Application

Our Vision

To Bring Peace of Mind To Everyone We Touch.

Our Mission

Keeping Our Promises.

Life Insurance Products Issued by
National Life Insurance Company®

Experience Life®

National Life Group® is a trade name of National Life Insurance Company (NLIC) and its affiliates.
National Life Variable Contracts distributed by Equity Services, Inc., Member FINRA/SIPC, Broker/Dealer Affiliate of NLIC.
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9212NJ(10/23/15)K
Cat. No. 47484

- e-mail scanned images to nbapplicationimages@nationallife.com or retirementservices@nationallife.com for qualified pension or profit sharing plan applications.
- Use the applications in this kit to apply for NL Life policies only.
- Form 9212, Individual Life Insurance Application, is to be used for single life, non-variable products.
- Form 20241, Variable Universal Individual Life Insurance Application, is to be used for single life, variable products.
- For survivorship products the 9212 along with form 8531, Second Proposed Insured/Other Insured Life Insurance Application, must be used.
- If you need additional room for Remarks, you may use the 20242 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** - 9212G 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 9212 or form 20241.
- **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 8411** - Required for all Indexed Universal Life products.
- **Qualified Pension or Profit Sharing Plan** - complete applications as follows:
  - **For Full Underwriting:** On Form 9212 complete all parts except parts B, C, E, and G.
  - **For Simplified Underwriting, Automatic Issue or Guaranteed Issue (requires form 0881)**: Use instructions for Full Underwriting except in Part J, only complete question 4 and do not complete Part I.
  - Form 1620, Pension/Profit Sharing Plan Insurer Only Agreement, needs to be included with each qualified plan.
  - Form 20240, Supplemental Application for Qualified Pension or Profit Sharing Trust, needs to be included with each pension application.
  - Form 0843, Fiduciary Approval Form, needs to be included with each qualified plan.
- **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
  - Variable Universal Life submit the Investment Allocation form 9201 (this form is an inclusion when the 9212 application kit is ordered)

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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 ____________________

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 ( )	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 #	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 other than Proposed Insured)*

☐ **Individual (Other than Insured):** ☐ **Check if Legal Guardian** *(include copy of documentation)*

(Legal Name & Relationship): ______ DOB: ______ ,
survivor(s), while living; thereafter
(Legal Name & Relationship): ______ DOB: ______ ,
the survivors or survivor, while living; thereafter (check one) ☐ the Insured **or** ☐ Estate of the last survivor of the named owners.
Note: If neither box is checked, the final owner will be the Proposed Insured.

☐ **Business Entity:** (Full Legal Name): ______ , a *(State):* ______ ,
☐ Corporation ☐ Limited Partnership ☐ Limited Liability Co. or ☐ General Partnership, or its successors, if any;
(Association): ______ otherwise the final owner will be Proposed Insured.

☐ **Trust:** *(Trustees)* ______ , trustee(s) under the
(Trust Name) ______ trust between said trustees and
(Trustor/Grantor) ______ dated: ______ ;
while trust is existent; thereafter Proposed Insured.

1. Owner Taxpayer ID No.: ______ Owner Daytime Telephone #: ( ) ______
2. Owner Complete Address: ______
3. Owner E-Mail Address: ______ Owner Social Sec. #: ______

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)*

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

4. Term Rider Amount: $ ______

5. Universal Life 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: *(N/A for any UL) (Choose **only** one.)*
   - ☐ Cash
   - ☐ Additions *(Whole Life)*
   - ☐ Applied *(N/A with EFT)*
   - ☐ Deposits
   - ☐ Flex Term Rider I - B Decreasing *(Whole Life)*
     One Yr. Term + Adds = $ ______
     A premium will be charged for this rider.
   - ☐ Internal Paid-Up Insurance *(Whole Life)*

8. Riders and Amounts
   - ☐ Accelerated Benefits (ABR) *(Complete ABR Disclosure form)*
   - ☐ Accidental Death Benefit (ADB) *(N/A with Term)* $ ______
   - ☐ Additional Insurance Option (AIO) *(Whole Life)* $ ______
   - ☐ Additional Paid Up *(Whole Life)*
     - Rider Modal Premium $ ______
     - Rider Single Premium (SPAR) $ ______
   - ☐ Additional Protection Benefit (APB) *(IUL)* $ ______
   - ☐ Balance Sheet Benefit *(FlexLife Only) (% Waived)* ______ %
   - ☐ Beneficiary Insurance Option (BIO) *(Whole Life) (Complete 1445)*
   - ☐ Children's Term (CTR) *(AssurePlus & FlexLife)* $ ______
   - ☐ Guaranteed Insurability (GIO) *(IUL & UL)* $ ______
   - ☐ Waiver of Monthly Deductions (WMD)
   - ☐ Waiver of Premiums (WP) *(All products)* $ ______
     (Annual Premium Waived if applicable)
   - ☐ Other ______ $ ______
   - ☐ Other ______ $ ______

The Death Benefit Protection Rider is automatically added, if eligible. *(AssurePlus & FlexLife)*

☐ 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 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. Planned Periodic/Modal Premium $ ____________________

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

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

   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.)*

   ☐ 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 they are within $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: ____________________

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. 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 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. 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 charged? *(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 & 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/lost more than 10 lbs in 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 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. 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
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, except those related 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
14. 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
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 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 - Owner's Taxpayer ID Number Certification

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.

Part N - 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 to the best of my knowledge and belief. I understand all such information and this application shall be part of any policy issued and that 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.

I have read the IMPORTANT NOTICES, including the Fair Credit Reporting Act and MIB, Inc. ("MIB") notices. To the extent allowed by law, I waive all rights governing disclosure of my information and that of any minor Proposed Insured(s) for whom I am a parent or guardian and authorize any organization, government or person to give such information to the Company. This authorization is valid for 30 months (or the length of time as per state regulation) from the date signed. I authorize the Company to re-disclose such information to its reinsurers, agents, service providers and affiliates, MIB and government authorities and when otherwise required by law or regulation or permitted by its privacy policy. I authorize the Company to obtain an investigative consumer report. I understand I may request to be interviewed in connection with such report as long as I can reasonably be contacted during normal business hours.

