NATIONAL WESTERN LIFE INSURANCE COMPANY®

APPLICATION FOR INDIVIDUAL LIFE INSURANCE

850 East Anderson Lane • Austin, Texas 78752-1602

I. PRIMARY INSURED (Please Print Clearly Using Black Ink)

Name of Proposed Insured (First, Middle, Last) _____ Date of Birth (mm/dd/yyyy) _____ Age _____ Place of Birth (State and Country) _____

❒ Male ❒ Female Marital Status ❒ Married ❒ Single ❒ Widowed ❒ Divorced ❒ Tobacco Use ❒ Tobacco Free

Home Address (number and street) _____ City _____ State _____ Zip _____

Social Security Number or Tax ID _____ Drivers License Number and State _____ Email _____

Home Phone Number _____ Best time and place to call ❒ Home_____ ❒AM ❒PM ❒ Work_____ ❒AM ❒PM

Citizenship ❒ U.S. Citizen ❒ Foreign National

If Non US Citizen: Type of Visa_____ Exp date _____ Country of Citizenship_____

Current Employer _____ Occupation and Duties _____ Work Phone Number _____

Employer Address (number and street) _____ City _____ State _____ Zip _____

II. COVERAGE APPLIED FOR

Plan of Insurance (Name of Product) _____ **Face Amount** $ _____

Riders: (Not all riders are available in all plans or in all states)

❒ Accidental Death Benefit_____

❒ Waiver of Cost of Insurance ❒ Critical Illness Rider ❒ Chronic Illness Rider ❒ Terminal Illness Rider

❒ Other Insured Rider: (complete Other Insured Rider Application) Face Amount $_____ (cannot exceed coverage on Primary insured)

❒ Child Rider: _____ # of units (Complete section XI for Children)

III. PREMIUMS AND FINANCES

Annual Premium $_____ Planned Modal Premium $_____ Cash with app $_____

Mode: ❒ Annual ❒ Semi-annual ❒ Quarterly ❒ Monthly ❒ Single pay ❒ Other _____

Method: ❒ Direct Billing ❒ Bank Draft ❒ Allotment ❒ Salary Deduction ❒ Other _____

Source of Premium: ❒ Salary ❒ Savings ❒ Investments ❒ 1035 Exchange ❒ Loan (premium financing)

❒ Other (specify) _____

Who will pay the premium? _____ Relationship to Proposed Insured _____

IV. OWNERSHIP INFORMATION (Complete only if Owner is other than the Proposed Insured)

Owner / Applicant / Trust Name _____ Date of Birth (mm/dd/yyyy) _____ SSN / TIN _____

Phone Number _____ Relationship to Proposed Insured _____

Address (number and street) _____ City _____ State _____ Zip Code _____

If the owner is a trust, please submit the Trust Information Form.

Proposed Insured _____

V. BENEFICIARY INFORMATION (If percentages are not given, the shares will be divided equally)

Primary Beneficiaries

Full Name	Relationship	% Share
1.		
2.		
3.		

Contingent Beneficiaries

Full Name	Relationship	% Share
1.		
2.		
3.		

VI. OTHER COVERAGE AND REPLACEMENT

1. Does the Proposed Insured have any existing life insurance or annuity policies with this company or any other company? (If yes provide details in #4) ..... ❒ Yes ❒ No
2. Is this policy intended to replace any existing life insurance or annuity? ..... ❒ Yes ❒ No (If yes, please submit appropriate state replacement forms)
3. Is the Proposed Owner or Proposed Insured considering using funds from an existing policy or contract to pay premiums on the Policy being applied for? (If Yes, complete the appropriate state replacement forms) ..... ❒ Yes ❒ No

4. Company	Policy Number	Type of Coverage	Amt of Coverage	To be Replaced	1035 Exchange
				❒ Yes ❒ No	❒ Yes ❒ No
				❒ Yes ❒ No	❒ Yes ❒ No
				❒ Yes ❒ No	❒ Yes ❒ No
				❒ Yes ❒ No	❒ Yes ❒ No

VII. HEIGHT AND WEIGHT

What is your height? _____ ft _____ in: What is your weight? _____Lbs

VIII. MEDICAL HISTORY QUESTIONS (If any question in Section VIII is answered yes, or height and weight is not within product guidelines, no coverage can be issued.)

