life, health, or disability insurance or reinstatement of same, which was declined, postponed, rated or modified in any way? ☐ Yes ☐ No
3. Within the past 12 months have you applied for or do you have any applications pending for life or disability insurance? ☐ Yes ☐ No
4. Is the policy or rider being applied for intended to replace any inforce life insurance or annuity contract(s) including long term care insurance, disability income insurance or riders? Replacement includes surrender, lapse, reissue, conversion, reduction in coverage, premium or period of coverage of any life, disability income or annuity contract. *(If yes, replacement forms must be provided)* ☐ Yes ☐ No
5. Is the Proposed Insured or Owner considering using funds from an inforce life or annuity contract to fund the policy or rider being applied for? *(If yes, replacement forms must be provided)* ☐ Yes ☐ No

Part I - General Information about the Proposed Insured *(If yes, provide details in Remarks)*

1. During the last 5 years have you plead guilty to or been convicted of any moving vehicle violations or DUI or have you had a suspended license? ☐ Yes ☐ No
2. Within the past 10 years, have you ever been convicted of a felony or misdemeanor? *(If 'Yes', complete form 20087.)* ☐ Yes ☐ No
3. Have you been or are you currently involved in any bankruptcy proceedings that have not been discharged? *(If 'Yes', provide type & date discharged)* ☐ Yes ☐ No
4. Do you participate in any type of racing, scuba diving, aerial sports, mountain climbing, BASE or bungee jumping, or cave exploration? *(If 'Yes', complete form 1480)* ☐ Yes ☐ No
5. Do you participate in any aviation activity other than as a fare paying passenger? *(If 'Yes', complete form 1480)* ☐ Yes ☐ No
6. During the next 2 years do you intend to travel or reside outside of the USA for more than 2 weeks in a year? *(If 'Yes', complete form 1480)* ☐ Yes ☐ No
7. Have you been offered any cash incentive or other consideration (such as free insurance) as an inducement to apply for or become an insured under this life insurance policy? ☐ Yes ☐ No
8. Have you been involved in any discussions about the possible sale or transfer of this policy to an unrelated third party, such as (but not limited to) a life settlement company or investor group? ☐ Yes ☐ No

Part J - Health History of the Proposed Insured *(Give details, dates and results for any 'Yes' questions in Remarks. Complete Part J if money was collected or authorization to draft the initial premium has been given. If an exam is required based on plan/age/amount requirements, Part J is optional.)*

1. Name and Address of Personal Physician and all other medical specialists seen, *(If none, so state)*	Date last Seen	Reason consulted & outcome

2. Height _____ Weight _____ Have you gained or lost weight during the last 12 months? *(If yes, provide details below.)* ☐ Yes ☐ No

Remarks: _____

3. Are you taking any medications? *(If yes, list type, dose, frequency and reason/diagnosis in the Remarks section.)* ☐ Yes ☐ No
4. Have you used any type of product containing tobacco or nicotine within the last five years? ☐ Yes ☐ No

   Product Type: _____ Frequency: _____ Date Last Used: _____

5. Within the past 5 years have you worked less than full time, received or applied for disability or worker's compensation? ☐ Yes ☐ No

Part J - Health History of the Proposed Insured *(Continued)*

6. In the past 10 years have you ever been diagnosed, treated, tested positive for, or been given medical advice by a member of the medical profession for: *(If yes, provide details including treating physician contact information.)*
   a. Any disease or abnormal condition of the heart, circulatory system, high blood pressure, high cholesterol, irregular heartbeat, murmur, rheumatic fever, coronary artery disease, chest pain, angina, transient ischemic attack or stroke? ☐ Yes ☐ No
   b. Any disease of the lungs or respiratory system, sleep apnea, emphysema, asthma, bronchitis, tuberculosis, allergies or disorder of the nose or throat? ☐ Yes ☐ No
   c. Any digestive system disease, including ulcer, chronic indigestion, liver, stomach, intestine or pancreas disorder, hepatitis, cirrhosis, jaundice, esophagus disorder, gallbladder disorder, or colon disorder? ☐ Yes ☐ No
   d. Any disorder of the nervous system, epilepsy, convulsions, paralysis, brain or eye disorders? ☐ Yes ☐ No
   e. Any spine, hip, knee, shoulder, back, bones, muscles, arthritis, rheumatism, joints, skin, thyroid, gout or other gland disorder? ☐ Yes ☐ No
   f. Any urinary system disease including protein, sugar or blood in urine, kidney infection or stones, disorder or disease of the breast, prostate or bladder, or pelvic organs? ☐ Yes ☐ No
   g. Any depression, anxiety, bipolar, schizophrenia, attention deficit disorder (ADD), or any other developmental or psychological condition including Alzheimer's, Dementia, or Post Traumatic Stress Disorder (PTSD)? ☐ Yes ☐ No
   h. Any anemia, hemophilia or disorders of the blood other than Acquired Immune Deficiency Syndrome (AIDS), Human Immunodeficiency Virus (HIV)? ☐ Yes ☐ No
   i. Human Immunodeficiency Virus (HIV), Acquired Immune Deficiency Syndrome (AIDS), or have you tested positive for exposure to or been diagnosed with HIV or AIDS? ☐ Yes ☐ No
   j. Any cancer, polyp, other tumors? ☐ Yes ☐ No
   k. Diabetes or high blood sugar? ☐ Yes ☐ No
   l. Amputation due to disease or other medical condition? ☐ Yes ☐ No
   m. Ataxia, transverse Myelitis, Myasthenia Gravis, Autoimmune Disorder such as Lupus, Blindness, or Post Polio Syndrome? ☐ Yes ☐ No
   n. Parkinson's disease, Muscular Dystrophy, Huntington's Chorea, Motor Neuron Disease, Lou Gehrig's Disease (ALS), or Multiple Sclerosis? ☐ Yes ☐ No
   o. For the past 5 years only: any shortness of breath, dizzy spells, unconsciousness, headaches, or memory loss? ☐ Yes ☐ No
7. In the past 10 years have you used marijuana, cocaine, heroin, or any other illicit drug or controlled substance, been advised by a physician to discontinue or reduce alcohol or drug intake, used drugs not prescribed by a physician, or been a member of a support group such as NA or AA? ☐ Yes ☐ No
8. Within the past 5 years have you:
   a. Consulted with a physician other than your personal physician or had x-rays, electrocardiograms, heart catheterization or other diagnostic tests, except those related to the Human Immunodeficiency Virus (AIDS Virus)? ☐ Yes ☐ No
   b. Been admitted to a hospital, or been advised by a member of the medical profession to enter a hospital for observation, operation or treatment of any kind? ☐ Yes ☐ No
9. Do you have any pending appointments with any medical professional? ☐ Yes ☐ No
10. Has a parent or sibling been diagnosed or treated by a health professional for cancer, heart disease, Huntington's Disease or polycystic kidney disease? ☐ Yes ☐ No
11. Do you currently:
   a. Use or require the use of any mechanical or medical devices such as: a wheelchair, walker, multi-prong cane, hospital bed, dialysis machine, respirator oxygen, motorized cart or stair lift? ☐ Yes ☐ No
   b. Need help, assistance or supervision for: bathing, eating, dressing, toileting, walking, transferring, or maintaining continence? ☐ Yes ☐ No
   c. Need help, assistance or supervision in: taking medication, doing housework, laundry, shopping or meal preparation? ☐ Yes ☐ No
12. During the past 5 years have you been diagnosed, treated, tested positive for, or been given medical advice by a member of the medical profession for: Falls, Paralysis, Numbness, Tremors, Imbalance, or any condition which causes limited motion? ☐ Yes ☐ No
13. During the past 5 years have you been diagnosed, treated, tested positive for, or been given medical advice by a member of the medical profession for: memory loss, confusion, amnesia? ☐ Yes ☐ No
14. Family History

	Age if alive	Age at death	Cause of death
Father	_____	_____	_____
Mother	_____	_____	_____

Part K - Remarks *(Provide the details to questions as requested.)*

Section & Number:	Additional Information:

Part L - Sales Illustration Certification ***(Please check one of the following boxes if applicable.)***

- ☐ An illustration was not used corresponding to the policy as applied for and will be provided upon policy delivery.
- ☐ An illustration was used and signed which corresponds with the policy as applied for and is attached.
- ☐ An illustration was **viewed** on a computer screen; and if use is allowed in this state, the "Computer View Illustration Certification" form is attached. An illustration corresponding to the policy as issued will be provided upon policy delivery. *(The Computer View Illustration Certification form is not allowed in: HI, ID, IL, MD, MI, MN, NE, NV and WA.)*

Part M - Agreement & Authorization

I represent all information in this application or an amendment, including all Social Security Numbers, and any medical exam is complete and true. I understand all such information and this application shall be part of any policy issued.

I understand and agree that all answers given above and in any medical exam are to the best of my knowledge and belief complete and true. All such answers and this application shall be part of any contract issued.

I have read the PRENOTIFICATIONS, including the notices required by the Fair Credit Reporting Act and MIB, Inc. ("MIB").

To the extent allowed by law, I waive all rights governing disclosure of medical exams or treatment. I authorize any medical practitioner or facility, insurer, MIB and any other organization or person that has any records or knowledge of me or my health to give such information to the Company or its reinsurers. I authorize the Company to request a copy of my driving record(s) from the state motor vehicle department. I understand and I authorize the Company, or its reinsurers, to make a brief report of my personal health information to MIB. This authorization is valid for 30 months (or the length of time as per state regulation) from the date signed and a photocopy shall be as valid as the original.

I also certify, under the penalties of perjury, that the Social Security Number of the Proposed Insured and Applicant/Owner (if different) is correct.

☐ I wish to be interviewed if an investigative consumer report is prepared.

The Company may make administrative corrections and changes to this application and attach them as an amendment to the policy at issue. Acceptance of any policy issued on this application will ratify and will be notice of any such change made. I understand and agree that: (1) I will notify the Company if any statement or answer given in this application changes prior to delivery and acceptance of the policy; and (2) Except as otherwise stated in any Conditional Receipt, no insurance will take effect unless the first full modal premium is paid and a policy is delivered and accepted while the health and insurability of any proposed insured continues, without material change, to be as represented in the application.

The Agent taking this application has no authority to make, change or discharge any contract hereby applied for. The Agent may not extend credit on behalf of the Company. No statement made to or information acquired by any representative of the Company shall bind the Company unless set out in writing in this application.

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

Benefit Distribution Option Rider Disclosure Statements:

- Under this rider, all or a portion of the policy's Death Benefit proceeds that become payable will be paid as a set of Benefit Payments to the Beneficiary. The Beneficiary of the policy will not be able to change the terms in which the Benefit Payments are paid out.
- A request to increase the Policy's base Face Amount in accordance with its provisions which has been underwritten and approved by us may also include a request to terminate the Benefit Distribution Option.
- In accordance with IRS rules and regulations, a portion of each Benefit Payment is reportable as interest income that may be taxable. We will annually report this interest income to the Beneficiary and the IRS as required.

Part N - Signatures

Signed at *(City & State)* _____ Date *(mm/dd/yyyy)* _____

Proposed Insured age 18 & up ***(Note: AL - Age 19, MS - Age 21)***
(Under 18, Parent or Legal Guardian)

_____

Applicant/Owner *(If Owner is other than Proposed Insured or a Minor.)*

_____

Soliciting Agent/Representative *(Sign name in full)*

_____

(Witness)

_____

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Second Proposed Insured / Other Insured Life Insurance Application

Part A - Proposed Insured Information

1. Name *(print first, middle, last)*	2. Place of Birth - State/Country	3. Sex ☐ M ☐ F

4. Home Address *(Street, City, State & Zip. If mailing address different, provide in Remarks)*	5. Date of Birth	6. Issue at Age	7. SS No.

8. Home Phone ( )	Mobile Phone ( )	Work Phone ( )	9. E-Mail Address	10a. Driver's License #	10b. State

11. Are you a citizen of ☐ USA ☐ Other Country _____	11a. Perm. Res. Card # *(include copy)*	11b. Type of VISA *(include copy)*

12. Employer & time employed	13. Occupation *(w/specific duties)*	14a. Annual Income	14b. Net Worth

15. Primary Insured	15a. Relationship	15b. SS No.

Part B - Beneficiary Information *(If a trust - include trustees, trustor, date and tax ID#.)*

Primary: The beneficiary is the Owner, unless otherwise provided. *(Name, Relationship, Address, Telephone #, E-mail, DOB & SSN)*	**Contingent:** *(Name, Relationship, Address, Telephone #, E-mail, DOB & SSN)*

A deceased beneficiary's share shall be paid equally to the surviving beneficiaries of the same class, unless otherwise provided.

