National Life Group®

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

Individual Life Insurance Application

Issuing Company: ☐ National Life Insurance Company or ☐ Life Insurance Company of the Southwest

Note: This application and the information provided on it are critical for consideration of life insurance coverage. Because of this you must be complete and accurate in all of your responses to ensure we are able to provide you with the best coverage possible. If we determine that any answers on this application are incorrect, incomplete or untrue it will delay your application and National Life Group may have the right to deny benefits or terminate coverage.

Part A - Proposed Insured Information

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

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

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

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

12. Employer & time employed	13. Industry & Occupation	14a. Annual Income	14b. Net Worth

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

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

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

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

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

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

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

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

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

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

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

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

If primary or contingent is a charitable organization, is this part of the Charitable Matching Gift Death Benefit Rider? ☐ Yes ☐ No
A deceased beneficiary's share shall be paid equally to the surviving beneficiaries of the same class, unless otherwise provided.

Part D - Policy Information

1a. Product Name:	1b. Company: *(Must match issuing company on Page 1.)* ☐ NL ☐ LSW	2. Face Amount:
3. Term Rider Plan: *(Whole Life)*		4. Term Rider Amount: $
5. Death Benefit Option: ☐ A - Level ☐ B - Increasing	6. Definition of Life Insurance Test: *(Applies to IUL & UL only.)* ☐ Guideline Premium Test (GPT) ☐ Cash Value Accumulation Test (CVAT)	

7. Use of Dividends: *(Whole Life) (Choose **only** one.)*
☐ Cash ☐ Additions ☐ Applied *(N/A with EFT)* ☐ Flex Term Rider **(*A premium will be charged for this rider.)***
☐ Deposits ☐ Internal Paid-Up Insurance One Yr. Term + Adds = $ _____

8. Riders and Amounts:
- ☐ Accelerated Benefits (ABR) *(Complete ABR Disclosure form)*
- ☐ Additional Paid Up
  - Rider Modal Premium (APAR) $ _____
  - Rider Single Premium (SPAR) $ _____
- ☐ Additional Protection Benefit (APB) $ _____
- ☐ Balance Sheet Benefit (BSB) *(% Waived)* _____ %
- ☐ Beneficiary Insurance Option (BIO) *(Complete 1445)*
- ☐ Benefit Distribution Option (BDO) *(Read the BDO Disclosure Statements in Part M)*
  1. Benefit Distribution Percentage _____ %
  2. Duration of Benefit Payments _____ Years
- ☐ Children's Term (CTR) *(Complete Part E)* $ _____
- ☐ Guaranteed Insurability (GIO, GIR) $ _____
- ☐ Other Insured Rider (OIR) *(Complete 8122)*
- ☐ Waiver of Monthly Deductions (WMD)
- ☐ Waiver of Premiums (WP) $ _____ *(Annual Premium Waived if applicable)*
- ☐ Other _____ $ _____

Death Benefit Protection Rider
Please check this box if you do NOT want this rider. ☐ Otherwise, it will be automatically added, if eligible. There is a minimum premium associated with this rider, but no separate charge.

- ☐ Accumulated Value Enhancement (AVE)
  Or ☐ Enhancer/Flexible Accumulated Value Enhancement (FAVE) *(PeakLife and SummitLife only)*

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 Part K.)*
   a. Has a licensed member of the medical profession diagnosed any Child as having Attention Deficit Disorder, dyslexia, autism, mental retardation, or any psychiatric disease? ☐ Yes ☐ No
   b. Has a licensed member of the medical profession diagnosed or treated any Child for seizures, juvenile diabetes, scoliosis, hemophilia, cancer, or a heart, lung, or respiratory disease? ☐ Yes ☐ No
   c. Does the Proposed Insured/child live with parent? ☐ Yes ☐ No
   d. Does any Child take medication prescribed by a doctor? ☐ Yes ☐ No

Part F - Premium Information

1. Initial Premium Payment Method

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

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

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

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

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

2. Billing Information

a. Planned Periodic/Modal Premium $ _____

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

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

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

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

☐ Single Premium *(no bill)*

d. Source of Funds for Premium Payment

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

☐ Other _____

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

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

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

Name of Bank _____ Name on Bank Account _____

Bank Routing No. *(9 digits)*

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

☐ Please select this box if you would like notification for premium increases of $25 or less. If you do not select this box, you will only receive advanced notification for premium changes greater than $25.