1. Have you ever been diagnosed by a member of the medical profession or tested positive for Human Immunodeficiency Virus (AIDS virus) or Acquired Immune Deficiency Syndrome (AIDS)? ..... ❒ Yes ❒ No
2. Do you have any impairment, whether physical or mental, for which you need or receive assistance or supervision in performing normal activities of daily living such as bathing, continence, dressing, eating, toileting, transferring or taking medications? ..... ❒ Yes ❒ No
3. Do you use a walker, wheelchair, motorized scooter or any medical appliance such as oxygen, respirator, or dialysis machine, or have a defibrillator implanted? ..... ❒ Yes ❒ No
4. Have you had or been advised by a member of the medical profession to have, an organ transplant, or have you been medically diagnosed as having a terminal illness or life expectancy of 12 months or less? ..... ❒ Yes ❒ No
5. Are you currently hospitalized, confined to a bed or nursing facility, residing in an assisted living facility or receiving hospice care? ..... ❒ Yes ❒ No
6. Have you ever been medically diagnosed, treated, or taken medication for:
   a. Congestive heart failure, cardiomyopathy, cirrhosis of the liver, liver failure, kidney (renal) failure, end stage kidney disease, chronic kidney disease or renal insufficiency? ..... ❒ Yes ❒ No
   b. Alzheimer's disease, dementia, memory loss, mental incapacity, schizophrenia, manic depression, bipolar disorder, brain disease, Lou Gehrig's disease (ALS), Huntington's disease, muscular dystrophy, cystic fibrosis, multiple sclerosis or multiple myeloma? ..... ❒ Yes ❒ No

Proposed Insured _____

VIII. MEDICAL HISTORY QUESTIONS CONTINUED (If any question in Section VIII is answered yes or height and weight is not within product guidelines, no coverage can be issued.)

7. Have you:
   a. Been diagnosed, treated, tested positive for, or been given medical advice by a member of the medical profession for diabetes prior to age 20? ❒ Yes ❒ No
   b. Taken insulin prior to age 40? ❒ Yes ❒ No
   c. Within the past 5 years been treated for insulin shock or diabetic coma? ❒ Yes ❒ No
   d. Been hospitalized two or more times for any diabetic complications within the last 2 years? ❒ Yes ❒ No
8. Within the past 3 years have you been diagnosed by a member of the medical profession with leukemia, lymphoma, melanoma or any internal cancer, or received chemotherapy, radiation or had surgery for any cancer (other than basal or squamous cell cancer of the skin)? ❒ Yes ❒ No
9. Have you been diagnosed by a member of the medical profession as having more than one occurrence or any metastasis of any cancer in your lifetime (excluding basal or squamous cell skin cancer), or an amputation caused by cancer or any other disease or are you currently being treated by a member of the medical profession for cancer or recurrence of cancer? ❒ Yes ❒ No
10. Within the past 2 years have you:
    a. Been diagnosed or treated by a member of medical profession for, been hospitalized for, or taken or been prescribed medication for: Chronic Obstructive Pulmonary or Lung Disease (COPD/COLD), emphysema, chronic bronchitis, respiratory failure, chronic hepatitis, liver disease, angina, stroke, transient ischemic attack (TIA), Hodgkin's disease, cerebral palsy, Parkinson's disease, grand mal epilepsy, systemic lupus (SLE) disease, or do you have paralysis of 2 or more extremities? ❒ Yes ❒ No
    b. Been diagnosed or treated by a member of the medical profession for, or been hospitalized for: Heart disease, heart attack, uncontrolled high blood pressure, heart or circulatory surgery, including coronary artery bypass, angioplasty, cardiac or vascular stent placement, pacemaker or pacemaker replacement, heart valve replacement, aneurysm, or any cardiac or vascular surgery or procedure to improve the circulation to the heart, brain or extremities? ❒ Yes ❒ No
    c. Been confined three or more times to a hospital, nursing facility, convalescent care facility, assisted living facility, or mental care facility? ❒ Yes ❒ No
    d. Been declined for life, health or long term care insurance? ❒ Yes ❒ No

IX. NON MEDICAL HISTORY QUESTIONS (IF ANY QUESTION IN SECTION IX IS ANSWERED YES, OR HEIGHT AND WEIGHT IS NOT WITHIN PRODUCT GUIDELINES, NO COVERAGE CAN BE ISSUED.)