☐ 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. A policy is not effective until the Owner accepts the policy as delivered and the first full modal premium is paid prior to any change in the Proposed Insured's good health and insurability.

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.

Part O - Signatures

The IRS does not require your consent to any provision of this document other than the certifications required to avoid backup withholding.

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)*

Depositor *(Exactly as it appears on bank records)*

____

(Exercise of AIO Only)
Owner of Base Policy

____

National Life Group®

National Life Insurance Company®

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 ( )	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 #	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 2, Face Amount, only)*

1. Product Name	2. Face Amount

3. Universal Life Death Benefit Option
   - ☐ A - Level
   - ☐ B - Increasing

4. Definition of Life Insurance Test *(Applies to SIUL only.)*
   - ☐ Guideline Premium Test (GPT)
   - ☐ Cash Value Accumulation Test (CVAT)

5. Use of Dividends: *(Whole Life only) (Choose **only** one.)*
   - ☐ Cash
   - ☐ Additions *(Whole Life)*
   - ☐ Applied *(N/A with EFT)*
   - ☐ Deposits
   - ☐ DTO Balance to: ____________ *(Whole Life only)*
   - ☐ Flex Term Rider I - B Decreasing *(Whole Life only)*
     One Yr. Term + Adds = $ ____________
     A premium will be charged for this rider.
   - ☐ Flex Term Rider II - A Level *(Whole Life only)*
     One Yr. Term = $ ____________ , + Adds
     A premium will be charged for this rider.

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) *(SIUL & SUL)* $ ____________
   - ☐ Automatic Increase (AIR) *(SUL only)*
     ☐ 2% ☐ 4% ☐ 5% ☐ 10% ☐ Stipulated
   - ☐ Balance Sheet Benefit *(SIUL) (% Waived)* _____ %
   - ☐ Continuing Coverage Rider (CCR) (SIUL only) $ ____________
   - ☐ Enhanced Death Benefit (EDBR) *(SUL)* Target Age ________
   - ☐ Estate Preservation Rider (EPR) *(SUL & SIUL)*
   - ☐ Policy Split Option (PSO) *(All Survivorship)*
   - ☐ Survivor Protection *(SIUL)*
   - ☐ Other ____________ $ ____________
   - ☐ Other ____________ $ ____________

The Death Benefit Protection Rider is automatically added, if eligible. *(SIUL only)*

☐ 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 it may have a monthly charge if issue age is over 50.

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.)*

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 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 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 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. 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 charged? ☐ 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 G - Health History of the Proposed Insured ***(Give details, dates & results for any 'Yes' questions in Remarks). Complete Part G 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/lost more than 10 lbs in 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 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. 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

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, except those related 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

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

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

14. 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

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

Section & Number:	Additional Information:

Part I - Owner's Taxpayer ID Number Certification

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.

Part J - 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 to the best of my knowledge and belief. I understand all such information and this application shall be part of any policy issued and that 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.

I have read the IMPORTANT NOTICES, including the Fair Credit Reporting Act and MIB, Inc. ("MIB") notices. To the extent allowed by law, I waive all rights governing disclosure of my information and that of any minor Proposed Insured(s) for whom I am a parent or guardian and authorize any organization, government or person to give such information to the Company. This authorization is valid for 30 months (or the length of time as per state regulation) from the date signed. I authorize the Company to re-disclose such information to its reinsurers, agents, service providers and affiliates, MIB and government authorities and when otherwise required by law or regulation or permitted by its privacy policy. I authorize the Company to obtain an investigative consumer report. I understand I may request to be interviewed in connection with such report as long as I can reasonably be contacted during normal business hours.

☐ 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. A policy is not effective until the Owner accepts the policy as delivered and the first full modal premium is paid prior to any change in the Proposed Insured's good health and insurability.

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 K - Signatures

The IRS does not require your consent to any provision of this document other than the certifications required to avoid backup withholding.

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)*

____

(Exercise of AIO Only)
Owner of Base Policy

____

National Life Insurance Company®

Supplemental Application for Qualified Pension or Profit Sharing Trust

Part A - Proposed Insured Information

1. Name *(print first, middle, last)*	2. Policy No.

Part B - Owner Information

1. Qualified Pension or Profit Sharing Trust *(Name of Trust Agreement)*

2. Address *(Street, City, State & Zip)*

3. Tax Identification Number for the Qualified Pension or Profit Sharing Trust:

4. Telephone Number ( )	5. E-Mail Address

Part C - Beneficiary Information (Do Not Write in Part C)

The Owner is always the Beneficiary for a Qualified Pension or Profit Sharing Trust.

Note: If the policy is owned by a qualified pension or profit sharing plan, all payments are protected by the Spendthrift Provision. The right to change the beneficiary is reserved.

Part D - Underwriting Information

1. Issue Date: ____________________

2. *(Check one.)* ☐ Sex Neutral ☐ Sex Distinct *(Complete Form 8644)*

(Answer a & b only for Simplified Underwriting)

3. ☐ Full Underwriting ☐ Guaranteed Issue ☐ Automatic Issue

☐ Simplified Underwriting *(If either questions a or b are answered 'Yes', give the following details in the space provided. Nature of ailment, date, duration and names and addresses of attending physicians.)*

a. Have you been admitted to, or been advised to be admitted to a hospital or medical facility in the past 90 days by a member of the medical profession? ☐ Yes ☐ No

b. In the past two years have you been treated for or advised by a member of the medical profession to seek treatment for heart problems (including angina), stroke, or cancer, or been treated for or diagnosed as having AIDS or AIDS Related Complex (ARC)? ☐ Yes ☐ No

4. Are you actively at work at the customary workplace, doing the usual duties and functions required by the position during the normal work hours and weekly period? *(If "No" give reason below)* ☐ Yes ☐ No

Part E - 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 to the best of my knowledge and belief. I understand all such information and this application shall be part of any policy issued and that 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.