Part C - Policy Information *(Other Insured complete Question 1, Face Amount, only)*

1. Face Amount _____

2. Riders and Amounts

- ☐ Accidental Death Benefit (ADB) $ _____
- ☐ Disability Income (DIR) ☐ 2 Yr ☐ 5 Yr $ _____
  - a. Do you have any disability insurance, including employer sponsored short or long-term coverage? *(If yes, give details in Remarks)* ☐ Yes ☐ No
- ☐ Estate Preservation Rider (EPR)
- ☐ Guaranteed Insurability (GIO, GIR) $ _____
- ☐ Policy Split Option (PSO)
- ☐ Survivor Protection Payment Period _____ $ _____
- ☐ Other _____ $ _____
- ☐ Other _____ $ _____

P: 800-732-8939 | www.NationalLife.com
NLIC: One National Life Drive, Montpelier, VT 05604 | **LSW:** 15455 Dallas Parkway, Suite 800, Addison, TX 75001

Part D - Juvenile Coverage - *Applicable for Ages 0-17 only* *(Complete HIPAA for each child. The entire application must be completed for minor age applicants.)*

1. Does the Proposed Insured/child live with parent? ☐ Yes ☐ No
   (*If 'No', explain in Remarks. Give name & relationship of person with whom the PI lives.)*

2. Amount of Insurance in force on Proposed Insured, the Applicant and other members of Proposed Insured's family:

	Age	Company	Amount In-Force	Amount Applied for
Applicant			$	$
Proposed Insured's father			$	$
Proposed Insured's mother			$	$
Brothers and sisters of Proposed Insured *(If none, so state)*			$	$
			$	$
			$	$

Part E - Recent Applications, Inforce Coverage, and Replacement Information ***(All questions must be answered.)***

1. Do you have any inforce life insurance or annuity contracts including long term care insurance, disability income insurance or riders? *(If yes, provide details)* ☐ Yes ☐ No

Company	Policy Number	Date Issued	Amount of Coverage	ADB Coverage	To be Replaced	1035 Exchange
					☐ Yes ☐ No	☐
					☐ Yes ☐ No	☐
					☐ Yes ☐ No	☐
					☐ Yes ☐ No	☐

2. Have you ever applied for life, health, or disability insurance or reinstatement of same, which was declined, postponed, rated or modified in any way? ☐ Yes ☐ No
3. Within the past 12 months have you applied for or do you have any applications pending for life or disability insurance? ☐ Yes ☐ No
4. Is the policy or rider being applied for intended to replace any inforce life insurance or annuity contract(s) including long term care insurance, disability income insurance or riders? Replacement includes surrender, lapse, reissue, conversion, reduction in coverage, premium or period of coverage of any life, disability income or annuity contract. *(If yes, replacement forms must be provided)* ☐ Yes ☐ No
5. Is the Proposed Insured or Owner considering using funds from an inforce life or annuity contract to fund the policy or rider being applied for? *(If yes, replacement forms must be provided)* ☐ Yes ☐ No

Part F - General Information about the Proposed Insured *(If yes, provide details in Remarks)*

1. During the last 5 years have you plead guilty to or been convicted of any moving vehicle violations or DUI or have you had a suspended license? ☐ Yes ☐ No
2. Within the past 10 years, have you ever been convicted of a felony or misdemeanor? *(If 'Yes', complete form 20087.)* ☐ Yes ☐ No
3. Have you been or are you currently involved in any bankruptcy proceedings that have not been discharged? *(If 'Yes', provide type & date discharged)* ☐ Yes ☐ No
4. Do you participate in any type of racing, scuba diving, aerial sports, mountain climbing, BASE or bungee jumping, or cave exploration? *(If 'Yes', complete form 1480)* ☐ Yes ☐ No
5. Do you participate in any aviation activity other than as a fare paying passenger? *(If 'Yes', complete form 1480)* ☐ Yes ☐ No
6. During the next 2 years do you intend to travel or reside outside of the USA for more than 2 weeks in a year? *(If 'Yes', complete form 1480)* ☐ Yes ☐ No
7. Have you been offered any cash incentive or other consideration (such as free insurance) as an inducement to apply for or become an insured under this life insurance policy? ☐ Yes ☐ No
8. Have you been involved in any discussions about the possible sale or transfer of this policy to an unrelated third party, such as (but not limited to) a life settlement company or investor group? ☐ Yes ☐ No

Part G - Health History of the Proposed Insured ***(Give details, dates and results for any 'Yes' questions in Remarks.) Complete Part G if money was collected or authorization to draft the initial premium has been given. If an exam is required based on plan/age/amount requirements, Part G is optional.)***

1. Name and Address of Personal Physician and all other medical specialists seen, *(If none, so state)*	Date last Seen	Reason consulted & outcome

2. Height _____ Weight _____ Have you gained or lost weight during the last 12 months? *(If yes, provide details below.)* ☐ Yes ☐ No

Remarks: _____

3. Are you taking any medications? *(If yes, list type, dose, frequency and reason/diagnosis in the Remarks section.)* ☐ Yes ☐ No

4. Have you used any type of product containing tobacco or nicotine within the last five years? ☐ Yes ☐ No

   Product Type: _____ Frequency: _____ Date Last Used: _____

5. Within the past 5 years have you worked less than full time, received or applied for disability or worker's compensation? ☐ Yes ☐ No

6. In the past 10 years have you ever been diagnosed, treated, tested positive for, or been given medical advice by a member of the medical profession for: *(If yes, provide details including treating physician contact information.)*

   a. Any disease or abnormal condition of the heart, circulatory system, high blood pressure, high cholesterol, irregular heartbeat, murmur, rheumatic fever, coronary artery disease, chest pain, angina, transient ischemic attack or stroke? ☐ Yes ☐ No

   b. Any disease of the lungs or respiratory system, sleep apnea, emphysema, asthma, bronchitis, tuberculosis, allergies or disorder of the nose or throat? ☐ Yes ☐ No

   c. Any digestive system disease, including ulcer, chronic indigestion, liver, stomach, intestine or pancreas disorder, hepatitis, cirrhosis, jaundice, esophagus disorder, gallbladder disorder, or colon disorder? ☐ Yes ☐ No

   d. Any disorder of the nervous system, epilepsy, convulsions, paralysis, brain or eye disorders? ☐ Yes ☐ No

   e. Any spine, hip, knee, shoulder, back, bones, muscles, arthritis, rheumatism, joints, skin, thyroid, gout or other gland disorder? ☐ Yes ☐ No

   f. Any urinary system disease including protein, sugar or blood in urine, kidney infection or stones, disorder or disease of the breast, prostate or bladder, or pelvic organs? ☐ Yes ☐ No

   g. Any depression, anxiety, bipolar, schizophrenia, attention deficit disorder (ADD), or any other developmental or psychological condition including Alzheimer's, Dementia, or Post Traumatic Stress Disorder (PTSD)? ☐ Yes ☐ No

   h. Any anemia, hemophilia or disorders of the blood other than Acquired Immune Deficiency Syndrome (AIDS), Human Immunodeficiency Virus (HIV)? ☐ Yes ☐ No

   i. Human Immunodeficiency Virus (HIV), Acquired Immune Deficiency Syndrome (AIDS), or have you tested positive for exposure to or been diagnosed with HIV or AIDS? ☐ Yes ☐ No

   j. Any cancer, polyp, other tumors? ☐ Yes ☐ No

   k. Diabetes or high blood sugar? ☐ Yes ☐ No

   l. Amputation due to disease or other medical condition? ☐ Yes ☐ No

   m. Ataxia, transverse Myelitis, Myasthenia Gravis, Autoimmune Disorder such as Lupus, Blindness, or Post Polio Syndrome? ☐ Yes ☐ No

   n. Parkinson's disease, Muscular Dystrophy, Huntington's Chorea, Motor Neuron Disease, Lou Gehrig's Disease (ALS), or Multiple Sclerosis? ☐ Yes ☐ No

   o. For the past 5 years only: any shortness of breath, dizzy spells, unconsciousness, headaches, or memory loss? ☐ Yes ☐ No

7. In the past 10 years have you used marijuana, cocaine, heroin, or any other illicit drug or controlled substance, been advised by a physician to discontinue or reduce alcohol or drug intake, used drugs not prescribed by a physician, or been a member of a support group such as NA or AA? ☐ Yes ☐ No

8. Within the past 5 years have you:

   a. Consulted with a physician other than your personal physician or had x-rays, electrocardiograms, heart catheterization or other diagnostic tests, except those related to the Human Immunodeficiency Virus (AIDS Virus)? ☐ Yes ☐ No

   b. Been admitted to a hospital, or been advised by a member of the medical profession to enter a hospital for observation, operation or treatment of any kind? ☐ Yes ☐ No

9. Do you have any pending appointments with any medical professional? ☐ Yes ☐ No

Part G - Health History of the Proposed Insured *(Continued)*

10. Has a parent or sibling been diagnosed or treated by a health professional for cancer, heart disease, Huntington's Disease or polycystic kidney disease? ☐ Yes ☐ No

11. Do you currently:
    a. Use or require the use of any mechanical or medical devices such as: a wheelchair, walker, multi-prong cane, hospital bed, dialysis machine, respirator oxygen, motorized cart or stair lift? ☐ Yes ☐ No
    b. Need help, assistance or supervision for: bathing, eating, dressing, toileting, walking, transferring, or maintaining continence? ☐ Yes ☐ No
    c. Need help, assistance or supervision in: taking medication, doing housework, laundry, shopping or meal preparation? ☐ Yes ☐ No

12. During the past 5 years have you been diagnosed, treated, tested positive for, or been given medical advice by a member of the medical profession for: Falls, Paralysis, Numbness, Tremors, Imbalance, or any condition which causes limited motion? ☐ Yes ☐ No

13. During the past 5 years have you been diagnosed, treated, tested positive for, or been given medical advice by a member of the medical profession for: memory loss, confusion, amnesia? ☐ Yes ☐ No

14. Family History

	Age if alive	Age at death	Cause of death
Father			
Mother			

Part H - Remarks *(Provide the details to questions as requested.)*

Section & Number:	Additional Information:

Part I - Agreement & Authorization

I represent all information in this application or an amendment, including all Social Security Numbers, and any medical exam is complete and true. I understand all such information and this application shall be part of any policy issued.

I understand and agree that all answers given above and in any medical exam are to the best of my knowledge and belief complete and true. All such answers and this application shall be part of any contract issued.

I have read the PRENOTIFICATIONS, including the notices required by the Fair Credit Reporting Act and MIB, Inc. ("MIB").

To the extent allowed by law, I waive all rights governing disclosure of medical exams or treatment. I authorize any medical practitioner or facility, insurer, MIB and any other organization or person that has any records or knowledge of me or my health to give such information to the Company or its reinsurers. I authorize the Company to request a copy of my driving record(s) from the state motor vehicle department. I understand and I authorize the Company, or its reinsurers, to make a brief report of my personal health information to MIB. This authorization is valid for 30 months (or the length of time as per state regulation) from the date signed and a photocopy shall be as valid as the original.

I also certify, under the penalties of perjury, that the Social Security Number of the Proposed Second Insured, Other Insured and Primary Beneficiary are correct.

☐ I wish to be interviewed if an investigative consumer report is prepared.

The Company may make administrative corrections and changes to this application and attach them as an amendment to the policy at issue. Acceptance of any policy issued on this application will ratify and will be notice of any such change made. I understand and agree that: (1) I will notify the Company if any statement or answer given in this application changes prior to delivery and acceptance of the policy; and (2) Except as otherwise stated in any Conditional Receipt, no insurance will take effect unless the first full modal premium is paid and a policy is delivered and accepted while the health and insurability of any proposed insured continues, without material change, to be as represented in the application.

The Agent taking this application has no authority to make, change or discharge any contract hereby applied for. The Agent may not extend credit on behalf of the Company. No statement made to or information acquired by any representative of the Company shall bind the Company unless set out in writing in this application.

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

Part J - Signatures

Signed at *(City & State)* _____ Date *(mm/dd/yyyy)* _____

Proposed Insured age 18 & up ***(Note: AL - Age 19, MS - Age 21)***
(Under 18, Parent or Legal Guardian)

_____

Applicant/Owner *(If Owner is other than Proposed Insured or a Minor.)*

_____

Soliciting Agent/Representative *(Sign name in full)*

_____

_____

(Witness)

For Electronic Funds Transfer (EFT) Only *(If Depositor other than Applicant/Owner)*

_____

National Life Group®

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Flexible Accumulated Value Enhancement Rider

Option Election

Insured Information

Insured's Name: _____ Policy Number: _____

Instructions

Choose one option below. The associated Interest Bonus Percentage, Maximum Interest Bonus Percentage, and any Interest Bonus Charge Percentage will apply to all Indexed Segments created going forward. The guaranteed minimum or maximum values for these percentages are shown in the policy's data section.

For After Issue business, send to: Contract Change - M305

Flexible Accumulated Value Enhancement Rider - Option Election

☐ Enhancer *(No charge)*

☐ Enhancer Plus

☐ Enhancer Max

Sign and Date

Applicant/Owner's Signature: _____ Date: _____

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Interest Crediting Strategies Allocations

Indexed Universal Life

Insured Information *(*If joint, list both Insureds)*

Insured's Name*: _____ Policy Number: _____

Instructions

The Net Premiums you pay are put into the Basic Strategy. There is a Basic Strategy Value Minimum amount which must remain within the Basic Strategy. If the Basic Strategy Value exceeds the Basic Strategy Value Minimum, the excess will be transferred into the other Strategies subject to a selection specified by you. Please specify this selection below.

Whole percentages must be used. A percentage must be at least 5%, and the total of all percentages must equal 100%.

For After Issue business, send to: Contract Change - M305

Section 1 - FlexLife, PeakLife and SurvivorLife Strategy Selection - One-Year Index Segments

Fixed-Term Strategy (105)	_____ %
S&P 500 Point-to-Point, Cap Focus (301)	_____ %
S&P 500 Point-to-Point, Participation Rate Focus (302)	_____ %
S&P 500 Point-to-Point, 1% Floor (306)	_____ %
Credit Suisse Balanced Trend Point-to-Point, No Cap (307)	_____ %
Hang Seng Point-to-Point, Cap Focus*** (305)	_____ %
	Total 100%

☐ Activate Systematic Allocations on New Premium Payments

☐ Activate Systematic Allocations on Renewing Index Segments *(applicable for one year period)***

☐ Terminate Systematic Allocations for future premiums and Renewing Index Segments *(existing SAR accounts will continue to sweep on a monthly basis until depleted)*

☐ Terminate all existing Systematic Allocation accounts on the next sweep date

***If available. Check your policy for rider availability.

Section 2 - FlexLife (2011), FlexLife II (2016) and PeakLife (2017) Strategy Selection - One-Year Index Segments

(Fixed-Term Strategy) (105)	_____ %
Point-to-Point, Cap Focus (Indexed Strategy 1) (301)	_____ %
Point-to-Point, Participation Rate Focus (Indexed Strategy 2) (302)	_____ %
Point-to-Point, No Cap (Indexed Strategy 3) (303)	_____ %
Point-to-Average, No Cap (Indexed Strategy 4) (300)	_____ %
Point-to-Point, Cap Focus, Emerging Markets (Indexed Strategy 5) (310)	_____ %
	Total 100%

☐ Activate Systematic Allocations on New Premium Payments

☐ Activate Systematic Allocations on Renewing Index Segments *(applicable for one year period)***

☐ Terminate Systematic Allocations for future premiums and Renewing Index Segments *(existing SAR accounts will continue to sweep on a monthly basis until depleted)*

☐ Terminate all existing Systematic Allocation accounts on the next sweep date

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Interest Crediting Strategies Allocations - Continued

Section 3 - SecurePlus Provider Strategy Selection - Five-Year Index Segments

(Fixed-Term Strategy) (105) _____ %

Point-to-Point, Cap Focus
(Equity Indexed Strategy 1) (107) (151) _____ %

Point-to-Average, No Cap
(Equity Indexed Strategy 2) (106) _____ %

Point-to Point, High Participation Rate Focus
(Equity Indexed Strategy 3) (154) _____ %

Point-to-Point, Cap Focus, Emerging Markets
(Equity Indexed Strategy 4) (156) _____ %

Total 100%

☐ Use Monthly Basic Strategy Value Minimum

☐ Activate Systematic Allocations on New Premium Payments

☐ Activate Systematic Allocations on Renewing Index Segments *(applicable for one year period)***

☐ Terminate Systematic Allocations for future premiums and Renewing Index Segments *(existing SAR accounts will continue to sweep on a monthly basis until depleted)*

☐ Terminate all existing Systematic Allocation accounts on the next sweep date

Section 4 - SecurePlus Paragon, SecurePlus Advantage 79 and LifeCycle Solution Strategy Selection - One-Year Index Segments

(Fixed-Term Strategy) (105) _____ %

Point-to-Point, Cap Focus
(Indexed Strategy 1) (107) _____ %

Point-to-Point, Participation Rate Focus
(Indexed Strategy 2) (108) _____ %

Point-to-Point, No Cap
(Indexed Strategy 3) (109) _____ %

Point-to-Average, No Cap
(Indexed Strategy 4) (106) _____ %

Point-to-Point, Cap Focus, Emerging Markets
(Indexed Strategy 5) (156) _____ %

Total 100%

☐ Activate Systematic Allocations on New Premium Payments

☐ Activate Systematic Allocations on Renewing Index Segments *(applicable for one year period)***

☐ Terminate Systematic Allocations for future premiums and Renewing Index Segments *(existing SAR accounts will continue to sweep on a monthly basis until depleted)*

☐ Terminate all existing Systematic Allocation accounts on the next sweep date

Sign and Date

Applicant/Owner's Signature: _____ Date: _____

**Only available after issue. Activation will be for both new premium payments and renewing index segments.

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Supplemental Information to the Application for Life Insurance

Insured's Name: _____ Social Sec. #: _____

Application Form Number: _____

Question Number:	**Application Information:** *(Specify if this information applies to the Proposed Insured, Second Proposed Insured, or Proposed Other Insured)*

Signed at *(City and State):* _____ on this day of: _____

Signature of Insured(s): _____

Signature of Applicant *(if different than Proposed Insured):* _____

Signature of Agent: _____

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Life Insurance Company of the Southwest™

Disclosure Statement for Accelerated Benefits Rider 1

Accelerated Benefits are payments made to the Owner while the Insured is living in lieu of payment of all or a portion of the death benefit that would otherwise be paid at the Insured's death. The Owner must apply for the Accelerated Benefits and must show the required proof stated in the Accelerated Benefits Rider attached to the policy that the Insured has a Terminal Illness.