11. Is household income under $20,000? ❒ Yes ❒ No
12. Is proposed insured currently undergoing Chapter 7 bankruptcy or is bankruptcy not yet discharged? ❒ Yes ❒ No
13. Within the last 5 years have you:
    a. Been convicted of a felony or are you currently incarcerated, on parole or probation? ❒ Yes ❒ No
    b. Been treated for or been advised by a medical professional to have treatment for alcohol or any drugs of abuse? ❒ Yes ❒ No
    c. Attempted suicide? ❒ Yes ❒ No
14. Within the last 3 years have you been convicted of operating a vehicle while intoxicated, impaired, or under the influence or for reckless driving? ❒ Yes ❒ No
15. Within the past 2 years did you or within the next 2 years do you intend to:
    a. Participate as a student aviation pilot? ❒ Yes ❒ No
    b. Fly less than 50 hours solo or over 300 hours (excluding commercial airline pilot)? ❒ Yes ❒ No
    c. Have any aviation related accident or violation? ❒ Yes ❒ No
    d. Fly as a crop duster, aerobatic pilot, Search and Rescue or flown experimental aircraft? ❒ Yes ❒ No
    e. Participate in hang gliding, parasailing, ultra light activity more than 10 times a year, stunt activity or over 3,000 feet in altitude? ❒ Yes ❒ No
    f. Do mountain climbing excluding recreational or less than 1 day of duration or outside of contiguous (lower 48) United States? ❒ Yes ❒ No
    g. Participate in scuba diving greater than 75 ft or more than 10 dives per year? ❒ Yes ❒ No
    h. Participate in auto racing, motorboat or motorcycle racing? ❒ Yes ❒ No
16. If applicant is active duty Military; Military Reserve or National Guard:
    a. Are you currently serving, have orders for, or aware of orders within the next year for, any hazardous job duties or war zone territory? ❒ Yes ❒ No
17. Have both of your parents died prior to age 45 from complications of heart disease, cerebral vascular accidents (strokes), cancer or chronic kidney disease? ❒ Yes ❒ No

X. ADDITIONAL INFORMATION

18. Are you taking any medication for any impairment or disease listed in Section VIII? ❒ Yes ❒ No
19. In the last 12 months, have you used any tobacco or nicotine products such as smoking cigarettes, pipes or cigars, using snuff or chewing tobacco, or a nicotine delivery device such as a patch, gum or lozenge? ❒ Yes ❒ No
20. Have you applied for life insurance with any other insurance companies in the last 2 years? ❒ Yes ❒ No
21. Do you believe that this life insurance policy is appropriate for your financial situation based on your income, net worth, funds, and retirement considerations? ❒ Yes ❒ No

XI. COMPLETE SECTION IF ANY INSURED IS UNDER 18 AND CHILD RIDER IS APPLIED FOR. IF ANY QUESTION IS ANSWERED YES, NO CHILD COVERAGE CAN BE ISSUED.

Name of Child (First, Middle, Last) ❒ Male ❒ Female	Date of Birth (mm/dd/yyyy)	Age	Place of Birth (State and Country)

1. Has any child ever been diagnosed by a member of the medical profession or tested positive for Human Immunodeficiency Virus (AIDS Virus) or Acquired Immune Deficiency Syndrome (AIDS) ❒ Yes ❒ No
2. Has any child ever been diagnosed by a member of the medical profession or taken medication for any neuromuscular disease, cerebral palsy, multiple sclerosis, muscular dystrophy, internal cancer, diabetes, cardio-vascular disease, kidney disease? ❒ Yes ❒ No
3. Has any child been diagnosed by a member of the medical profession with having paralysis of 2 or more extremities, or any heredity or congenital defects? ❒ Yes ❒ No

Each of the undersigned: Declares that all answers in this application are true and complete to the best of their knowledge and belief, and understands that: (a) all statements and answers in this application will be relied upon by the Company to determine insurability and to issue the policy; (b) no information will be considered given to the Company unless it is stated in the application; (c) the agent does not have the Company's authorization to accept risk, pass on insurability, or make, void, waive, or change any conditions or provisions in the application, policy or receipt, as applicable; and (d) a material misrepresentation may void the policy during the contestable period. This policy will take effect when: (1) the application is approved at National Western's Office in Austin, Texas; (2) National Western delivers the policy; (3) the initial premium has been paid; and (4) each of the prior three conditions is satisfied while the proposed insureds are alive and their health and insurability are as described herein.