I have read the IMPORTANT NOTICES, including the Fair Credit Reporting Act and MIB, Inc. ("MIB") notices. To the extent allowed by law, I waive all rights governing disclosure of my information and authorize any organization, government or person to give such information to the Company or its reinsurers. I understand and agree that any such information may be reported to the MIB. This authorization is valid for 30 months (or the length of time as per state regulation) from the date signed.

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.

Part F - Owner's Taxpayer ID Number Certification

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.

Part G - Signatures

The Internal Revenue Service does not require your consent to any provision of this document other than the certifications required to avoid backup withholding.

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

Proposed Insured *(Sign name in full)*

____

Licensed Agent *(Sign name in full)*

____

Applicant/Trustee *(Print name of Pension/Profit Sharing Trust)*

____

(Trustee)

National Life Insurance Company®

Variable Universal 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 #	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 other than Proposed Insured.) (Qualified Plans use Supplemental Application 20240.)*

☐ **Individual (Other than Insured):** ☐ **Check if Legal Guardian** *(include copy of documentation)*

(Legal Name & Relationship): ______ DOB: ______ ,
survivor(s), while living; thereafter

(Legal Name & Relationship): ______ DOB: ______ ,
the survivors or survivor, while living; thereafter (check one) ☐ the Insured **or** ☐ Estate of the last survivor of the named owners.
Note: If neither box is checked, the final owner will be the Proposed Insured.

☐ **Business Entity:** (Full Legal Name): ______ , a *(State):* ______ ,
☐ Corporation ☐ Limited Partnership ☐ Limited Liability Co. or ☐ General Partnership, or its successors, if any;
(Association): ______ otherwise the final owner will be Proposed Insured.

☐ **Trust:** *(Trustees)* ______ , trustee(s) under the
(Trust Name) ______ trust between said trustees and
(Trustor/Grantor) ______ dated: ______ ;
while trust is existent; thereafter Proposed Insured.

1. Owner Taxpayer ID No.: ______ Owner Daytime Telephone #: ( ) ______
2. Owner Complete Address: ______
3. Owner E-Mail Address: ______ Owner Social Sec. #: ______

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)*

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
   (GPT is used if policy NOT a MEC.)
   - ☐ Guideline Premium Test (GPT)
   - ☐ Cash Value Accumulation Test (CVAT)
5. Riders and Amounts
   - ☐ Accelerated Benefits (ABR) *(Complete ABR Disclosure form)*
   - ☐ Accidental Death Benefit (ADB) $ __________
   - ☐ Balance Sheet Benefit *(% Waived)* ______ %
   - ☐ Children's Term (CTR) $ __________
   - ☐ Guaranteed Insurability (GIR) $ __________
   - ☐ Other Insured (OIR)
   - ☐ Waiver of Monthly Deductions (WMD)
   - ☐ Waiver of Specified Premiums (WSP) $ __________ *(Annual Premium Waived)*
   - ☐ Other ____________________ $ __________
   - ☐ Other ____________________ $ __________

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

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.)*

☐ Single Premium ☐ Group Bill No.: ____________________

3. 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.

Part F - Premium Information *(Continued)*

4. Identify the source of funds for premium payment

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

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

6. 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 they are within $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: ______________

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. 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

Part H - Recent Applications, Inforce Coverage, and Replacement Information *(Continued)*

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 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. 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 charged? *(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 & 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/lost more than 10 lbs in 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 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

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

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

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, except those related 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
14. 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
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 - Variable Insurance Information

Following questions to be completed by the Applicant.

1. Have you received a current prospectus which describes the variable nature of this product and the utilization of a Separate Account or a Variable Account? ☐ Yes ☐ No
2. Do you believe that this Policy will meet your insurance needs and financial objectives? ☐ Yes ☐ No
3. Do you understand that the Cash Surrender Value and Death Benefit may increase or decrease based on the policy's investment return, even to the extent of being reduced to zero? ☐ Yes ☐ No

Part L - Telephone Transaction Agreement

Unless waived below, I appoint the Company as my agent to act upon telephoned instructions reasonably believed to be authorized by me. I hereby ratify any telephoned instructions so given and consent to the tape recording of these instructions. So long as the Company employs reasonable procedures to confirm that the instructions are genuine, I agree that I will not hold the Company liable for any unauthorized telephoned instructions. This will allow me and my representative named below to transfer account values between available accounts, change premium allocations, and add, cancel or change the Portfolio Rebalancing or Dollar Cost Averaging features. *Owner can request policy loans only up to $25,000.*

Representative(s): ______________________

☐ I do **not** authorize the Company to accept telephone instructions.

Part M - Investment Information

1. Do you want monthly charges deducted from the Money Market sub-account? ☐ Yes ☐ No
   (If 'No', charges will be deducted from the General Account and all sub-accounts on a pro rata basis.)

Note: Elect Portfolio Rebalancing (2.a.) or Dollar Cost Averaging, (2.b.) but not both. *(See Investment Allocation, form 9201)*

2.a. ☐ I elect semi-annual Portfolio Rebalancing.

OR

2.b. ☐ I elect monthly Dollar Cost Averaging. Transfer funds from the Money Market sub-account using the allocation provided on the Investment Allocation, form 9201.

The amount and duration of the Death Benefit may increase or decrease daily as described in the DEATH BENEFIT AND POLICY CHANGES section of the policy at issue. The dollar amount of the Death Benefit is not guaranteed. The Cash Surrender Value of this policy is dependent on the Accumulated Value in the Separate Account or Variable Account, which fluctuates according to the investment experience of the Sub-Accounts of the Separate Account or Variable Account chosen by the Owner. The Cash Surrender Value may increase or decrease daily, and is not guaranteed as to dollar amount.

The investment in this policy could be lost entirely, depending on the performance of the Separate Account or Variable Account, and as a result the Death Benefit may terminate unless additional premium payments are made to keep this policy in force.

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

Section & Number:	Additional Information:

Part O - 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 P - Owner's Taxpayer ID Number Certification

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.

Part Q - 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 to the best of my knowledge and belief. I understand all such information and this application shall be part of any policy issued and that 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.

