National Life Group®

Life Insurance Company of the Southwest®

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 ( )	Cell 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 - *Relationship, Address, Telephone #, E-Mail, DOB & SSN (If different than Proposed Insured)*

Or the survivor(s); while living; thereafter the First Proposed Insured (FPI), unless otherwise provided.

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.

Part D - Policy Information

1. Product Name	2. Face Amount	3. Universal Life Death Benefit Option ☐ A - Level ☐ B - Increasing

4. Definition of Life Insurance Test *(Applies to IUL & UL only except Foundation.)* ☐ GPT ☐ CVAT *(Illustration needed.)*	5. Use of Dividends: *(Whole Life only) (Choose **only** one.)* ☐ Cash ☐ Additions ☐ Applied *(N/A with EFT)* ☐ Deposits

6. Riders and Amounts

☐ Accelerated Benefits (ABR) *(Complete ABR Disclosure form)*

☐ Additional Paid Up *(Whole Life)*

Rider Modal Premium $ _____

Rider Single Premium (SPAR) $ _____

☐ Additional Protection Benefit (APB) *(Adv 79, FlexLife I & II, Horizon)*

$ _____

☐ Automatic Conversion Rider *(Whole Life)* ☐ 10 Yrs ☐ 20 Yrs

☐ Benefit Distribution Option (BDO) *(FlexLife II only. Read the BDO Disclosure Statements in Part M.)*

1. Benefit Distribution Percentage _____ %
2. Duration of Benefit Payments _____ Years

☐ Children's Term (CTR) *(IUL & UL except IncomeBuilder)* $ _____

☐ Guaranteed Insurability (GIR) *(IUL & UL)* $ _____

☐ 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

☐ Waiver of Premiums (WP) *(All products)* $ _____

(Annual Premium Waived if applicable)

☐ Other _____ $ _____

The Death Benefit Protection Rider is automatically added, if eligible. *(FlexLife I & II, IncomeBuilder, Provider)*

☐ 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 IncomeBuilder product will have a monthly charge if issue age is over 50.

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

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. Planned Periodic/Modal Premium $ _____

2. Premium Mode ☐ Annual ☐ Semi-Annual ☐ Quarterly ☐ Monthly *(Electronic Funds Transfer (EFT))*

If EFT was selected, you may choose a draft date from the 1st - 28th _____ *(If EFT is chosen in #4 below, advanced dating will occur to align the requested draft date with the effective date of your policy.)*

If no day is selected, recurring drafts will be initiated on the day of issue. *(Policy effective date current)*

☐ Single Premium ☐ Group Bill No.: _____

3. Automatic Payment of Premium ***(Whole life only, also known as APL.)*** ☐ Yes ☐ No

4. Initial Premium Payment Method ***(Choose one.)***

☐ Check/Cash with application *(Cash equivalent payment must be accompanied by form 7953.)*

☐ COD *(collect payment on delivery of policy.)*

☐ Draft initial premium *(EFT - only available if Monthly is selected in #2.)*

If Draft initial premium is selected, the draft will be initiated on the day chosen above in #2, the policy effective date will be advanced dated to this requested day and commissions will not be generated until this advanced date. If no option is selected, coverage under the Conditional Receipt is not available and coverage under a policy (if one is issued to you) will not be effective until we receive your initial premium.

5. Identify the source of funds for premium payment

☐ Income/Savings ☐ Home equity ☐ Payment by third party ☐ Loan/Premium Finance ☐ Other: _____

6. Send premium notices to: ☐ Owner ☐ Proposed Insured ☐ Other: *(street, city, state & zip)* _____

7. Bank Information ***(Complete if Monthly EFT is selected)***

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

Name of Bank: _____ Name on Account: _____

Bank Routing No. *(9 digits)*

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

☐ Please check this box if you agree that premiums may be deducted if the premium amount increases by $25 of the amount included above. You will be given prior notification for any draft amounts that exceed this $25 limit.

I understand that recurring premiums will be initiated on my chosen draft date, however, they 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 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. Within the past 12 months have you applied for or do you have any applications pending for life or disability insurance? ☐ Yes ☐ No

3. Is the policy or rider being applied for intended to replace any inforce life insurance or annuity contract(s) including long term care 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

4. 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. 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? ☐ Yes ☐ No
   (If 'Yes', provide type & date discharged)

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 & results for any 'Yes' questions in Remarks). Complete Part J if money was collected with the application or an exam is not being done.***

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 prescribed 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 or taken medication 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, shortness of breath, 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, dizzy spells, epilepsy, convulsions, paralysis, unconsciousness, brain or eye disorders, or headaches? ☐ 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 memory loss, 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. Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC)? ☐ Yes ☐ No
   j. Any cancer, polyp, other tumors? ☐ Yes ☐ No
   k. Diabetes or high blood sugar? ☐ Yes ☐ No

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

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

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

10. 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

11. 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, not including tests for exposure to the Human Immunodeficiency Virus (AIDS Virus)? ☐ Yes ☐ No
    b. been admitted to a hospital, or been advised or plan to enter a hospital for observation, operation or treatment of any kind? ☐ Yes ☐ No

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

13. 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

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

14. Do you currently:
    a. Use or require the use of 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
15. Have you ever 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
16. Have you ever 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
17. 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 the "Computer View Illustration Certification" form is attached. An illustration corresponding to the policy as issued will be provided upon policy delivery.

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. For purposes of underwriting this risk and verifying answers on this application, I authorize any medical practitioner or facility, insurer, MIB, or credit bureau 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 from the date signed and a photocopy shall be as valid as the original. This authorization is subject to revocation by the applicant at any time. 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.
- ☐ I wish to receive a copy of the investigative consumer report if one 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

Caution: If your answers on this application are misstated or untrue, the insurer may have the right to deny benefits, including the denial of your accelerated death benefit coverage.

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

Proposed Insured age 18 & up *(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)

_____

(Exercise of AIO Only)
Owner of Base Policy

_____