Benefits may be elected under this rider if the Insured is Terminally Ill. Terminally Ill means that the Insured has been certified by a Physician as having an illness or chronic condition which can reasonably be expected to result in death in 24 months or less from the date of the certification.

The Owner may elect to accelerate all or a portion of the Insured's death benefit in force on the election date. **The Company reserves the right to set a maximum death benefit that may be accelerated under all Accelerated Benefits Riders on the life of the Insured. This maximum limit will be no less than $500,000.**

Accelerated Benefits are paid as a lump sum. The amount paid is calculated as the present value of the death benefit accelerated, less an adjustment for future premiums, and less an administrative fee. The benefit will first be used to pay a pro rata share of any outstanding debt to us. The benefit will never exceed the death benefit being accelerated. It will never be less than the cash surrender value, if any, that corresponds to the death benefit accelerated.

The Insured's death benefit in force will be reduced each time an Accelerated Benefit is paid. The reduction will equal the portion of the death benefit that is accelerated on the election date. The face amount, and any accumulated value, cash surrender value, and outstanding debt will also be reduced. Each of these will be reduced in the same proportion as the reduction in the death benefit. The premiums and charges for any remaining life coverage will be determined as if the contract had been originally issued at the reduced face amount.

Death benefits, cash values and loan values (for policies with such values) will be reduced if an Accelerated Benefit is paid.

The Accelerated Benefits offered under this rider may or may not qualify for favorable tax treatment under the Internal Revenue Code of 1986. Whether such benefits qualify depends on factors such as your life expectancy at the time benefits are accelerated or whether you use the benefits to pay for necessary long-term care expenses, such as nursing home care. If the Accelerated Benefits qualify for favorable tax treatment, the benefits will be excludable from your income and not subject to federal taxation. Tax laws relating to Accelerated Benefits are complex. You are advised to consult with a qualified tax advisor about circumstances under which you could receive Accelerated Benefits excludable from income under federal law.

Receipt of Accelerated Benefits may affect you, your spouse or your family's eligibility for public assistance programs such as medical assistance (Medicaid), Aid to Families with Dependent Children (AFDC), supplementary social security income (SSI), and drug assistance programs. You are advised to consult with a qualified tax advisor and with social service agencies concerning how receipt of such a payment will affect you, your spouse and your family's eligibility for public assistance.

Signed at: *(City & State)* _____ Date: *(mm/dd/yyyy)* _____

Licensed Agent: *(Sign name in full)* _____

Applicant/Owner: *(Sign name in full)* _____

Copies to the Company, the Customer, and the Agent

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Life Insurance Company of the Southwest™

Disclosure Statement for Accelerated Benefits Rider 1

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The Owner may elect to accelerate all or a portion of the Insured's death benefit in force on the election date. **The Company reserves the right to set a maximum death benefit that may be accelerated under all Accelerated Benefits Riders on the life of the Insured. This maximum limit will be no less than $500,000.**

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Death benefits, cash values and loan values (for policies with such values) will be reduced if an Accelerated Benefit is paid.

The Accelerated Benefits offered under this rider may or may not qualify for favorable tax treatment under the Internal Revenue Code of 1986. Whether such benefits qualify depends on factors such as your life expectancy at the time benefits are accelerated or whether you use the benefits to pay for necessary long-term care expenses, such as nursing home care. If the Accelerated Benefits qualify for favorable tax treatment, the benefits will be excludable from your income and not subject to federal taxation. Tax laws relating to Accelerated Benefits are complex. You are advised to consult with a qualified tax advisor about circumstances under which you could receive Accelerated Benefits excludable from income under federal law.

Receipt of Accelerated Benefits may affect you, your spouse or your family's eligibility for public assistance programs such as medical assistance (Medicaid), Aid to Families with Dependent Children (AFDC), supplementary social security income (SSI), and drug assistance programs. You are advised to consult with a qualified tax advisor and with social service agencies concerning how receipt of such a payment will affect you, your spouse and your family's eligibility for public assistance.

Signed at: *(City & State)* _____ Date: *(mm/dd/yyyy)* _____

Licensed Agent: *(Sign name in full)* _____

Applicant/Owner: *(Sign name in full)* _____

Copies to the Company, the Customer, and the Agent

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Disclosure Statement for Accelerated Benefits Rider 2

Accelerated Benefits are payments made to the Owner while the Insured is living in lieu of payment of all or a portion of the death benefit that would otherwise be paid at the Insured's death. The Owner must apply for the Accelerated Benefits and must show the required proof stated in the Accelerated Benefits Rider attached to the policy.

Benefits may be elected under this rider if the Insured has been certified, within the last 12 months, by a Licensed Health Care Practitioner as:

1. being unable to perform (without substantial assistance from another person) at least two Activities of Daily Living for a period of at least 90 consecutive days due to a loss of functional capacity; or
2. requiring substantial supervision for a period of at least 90 consecutive days by another person to protect oneself from threats to health and safety due to Severe Cognitive Impairment.

The Activities of Daily Living are:

- Bathing means washing oneself by sponge bath, or in a tub or shower, including the task of getting into and out of the tub or shower.
- Continence means 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 personal hygiene (including caring for a catheter or colostomy bag).
- Dressing means putting on and taking off all items of clothing and any necessary braces, fasteners, or artificial limbs.
- Eating means 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.
- Toileting means getting to and from the toilet, getting on and off the toilet, and performing associated personal hygiene.
- Transferring means having sufficient mobility for moving into or out of a bed, chair, or wheelchair or for moving from place to place, either via walking, a wheelchair, or other means.

Severe Cognitive Impairment means deterioration or loss in intellectual capacity that is measured by clinical and standardized tests which reliably measure impairment in:

1. short-term or long-term memory; or
2. orientation to people, places, or time; or
3. deductive or abstract reasoning.

Substantial Supervision means continual supervision (which may include cueing by verbal prompting, gestures, or other demonstrations) by another person that is necessary to protect a cognitively impaired individual from threats to the individual's health or safety.

The Owner may elect to accelerate all or a portion of the Insured's death benefit in force on the election date. **The Company reserves the right to set a maximum death benefit that may be accelerated under all Accelerated Benefits Riders on the life of the Insured. This maximum limit will be no less than $500,000.**

Accelerated Benefits are paid as a lump sum. The amount paid is calculated as the present value of the death benefit accelerated, less an adjustment for future premiums, and less an administrative fee. The benefit will first be used to pay a pro rata share of any outstanding debt to us. The benefit will never exceed the death benefit being accelerated. It will never be less than the cash surrender value, if any, that corresponds to the death benefit accelerated.

The Insured's death benefit in force will be reduced each time an Accelerated Benefit is paid. The reduction will equal the portion of the death benefit that is accelerated on the election date. The face amount, and any accumulated value, cash surrender value, and outstanding debt will also be reduced. Each of these will be reduced in the same proportion as the reduction in the death benefit. The premiums and charges for any remaining life coverage will be determined as if the contract had been originally issued at the reduced face amount.

Death benefits, cash values and loan values (for policies with such values) will be reduced if an Accelerated Benefit is paid.

The Accelerated Benefits offered under this rider may or may not qualify for favorable tax treatment under the Internal Revenue Code of 1986. Whether such benefits qualify depends on factors such as your life expectancy at the time benefits are accelerated or whether you use the benefits to pay for necessary long-term care expenses, such as nursing home care. If the Accelerated Benefits qualify for favorable tax treatment, the benefits will be excludable from your income and not subject to federal taxation. Tax laws relating to Accelerated Benefits are complex. You are advised to consult with a qualified tax advisor about circumstances under which you could receive Accelerated Benefits excludable from income under federal law.

Receipt of Accelerated Benefits may affect you, your spouse or your family's eligibility for public assistance programs such as medical assistance (Medicaid), Aid to Families with Dependent Children (AFDC), supplementary social security income (SSI), and drug assistance programs. You are advised to consult with a qualified tax advisor and with social service agencies concerning how receipt of such a payment will affect you, your spouse and your family's eligibility for public assistance.

Signed at: *(City & State)* _____ Date: *(mm/dd/yyyy)* _____

Licensed Agent: *(Sign name in full)* _____

Applicant/Owner: *(Sign name in full)* _____

Copies to the Company, the Customer, and the Agent

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Disclosure Statement for Accelerated Benefits Rider 2

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Benefits may be elected under this rider if the Insured has been certified, within the last 12 months, by a Licensed Health Care Practitioner as:

1. being unable to perform (without substantial assistance from another person) at least two Activities of Daily Living for a period of at least 90 consecutive days due to a loss of functional capacity; or
2. requiring substantial supervision for a period of at least 90 consecutive days by another person to protect oneself from threats to health and safety due to Severe Cognitive Impairment.

The Activities of Daily Living are:

- Bathing means washing oneself by sponge bath, or in a tub or shower, including the task of getting into and out of the tub or shower.
- Continence means 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 personal hygiene (including caring for a catheter or colostomy bag).
- Dressing means putting on and taking off all items of clothing and any necessary braces, fasteners, or artificial limbs.
- Eating means 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.
- Toileting means getting to and from the toilet, getting on and off the toilet, and performing associated personal hygiene.
- Transferring means having sufficient mobility for moving into or out of a bed, chair, or wheelchair or for moving from place to place, either via walking, a wheelchair, or other means.

Severe Cognitive Impairment means deterioration or loss in intellectual capacity that is measured by clinical and standardized tests which reliably measure impairment in:

1. short-term or long-term memory; or
2. orientation to people, places, or time; or
3. deductive or abstract reasoning.

Substantial Supervision means continual supervision (which may include cueing by verbal prompting, gestures, or other demonstrations) by another person that is necessary to protect a cognitively impaired individual from threats to the individual's health or safety.

The Owner may elect to accelerate all or a portion of the Insured's death benefit in force on the election date. **The Company reserves the right to set a maximum death benefit that may be accelerated under all Accelerated Benefits Riders on the life of the Insured. This maximum limit will be no less than $500,000.**

Accelerated Benefits are paid as a lump sum. The amount paid is calculated as the present value of the death benefit accelerated, less an adjustment for future premiums, and less an administrative fee. The benefit will first be used to pay a pro rata share of any outstanding debt to us. The benefit will never exceed the death benefit being accelerated. It will never be less than the cash surrender value, if any, that corresponds to the death benefit accelerated.

The Insured's death benefit in force will be reduced each time an Accelerated Benefit is paid. The reduction will equal the portion of the death benefit that is accelerated on the election date. The face amount, and any accumulated value, cash surrender value, and outstanding debt will also be reduced. Each of these will be reduced in the same proportion as the reduction in the death benefit. The premiums and charges for any remaining life coverage will be determined as if the contract had been originally issued at the reduced face amount.

Death benefits, cash values and loan values (for policies with such values) will be reduced if an Accelerated Benefit is paid.

The Accelerated Benefits offered under this rider may or may not qualify for favorable tax treatment under the Internal Revenue Code of 1986. Whether such benefits qualify depends on factors such as your life expectancy at the time benefits are accelerated or whether you use the benefits to pay for necessary long-term care expenses, such as nursing home care. If the Accelerated Benefits qualify for favorable tax treatment, the benefits will be excludable from your income and not subject to federal taxation. Tax laws relating to Accelerated Benefits are complex. You are advised to consult with a qualified tax advisor about circumstances under which you could receive Accelerated Benefits excludable from income under federal law.

Receipt of Accelerated Benefits may affect you, your spouse or your family's eligibility for public assistance programs such as medical assistance (Medicaid), Aid to Families with Dependent Children (AFDC), supplementary social security income (SSI), and drug assistance programs. You are advised to consult with a qualified tax advisor and with social service agencies concerning how receipt of such a payment will affect you, your spouse and your family's eligibility for public assistance.

Signed at: *(City & State)* _____ Date: *(mm/dd/yyyy)* _____

Licensed Agent: *(Sign name in full)* _____

Applicant/Owner: *(Sign name in full)* _____

Copies to the Company, the Customer, and the Agent

National Life Group®

Life Insurance Company of the Southwest®

Disclosure Statement for Accelerated Benefits Rider (Critical Illness)

Accelerated Benefits are payments made to the Owner while the Insured is living in lieu of payment of all or a portion of the death benefit that would otherwise be paid at the Insured's death. The Owner must apply for the Accelerated Benefits and must show the required proof stated in the Accelerated Benefits Rider attached to the policy.

The Critical Illness Qualifying Events covered under this rider are:

1. **Aorta Graft Surgery:** A definite diagnosis by a Specialist that surgery is medically necessary for disease or trauma to the aorta requiring excision and surgical replacement of the diseased or traumatized aorta with a graft. Aorta refers to the thoracic and abdominal aorta but not its branches. The Insured must survive for 30 days following the Date of Diagnosis.