I have read the IMPORTANT NOTICES, including the Fair Credit Reporting Act and MIB, Inc. ("MIB") notices. To the extent allowed by law, I waive all rights governing disclosure of my information and that of any minor Proposed Insured(s) for whom I am a parent or guardian and authorize any organization, government or person to give such information to the Company. This authorization is valid for 30 months (or the length of time as per state regulation) from the date signed. I authorize the Company to re-disclose such information to its reinsurers, agents, service providers and affiliates, MIB and government authorities and when otherwise required by law or regulation or permitted by its privacy policy. I authorize the Company to obtain an investigative consumer report. I understand I may request to be interviewed in connection with such report as long as I can reasonably be contacted during normal business hours.

☐ 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. A policy is not effective until the Owner accepts the policy as delivered and the first full modal premium is paid prior to any change in the Proposed Insured's good health and insurability.

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 R - Signatures

The IRS does not require your consent to any provision of this document other than the certifications required to avoid backup withholding.

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)*

Depositor *(Exactly as it appears on bank records)*

____

(Exercise of AIO Only)

Owner of Base Policy

____

National Life Insurance Company®

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: ______________________

National Life Group® is a trade name of National Life Insurance Company, Montpelier, VT and its affiliates.

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

National Life Insurance Company®

Interest Crediting Strategies

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 - Ultra Strategy Selection - Five-Year Crediting Periods

(Fixed-Term Strategy) (102) ______ %

Point-to-Point
(Equity Indexed Strategy) 1 (104) ______ %

Point-to-Average
(Equity Indexed Strategy) 2 (103) ______ %

Point-to-Point, Cap Focus, Emerging Markets
(Equity Indexed Strategy 3) (155) ______ %

Total 100%

☐ Activate Systematic Allocations on New Premium Payments

☐ Activate Systematic Allocations on Renewing Index Segments**

☐ Terminate Systematic Allocations for future premiums and Renewing Index Segments

☐ Terminate all existing Systematic Allocation accounts

Section 2 - Ultra Select and LifeCycle Solution Strategy Selection - One-Year Crediting Periods

(Fixed-Term Strategy) (102) ______ %

Point-to-Point, Cap Focus
(Indexed Strategy 1) (104) ______ %

Point-to-Point, Participation Rate Focus
(Indexed Strategy 2) (143) ______ %

Point-to-Point, No Cap
(Indexed Strategy 3) (144) ______ %

Point-to-Average, No Cap
(Indexed Strategy 4) (103) ______ %

Point-to-Point, Cap Focus, Emerging Markets
(Indexed Strategy 5) (155) ______ %

Total 100%

☐ Activate Systematic Allocations on New Premium Payments

☐ Activate Systematic Allocations on Renewing Index Segments**

☐ Terminate Systematic Allocations for future premiums and Renewing Index Segments

☐ Terminate all existing Systematic Allocation accounts

Section 3 - FlexLife Strategy Selection - One-Year Crediting Periods

(Fixed-Term Strategy) (102) ______ %

Point-to-Point, Cap Focus
(Indexed Strategy 1) (351) ______ %

Point-to-Point, Participation Rate Focus
(Indexed Strategy 2) (352) ______ %

Point-to-Point, No Cap
(Indexed Strategy 3) (353) ______ %

Point-to-Average, No Cap
(Indexed Strategy 4) (350) ______ %

Point-to-Point, Cap Focus, Emerging Markets
(Indexed Strategy 5) (360) ______ %

Total 100%

☐ Activate Systematic Allocations on New Premium Payments

☐ Activate Systematic Allocations on Renewing Index Segments**

☐ Terminate Systematic Allocations for future premiums and Renewing Index Segments

☐ Terminate all existing Systematic Allocation accounts

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

Sign and Date

Applicant/Owner's Signature: ______________________ Date: ______________

National Life Group® is a trade name of National Life Insurance Company, Montpelier, VT and its affiliates.

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

Disclosure Statement for Accelerated Benefits

(Terminal Illness, Critical Illness & 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 condition under which accelerated benefits may be elected varies by rider as described below.

NOTE: Your policy may not be eligible for coverage under all the Accelerated Benefits Riders described below. Please check your policy for details on each Accelerated Benefits Rider that is included in your policy and the insured(s) covered under each rider.

Accelerated Benefits Rider for 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 Specialist 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.

Accelerated Benefits Rider for Critical Illness

Benefits may be elected under this rider if the Insured has experienced a covered Critical Illness Qualifying Event. 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.
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.
3. **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.

   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.
4. **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.
5. **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.
6. **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.
7. **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.

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

Copies to the Company, the Customer, and the Agent

8. **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.

9. **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.

10. **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.

11. **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.

    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.

12. **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.

    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.

Accelerated Death Benefits Rider for Critical Injury

Benefits may be elected under this rider if the Insured has experienced a Critical Injury Qualifying Event. 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.

   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.

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.

   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 either the Critical Illness Rider or the Critical Injury Rider for any 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 amount that we will pay under this and any other Accelerated Benefits Rider on the policy to which this rider is attached. If we do so, it 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 not to exceed $250. 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.

If the benefit replaces only a portion of the life insurance coverage, a pro rata share of any outstanding policy debt will be deducted before the payment of the benefit. Any Waiver of Premium, Accidental Death Benefit or Exchange to New Insured riders will remain in full effect. Other riders may be continued at reduced levels. Premium for the life insurance coverage that is continued will be the premium which would have been charged for that amount of coverage at the time of issue of the policy. Any cash value or cash surrender value of the policy will be reduced in the same proportion as the face amount.

Payment of Accelerated Benefits will reduce the death benefit otherwise payable under the policy. Receipt of Accelerated Benefits may be a taxable event. Please consult your personal tax advisor to determine the tax status of any benefits paid under this rider.

Receipt of Accelerated Benefits may adversely affect the recipient's eligibility for Medicaid or other government benefits or entitlements. Accelerated Benefits do not and are not intended to qualify as long-term care insurance.

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

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

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

Disclosure Statement for Accelerated Benefits

(Terminal Illness, Critical Illness & Critical Injury)

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Copies to the Company, the Customer, and the Agent

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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.

   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.

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.

   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 either the Critical Illness Rider or the Critical Injury Rider for any 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 amount that we will pay under this and any other Accelerated Benefits Rider on the policy to which this rider is attached. If we do so, it 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 not to exceed $250. 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.