Proposed Insured: I authorize any licensed physician, medical practitioner, hospital, other health care provider, veterans administration, pharmacy benefit manager, pharmacy, consumer reporting agency, insurance support organization, laboratory, insurance company, reinsuring company or the MIB, Inc., formerly known as Medical Information Bureau, or other organization or person to give any information about me or my mental or physical health to the Company and/or its authorized agents to determine my eligibility for life insurance coverage. The Company may disclose such information to its reinsurers and the MIB, Inc. National Western or its reinsurers may also release such information to other life or health insurance companies to whom an application for insurance or to whom a claim for benefits is submitted. This authorization also applies to any member of my family proposed for coverage in the application and is valid for 2 years after the date shown below or such time limit permitted by applicable law in the state where the policy is delivered or issued for delivery. A photocopy of this form is as valid as the original. I may have a copy of this form upon request.

Each of the undersigned acknowledges receipt of the Notice under the Fair Credit Reporting Act (Consumer Report Notice), MIB Disclosure Notice, and Notice of Information Practices (if applicable).

FRAUD WARNING: ANY PERSON WHO KNOWINGLY PRESENTS A FALSE STATEMENT IN AN APPLICATION FOR INSURANCE MAY BE GUILTY OF A CRIMINAL OFFENSE AND SUBJECT TO PENALTIES UNDER STATE LAW.

Signed at _____ Date _____
City and State

_____
Signature of Proposed Insured (parent if age 17 or less)

_____
Signature of Owner if other than Proposed Insured
(If a Trust, signature of trustee)
(If business or corporation, officer, other than Proposed insured, and Title)

_____ _____
Agent Name (please print) License No.

_____
Signature of Agent

AGENT REPORT

1. How long have you known the Proposed Insured?_____ Are you related? ❒ Yes ❒ No If yes, How? _____
2. Did you personally see the Proposed Insured(s) and complete the application in his and/or her presence? ..... ❒ Yes ❒ No
   If No, please explain: _____
3. Are you aware of any information about any of the Proposed Insured(s) that might affect his/her insurability? ..... ❒ Yes ❒ No
   If Yes, give details: _____
4. Will the policy applied for replace or change any existing life insurance or annuity? ..... ❒ Yes ❒ No
5. Do you have any knowledge or reason to believe:
   a. that the Proposed Insured or Owner is considering assigning or transferring any rights or interest in this policy to an unrelated third party such as a Life Settlement company, Viatical, Investor, trust, bank, lending institution or other third party? ..... ❒ Yes ❒ No
   b. that any of the initial or future premiums will be borrowed, loaned or otherwise financed? ..... ❒ Yes ❒ No
   c. that the Proposed Insured or Owner has taken or been offered any incentive, financial or other, or been offered free insurance as an inducement to purchase this policy? ..... ❒ Yes ❒ No

USA PATRIOT Act Notice

1. The USA PATRIOT Act requires that we establish an Anti-Money Laundering (AML) Compliance Program, and as part of our Program, National Western Life Insurance Company® requires that its agents/brokers/consultants verify the identity of the proposed owner(s) of our contracts and collect documents and/or information sufficient to provide such verification. Please refer to your company-specific AML training materials for more detailed information.
   Owner/Trustee Verification - In order to satisfy such obligations, we require that you review and verify a current driver's license or government-issued photo ID for the proposed Owner/Trustee associated with the contract.
2. Do you certify that you personally met with the proposed Owner/Trustee and reviewed his or her identification document (driver's license or government-issued photo ID) and that to the best of your knowledge, it accurately reflects the identity of the proposed Owner/Trustee? ..... ❒ Yes ❒ No
   If no, please explain_____
   _____

I certify that:
a. the insurance being applied for is suitable for the Proposed Insured's needs and financial objectives;
b. the consumer notices were delivered to the Proposed Insured or Owner;
c. all questions on the application were asked of each Proposed Insured, and the answers were recorded as given, prior to the application being signed;
d. the temporary insurance agreement was explained fully and (if applicable), the receipt was given; and
e. the answers given in this application and Agent's Report are complete and accurate to the best of my knowledge and belief.