2. **Aplastic Anemia:** A definite diagnosis of a chronic persistent bone marrow failure, confirmed by biopsy, which results in anemia, neutropenia and thrombocytopenia requiring blood product transfusion, and treatment with at least one of the following: a) Marrow stimulating agents; b) Immunosuppressive agents; c) Bone marrow transplantation. The diagnosis of Aplastic Anemia must be made by a Specialist. The Insured must survive for 30 days following the Date of Diagnosis.

3. **Blindness:** The total and permanent loss of sight in both eyes as a result of disease or injury. Total loss of sight in an eye is defined as corrected vision of 20/200 or worse.

4. **Cancer:** A definite diagnosis of a disease manifested by the presence of one or more malignant tumors and characterized by the uncontrolled growth and spread of malignant cells and the invasion of normal tissue.

   Diagnosis of 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. The Insured must survive for 90 days following the Date of Diagnosis.

   Exclusion: No benefit will be payable under this condition for: a) Any non-melanoma skin cancer, except those with distant lymph node metastasis; or b) Pre-malignant lesions, benign tumors, or dysplasias; or c) Carcinoma in-situ; or d) Localized non-invasive cancers such as, but not limited to: i. Thyroid cancers less than Stage 4; or ii. Early prostate cancer diagnosed as T1N0M0 or equivalent staging including T2a unless the Gleason score is higher than 6; or iii. Chronic lymphocytic leukemia classified as Rai Stage 0; or iv. Noninvasive papillary cancer of the bladder AJCC TaN0M0.

5. **Cystic Fibrosis:** A definitive diagnosis of Cystic Fibrosis with evidence of chronic lung disease and pancreatic insufficiency. The diagnosis must be made by a Specialist and must be made before the Insured's 20th birthday. The Insured must survive 30 days following the Date of Diagnosis.

6. **Diagnosis of ALS (Amyotrophic Lateral Sclerosis):** A definite diagnosis of ALS made by a Specialist. There must be permanent clinical impairment. Permanent clinical impairment is the situation in which the clinical specialist notes that the impairment caused by the condition is not reversible and hence permanent. The Insured must survive for 30 days following the Date of Diagnosis.

7. **End Stage Renal Failure:** A definite diagnosis of chronic irreversible failure of both kidneys to function, which necessitates regular haemodialysis or peritoneal dialysis continuously for a period of at least 6 months or result in renal transplantation. The diagnosis of Kidney Failure must be made by a Specialist. The Insured must survive 30 days following the Date of Diagnosis.

8. **Heart Attack:** A definite diagnosis of the death of a portion of the heart muscle resulting from inadequate blood supply to the relevant area. The diagnosis of Heart Attack must be made by a Specialist, supported by symptoms clinically accepted as consistent with the diagnosis of an acute myocardial infarction and at least one of the following conditions: a) New characteristic electrocardiographic changes; or b) The characteristic rise above laboratory accepted normal values of biochemical cardiac specific markers such as CK-MB or cardiac troponins; or c) An abnormal myocardial perfusion or other scan showing characteristic findings of new heart muscle death; or d) An echocardiogram with new wall abnormalities indicating new heart muscle death. The Insured must survive for 30 days following the Date of Diagnosis.

   Exclusion: No benefit will be payable under this condition for other acute coronary syndromes including but not limited to angina.

9. **Heart Valve Replacement:** A definite diagnosis determined by a Specialist that surgery is medically necessary to replace any heart valve with either a natural or mechanical valve. The Insured must survive 30 days following the Date of Diagnosis.

10. **Major Organ Transplant:** A definite diagnosis of the irreversible failure of any of the following organs or tissues: heart, both lungs, liver, both kidneys, pancreas, or bone marrow, and transplantation must be medically necessary. To qualify under Major Organ Transplant, a Transplant specialist must document that transplantation is necessary and the Insured must be placed on a transplant list as the recipient of a heart, lung, liver, kidney, pancreas or bone marrow, and limited to these entities. The Insured must survive 30 days following the Date of Diagnosis.

Copies to the Company, the Customer, and the Agent

P: 800-732-8939 | www.NationalLife.com
Centralized Mailing Address: One National Life Drive, Montpelier, VT 05604 | Home Office: Addison, TX

11. **Motor Neuron Disease:** A definite diagnosis of one of the following conditions and is limited to these conditions: a) Primary lateral sclerosis; or b) Progressive spinal muscular atrophy; or c) Progressive bulbar palsy; or d) Pseudo bulbar palsy. There must be permanent clinical impairment. Permanent clinical impairment is the situation in which the clinical specialist notes that the impairment caused by the condition is not reversible and hence permanent. The diagnosis of Motor Neuron Disease must be made by a Specialist. The Insured must survive for 30 days following the Date of Diagnosis.

12. **Stroke:** A definite diagnosis of an acute cerebrovascular accident or infarction (death) of brain tissue caused by hemorrhage, embolism, or thrombosis resulting in neurological deficit with persistent clinical symptoms for at least 30 consecutive days following the occurrence of the Stroke, and also resulting in either: a) Permanent Neurological Deficit with Persisting Clinical Symptoms that are expected to last throughout the Insured's life; or b) Definite evidence of death of brain tissue or hemorrhage on a brain scan. The diagnosis of Stroke must be made by a Specialist. The Insured must survive for 30 days following the Date of Diagnosis.

    Exclusion: No benefit will be payable under this condition for: a) Transient ischemic attacks; or b) Intracerebral vascular events due to trauma; or c) Lacunar infarcts which do not meet the definition of Stroke as described above; or d) Asymptomatic silent stroke found on imaging.

13. **Sudden Cardiac Arrest:** Defined as the sudden loss of heart function with interruption of blood circulation around the body resulting in unconsciousness and requiring resuscitation. After resuscitation, treatment may include: a) Surgical implantation of an Implantable Cardioverter-Defibrillator (ICD); or b) Surgical implantation of a Cardiac Resynchronization Therapy with Defibrillator (CRT-D); or c) Electrophysiological mapping with radio frequency ablation; or d) Cardiac surgery; or e) Long-term medication therapy.

    Exclusion: No benefit will be payable under this condition for: a) Insertion of a pacemaker; or b) Insertion of a defibrillator without cardiac arrest; or c) Cardiac arrest resulting directly from alcohol or drug abuse. The Insured must survive for 30 days following the date of Sudden Cardiac Arrest.

No Accelerated Benefit will be paid under this rider for any Critical Illness Qualifying Event that directly results from self-inflicted injury or attempted suicide. This benefit is underwritten and may not be available on your policy.

The Owner may elect to accelerate all or a portion of the Insured's death benefit in force on the election date. **The Company reserves the right to set a maximum death benefit that may be accelerated under this and any other Accelerated Benefits Rider on the life of any insured person. This maximum limit will be no less than $500,000.**

Accelerated Benefits will be paid as a lump sum. The amount paid is calculated as the present value of the death benefit accelerated, less an adjustment for future premiums, and less an administrative fee. The benefit will first be used to pay a pro rata share of any outstanding debt to us. The benefit will never exceed the death benefit being accelerated. It will never be less than the cash surrender value, if any, that corresponds to the death benefit accelerated.

The Insured's death benefit in force will be reduced each time an Accelerated Benefit is paid. The reduction will equal the portion of the death benefit that is accelerated on the election date. The face amount, and any accumulated value, cash surrender value, and outstanding debt will also be reduced. Each of these will be reduced in the same proportion as the reduction in the death benefit. The premiums and charges for any remaining life coverage will be determined as if the contract had been originally issued at the reduced face amount.

Death benefits, cash values and loan values (for policies with such values) will be reduced if an Accelerated Benefit is paid.

The Accelerated Benefits offered under this rider may or may not qualify for favorable tax treatment under the Internal Revenue Code of 1986. If the Accelerated Benefits qualify for such favorable tax treatment, the benefits will be excludable from your income and not subject to federal taxation. Tax laws relating to Accelerated Benefits are complex. You are advised to consult with a qualified tax advisor about circumstances under which you could receive Accelerated Benefits excludable from income under federal law.

Receipt of Accelerated Benefits may affect eligibility for public assistance programs such as medical assistance (Medicaid), Aid to Families with Dependent Children (AFDC), supplementary social security income (SSI), and drug assistance programs. You are advised to consult with a qualified tax advisor and with social service agencies concerning how receipt of such a payment will affect your eligibility, your spouse's eligibility, and your family's eligibility for public assistance.

Signed at: *(City & State)* _____ Date: *(mm/dd/yyyy)* _____

Licensed Agent: *(Sign name in full)* _____

Applicant/Owner: *(Sign name in full)* _____

National Life Group®

Life Insurance Company of the Southwest®

Disclosure Statement for Accelerated Benefits Rider (Critical Injury)

Accelerated Benefits are payments made to the Owner while the Insured is living in lieu of payment of all or a portion of the death benefit that would otherwise be paid at the Insured's death. The Owner must apply for the Accelerated Benefits and must show the required proof stated in the Accelerated Benefits Rider attached to the policy.

The Critical Injury Qualifying Events covered under this rider are:

1. **Coma:** A definite diagnosis of a state of unconsciousness with no reaction to external stimuli or response to internal needs for a continuous period of at least 96 hours, which: a) Has a Glasgow Coma score of 4 or less; and b) Requires the use of life support systems; and c) Results in Permanent Neurological Deficit with Persisting Clinical Symptoms that are expected to last throughout the Insured's life. The diagnosis of Coma must be made by a Specialist.

   Exclusion: No benefit will be payable under this condition for: a) A medically induced Coma; or b) A Coma which results directly from alcohol or drug abuse.

2. **Paralysis:** Defined as Quadriplegia, Paraplegia or Hemiplegia that has been present for 90 days from the Date of Diagnosis confirmed by a Specialist and which is expected to be permanent without expectation of recovery. a) Quadriplegia means the complete and irreversible Paralysis of both upper and lower Limbs. b) Paraplegia means the complete and irreversible Paralysis of both lower Limbs. c) Hemiplegia means the complete and irreversible Paralysis of the upper and lower Limbs of the same side of the body. d) Limb means entire arm or entire leg.

3. **Severe Burns:** A definite diagnosis of third degree burns covering at least 30% of the body's surface area or 30% of the area of the face or head. The diagnosis of Severe Burns must be made by a Specialist. The Insured must survive for 30 days following the Date of Diagnosis.

4. **Traumatic Brain Injury:** A definite diagnosis of damage to brain tissue due to Traumatic Brain Injury, which: a) Has a Glasgow Coma score of 12 or less in the first 48 hours after injury; and b) Has skull fracture, brain contusion or hemorrhage on CT scan of head; and c) Results in a Permanent Neurological Deficit with Persisting Clinical Symptoms that are expected to last throughout the Insured's life.

   The diagnosis of Traumatic Brain Injury must be made by a Specialist. The Insured must survive for 60 days following the Date of Diagnosis.

   Exclusion: No benefit will be payable under this condition for: a) Mild Traumatic Brain Injury; or b) Traumatic Brain Injury due to repetitive head trauma; or c) Traumatic Brain Injury which results directly from intentional self-inflicted injury.

No Accelerated Benefit will be paid under this rider for any Critical Injury Qualifying Event that directly results from self-inflicted injury or attempted suicide. This benefit is underwritten and may not be available on your policy.

The Owner may elect to accelerate all or a portion of the Insured's death benefit in force on the election date. **The Company reserves the right to set a maximum death benefit that may be accelerated under this and any other Accelerated Benefits Rider on the life of any insured person. This maximum limit will be no less than $500,000.**

Accelerated Benefits will be paid as a lump sum. The amount paid is calculated as the present value of the death benefit accelerated, less an adjustment for future premiums, and less an administrative fee. The benefit will first be used to pay a pro rata share of any outstanding debt to us. The benefit will never exceed the death benefit being accelerated. It will never be less than the cash surrender value, if any, that corresponds to the death benefit accelerated.

The Insured's death benefit in force will be reduced each time an Accelerated Benefit is paid. The reduction will equal the portion of the death benefit that is accelerated on the election date. The face amount, and any accumulated value, cash surrender value, and outstanding debt will also be reduced. Each of these will be reduced in the same proportion as the reduction in the death benefit. The premiums and charges for any remaining life coverage will be determined as if the contract had been originally issued at the reduced face amount.

Death benefits, cash values and loan values (for policies with such values) will be reduced if an Accelerated Benefit is paid.

The Accelerated Benefits offered under this rider may or may not qualify for favorable tax treatment under the Internal Revenue Code of 1986. If the Accelerated Benefits qualify for such favorable tax treatment, the benefits will be excludable from your income and not subject to federal taxation. Tax laws relating to Accelerated Benefits are complex. You are advised to consult with a qualified tax advisor about circumstances under which you could receive Accelerated Benefits excludable from income under federal law.

Receipt of Accelerated Benefits may affect eligibility for public assistance programs such as medical assistance (Medicaid), Aid to Families with Dependent Children (AFDC), supplementary social security income (SSI), and drug assistance programs. You are advised to consult with a qualified tax advisor and with social service agencies concerning how receipt of such a payment will affect your eligibility, your spouse's eligibility, and your family's eligibility for public assistance.

Signed at: *(City & State)* _____ Date: *(mm/dd/yyyy)* _____

Licensed Agent: *(Sign name in full)* _____

Applicant/Owner: *(Sign name in full)* _____

Copies to the Company, the Customer, and the Agent

National Life Group®

☐ National Life Insurance Company
☐ Life Insurance Company of the Southwest

NOTICE AND CONSENT FOR HIV RELATED BLOOD AND OTHER BODILY FLUID TESTING

This Notice is submitted in conjunction with an application to a Company of the National Life Group:

National Life Insurance Company
Home / Administrative Office: One National Life Drive, Montpelier, VT 05604

Life Insurance Company of the Southwest
Administrative Office: One National Life Drive, Montpelier, VT 05604
Home Office: 1300 West Mockingbird Lane, Dallas, TX 75247-4921

To evaluate your insurability, the Insurer named above (the Insurer) has requested that you provide a sample of your blood, oral fluid extracted from cheek and gum tissue, urine for testing and analysis to determine the presence of human immunodeficiency virus (HIV) antibodies. By signing and dating this form you agree that this test may be done and that underwriting decisions will be based on the test results. A series of tests will be performed by a licensed laboratory through a medically accepted procedure.

PRE TESTING CONSIDERATIONS

Many public health organizations have recommended that before taking an HIV related blood or other bodily fluid test a person seek counseling to become informed concerning the implications of such a test. You may wish to consider counseling, at your expense, prior to being tested.

MEANING OF POSITIVE TEST RESULTS

The test is not a test for AIDS. It is a test for antibodies to the HIV virus, the causative agent for AIDS, and shows whether you have been exposed to the virus. A positive test result does not mean that you have AIDS but that you are at a significantly increased risk of developing problems with your immune system. The test for HIV antibodies is very sensitive. Errors are rare, but they do occur. Your private physician, a public health clinic, or an AIDS information organization in your city might provide you with further information on the medical implications of a positive test.