If the benefit replaces only a portion of the life insurance coverage, a pro rata share of any outstanding policy debt will be deducted before the payment of the benefit. Any Waiver of Premium, Accidental Death Benefit or Exchange to New Insured riders will remain in full effect. Other riders may be continued at reduced levels. Premium for the life insurance coverage that is continued will be the premium which would have been charged for that amount of coverage at the time of issue of the policy. Any cash value or cash surrender value of the policy will be reduced in the same proportion as the face amount.

Payment of Accelerated Benefits will reduce the death benefit otherwise payable under the policy. Receipt of Accelerated Benefits may be a taxable event. Please consult your personal tax advisor to determine the tax status of any benefits paid under this rider.

Receipt of Accelerated Benefits may adversely affect the recipient's eligibility for Medicaid or other government benefits or entitlements. Accelerated Benefits do not and are not intended to qualify as long-term care insurance.

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

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

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

National Life Insurance Company®

Disclosure Statement for Accelerated Benefits

(Covered Chronic Illness)

Acceleration of your life insurance policy means that some or all of the benefits that would go to the Beneficiary after the death of the Insured will be paid to the Owner before the death of the Insured. The Owner of the policy must ask for the Accelerated Benefits and must show that the Insured has a Covered Chronic Illness.

Covered Chronic Illness: Covered Chronic Illness means that the Insured has an illness or physical condition such that he or she:

1. is unable to perform (without substantial assistance from another individual) at least two Activities of Daily Living for a period of at least 90 days due to a loss of functional capacity; or

2. requires substantial supervision by another person to protect the Insured from threats to health and safety due to his or her own severe cognitive impairment.

The Activities of Daily Living are bathing, continence, dressing, eating, toileting, and transferring.

Accelerated Benefits are paid as a lump sum. The amount of the Accelerated Benefit will be the discounted present value of the accelerated face amount, adjusted by future premiums payable and anticipated dividends. An administrative fee may be assessed. The amount of benefit will be no more than the face amount, and no less than the cash value or cash surrender value of the portion of the life insurance coverage being replaced.

Accelerated Benefits may be paid in lieu of either the entire face amount of the policy or a portion of the face amount. **The Company reserves the right to set a maximum amount that we will pay under this and any other Accelerated Benefits Rider on the policy to which this rider is attached. If we do so, it will be no less than $500,000.**

If the benefit replaces the entire life insurance coverage, any outstanding policy debt will be deducted before the payment of the benefit. All added benefit riders attached to the policy will cease. Some riders which provide for additional term life insurance may be converted. The value of some of the riders may be added to the benefit amount. See the rider for specific details.

If the benefit replaces only a portion of the life insurance coverage, a pro rata share of any outstanding policy debt will be deducted before the payment of the benefit. Any Waiver of Premium, Accidental Death Benefit or Exchange to New Insured riders will remain in full effect. Other riders may be continued at reduced levels. Premium for the life insurance coverage that is continued will be the premium which would have been charged for that amount of coverage at the time of issue of the policy. The Amount shall be at least equal to the acceleration percentage multiplied by the difference between the current policy Cash Value or Cash Surrender Value and any outstanding policy loans. The current policy Cash Value or Cash Surrender Value shall include any termination dividend payable on the surrender of the policy.

Payment of Accelerated Benefits will reduce the Death Benefit otherwise payable under the policy. Receipt of Accelerated Benefits may be a taxable event. Please consult your personal tax advisor to determine the tax status of any benefits paid under this rider.

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® is a trade name of National Life Insurance Company (NLIC) and its affiliates.
National Life Variable Contracts distributed by Equity Services, Inc., Member FINRA/SIPC, Broker/Dealer Affiliate of NLIC.

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

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Prenotifications

Notification of Information Practices

Thank you for applying to the National Life Insurance Company and Life Insurance Company of the Southwest (the Company) for your insurance. This description of the Information Practices of the Company and your agent is being provided in accordance with the requirements of the Insurance Information and Privacy Protection Law in effect in your state of residence.

Collection of Information

In order to properly underwrite and administer your insurance coverage, we must collect a certain amount of necessary and helpful information. The amount and type of information collected may vary depending on the amount and type of coverage applied for, but in general we will be seeking information about your age, occupation, physical condition, health history, mode of living, finances, avocations, character, general reputation and other personal characteristics. In addition, your agent may collect information intended to aid in the updating and improvement of your insurance program.

Your application, with the medical history and other information you furnish, is our main source of information. We may also collect or verify information by contacting medical professionals and institutions which have provided care to you or members of your family proposed for coverage, employers and business associates, friends and neighbors, and other insurance companies you have applied to. We may collect information by exchanges of correspondence, by phone, or by personal contact.

In some cases, we may ask an insurance support organization to collect information and submit an investigative consumer report to confirm or supplement information on your application. That organization may retain a copy of the report and may disclose its contents to others for whom it performs such services.

Disclosures by the Company

In some circumstances, the Company or your agent will make disclosures of personal information, without your authorization, to third parties. Following is a brief description of some of the persons or organizations to whom certain items of information might be disclosed:

- Persons or organizations which perform professional, business or insurance functions for us;
- Your agent, consumer reporting agencies hired to prepare investigative reports, and other insurance companies to which you have applied for coverage or benefits;
- Your attending physician or treating medical professional;
- Persons or organizations conducting bona fide actuarial or scientific research studies, audits or evaluations;
- Unless you object, to persons or organizations who may wish to market products or services, including affiliates of the Company.

Please be assured that the above describes some of the disclosures which may be made, not disclosures which are always or even often made. In any event, the information disclosed without your authorization will be only as much as is reasonably necessary to accomplish the intended purpose.

For example, we would ordinarily disclose only name and address to a marketing firm, and perhaps additional information relating to age, amounts of insurance and claims experience to a scientific research organization. Information relating to physical condition or medical history would ordinarily be disclosed only to your attending physician or treating medical professional. In short, the types of information disclosed will vary depending upon the needs of the recipient and the sensitivity of the data.