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

Depositor's Mailing Address _____

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

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

Part G - Family Coverage - Applicable for Proposed Insured's Ages 0-17 Only

Complete the following questions for Juvenile Coverage only:

1. Does the Proposed Insured/child live with guardian/parent? ☐ Yes ☐ No
   (*If 'No', provide in Part K name and relationship of person with whom the Proposed Insured lives.)*
2. Amount of Insurance on Owner and other members of Proposed Insured's family:

	Age	Company	Amount In-Force	Amount Applied for
Owner *(if other than Parent/Guardian)*			$	$
Proposed Insured's Parent/Guardian			$	$
Proposed Insured's Parent/Guardian			$	$
Siblings of Proposed Insured *(or indicate if none)*			$	$
			$	$
			$	$

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

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

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

2. Have you ever applied for life, health, or disability insurance or reinstatement of same, which was declined, postponed, rated or modified in any way? ☐ Yes ☐ No
3. Within the past 12 months have you applied for or do you have any applications pending for life or disability insurance? ☐ Yes ☐ No
4. Is the policy or rider being applied for replacing any inforce life insurance or annuity contract(s) including long term care insurance, disability income insurance or riders? ☐ Yes ☐ No
   Replacement activity includes any of the following actions that have occurred or are being considered:
   a. Lapse, forfeit, surrender (partial or full) or termination
   b. Reduction in coverage, premium, policy value or period of coverage (including reduced paid-up and extended term)
   (If yes to any of the above, explain in Part K and replacement forms must be provided)
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 Part K.)*

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

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

1. Name and address of medical care facility and/or health care provider *(or indicate if none)*	Date last Seen	Reason consulted & outcome

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

Remarks: _____

3. Are you currently taking, or have you taken within the last 12 months, any prescription medications or over the counter drugs, including aspirin and/or herbal supplements? *(If yes, provide name of medication and reason/diagnosis.)* ☐ Yes ☐ No
4. Within the last 5 years have you used any product containing tobacco or nicotine, including but not limited to cigarettes, e-cigarettes, vape pens, cigars, pipes, chewing tobacco, snuff, nicotine gum and/or nicotine patch? *(If yes, provide type of product used, frequency, and date of last use.)* ☐ Yes ☐ No
   Product Type: _____ Frequency: _____ Date Last Used: _____
5. Within the past 5 years have you worked less than full time, received or applied for disability or worker's compensation? ☐ Yes ☐ No