Positive HIV antibody test results will adversely affect your application for insurance. This means that your application may be declined, that an increased premium may be charged, or that other policy changes may be necessary.

CONFIDENTIALITY OF TEST RESULTS

All test results are required to be treated confidentially. They will be reported by the laboratory to the Insurer. The test results may be disclosed as required by law or may be disclosed to employees of the Insurer who have the responsibility to make underwriting decisions on behalf of the Insurer or to outside legal counsel who needs such information to effectively represent the Insurer in regard to your application. The results may be disclosed to a reinsurer, if the reinsurer is involved in the underwriting process. The test may be released to an insurance medical information exchange under procedures that are designed to assure confidentiality, including the use of general codes that also cover results to tests for other diseases or conditions not related to AIDS, or for the preparation of statistical reports that do not disclose the identity of any particular person.

NOTIFICATION OF TEST RESULTS

If your test results are negative, no routine notification will be sent to you. If your test results are reported by the laboratory to the Insurer as being positive, you will receive written notification of such results from a physician you have designated or, in the absence of such designation, from the Texas Department of Health. Because a trained person should deliver that information so that you understand clearly what the test result means, please list your private physician so that the Insurer can have him or her tell you the test result and explain its meaning.

Name of physician for reporting a positive test result: *(Print or Type)*

_____

Address: *(Street, City, State, Zip Code)*

_____

_____

In the event the test is positive and you are denied coverage because of that fact and you request the reason for the denial, the Insurer may require you to name a physician at that time in order to receive the information.

If the test indicates a positive result, but you do not designate a private physician, the test results will be provided to you by a representative of the Texas Department of Health.

Consent

I have read and I understand this Notice and Consent for HIV Related Blood and Other Bodily Fluid Testing. I voluntarily consent to the collection of a sample of blood, oral fluid extracted from cheek and gum tissue, or urine from me, the testing of the samples, and the disclosure of the test results as described above. I have read the information on this form about what a test result means.

I understand that I have the right to request and receive a copy of this authorization. A photocopy of this form will be as valid as the original.

Proposed Insured's Name: *(Print or type)* _____

Date of Birth: *(mm/dd/yyyy)* _____

State of Residence: _____

Signature of Proposed Insured or Parent/Guardian: _____

Date: *(mm/dd/yyyy)* _____

Copies to the Company, the Customer, the Examiner, and the Agent

National Life Group®

☐ National Life Insurance Company
☐ Life Insurance Company of the Southwest

NOTICE AND CONSENT FOR HIV RELATED BLOOD AND OTHER BODILY FLUID TESTING

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Home / Administrative Office: One National Life Drive, Montpelier, VT 05604

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Many public health organizations have recommended that before taking an HIV related blood or other bodily fluid test a person seek counseling to become informed concerning the implications of such a test. You may wish to consider counseling, at your expense, prior to being tested.

MEANING OF POSITIVE TEST RESULTS

The test is not a test for AIDS. It is a test for antibodies to the HIV virus, the causative agent for AIDS, and shows whether you have been exposed to the virus. A positive test result does not mean that you have AIDS but that you are at a significantly increased risk of developing problems with your immune system. The test for HIV antibodies is very sensitive. Errors are rare, but they do occur. Your private physician, a public health clinic, or an AIDS information organization in your city might provide you with further information on the medical implications of a positive test.

Positive HIV antibody test results will adversely affect your application for insurance. This means that your application may be declined, that an increased premium may be charged, or that other policy changes may be necessary.

CONFIDENTIALITY OF TEST RESULTS

All test results are required to be treated confidentially. They will be reported by the laboratory to the Insurer. The test results may be disclosed as required by law or may be disclosed to employees of the Insurer who have the responsibility to make underwriting decisions on behalf of the Insurer or to outside legal counsel who needs such information to effectively represent the Insurer in regard to your application. The results may be disclosed to a reinsurer, if the reinsurer is involved in the underwriting process. The test may be released to an insurance medical information exchange under procedures that are designed to assure confidentiality, including the use of general codes that also cover results to tests for other diseases or conditions not related to AIDS, or for the preparation of statistical reports that do not disclose the identity of any particular person.

NOTIFICATION OF TEST RESULTS

If your test results are negative, no routine notification will be sent to you. If your test results are reported by the laboratory to the Insurer as being positive, you will receive written notification of such results from a physician you have designated or, in the absence of such designation, from the Texas Department of Health. Because a trained person should deliver that information so that you understand clearly what the test result means, please list your private physician so that the Insurer can have him or her tell you the test result and explain its meaning.

Name of physician for reporting a positive test result: *(Print or Type)*

_____

Address: *(Street, City, State, Zip Code)*

_____

_____

In the event the test is positive and you are denied coverage because of that fact and you request the reason for the denial, the Insurer may require you to name a physician at that time in order to receive the information.

If the test indicates a positive result, but you do not designate a private physician, the test results will be provided to you by a representative of the Texas Department of Health.

Consent

I have read and I understand this Notice and Consent for HIV Related Blood and Other Bodily Fluid Testing. I voluntarily consent to the collection of a sample of blood, oral fluid extracted from cheek and gum tissue, or urine from me, the testing of the samples, and the disclosure of the test results as described above. I have read the information on this form about what a test result means.

I understand that I have the right to request and receive a copy of this authorization. A photocopy of this form will be as valid as the original.

Proposed Insured's Name: *(Print or type)* _____

Date of Birth: *(mm/dd/yyyy)* _____

State of Residence: _____

Signature of Proposed Insured or Parent/Guardian: _____

Date: *(mm/dd/yyyy)* _____

Copies to the Company, the Customer, the Examiner, and the Agent

National Life Group®

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Important Notice
Replacement of Life Insurance or Annuities

This document must be signed by the applicant and the producer, if there is one, and a copy left with the applicant.

You are contemplating the purchase of a life insurance policy or annuity contract. In some cases this purchase may involve discontinuing or changing an existing policy or contract. If so, a replacement is occurring. Financed purchases are also considered replacements.

A replacement occurs when a new policy or contract is purchased and, in connection with the sale, you discontinue making premium payments on the existing policy or contract, or an existing policy or contract is surrendered, forfeited, assigned to the replacing insurer, or otherwise terminated or used in a financed purchase.

A financed purchase occurs when the purchase of a new life insurance policy involves the use of funds obtained by the withdrawal or surrender of or by borrowing some or all of the policy values, including accumulated dividends, of an existing policy, to pay all or part of any premium or payment due on the new policy. A financed purchase is a replacement.

You should carefully consider whether a replacement is in your best interest. You will pay acquisition costs and there may be surrender costs deducted from your policy or contract. You may be able to make changes to your existing policy or contract to meet your insurance needs at less cost. A financed purchase will reduce the value of your existing policy and may reduce the amount paid upon the death of the insured.

We want you to understand the effects of replacements before you make your purchase decision and ask that you answer the following questions and consider the questions on page 2.

1. Are you considering discontinuing making premium payments, surrendering, forfeiting, assigning to the insurer, or otherwise terminating your existing policy or contract? ☐ Yes ☐ No
2. Are you considering using funds from your existing policies or contracts to pay premiums due on the new policy or contract? ☐ Yes ☐ No

If you answered 'Yes' to either of the above questions, list each existing policy or contract you are contemplating replacing (include the name of the insurer, the insured, and the contract number if available) and whether each policy will be replaced or used as a source of financing:

	INSURER NAME	CONTRACT OR POLICY NO.	INSURED	REPLACED (R) OR FINANCING (F)
1.				
2.				
3.				

The existing policy or contract is being replaced because: _____

Make sure you know the facts. Contact your existing company or its agent for information about the old policy or contract. If you request one, an in-force illustration, policy summary or available disclosure documents must be sent to you by the existing insurer. Ask for and retain all sales material used by the agent in the sales presentation. Be sure that you are making an informed decision.

I do not want this notice read aloud to me. _____
(Applicants must initial only if they do not want the notice read aloud.)

I certify that the responses herein are, to the best of my knowledge, accurate:

Applicant's Signature: Date: *(mm/dd/yyyy)*

Applicant's Name: *(Print.)* Date: *(mm/dd/yyyy)*

Producer's Signature: Date: *(mm/dd/yyyy)*

Producer's Name: *(Print.)* Date: *(mm/dd/yyyy)*

Copies to the Company, the Customer, and the Agent

Centralized Mailing Address: One National Life Drive, Montpelier, VT 05604 | www.NationalLifeGroup.com

Important Notice: Replacement of Life Insurance or Annuities

A replacement may not be in your best interest, or your decision could be a good one. You should make a careful comparison of the costs and benefits of your existing policy or contract and the proposed policy or contract. One way to do this is to ask the company or agent that sold you your existing policy or contract to provide you with information concerning your existing policy or contract. This may include an illustration of how your existing policy or contract is working now and how it would perform in the future based on certain assumptions. Illustrations should not, however, be used as a sole basis to compare policies or contracts. You should discuss the following with your agent to determine whether replacement or financing your purchase makes sense:

PREMIUMS:

Are they affordable?
Could they change?
You're older--are premiums higher for the proposed new policy?
How long will you have to pay premiums on the new policy? On the old policy?

POLICY VALUES:

New policies usually take longer to build cash values and to pay dividends.
Acquisition costs for the old policy may have been paid; you will incur costs for the new one.
What surrender charges do the policies have?
What expense and sales charges will you pay on the new policy?
Does the new policy provide more insurance coverage?

INSURABILITY:

If your health has changed since you bought your old policy, the new one could cost you more, or you could be turned down.
You may need a medical exam for a new policy.
Claims on most new policies for up to the first two years can be denied based on inaccurate statements. Suicide limitations may begin anew on the new coverage.

IF YOU ARE KEEPING THE OLD POLICY AS WELL AS THE NEW POLICY:

How are premiums for both policies being paid?
How will the premiums on your existing policy be affected?
Will a loan be deducted from death benefits?
What values from the old policy are being used to pay premiums?

IF YOU ARE SURRENDERING AN ANNUITY OR INTEREST SENSITIVE LIFE PRODUCT:

Will you pay surrender charges on your old contract?
What are the interest rate guarantees for the new contract?
Have you compared the contract charges or other policy expenses?

OTHER ISSUES TO CONSIDER FOR ALL TRANSACTIONS:

What are the tax consequences of buying the new policy?
Is this a tax-free exchange? (See your tax advisor).
Is there a benefit from favorable "grandfathered" treatment of the old policy under the federal tax code?
Will the existing insurer be willing to modify the old policy?
How does the quality and financial stability of the new company compare with your existing company?

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HIPAA Compliant Authorization

for Release of Health-Related and Other Information

I authorize any health plan, physician, health care professional, hospital, clinic, laboratory, pharmacy, medical facility, prescription benefit manager, or other health care provider that has provided payment, treatment or services to me or on my behalf within the past 10 years (collectively, "My Providers") to disclose my entire medical record, prescription drug information, and any other protected health information concerning me to National Life Insurance Company and Life Insurance Company of the Southwest (collectively, "The Company") and The Company's agents, employees, reinsurers, and representatives. I further authorize MIB, Inc. to disclose to The Company, or its reinsurers, any knowledge of me or my health, and any other protected health information concerning me. This includes information on the diagnosis or treatment of Human Immunodeficiency Virus (HIV) infection and sexually transmitted diseases. This also includes information on the diagnosis and treatment of mental illness and the use of alcohol, drugs and tobacco, but excludes psychotherapy notes. I further authorize The Company to re-disclose any protected health information or other knowledge or records concerning me to The Company's reinsurers and to MIB, Inc., which operates an information exchange on behalf of life and health insurance companies. I further authorize the Company to request a copy of my driving record(s) from the state motor vehicle department (collectively, “DMVs”).

By my signature below, I acknowledge that any agreements I have made to restrict my protected health information do not apply to this Authorization and I instruct My Providers to release and disclose my entire medical record without restriction. I also acknowledge that I have read the PRENOTIFICATIONS, including the notices required by the Fair Credit Reporting Act and MIB, Inc. ("MIB").

The protected health information and driving records are to be disclosed under this Authorization so that The Company may: (1) underwrite my application for coverage, make eligibility, risk rating, policy issuance and enrollment determinations; (2) obtain reinsurance; (3) administer claims and determine or fulfill responsibility for coverage and provision of benefits; (4) administer coverage; and (5) conduct other legally permissible activities that relate to any coverage I have or have applied for with The Company.

This Authorization shall remain in force for 30 months following the date of my signature below, and a copy of this Authorization is as valid as the original. I understand that I have the right to revoke this Authorization in writing, at any time, by sending a written request for revocation to National Life Insurance Company or Life Insurance Company of the Southwest, Centralized Mailing Address, One National Life Drive, Montpelier, VT 05604, Attention: Privacy Officer. I understand that a revocation is not effective to the extent that any of My Providers or DMVs has relied on this Authorization or to the extent that The Company has a legal right to contest a claim under an insurance policy or to contest the policy itself. I understand that any information that is disclosed pursuant to this Authorization may be re-disclosed and no longer covered by federal rules governing privacy and confidentiality of health information or driving records.

Centralized Mailing Address: One National Life Drive, Montpelier, VT 05604 | P: 800-732-8939 | www.NationalLife.com

I understand that My Providers may not refuse to provide treatment or payment for health care services if I refuse to sign this Authorization. I further understand that if I refuse to sign this Authorization to release my complete medical record and driving records, The Company may not be able to process my application, or if coverage has been issued, may not be able to make any benefit payments. I acknowledge that I have received a copy of this Authorization.

Proposed Insured/Patient: *(Print)* Date of Birth:

Signature of Proposed Insured/Patient or Personal Representative: Today's Date: *(mm/dd/yyyy)*

Description of Personal Representative's Authority or Relationship to Patient:

Questions & Answers about Release of Protected Health Information to a Life or Disability Income Insurer.

1. May I release complete personal medical information to a life or disability income insurance company?

Yes. As you did before the Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule became effective, a medical care provider may disclose complete Protected Health Information (PHI) to organizations not subject to the Privacy Rule as long as the applicant has signed a HIPAA compliant authorization.

2. Does the "minimum amount necessary" rule apply to this release to a life or disability income insurer?

No. The "minimum amount necessary" rule does not apply as long as a HIPAA compliant authorization is signed. This question was specifically addressed by Health and Human Services (HHS) in a Q and A published December 4, 2002: "Uses and disclosures that are authorized by the individual are exempt from the minimum necessary requirements. For example, if a covered health care provider receives an individual's authorization to disclose medical information to a life insurer for underwriting purposes, the provider is permitted to disclose the information requested on the authorization without making any minimum necessary determination. The authorization must meet the requirements of 45 CFR 164.508."