A description of the circumstances under which information about you might be disclosed without your authorization to the types of persons and organizations referred to above will be sent to you upon request.

Access and Correction

There are procedures by which you can obtain access to personal information about you appearing in our policy files, including information contained in investigative consumer reports. We have also established procedures by which you may request, in writing, correction, amendment or deletion of any personal information in our files. A description of these procedures will also be sent to you upon request.

Obtaining Additional Information

We hope that you find this description of our information practices helpful. If you have any further questions about the items just discussed, please write to the New Business Department, Administrative Office, One National Life Drive, Montpelier, Vermont 05604.

Leave with Applicant

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

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 - 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.

Upon written request, made within a reasonable period of time, you will be informed whether or not an investigative consumer report was requested and, if so, the name and address of the consumer reporting agency that prepared the report. By contacting that agency you will be permitted to inspect and receive a copy of that report.

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 MIB'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.

National Life Group®

National Life Insurance Company®
Life Insurance Company of the Southwest™

Prenotifications

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Collection of Information

In order to properly underwrite and administer your insurance coverage, we must collect a certain amount of necessary and helpful information. The amount and type of information collected may vary depending on the amount and type of coverage applied for, but in general we will be seeking information about your age, occupation, physical condition, health history, mode of living, finances, avocations, character, general reputation and other personal characteristics. In addition, your agent may collect information intended to aid in the updating and improvement of your insurance program.

Your application, with the medical history and other information you furnish, is our main source of information. We may also collect or verify information by contacting medical professionals and institutions which have provided care to you or members of your family proposed for coverage, employers and business associates, friends and neighbors, and other insurance companies you have applied to. We may collect information by exchanges of correspondence, by phone, or by personal contact.

In some cases, we may ask an insurance support organization to collect information and submit an investigative consumer report to confirm or supplement information on your application. That organization may retain a copy of the report and may disclose its contents to others for whom it performs such services.

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- Persons or organizations which perform professional, business or insurance functions for us;
- Your agent, consumer reporting agencies hired to prepare investigative reports, and other insurance companies to which you have applied for coverage or benefits;
- Your attending physician or treating medical professional;
- Persons or organizations conducting bona fide actuarial or scientific research studies, audits or evaluations;
- Unless you object, to persons or organizations who may wish to market products or services, including affiliates of the Company.

Please be assured that the above describes some of the disclosures which may be made, not disclosures which are always or even often made. In any event, the information disclosed without your authorization will be only as much as is reasonably necessary to accomplish the intended purpose.

For example, we would ordinarily disclose only name and address to a marketing firm, and perhaps additional information relating to age, amounts of insurance and claims experience to a scientific research organization. Information relating to physical condition or medical history would ordinarily be disclosed only to your attending physician or treating medical professional. In short, the types of information disclosed will vary depending upon the needs of the recipient and the sensitivity of the data.

A description of the circumstances under which information about you might be disclosed without your authorization to the types of persons and organizations referred to above will be sent to you upon request.

Access and Correction

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Upon written request, made within a reasonable period of time, you will be informed whether or not an investigative consumer report was requested and, if so, the name and address of the consumer reporting agency that prepared the report. By contacting that agency you will be permitted to inspect and receive a copy of that report.

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 MIB'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.

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

NOTICE AND CONSENT FOR TESTING WHICH MAY INCLUDE AIDS VIRUS (HIV) ANTIBODY/ANTIGEN TESTING

To determine your insurability, the Insurer named above (the Insurer) has requested that you provide a sample of your blood, oral fluid and/or urine for testing and analysis. All tests will be performed by a licensed laboratory.

Unless precluded by law, tests may be performed to determine the presence of antibodies or antigens to the Human Immunodeficiency Virus (HIV), also known as the AIDS virus. The HIV antibody test that we perform is actually a series of tests done by a medically accepted procedure. The HIV antigen test directly identifies AIDS viral particles. These tests are extremely reliable. Other tests which may be performed include determinations of blood cholesterol and related lipids (fats) and screening for liver or kidney disorders, diabetes, and immune disorders.

All test results will be treated confidentially. They will be reported by the laboratory to the Insurer. When necessary for business reasons in connection with insurance you have or have applied for with the Insurer, the Insurer may disclose test results to others such as its affiliates, reinsurers, employees, or contractors. If the Insurer is a member of the Medical Information Bureau (MIB, Inc.), and if the test results for HIV antibodies/antigens are other than normal, the Insurer will report to the MIB, Inc. a generic code which signifies only a non-specific test abnormality. If your HIV test is normal, no report will be made about it to the MIB, Inc. Other test results may be reported to the MIB, Inc. in a more specific manner. The organizations described in this paragraph may maintain the test results in a file or data bank. There will be no other disclosure of test results or even that the tests have been done except as may be required or permitted by law or as authorized by you.

If your HIV test results are normal, no routine notification will be sent to you. If the HIV test results are other than normal, the Insurer will contact you. The Insurer may also contact you if there are other abnormal test results which, in the Insurer's opinion, are significant. The Insurer may ask you for the name of a physician or other health care provider to whom you may authorize disclosure and with whom you may wish to discuss the results. You may designate below the physician or other person to whom positive or indeterminate test results will be reported:

Name: *(Print or Type)*

____

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

____

____

Positive HIV antibody/antigen test results do not mean that you have AIDS, but that you are at a significantly increased risk of developing AIDS or AIDS-related conditions. Federal authorities say that persons who are HIV antibody/antigen positive should be considered infected with the AIDS virus and capable of infecting others.

Positive HIV antibody or antigen test results or other significant test abnormalities 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.

I have read and I understand this Notice of Consent For Testing Which May Include HIV Antibody/Antigen Testing. I voluntarily consent to the withdrawal of blood from me by needle, the collection of oral fluid and/or urine samples, the testing of the samples, and the disclosure of the test results as described above.

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)*	

To determine your insurability, the Insurer named above (the Insurer) has requested that you provide a sample of your blood, oral fluid and/or urine for testing and analysis. All tests will be performed by a licensed laboratory.