Date _____ Agent Signature _____ Print Agent Name _____

Licensed agent(s) to receive commissions (please print)

Name of Agent	Agent No.	Percent of commission	Agent phone #	Agent Email address
1. _____	_____	_____	_____	_____
2. _____	_____	_____	_____	_____
3. _____	_____	_____	_____	_____

TEMPORARY INSURANCE AGREEMENT & RECEIPT

This agreement shall be void if altered or modified. • Premium checks must be made payable to National Western Life.
Proposed Insured _____ Amount Paid $ _____ Application Date_____
Subject to all terms and conditions of the insurance policy applied for in this application, this Temporary Insurance Agreement & Receipt (TIA) provides Temporary Insurance in the amount of the lesser of: (a) the amount of insurance applied for; or (b) $50,000 on each proposed insured; or (c) $250,000 in the aggregate for all insureds listed on the application. This Temporary Insurance will take effect and end as defined below.
I have read this Temporary Insurance Agreement & Receipt and it has been explained to me by the agent. I understand and agree to all conditions and limitations. Proposed owner's signature _____Date _____

I explained and witnessed the signing of this Agreement.
ICC15 01-9064-15 Receipt Agent's signature _____ Date _____

Temporary Insurance will take effect on the date that the following four requirements are met: (1) the application is fully completed, including any amendments required by National Western; (2) the initial premium has been paid; and (3) all medical exams or tests required by National Western are completed; and (4) as of the date of this Agreement, the proposed insured must be insurable at standard rates for the type and amount of insurance applied for.

Temporary Insurance will end on the earliest of the following dates: (1) the date insurance begins under the policy applied for; (2) the date this application is cancelled or declined; or (3) 60 days have passed since the date of this application.

DETACH AND LEAVE WITH APPLICANT
(DO NOT SEND TO NATIONAL WESTERN)

Date_____

NOTICE UNDER THE FAIR CREDIT REPORTING ACT. This is to inform you that, as part of our procedure for processing your application for insurance, an investigative consumer report may be prepared whereby information is obtained through personal interviews with your neighbors, friends, or others with whom you are acquainted. This inquiry includes information as to your character, general reputation, personal characteristics and mode of living. None of the information described in this paragraph will be used to establish, or aid in establishing, the proposed insured's sexual orientation. You have the right to make a written request within a reasonable period of time to receive additional, detailed information about the nature and scope of this investigation.

MIB DISCLOSURE NOTICE. Information regarding your insurability will be treated as confidential; however, we or our reinsurers may make a brief report thereon to the MIB, Inc., formerly known as Medical Information Bureau, a not-for-profit membership of insurance companies which operates an information exchange on behalf of its members. If you apply to another MIB member company for life or health insurance coverage, or a claim for benefits is submitted to such company, MIB, upon request, will supply such company with the information about you in its file. Upon receipt of a request from you, MIB will arrange disclosure of any information in your file. Please contact MIB at 866 692-6901 (TTY 866 346-3642). If you question the accuracy of information in MIB's file, you may contact MIB and seek a correction in accordance with the procedures set forth in the federal Fair Credit Reporting Act. The address of MIB's information office is 50 Braintree Hill Park, Suite 400, Braintree, Massachusetts 02184-8734. We or our reinsurers may also release information to other life or health insurance companies to whom you may (1) apply for life or health insurance, or (2) submit a claim for benefits. Information for consumers about MIB may be obtained on its website at www.mib.com.

NOTICE OF INFORMATION PRACTICES. Residents of Arizona, California, Connecticut, Georgia, Illinois, Maine, Massachusetts, Minnesota, Montana, New Mexico, Nevada, New Jersey, North Carolina, Ohio, Oregon and Virginia must be given and sign an Authorization to Obtain and Disclose Information and Notice of Information Practices [SU-6412(current version)]. New Mexico residents are to use SU-6412-NM(current version).