3. Can an insurer request disclosure of a person's "entire" medical record or does it have to refer to specific items in a medical file only?

Yes. HIPAA allows insurers to seek and providers to disclose a person's entire medical record, if the authorization used clearly states that the entire medical record is to be disclosed (e.g., "I authorize you to disclose my entire medical record.")

4. Does HIPAA mandate the use of one specified form of authorization by everyone?

No. HIPAA requires that certain specified "elements" be included in a valid authorization to disclose protected health information. HIPAA does not mandate that a specific form be used. Both covered and non-covered entities are free to use any format they wish so long as it is compliant with HIPAA's requirements. The signed authorization contains all of the elements required by HIPAA.

5. What should I do if I had previously agreed to a restriction and now receive an authorization to release the "entire medical record?" Does the authorization cover PHI that was restricted?

You may release all medical records, restricted and otherwise if a patient has previously requested a restriction and later signs an authorization which removes the restriction. The wording of this authorization specifically releases any restricted information.

This HIPAA compliant authorization and Questions and Answers were created by the American Council of Life Insurers.

National Life Group®

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HIPAA Compliant Authorization

for Release of Health-Related and Other Information

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The protected health information and driving records are to be disclosed under this Authorization so that The Company may: (1) underwrite my application for coverage, make eligibility, risk rating, policy issuance and enrollment determinations; (2) obtain reinsurance; (3) administer claims and determine or fulfill responsibility for coverage and provision of benefits; (4) administer coverage; and (5) conduct other legally permissible activities that relate to any coverage I have or have applied for with The Company.

This Authorization shall remain in force for 30 months following the date of my signature below, and a copy of this Authorization is as valid as the original. I understand that I have the right to revoke this Authorization in writing, at any time, by sending a written request for revocation to National Life Insurance Company or Life Insurance Company of the Southwest, Centralized Mailing Address, One National Life Drive, Montpelier, VT 05604, Attention: Privacy Officer. I understand that a revocation is not effective to the extent that any of My Providers or DMVs has relied on this Authorization or to the extent that The Company has a legal right to contest a claim under an insurance policy or to contest the policy itself. I understand that any information that is disclosed pursuant to this Authorization may be re-disclosed and no longer covered by federal rules governing privacy and confidentiality of health information or driving records.

Centralized Mailing Address: One National Life Drive, Montpelier, VT 05604 | P: 800-732-8939 | www.NationalLife.com

I understand that My Providers may not refuse to provide treatment or payment for health care services if I refuse to sign this Authorization. I further understand that if I refuse to sign this Authorization to release my complete medical record and driving records, The Company may not be able to process my application, or if coverage has been issued, may not be able to make any benefit payments. I acknowledge that I have received a copy of this Authorization.

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This HIPAA compliant authorization and Questions and Answers were created by the American Council of Life Insurers.

National Life Group®

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☐ **Life Insurance Company of the Southwest®**

Cash Equivalent Payment Receipt

Use for cash equivalent remittance only

Policy No.: _____

To: *(Agency or Office Name)* _____

Received From: _____

Applicant/policy holder name if different then above: _____

I hereby certify that I have given my Agent, *(Name)* _____

one of the following in the amount of $ _____ to be submitted with my application and/or in satisfaction of my premium due.

☐ Money Order ☐ Cashier's Check ☐ Official Bank Check ☐ Treasurer's Check

Signatures:

Applicant/Policyholder: _____ Last 4 SSN: _____ Date: _____

Received From: *(Only needed if different then applicant/policyholder)* _____ SSN: _____ Date: _____

Agent: _____ Date: _____

Note: Incomplete forms will be returned causing a delay in processing.
Forward this portion to Treasury Operations Administrative Office with cash equivalent payment

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Cash Equivalent Payment Receipt

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☐ Money Order ☐ Cashier's Check ☐ Official Bank Check ☐ Treasurer's Check

Signatures:

Applicant/Policyholder: _____ Last 4 SSN: _____ Date: _____

Received From: *(Only needed if different then applicant/policyholder)* _____ SSN: _____ Date: _____

Agent: _____ Date: _____

Note: Incomplete forms will be returned causing a delay in processing.
This portion retained by Client

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Cat. No. 47093

National Life Group® is a trade name of National Life Insurance Company, Montpelier, VT, Life Insurance Company of the Southwest (LSW), Addison, TX and their affiliates. Each company of National Life Group is solely responsible for its own financial condition and contractual obligations. LSW is not an authorized insurer in New York and does not conduct insurance business in New York.

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National Life Group®

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Conditional Life Insurance Receipt

For use if a plan or trust applies for life insurance

Conditional Life Insurance Receipt

This receipt may not be used (and will be deemed void) if (a) either at least the first full modal premium does not accompany the application or Part F of the application is not completed in good order with "EFT" checked as the Initial Premium Payment Method or (b) the application is not accurately and fully completed in good order, including (without limitations) Parts A-J of the application. No agent or medical examiner may waive a complete answer to any question in the application.

Check one:

☐ $ _____ has been submitted by the applicant with the application, subject to the terms of this receipt.

☐ Part F of the application has been completed by the applicant in good order with "EFT" checked as the Initial Premium Payment Method, subject to the terms of this receipt.

If the check or draft, as applicable, when processed is returned as insufficient funds, no coverage is provided under this receipt.

Terms & Conditions

A. Effective Date of Receipt. With respect to any life insurance applied for, the Effective Date of Receipt shall be the date of the application.

B. If Policy Cannot Be Issued. If as of the Effective Date of Receipt the underwriting rules of the Company do not permit a policy to be issued either as applied for or on a modified basis, no insurance of any type whatever will take effect.

C. If Policy Can Be Issued But Not As Applied For. If as of the Effective Date of Receipt the underwriting rules of the Company prevent issuance of a policy for the plan, amount, additional benefits or rate class applied for but permit the issuance of a policy on a modified basis, then **subject to the following conditions** the policy with the needed changes, called the Issuable Policy shall take effect subject to all its terms and conditions, as of the Effective Date of Receipt.

1. The applicant must accept the Issuable Policy.
2. The applicant must complete payment of at least one premium for the Issuable Policy.
3. The Insured must be living at the time of such acceptance and payment.

If the Proposed Insured dies within 90 days after the Effective Date of Receipt and before the Issuable Policy takes effect, then it shall be deemed to be effective subject to its terms and conditions.

However, it shall be for an amount which the first premium for the policy applied for, exclusive of premium for any additional benefits not available in the Issuable Policy, would purchase when applied as the first premium with the same premium interval as the Issuable Policy. If the plan of insurance applied for is not available, the Issuable Policy shall be deemed to be on a plan which would not violate the terms of the plan or trust document.

D. If Policy Can Be Issued As Applied For. If as of the Effective Date of Receipt the underwriting rules of the Company permit a policy to be issued for the plan, amount, additional benefits and rate class applied for, such policy shall take effect subject to all its terms and conditions, as of the Effective Date of Receipt.

E. Termination and Limitation. This Conditional Receipt will TERMINATE ON AND BE OF NO FORCE OR EFFECT AFTER the earlier of:

1. 90 days from the Effective Date of Receipt; or
2. The issuance of a policy of insurance pursuant to this application.

F. Evidence of Insurability. The Company may require additional evidence of insurability. If the Proposed Insured dies within 90 day after the Effective Date of Receipt and before insurability has been determined, insurability shall be determined as of the Effective Date of Receipt. Facts available at date of death and any additional facts which can be obtained from other sources will be used to determine insurability.

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G. Maximum Death Benefits. Any death benefits under this Receipt for death occurring prior to termination of this Receipt SHALL NOT exceed the lesser of:

1. the amount applied for, or
2. $250,000.00

If death should occur while more than one receipt is in effect with respect to applications for life insurance made to Life Insurance Company of the Southwest or National Life Insurance Company ("the Company"), the maximum under (2) above shall apply to total death benefits under all policies pursuant to all such receipts. This maximum shall be pro-rated on the basis of the amounts which would have been paid in the absence of this Section G.

H. Refund of Amount Received. After 90 days from the Effective Date of Receipt if no policy of insurance has been issued and taken effect, the amount received will be refunded.

I. General. This Receipt is not valid unless signed by an agent of the Company. No agent has authority to modify or alter the provisions of this Receipt.

Notice to Applicant

If you do not hear from the Company about your application within 60 days from the date of this Receipt, write the Company at One National Life Drive, Montpelier, Vermont 05604, or call (800) 732-8939. Please state the facts about your application for insurance.

Make all premium checks payable to the Company: Do Not make checks payable to the agent or leave the payee blank. Checks and drafts are accepted only subject to collection.

Signed at: *(City & State)* _____ on this day of: *(mm/dd/yyyy)* _____

Agent's Signature: _____ Agent's Name: *(Print)* _____

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Conditional Receipt

Complete for Single Life and Survivorship Life

Conditional Receipt *(to be given to applicant only upon (a) premium payment to agent or (b) completion of Part F of the application in good order and checking "EFT" as the Initial Premium Payment Method) (Not to be used for Qualified Pension or Profit Sharing Trust.)*

NOTE: ALL PREMIUM CHECKS SHOULD BE MADE PAYABLE TO LIFE INSURANCE COMPANY OF THE SOUTHWEST OR NATIONAL LIFE INSURANCE COMPANY ("THE COMPANY"). DO NOT MAKE CHECK PAYABLE TO THE AGENT OR LEAVE THE PAYEE BLANK.

This receipt may not be used (and will be deemed void) if (a) either at least the first full modal premium does not accompany the application or Part F of the application is not completed in good order with "EFT" checked as the Initial Premium Payment Method or (b) the application is not accurately and fully completed in good order, including (without limitations) Parts A-J of the application. No agent or medical examiner may waive a complete answer to any question in the application.

Check one:

☐ $ _____ has been submitted by the applicant with the application, subject to the terms of this receipt.

☐ Part F of the application has been completed by the applicant in good order with "EFT" checked as the Initial Premium Payment Method, subject to the terms of this receipt.

If the check or draft, as applicable, when processed is returned as insufficient funds, no coverage is provided under this receipt.

Coverage under this receipt shall not exceed the face amount(s) applied for or $1,000,000, whichever is less. If a Proposed Insured dies by suicide, the Company's liability under this receipt is limited to a full refund of the premium paid. If applicant directed the Company to draft the initial premium payment and the Company had not yet done so, no refund will be due.

Coverage under this receipt will begin on the LATER of:

a) either (i) the date the application in good order is signed, including Part F of the application with "EFT" checked as the Initial Premium Payment Method, or (ii) the date the application in good order is signed and the first full modal premium has been received by the Company in good funds,

b) the date the last medical requirement requested by the Company is completed; provided no coverage under this receipt will begin if medical requirements requested by the Company have not been received by the Company within 90 days of the date of the application, or

c) the Company determines that each Proposed Insured is acceptable to it, under applicable underwriting standards, for the plan, benefits, amount and rate class for which the applicant applied.

Termination of Coverage. Coverage under this receipt will end on the FIRST of:

a) insurance beginning under the policy for which the applicant applied,

b) the Company declines the application or offers the applicant a policy for other than the one for which the applicant applied,

c) 90 days from the date coverage under this receipt begins, or

d) the Company notifies the applicant in writing that coverage is ended. If the Company terminates coverage under this receipt or declines the application, or if the applicant refuses a policy issued other than that for which the applicant applied, the Company will refund the full amount paid under this receipt. If applicant directed the Company to draft the first premium payment and the Company had not yet done so, no refund will be due.

Signed at: *(City & State)* _____ on this day of: *(mm/dd/yyyy)* _____

Licensed Agent's Signature: _____ Licensed Agent's Name: *(Print)* _____

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National Life Insurance Company®
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Prenotifications

The Underwriting Process and Consumer Rights

Thank you for your application. A primary goal of National Life Insurance Company and Life Insurance Company of the Southwest (the Company) is to provide insurance protection that best meets your needs and to service these needs through the years. To keep costs at a minimum, we evaluate every proposed insured to be sure that the premium rate for each person is in relation to each person's fair share of the cost.

This evaluation - the underwriting process - may consist of a physical examination, review of medical history and reports from physicians or medical facilities which you have visited for treatment or consultation. In addition, a routine investigative consumer report is sometimes obtained.

We also check the records of the MIB, Inc. ("MIB"). The MIB is a nonprofit membership organization of life insurance companies which operates an information exchange on behalf of its members. The basic purpose of this organization is the protection of policyholders of member companies. It is not a repository of medical records. The information in its files serves only as an indication that additional data may be needed to evaluate the risk. No member company can refuse coverage on the basis of this information, nor does the information reveal whether an application was approved, rated or declined.

This program helps to assure that the true cost of the insurance is shared proportionately. Consumer rights bearing on insurance cost, needs and service are just as important to us as they are to you.

Prenotification - Investigative Consumer Report

This is to inform you in compliance with Public Law 91-508, known as the Fair Credit Reporting Act, that as part of our processing procedure for your insurance application an investigative consumer report may be made. This means information is obtained through personal interviews with third parties such as family members, business associates, financial sources, friends, neighbors or others with whom you are acquainted. This report may include information as to your character, general reputation, personal characteristics and mode of living. You have the right to make a written request within a reasonable period of time for a complete and accurate disclosure of additional information concerning the nature and scope of the investigation.

Prenotification - Personal History Interview

To obtain the information described in Investigative Consumer Report Prenotification, the Company may telephone you directly for a Personal History Interview. An Administrative Office interviewer may phone you to review and clarify information you provided on your application and to ask additional questions which will aid in considering your application.

Whenever possible, calls will be made at your convenience and to the telephone number you have provided. A separate form contains the information we need to complete the call. If for any reason it is necessary to make a change, please let your Agent know promptly.

Prenotification - MIB, Inc. ("MIB")

Information regarding your insurability and/or any past or future claims will be treated as confidential. The Company or its reinsurers may, however, make a brief report to the MIB. If you apply to another MIB member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, the MIB, upon request, will supply such company with the information in its file.

Upon receipt of a request from you, the MIB will arrange disclosure of any information it may have in your file. Medical information can be released to you or to your attending physician. If you question the accuracy of information in the MIB's file, you may contact the MIB and seek a correction in accordance with the procedures set forth in the Federal Fair Credit Reporting Act. The address of the Bureau's information office is 50 Braintree Hill, Suite 400, Braintree, MA 02184-8734, telephone number: (866) 692-6901, website: www.mib.com.

The Company may also release information in its files to its reinsurers and to other life insurance companies to whom you may apply for life or health insurance, or to whom a claim for benefits may be submitted.