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

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Name: *(Print or Type)*

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

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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)*

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National Life Insurance Company®
Life Insurance Company of the Southwest™

Payment Form

Agency/Branch No.:	Agent Name:

Policy/Contract/Group/Trust No.:

Name of Individual/Group/Trust:

Date of Check:	Amount:	Date Sent to NLG:

Check one: ☐ Initial Payment ☐ Renewal Payment ☐ Contract Change HO Use: ☐
☐ Loan Repayment ☐ Loan Interest

Check one: ☐ Life ☐ Variable Life ☐ Disability Income ☐ Annuity ☐ Variable Annuity

Change Mode to: ☐ Annual ☐ Semi annual ☐ Quarterly

If payment covers multiple insureds, please give breakdown. Attach separate listing if needed.

Instructions:

Use this form with payments for all National Life Group products.

Checks must be made payable to National Life Group, National Life Insurance Company or Life Insurance Company of the Southwest.

- NLFA Agents - Submit Variable Annuity applications, form 2012 and check to Equity Services, Inc.
- Submit all other applications and checks with form 2012 to NLG.

Unacceptable forms of payment:

- CASH
- Endorsed checks (not allowed for variable products only)
- Post dated checks
- Agent/representative or agency/broker dealer check
- Money orders purchased by agent/representative or agency/broker dealer staff

We cannot accept money prior to submission of an application.

Forward 2012's with checks to NLG within 48 hours of receipt. Checks dated more than 5 days from the date of receipt at NLG will require a letter of explanation.

All money orders, bank checks, cashier's checks, Treasurer's checks and Traveler's checks purchased by the policyowner or payor must be accompanied by a Cash Equivalent Payment Receipt form 7953.

Minimum Initial Payments:

- Variable Universal Life: An amount no less than one minimum monthly premium will be accepted for the Initial Premium
- Variable Annuity: Non-Qualified - $5,000; Qualified - $1,500 ($3,000 in South Carolina)

Any payment not in compliance will be returned directly to the issuer of the check.

2012(0513)
Cat. No. 45447

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

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

HIPAA Compliant Authorization

for Release of Health-Related 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 records or knowledge of me or my health, my entire medical record, prescription drug information, 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 redisclose any protected health information concerning me to The Company's reinsurers and to MIB, Inc., which operates an information exchange on behalf of life and health insurance companies.

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.

This protected health information is 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 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 redisclosed and no longer covered by federal rules governing privacy and confidentiality of health information.

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, 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:

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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.

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

HIPAA Compliant Authorization

for Release of Health-Related Information

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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.

This protected health information is 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 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 redisclosed and no longer covered by federal rules governing privacy and confidentiality of health information.

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

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

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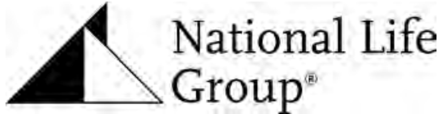
   You may release all medical records, restricted and otherwise if a patient has previously requested a restriction and later signs an authorization which removes the restriction. The wording of this authorization specifically releases any restricted information.

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



National Life Insurance Company®

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 NATIONAL LIFE INSURANCE COMPANY.
Do not make a 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, National Life Insurance Company's (NLIC) liability under this receipt is limited to a full refund of the premium paid. If applicant directed NLIC to draft the initial premium payment and NLIC 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 NLIC in good funds,

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

c) NLIC 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) NLIC 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) NLIC notifies the applicant in writing that coverage is ended. If NLIC 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, NLIC will refund the full amount paid under this receipt. If applicant directed NLIC to draft the first premium payment and NLIC 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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P: 800-732-8939 | www.NationalLifeGroup.com
Centralized Mailing Address: One National Life Drive, Montpelier, VT 05604

National Life Group®

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.

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 National Life Insurance 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 National Life Insurance Company, 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 National Life Insurance 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)* ______________________

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

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

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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?

National Life Group®

National Life Insurance Company®
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.

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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.

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

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)* _______________

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.

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

National Life Group®

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

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-T**
(Rev. September 2015)
Department of the Treasury
Internal Revenue Service

Request for Transcript of Tax Return

▶ **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-T, visit *www.irs.gov/form4506t*.**

OMB No. 1545-1872

Tip. Use Form 4506-T to order a transcript or other return information free of charge. See the product list below. You can quickly request transcripts by using our automated self-help service tools. Please visit us at IRS.gov and click on "Get a Tax Transcript..." under "Tools" or call 1-800-908-9946. If you need a copy of your return, use **Form 4506, Request for Copy of Tax Return.** There is a fee to get a copy of your return.

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)

5 If the transcript or tax information is to be mailed to a third party (such as a mortgage company), enter the third party's name, address, and telephone number.

NCS/TRV Processing PO Box 321, Egg Harbor City, NJ 08215-0321 800-582-7066

Caution: If the tax transcript is being mailed to a third party, ensure that you have filled in lines 6 through 9 before signing. Sign and date the form once you have filled in these lines. Completing these steps helps to protect your privacy. Once the IRS discloses your tax transcript to the third party listed on line 5, the IRS has no control over what the third party does with the information. If you would like to limit the third party's authority to disclose your transcript information, you can specify this limitation in your written agreement with the third party.

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. Most requests will be processed within 10 business days . . . . ☑

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. Most requests will be processed within 10 business days . ☐

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. Most requests will be processed within 10 business days . . . . ☐

7 **Verification of Nonfiling,** which is proof from the IRS that you **did not** file a return for the year. Current year requests are only available after June 15th. There are no availability restrictions on prior year requests. Most requests will be processed within 10 business days . . ☐

8 **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 2011, filed in 2012, will likely not be available from the IRS until 2013. If you need W-2 information for retirement purposes, you should contact the Social Security Administration at 1-800-772-1213. Most requests will be processed within 10 business days . ☐

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.

9 **Year or period requested.** Enter the ending date of the year or period, using the mm/dd/yyyy format. If you are requesting more than four years or periods, you must attach another Form 4506-T. For requests relating to quarterly tax returns, such as Form 941, you must enter each quarter or tax period separately. / / | / / | / / | / /

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-T on behalf of the taxpayer. **Note:** For transcripts being sent to a third party, this form must be received 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-T.** See instructions.