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

6. In the past 10 years have you ever been diagnosed, treated, tested positive for, or been given medical advice by a member of the medical profession for: *(If yes, provide details including treating physician contact information.)*
   a. Any disorder or abnormal condition of the heart, including irregular heartbeat, murmur, rheumatic fever, coronary artery disease, heart attack, chest pain, angina, high blood pressure, or high cholesterol? ☐ Yes ☐ No
   b. Any disorder or abnormal condition of the circulatory or vascular system, including aneurysm, transient ischemic attack, stroke, carotid artery or arterial disease? ☐ Yes ☐ No
   c. Any disorder or abnormal condition of the lungs or respiratory system, including sleep apnea, shortness of breath, asthma, bronchitis, emphysema, chronic obstructive pulmonary disease, tuberculosis, or allergies? ☐ Yes ☐ No
   d. Any digestive system disorder, including ulcer, chronic indigestion, hepatitis, cirrhosis, jaundice, or abnormal condition of the liver, stomach, intestine or pancreas, esophagus, gallbladder, or colon? ☐ Yes ☐ No
   e. Any disorder or abnormal condition of the brain or nervous system, including seizures/epilepsy, tremors, falls or imbalance, fainting, dizzy spells, headaches or migraines, loss of consciousness, confusion or memory loss, paralysis, numbness, or any condition which causes limited motion? ☐ Yes ☐ No
   f. Any disorder or abnormal condition of the eyes, ears, nose, throat, or sinuses? ☐ Yes ☐ No
   g. Any disorder or abnormal condition of the endocrine system, including thyroid, pituitary, adrenal or other gland? ☐ Yes ☐ No
   h. Any disorder or abnormal condition of the spine, hip, knee, shoulder, back, joints, bones, muscles, arthritis, rheumatism or gout? ☐ Yes ☐ No
   i. Any disorder or abnormal condition of the urinary system, including bladder, kidney, or urinary abnormalities such as protein, sugar or blood in urine? ☐ Yes ☐ No
   j. Any disorder or abnormal condition of the genital system, including prostate, testicles, pelvic organs, ovaries, cervix, uterus, or breast? ☐ Yes ☐ No
   k. Any disorder or abnormal condition of the skin, including psoriasis, eczema, non-healing wounds, melanoma, nevi or moles? ☐ Yes ☐ No
   l. Any depression, anxiety, bipolar, schizophrenia, Attention Deficit Disorder (ADD), autism, Down Syndrome or any other developmental or psychological condition including Alzheimer's, dementia, or Post Traumatic Stress Disorder (PTSD)? ☐ Yes ☐ No
   m. Any anemia, hemophilia or disorders of the blood other than Acquired Immune Deficiency Syndrome (AIDS), Human Immunodeficiency Virus (HIV)? ☐ Yes ☐ No
   n. 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
   o. Any cancer, tumor, polyp, lump, nodule, cyst, lymphoma or any disorder of the lymph nodes? ☐ Yes ☐ No
   p. Diabetes, high blood sugar, pre-diabetes, impaired glucose tolerance, impaired fasting glucose, insulin deficiency, hyperglycemia, or diabetes associated with pregnancy? ☐ Yes ☐ No
   q. Amputation due to disease or other medical condition? ☐ Yes ☐ No
   r. Ataxia, transverse myelitis, myasthenia gravis, autoimmune disorder such as lupus, blindness, or post-polio syndrome? ☐ Yes ☐ No
   s. Parkinson's disease, muscular dystrophy, Huntington's chorea, motor neuron disease, Lou Gehrig's Disease (ALS), or multiple sclerosis? ☐ Yes ☐ No
7. In the past 10 years have you used marijuana, cocaine, heroin, or any other illicit drug or controlled substance, been advised by a physician to discontinue or reduce alcohol or drug intake, used drugs not prescribed by a physician, been self-admitted to a drug or alcohol treatment facility, or been a member of a support group such as NA or AA? ☐ Yes ☐ No
8. Within the past 5 years have you:
   a. Consulted with a physician other than your personal physician or had x-rays, electrocardiograms, heart catheterization, mammograms, ultrasounds, biopsy, or any other medical tests and/or procedures, except those related to the Human Immunodeficiency Virus (AIDS Virus)? ☐ Yes ☐ No
   b. Been admitted to a hospital, seen in an Emergency Department or been advised by a member of the medical profession to enter a hospital for observation, operation or treatment of any kind? ☐ Yes ☐ No
9. Do you have any pending appointments with any health care provider or medical facility? *(If yes, provide date, physician/facility name and address, and reason for visit.)* ☐ Yes ☐ No
10. Has a biological parent or sibling been diagnosed or treated by a health professional for cancer, heart disease, Huntington's Disease, Lou Gehrig's Disease (ALS), or polycystic kidney disease? ☐ Yes ☐ No
11. Do you currently:
    a. Use or require the use of any mechanical or medical devices such as: a wheelchair, walker, multi-prong cane, hospital bed, dialysis machine, respirator oxygen, motorized cart or stair lift? ☐ Yes ☐ No
    b. Need help, assistance or supervision for: bathing, eating, dressing, toileting, walking, transferring, or maintaining continence? ☐ Yes ☐ No
    c. Need help, assistance or supervision in: taking medication, doing housework, laundry, shopping or meal preparation? ☐ Yes ☐ No
12. Family History

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

Part K - Remarks *(Provide the details to questions as requested. Attach additional sheets if necessary.)*

Section & Number:	Additional Information:

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

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

Part M - Agreement & Authorization

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

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

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

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

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

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

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

Benefit Distribution Option Rider Disclosure Statements:

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

If I have elected any of the Accelerated Benefits Riders, I understand that there is no separate premium or charge for these riders. The Accelerated Benefits Riders are available on all products (traditional and universal life) offered by the Company. Receipt of accelerated death benefits may affect eligibility for public assistance programs and may be taxable. I understand that the amount of the accelerated death benefits will be discounted and will be less than the policy's current death benefit. I understand that an administrative fee may be assessed upon acceleration.

Part N - Signatures

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

Proposed Insured ***(If Under age 18, Parent or Legal Guardian must sign.) (Note: AL - Age 19, MS - Age 21)***

_____

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

_____

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

_____

_____

(Witness)