Leave with Applicant

6496(0412)

Cat. No. 42577

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Prenotifications

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Leave with Applicant

6496(0412)

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Computer View Illustration Certification

Complete one form for each application

Name of primary Proposed Insured: *(print title, first, middle, last name and suffix, as applicable)*

Name of Owner if other than Proposed Insured:

I certify that I displayed a computer screen illustration for (name) _____

that complies with state requirements and for which no paper copy was furnished. The illustration was based on the following personal and contract information:

Plan of insurance: Underwriting or rating class:

Gender ☐ M ☐ F	Age	Initial death benefit	Annual Premium	Dividend option/death benefit option

Signature of Licensed Agent Date Signed: *(mm/dd/yyyy)*

Licensed Agent Name & Number *(Print)*

I acknowledge that I viewed a computer screen illustration based on the information as stated above. No paper copy of the illustration was furnished. I understand that an illustration conforming to the contract as issued will be provided to me no later than at the time the contract is delivered.

Signature of Primary Proposed Insured age 15 & up *(or Parent or Guardian)* Date Signed: *(mm/dd/yyyy)*

Signature of Other Proposed Insured Date Signed: *(mm/dd/yyyy)*

Signature of Applicant/Owner *(if other than First Proposed Insured)* Date Signed: *(mm/dd/yyyy)*

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Life Insurance Company of the Southwest®

Privacy Notice To Our Customers

FACTS	**WHAT DOES NATIONAL LIFE INSURANCE COMPANY ("NLIC") AND LIFE INSURANCE COMPANY OF THE SOUTHWEST ("LSW")** (each herein referred to as "the Company", and collectively as "the Companies") **DO WITH YOUR PERSONAL INFORMATION?**
Why?	We know how much your privacy means to you so we want you to understand how we collect and share your personal information. Please read this notice carefully to understand what we do and what rights you have.
How and what do we collect?	We collect your personal information: • From you, including application information, such as assets and income and identifying information, such as name, address, and social security number; • From your transactions with us, our affiliates, and nonaffiliates, such as balance information, payment history, and parties to a transaction; • From consumer reporting agencies, such as creditworthiness and credit history; and • With your authorization, medical information from other individuals or businesses.
How do we share?	In the section below, we list some of the reasons the Company may share their customers' personal information; the reasons we choose to share personal information about you, and whether you can limit this sharing.

Reasons we can share your personal information	**Do the Companies share?**	**Can you limit sharing?**
For our everyday business purposes - such as to process your transactions, to respond to court orders and legal investigations, to prevent fraud, to our regulators, to group policyholders, and other disclosures to affiliates and nonaffiliates as permitted by law	**YES**	**NO**
For our marketing purposes - to offer our products and services to you	**YES**	**NO**
For joint marketing with other financial companies	**NO**	**We don't share**
For our affiliates' everyday business purposes - information about your transactions and experiences	**YES**	**NO**
For our affiliates' everyday business purposes - information about your creditworthiness	**NO**	**We don't share**
For our affiliates to market to you	**NO**	**We don't share**
For nonaffiliates to market to you	**NO**	**We don't share**

To whom?	• When we disclose your personal information for the reasons discussed above, we do so to our affiliates and to nonaffiliates. • Our affiliates include NLIC, LSW, Equity Services, Inc. and Sentinel Investments*. • The nonaffiliates to whom we disclose your personal information include those who perform services on our behalf. • We require the parties to whom we disclose your information to protect it and keep it confidential.
How do we protect?	• To protect your personal information we restrict access to personal information to those individuals, such as employees and agents, who provide you with our products and services. • We require those individuals to protect it and keep it confidential. • We maintain physical, electronic and procedural safeguards that comply with applicable standards to guard your information in accordance with the policies described in this notice.

Centralized Mailing Address: One National Life Drive, Montpelier, VT 05604 | www.NationalLifeGroup.com

Confidentiality of information for victims of domestic violence or abuse	The Companies have established policies and procedures to safeguard personal information, including contact, location or other confidential abuse information, for victims of domestic abuse and children residing with those victims. A "protected person" is a victim of domestic violence or abuse who notifies the Companies and requests confidential treatment of their personal information. If you wish to be a protected person or otherwise request confidential treatment of your information or that of your children and/or provide alternative contact information, please send your written request to the address listed below.
Other important information	• You have certain rights to access the personal information we maintain about you if it is reasonably locatable and retrievable. • To obtain your personal information, submit a written request to the email or mail address below. You have certain rights to correct, amend, or delete information we maintain about you. • To correct, amend, or delete information we maintain about you, submit a written request to the email or mail address below. • If we agree to your request, we will correct, amend, or delete your information as applicable and notify affected parties as required by law. • If we do not agree to your request, you may file a concise statement regarding your information, which will be provided to affected parties as required by law. • Before we disclose information about your creditworthiness or your personal information other than as discussed above (which we do not currently do) we will provide you the opportunity to opt out of such disclosures. • Finally, information obtained from a report prepared by an insurance-support organization may be retained by the insurance-support organization and disclosed to other persons.
Questions?	For more information, please contact us at • Email: NLGCompliance@nationallifegroup.com • Phone: 800-732-8939 • Mail: National Life Group Market Conduct and Compliance M530 One National Life Drive Montpelier, VT 05604

*Sentinel Investments is the unifying brand name for Sentinel Financial Services Company, Sentinel Asset Management, Inc., and Sentinel Administrative Services, Inc.

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Life Insurance Company of the Southwest®

Military Sales Disclosure

DISCLOSURE NOTICE FOR MILITARY SERVICE MEMBERS AND THEIR DEPENDENTS.

This form is to be completed at the time of application when selling any life insurance or annuity product to any active duty member of the Armed Forces and if applicable their spouse or dependent.

Thank you for your interest in our insurance product. Members of the Armed Forces, spouses and dependent children have access to subsidized life insurance from the Federal Government provided by the Service Members' Group Life Insurance Program (SGLI), under Subchapter III of Chapter 19 of Title 38, United States Code. Additional information on the SGLI program can be obtained by contacting SGLI at 800-419-1473 or www.insurance.va.gov. You may also be eligible for free legal advice from the Office of the Staff Judge Advocate.

The following chart outlines the amount of coverage available under the SGLI program for the Armed Forces member and the costs for such coverage (as of July 1, 2014). The premium includes an additional $1.00 per month for Traumatic Injury Protection coverage (TSGLI).

Coverage Amount	Total Monthly Premium
$50,000	$4.50
$100,000	$8.00
$150,000	$11.50
$200,000	$15.00
$250,000	$18.50
$300,000	$22.00
$350,000	$25.50
$400,000	$29.00

The National Life or Life Insurance Company of the Southwest insurance product being discussed with you is not offered or provided by the Federal Government, and the Federal Government has in no way sanctioned, recommended or encouraged the sale of the insurance product being offered.

No person has received any referral fee or incentive compensation in connection with the offer or sale of the insurance product, unless such person is engaged in the business of insurance and is properly licensed and appointed with the issuing company.

If you purchase a life insurance product, the contract will contain a right to return or "free look" period, as required by law. When you receive your contract, review it immediately and if you decide you do not wish to keep it, return it within the free look period and your contract will be void from the beginning. Any payment will be returned as specified in the contract.

Some life insurance creates a cash value within the policy - allowing loans or withdrawals during the life of the policy. Any amounts accumulated as cash value may be used to pay, reduce, or offset premiums due for continuation of coverage.

If you have a complaint that you are unable to resolve with the issuing company, you may contact the state insurance commissioner of your state who has the duty to regulate the sale of insurance products. State contact information can be obtained by calling the National Association of Insurance Commissioner executive headquarters at (816) 842-3600.

Sales Representative Certification (To be submitted to Home Office with the application for coverage)

I have reviewed and left a copy of this Disclosure document with the Service Member, or dependent if insurance is for the dependent, and provided a copy of DD Form 2885, Personal Commercial Solicitation Evaluation Sheet, if required. All representations made are consistent with these disclosures. I have reviewed the federal and state specific regulations for military sales and have complied with all requirements.

Signature of Sales Representative: _____

Date: *(mm/dd/yyyy)* _____

Name of Applicant: _____

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State of Execution Certification

It is necessary to document the reason the application for this life insurance policy or annuity contract was completed and executed in a state other than the insured, owner or applicant's state of residence.

State of execution: _____

Please check the correct box below indicating the reason the application was executed in a state other than the insured, owner or applicant's residence state:

☐ Owner or Applicant is a Trust or Other Entity domiciled in the state of execution. Tax I.D. Number: _____

☐ Insured, Owner, or Applicant's second residence is located in the state of execution.

☐ Insured, Owner, or Applicant is employed or conducts business in State of execution. Work address: _____

_____

_____

Note: If business is written on a resident of any of the following states, the state requires that the agent be licensed in the resident state: **ME and MI**.

By signing below, you certify the above facts to be true and correct and to be the reason why the application was completed and executed in a state other than the insured, owner or applicant's state of residence.

Insured, Owner or Applicant's Signature: Tax I.D. No.: Date: *(mm/dd/yyyy)*

_____

Agent's Signature: Date: *(mm/dd/yyyy)*

_____

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Form **4506-C**
(September 2020)

Department of the Treasury - Internal Revenue Service

IVES Request for Transcript of Tax Return

OMB Number
1545-1872

▶ **Do not sign this form unless all applicable lines have been completed.**
▶ **Request may be rejected if the form is incomplete or illegible.**
▶ **For more information about Form 4506-C, visit *www.irs.gov* and search IVES.**

1a. Name shown on tax return *(if a joint return, enter the name shown first)*	**1b. First social security number on tax return, individual taxpayer identification number, or employer identification number *(see instructions)***
2a. If a joint return, enter spouse's name shown on tax return	**2b. Second social security number or individual taxpayer identification number if joint tax return**

3. Current name, address (including apt., room, or suite no.), city, state, and ZIP code *(see instructions)*

4. Previous address shown on the last return filed if different from line 3 *(see instructions)*

5a. IVES participant name, address, and SOR mailbox ID
NCS TRV Processing, P.O. BOX 321, EGG HARBOR CITY, NJ 08215 800-582-7066

5b. Customer file number *(if applicable) (see instructions)*

Caution: This tax transcript is being sent to the third party entered on Line 5a. Ensure that lines 5 through 8 are completed before signing. *(see instructions)*

6. **Transcript requested**. Enter the tax form number here (1040, 1065, 1120, etc.) and check the appropriate box below. Enter only one tax form number per request _____

a. **Return Transcript**, which includes most of the line items of a tax return as filed with the IRS. A tax return transcript does not reflect changes made to the account after the return is processed. Transcripts are only available for the following returns: Form 1040 series, Form 1065, Form 1120, Form 1120-A, Form 1120-H, Form 1120-L, and Form 1120S. Return transcripts are available for the current year and returns processed during the prior 3 processing years ☐

b. **Account Transcript**, which contains information on the financial status of the account, such as payments made on the account, penalty assessments, and adjustments made by you or the IRS after the return was filed. Return information is limited to items such as tax liability and estimated tax payments. Account transcripts are available for most returns ☐

c. **Record of Account**, which provides the most detailed information as it is a combination of the Return Transcript and the Account Transcript. Available for current year and 3 prior tax years ☐

7. **Form W-2, Form 1099 series, Form 1098 series, or Form 5498 series transcript**. The IRS can provide a transcript that includes data from these information returns. State or local information is not included with the Form W-2 information. The IRS may be able to provide this transcript information for up to 10 years. Information for the current year is generally not available until the year after it is filed with the IRS. For example, W-2 information for 2016, filed in 2017, will likely not be available from the IRS until 2018. If you need W-2 information for retirement purposes, you should contact the Social Security Administration at 1-800-772-1213 ☐

Caution: If you need a copy of Form W-2 or Form 1099, you should first contact the payer. To get a copy of the Form W-2 or Form 1099 filed with your return, you must use Form 4506 and request a copy of your return, which includes all attachments.

8. Year or period requested. Enter the ending date of the tax year or period using the mm/dd/yyyy format *(see instructions)*

/ / / / / / / /

Caution: Do not sign this form unless all applicable lines have been completed.

Signature of taxpayer(s). I declare that I am either the taxpayer whose name is shown on line 1a or 2a, or a person authorized to obtain the tax information requested. If the request applies to a joint return, at least one spouse must sign. If signed by a corporate officer, 1 percent or more shareholder, partner, managing member, guardian, tax matters partner, executor, receiver, administrator, trustee, or party other than the taxpayer, I certify that I have the authority to execute Form 4506-C on behalf of the taxpayer. **Note**: This form must be received by IRS within 120 days of the signature date.

☐ **Signatory attests that he/she has read the attestation clause and upon so reading declares that he/she has the authority to sign the Form 4506-C. See instructions.**

Sign Here			
	Signature *(see instructions)*	Date	Phone number of taxpayer on line 1a or 2a
	Print/Type name		
	Title *(if line 1a above is a corporation, partnership, estate, or trust)*		
	Spouse's signature		Date
	Print/Type name		

Instructions for Form 4506-C, IVES Request for Transcript of Tax Return

Section references are to the Internal Revenue Code unless otherwise noted.

Future Developments

For the latest information about Form 4506-C and its instructions, go to *www.irs.gov* and search IVES. Information about any recent developments affecting Form 4506-C (such as legislation enacted after we released it) will be posted on that page.

What's New. Form 4506-C was created to be utilized by authorized IVES participants to order tax transcripts with the consent of the taxpayer.

General Instructions

Caution: Do not sign this form unless all applicable lines have been completed.

Designated Recipient Notification. Internal Revenue Code, Section 6103(c), limits disclosure and use of return information received pursuant to the taxpayer's consent and holds the recipient subject to penalties for any unauthorized access, other use, or redisclosure without the taxpayer's express permission or request.

Taxpayer Notification. Internal Revenue Code, Section 6103(c), limits disclosure and use of return information provided pursuant to your consent and holds the recipient subject to penalties, brought by private right of action, for any unauthorized access, other use, or redisclosure without your express permission or request.

Purpose of form. Use Form 4506-C to request tax return information through an authorized IVES participant. You will designate an IVES participant to receive the information on line 5a.

Note: If you are unsure of which type of transcript you need, check with the party requesting your tax information.

Where to file. The IVES participant will fax Form 4506-C with the approved IVES cover sheet to their assigned Service Center.

Chart for ordering transcripts

If your assigned Service Center is:	Fax the requests with the approved coversheet to:
Austin Submission Processing Center	Austin IVES Team 844-249-6238
Fresno Submission Processing Center	Fresno IVES Team 844-249-6239
Kansas City Submission Processing Center	Kansas City IVES Team 844-249-8128
Ogden Submission Processing Center	Ogden IVES Team 844-249-8129

Specific Instructions

Line 1b. Enter the social security number (SSN) or individual taxpayer identification number (ITIN) for the individual listed on line 1a, or enter the employer identification number (EIN) for the business listed on line 1a.