Phone number of taxpayer on line 1a or 2a

Sign Here

Signature (see instructions) Date

Title (if line 1a above is a corporation, partnership, estate, or trust)

Spouse's signature Date

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

Future Developments

For the latest information about Form 4506-T and its instructions, go to *www.irs.gov/form4506t.* Information about any recent developments affecting Form 4506-T (such as legislation enacted after we released it) will be posted on that page.

General Instructions

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

Purpose of form. Use Form 4506-T to request tax return information. You can also designate (on line 5) a third party to receive the information. Taxpayers using a tax year beginning in one calendar year and ending in the following year (fiscal tax year) must file Form 4506-T to request a return transcript.

Note: If you are unsure of which type of transcript you need, request the Record of Account, as it provides the most detailed information.

Tip. Use Form 4506, Request for Copy of Tax Return, to request copies of tax returns.

Automated transcript request. You can quickly request transcripts by using our automated self-help service tools. Please visit us at IRS.gov and click on "Get a Tax Transcript..." under "Tools" or call 1-800-908-9946.

Where to file. Mail or fax Form 4506-T to the address below for the state you lived in, or the state your business was in, when that return was filed. There are two address charts: one for individual transcripts (Form 1040 series and Form W-2) and one for all other transcripts.

If you are requesting more than one transcript or other product and the chart below shows two different addresses, send your request to the address based on the address of your most recent return.

Chart for individual transcripts (Form 1040 series and Form W-2 and Form 1099)

If you filed an individual return and lived in:	Mail or fax to:
Alabama, Kentucky, Louisiana, Mississippi, Tennessee, Texas, a foreign country, American Samoa, Puerto Rico, Guam, the Commonwealth of the Northern Mariana Islands, the U.S. Virgin Islands, or A.P.O. or F.P.O. address	Internal Revenue Service RAIVS Team Stop 6716 AUSC Austin, TX 73301 512-460-2272
Alaska, Arizona, Arkansas, California, Colorado, Hawaii, Idaho, Illinois, Indiana, Iowa, Kansas, Michigan, Minnesota, Montana, Nebraska, Nevada, New Mexico, North Dakota, Oklahoma, Oregon, South Dakota, Utah, Washington, Wisconsin, Wyoming	Internal Revenue Service RAIVS Team Stop 37106 Fresno, CA 93888 559-456-7227
Connecticut, Delaware, District of Columbia, Florida, Georgia, Maine, Maryland, Massachusetts, Missouri, New Hampshire, New Jersey, New York, North Carolina, Ohio, Pennsylvania, Rhode Island, South Carolina, Vermont, Virginia, West Virginia	Internal Revenue Service RAIVS Team Stop 6705 P-6 Kansas City, MO 64999 816-292-6102

Chart for all other transcripts

If you lived in or your business was in:	Mail or fax to:
Alabama, Alaska, Arizona, Arkansas, California, Colorado, Florida, Hawaii, Idaho, Iowa, Kansas, Louisiana, Minnesota, Mississippi, Missouri, Montana, Nebraska, Nevada, New Mexico, North Dakota, Oklahoma, Oregon, South Dakota, Texas, Utah, Washington, Wyoming, a foreign country, American Samoa, Puerto Rico, Guam, the Commonwealth of the Northern Mariana Islands, the U.S. Virgin Islands, or A.P.O. or F.P.O. address	Internal Revenue Service RAIVS Team P.O. Box 9941 Mail Stop 6734 Ogden, UT 84409 801-620-6922
Connecticut, Delaware, District of Columbia, Georgia, Illinois, Indiana, Kentucky, Maine, Maryland, Massachusetts, Michigan, New Hampshire, New Jersey, New York, North Carolina, Ohio, Pennsylvania, Rhode Island, South Carolina, Tennessee, Vermont, Virginia, West Virginia, Wisconsin	Internal Revenue Service RAIVS Team P.O. Box 145500 Stop 2800 F Cincinnati, OH 45250 859-669-3592

Line 1b. Enter your employer identification number (EIN) if your request relates to a business return. Otherwise, enter the first social security number (SSN) or your individual taxpayer identification number (ITIN) shown on the return. For example, if you are requesting Form 1040 that includes Schedule C (Form 1040), enter your SSN.

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. For a business address, file Form 8822-B, Change of Address or Responsible Party — Business.

Line 6. Enter only one tax form number per request.

Signature and date. Form 4506-T must be signed and dated by the taxpayer listed on line 1a or 2a. If you completed line 5 requesting the information be sent to a third party, the IRS must receive Form 4506-T within 120 days of the date signed by the taxpayer or it will be rejected. Ensure that all applicable lines 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 and returned to you if the box is unchecked.

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

Corporations. Generally, Form 4506-T 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-T but must provide documentation to support the requester's right to receive the information.

Partnerships. Generally, Form 4506-T can be signed by any person who was a member of the partnership during any part of the tax period requested on line 9.

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-T 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 Form 4506-T.

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-T 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.; and **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-T 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.

National Life Group®

National Life Insurance Company®

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 NL Life Applications *(Check appropriate box to indicate requirement is accompanying application)*

PI	2nd/OIR	COMP	Form	Requirement
☐	☐	☐	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)	*(When ABR is desired)*
☐	☐	☐	Agents or Reg. Rep. Report	*(Always Required)*
☐	☐	☐	Initial Payment & Receipt	*(If money is collected)*
☐	☐	☐	Interest Crediting Strategies Form (8411)	*(for Ultra Select & LifeCycle Solution only)*
☐	☐	☐	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 & Term Out cases. Term Out N/A in NY)*
☐	☐	☐	Investment Allocation Form (9201)	*(Needed on Variable cases)*
☐	☐	☐	Supplemental Other Insured Form (8531)	*(AssurePlus & Investor Select only. Needed If more than one OIR. N/A in NY)*
☐	☐	☐	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 **Note:** Mature assessment needed at age 70 or older.

Exam service ordered from ______________________

PI	2nd/OIR	COMP	Requirement
☐	☐	☐	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.)*

Agent Use Only - Not For Use With the Public

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