Line 3. Enter your current address. If you use a P.O. box, include it on this line.

Line 4. Enter the address shown on the last return filed if different from the address entered on line 3.

Note: If the addresses on lines 3 and 4 are different and you have not changed your address with the IRS, file Form 8822, Change of Address, or Form 8822-B,Change of Address or Responsible Party — Business, with Form 4506-C.

Line 5b. Enter up to 10 numeric characters to create a unique customer file number that will appear on the transcript. The customer file number cannot contain an SSN, ITIN or EIN. Completion of this line is not required.

Note. If you use an SSN, name or combination of both, we will not input the information and the customer file number will reflect a generic entry of "9999999999" on the transcript.

Line 8. Enter the end date of the tax year or period requested in mm/dd/yyyy format. This may be a calendar year, fiscal year or quarter. Enter each quarter requested for quarterly returns. Example: Enter 12/31/2018 for a calendar year 2018 Form 1040 transcript.

Signature and date. Form 4506-C must be signed and dated by the taxpayer listed on line 1a or 2a. The IRS must receive Form 4506-C within 120 days of the date signed by the taxpayer or it will be rejected. Ensure that all applicable lines, *including lines 5a through 8*, are completed before signing.

You must check the box in the signature area to acknowledge you have the authority to sign and request the information. The form will not be processed if unchecked.

Individuals. Transcripts listed on on line 6 may be furnished to either spouse if jointly filed. Only one signature is required. Sign Form 4506-C exactly as your name appeared on the original return. If you changed your name, also sign your current name.

Corporations. Generally, Form 4506-C can be signed by:

(1) an officer having legal authority to bind the corporation, (2) any person designated by the board of directors or other governing body, or (3) any officer or employee on written request by any principal officer and attested to by the secretary or other officer. A bona fide shareholder of record owning 1 percent or more of the outstanding stock of the corporation may submit a Form 4506-C but must provide documentation to support the requester's right to receive the information.

Partnerships. Generally, Form 4506-C can be signed by any person who was a member of the partnership during any part of the tax period requested on line 8.

All others. See section 6103(e) if the taxpayer has died, is insolvent, is a dissolved corporation, or if a trustee, guardian, executor, receiver, or administrator is acting for the taxpayer.

Note: If you are Heir at law, Next of kin, or Beneficiary you must be able to establish a material interest in the estate or trust.

Documentation. For entities other than individuals, you must attach the authorization document. For example, this could be the letter from the principal officer authorizing an employee of the corporation or the letters testamentary authorizing an individual to act for an estate.

Signature by a representative. A representative can sign Form 4506-C for a taxpayer only if the taxpayer has specifically delegated this authority to the representative on Form 2848, line 5. The representative must attach Form 2848 showing the delegation to sign Form 4506-C.

Privacy Act and Paperwork Reduction Act Notice. We ask for the information on this form to establish your right to gain access to the requested tax information under the Internal Revenue Code. We need this information to properly identify the tax information and respond to your request. You are not required to request any transcript; if you do request a transcript, sections 6103 and 6109 and their regulations require you to provide this information, including your SSN or EIN. If you do not provide this information, we may not be able to process your request. Providing false or fraudulent information may subject you to penalties.

Routine uses of this information include giving it to the Department of Justice for civil and criminal litigation, and cities, states, the District of Columbia, and U.S. commonwealths and possessions for use in administering their tax laws. We may also disclose this information to other countries under a tax treaty, to federal and state agencies to enforce federal nontax criminal laws, or to federal law enforcement and intelligence agencies to combat terrorism.

You are not required to provide the information requested on a form that is subject to the Paperwork Reduction Act unless the form displays a valid OMB control number. Books or records relating to a form or its instructions must be retained as long as their contents may become material in the administration of any Internal Revenue law. Generally, tax returns and return information are confidential, as required by section 6103.

The time needed to complete and file Form 4506-C will vary depending on individual circumstances. The estimated average time is:

Learning about the law or the form . . . 10 min.
Preparing the form . . . . . 12 min.
Copying, assembling, and sending the form to the IRS . . . . . 20 min.

If you have comments concerning the accuracy of these time estimates or suggestions for making Form 4506-C simpler, we would be happy to hear from you. You can write to:

Internal Revenue Service
Tax Forms and Publications Division
1111 Constitution Ave. NW, IR-6526
Washington, DC 20224

Do not send the form to this address. Instead, see Where to file on this page.

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Transfer/Exchange/Rollover

Please complete Section VIII for all plan administered accounts (i.e.: 403(b), 457, Pension, etc.)

Section I

Transferring Financial Institution Information
(Complete a separate form for each company.)

Name of Financial Institution _____ Phone Number _____

Address _____ City _____ State _____ Zip _____

Section II

Owner/Annuitant of Policy

Owner's Name _____ Owner's TIN/SSN _____

Annuitant's/Insured's Name *(if different)* _____

Joint Owner's Name _____ Joint Owner's TIN/SSN _____

Section III

Transferring Company Instructions

*(Please note: Any future dated transactions will be initiated immediately. The Transferring Company is responsible for processing according to the instructions indicated in this section. Annuity to Life transfers **are taxable** and not considered Replacements.)*

Policy/Acct #1: _____ **Approximate Transfer Amount: $** _____

◯ Full ◯ Partial ◯ Periodic Payment: Frequency: *(i.e. monthly, quarterly, annually)* _____ Years: _____

Policy/Acct #2: _____ **Approximate Transfer Amount: $** _____

◯ Full ◯ Partial ◯ Periodic Payment: Frequency: *(i.e. monthly, quarterly, annually)* _____ Years: _____

Apply proceeds to: ◯ A New Policy or ◯ An Existing Policy: _____

Proceeds to be transferred from: ◯ Bank Account/CD/Mutual Fund/Brokerage Account ◯ Annuity ◯ Life Policy ◯ Other _____

Loan to be carried forward $ _____ Loan type: ◯ Standard ◯ Variable ◯ Fixed *(for FlexLife II only)*

(Note: Carryover of loans only available with 403(b), 457 & Life. NLG will not accept defaulted loan balances.)

Please select the plan type for both the Existing and New policies below

From Existing Life Type:
◯ Qualified ◯ Non-Qualified

OR

From Existing Annuity Type:
◯ 403(b)
◯ Traditional IRA
◯ Roth IRA
◯ 401(k)/Pension/Profit Sharing
◯ SEP IRA
◯ SIMPLE IRA
◯ Roth 403(b)
◯ 457
◯ Non-Qualified
◯ Other _____

To New Life Type:
◯ Qualified ◯ Non-Qualified

OR

To New Annuity Type:
◯ 403(b)
◯ Traditional IRA
◯ Roth IRA
◯ 401(k)/Pension/Profit Sharing
◯ SEP IRA
◯ SIMPLE IRA
◯ Roth 403(b)
◯ 457 *(Note: 403(b) to 457 is not available)*
◯ Non-Qualified
◯ Other _____

Under IRC Section 1035 an exchange of an annuity contract for a life insurance policy does not qualify as a 1035 Exchange.

Section IV

Important Notices

1. The company will hold issuance of a single premium policy for 30 days from receipt of the first premium pending additional premium and will not credit interest during this period. Once 30 days expires, the policy will be issued. An additional policy will be issued if premiums are received after the 30-day period.
2. For 403(b) LSW will not maintain a separate account for the rollover amount. All values in the annuity will become part of the new plan. If the plan requires segregation of the rollover contribution, a new LSW annuity will be required.

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Section V General Agreement

a) Under penalties of perjury, I certify that (1) the number shown on this application is my correct taxpayer identification number; (2) the IRS has never notified me that I am subject to backup withholding, or has notified me that I am no longer subject to such withholding or I am exempt from such withholding; and (3) I am a U.S. person (including a U.S. resident alien). You must cross out item 2 if you have been notified by the IRS that you are currently subject to backup withholding because of underreporting interest or dividends on your tax return. **b)** I represent and warrant that the said current policy/account has not been assigned or pledged as collateral and is not subject to any lien, encumbrance, or legal proceedings of any kind, including bankruptcy. I am responsible for continuing any premium payment for my current policy (if necessary to keep the policy in force) until the surrendering company mails the policy proceeds to Issuing Company. I further agree that the Issuing Company is not responsible for any tax effect of this transfer or any delay by the surrendering company in processing this request. I am responsible for surrender charges and/or fees that result from this transfer. **c)** Upon surrender, transfer, or rollover on the current policy/account, the cash value when received by the Issuing Company at its Administrative/Home Office, will be applied to the new policy. To the extent that the Issuing Company agrees to a loan being carried forward from the current policy, the amount of the loan will be applied to the new policy. All proceeds from the surrender are intended to be applied to the new policy, subject to its terms. If for any reason the new policy is not placed, the policy/account owner will receive an amount equal to the cash value received from the surrendering company. **d)** All exchanges, transfers and rollovers are subject to the applicable IRS rules. Any rollover proceeds must comply with the rollover rules of IRC Section 402, et al. Any Required Minimum Distribution has been or will be taken prior to the transfer of these proceeds as required by IRC Section 401(a)(9). Information relative to this transaction may be furnished to the Issuing Company.

Section VI Full 1035 Exchange Assignment and Exchange Agreement

a) I, the Owner, assign and transfer to the Issuing Company, all right, title and beneficial interest in the current policy for the sole purpose of effecting an exchange under Section 1035 of the Internal Revenue Code. *If the new policy applied for is, due to any reason, not issued, the current policy will be reassigned to the policy owner named above.* **b)** For internal exchanges, the Applicant agrees that if the original policy is a variable policy, its Cash Surrender Value shall be determined as of the last market day prior to issue of the new policy and agrees that all proceeds from the exchange are intended to be applied to the new policy. **c)** I recognize that the discharge of any loan on the current policy may constitute cash received under IRC Section 1031(b), and that cash received as a result of the exchange may be reported as income to me to the extent there is a gain in the current policy. **d)** If the Issuing Company is unable, within 6 months, to effect a surrender of the current policy issued by the current Company, then this Agreement and any assignment of the current policy to the Issuing Company shall become null and void. The Issuing Company will reassign the current policy to the owner.

Section VII Signature(s)

I request liquidation and transfer of the proceeds to: ◯ Life Insurance Company of the Southwest or ◯ National Life Insurance Company.

Policy Statement - Please Select One (Required):

◯ My Policy/Contract has been lost or destroyed or ◯ My Policy/Contract is enclosed

Applicant/Owner _____ Date _____

Joint Owner _____ Date _____

Spouse *(Required in community property states: AZ, CA, ID, LA, NM, NV, TX, WA, WI)* _____ Date _____

Signature Guarantee *(if required by Transferring Company)*

Other Signatures Required *(i.e. Trustee, Collateral Assignee, Irrevocable Beneficiary, etc.)* _____

Capacity *(i.e. Trustee, Power of Attorney, etc.)* _____ Date _____

Section VIII Required for Qualified Plans: i.e., 403(b), 457, Pension, etc.

Note: If either one of these questions below is "yes", the plan administrator's signature is required. If the questions are not completed, the answer will default to "no".

Is the employer listed with the transfer company different than the employer listed with NLG? ◯ Yes ◯ No

If yes, please provide the employer's name: _____

Is the plan type, (i.e.:403(b), 457, Pension, etc.) at the transfer company different than the plan type at NLG? ◯ Yes ◯ No

Please review signature requirements with the Plan Administrator and transfer company to determine if the Plan Administrator's signature is required. Please obtain signature if necessary.

Plan Administrator's Signature _____ Date _____

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New Business Checklist

Date *(mm/dd/yyyy)* _____ Base # _____ Alt/Add'l #'s _____

Agency Number / MGA / IMO _____ Agent Name & Number _____

Agency Contact / Email _____ Second/Other Insured _____

Primary Insured _____ Companion Name _____

For use with all LSW/NL Life Applications *(Check appropriate box to indicate form is accompanying application)*

PI	2nd/OIR	COMP		
☐	☐	☐	HIV Consent Form	*(Always Required for each Insured, State specific)*
☐	☐	☐	HIPAA Compliant Authorization (8164)	*(Always Required for each Insured, State specific)*
☐	☐	☐	ABR Disclosure Form(s)	*(Always Required)*
☐	☐	☐	Agent's Report (8121G)	*(Always Required)*
☐	☐	☐	Initial Payment & Receipt	*(If money is collected)*
☐	☐	☐	Illustration	*(Required in NAIC states for non-variable products)*
☐	☐	☐	Replacement Form (8027)	*(Replacement cases or State requirement)*
☐	☐	☐	Transfer or 1035 Exchange (9685, Cat. No. 51189)	*(1035 cases)*
☐	☐	☐	Original Policy	*(1035 cases & Term Out)*
☐	☐	☐	Interest Crediting Strategies (8613/8411)	*(Indexed UL Products)*
☐	☐	☐	Supplemental App for QP or PS Trust (8533/20240)	*(Needed if policy will fund a Pension/Profit Sharing Plan)*
☐	☐	☐	Pension/Profit Sharing Plan Agreement (1620)	*(Used for PP with third party admin.)*
☐	☐	☐	Instructions for Completing Fiduciary Approval (0843)	*(Needed if policy will fund a Pension/Profit Sharing Plan)*

Underwriting Requirements *(Refer to Life Insurance Underwriting Guide for appropriate requirements)*

Note - Mature assessment needed at age 70 or older.

Exam service ordered from _____

PI	2nd/OIR	COMP	
☐	☐	☐	Jump In / Term Out *(If available)* Policy Spec Pages Attached
☐	☐	☐	No Fluid
☐	☐	☐	Blood / Urine and Vitals (Mini-Exam)
☐	☐	☐	Blood, Urine, Paramed Exam
☐	☐	☐	Blood, Urine, Paramed Exam, EKG
☐	☐	☐	Blood, Urine, Paramed Exam, EKG, Mature Assessment

APS Ordered Insured _____ Doctor _____ Date _____

Premium Finance Cases Only

Premium Financing Program _____

- ☐ Vetted by Home Office Advanced Sales
- ☐ Cover letter from producer
- ☐ Product Illustrations
- ☐ Hold Harmless Agreement (8656)
- ☐ Premium Finance Documentation (spreadsheets, loan agreements, etc.)
- ☐ 3rd Party Financials verifying minimum net worth requirement of $5 million and justifying amount applied for

Comments / Refer to Prior File or Quick Quote ***(attached)***

Attach Void Check Here *(If premium frequency is COM, be sure to attach void check here or provide savings account information. Please attach check with glue or tape. Do not staple.)*

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