NATIONAL WESTERN LIFE INSURANCE COMPANY®

APPLICATION FOR INDIVIDUAL TERM LIFE INSURANCE

[850 East Anderson Lane • Austin, Texas 78752-1602]

I. PROPOSED INSURED

Name (First, Middle, Last) _____ Date of Birth (mm/dd/yyyy) ____/____/____ Age _____ Social Security Number _____

Home Address (Number and Street) _____ City _____ State _____ Zip Code _____

Place of Birth (State and Country) _____ Phone Number: ❒ Home ❒ Work ❒ Cell (____)_____ Email Address _____

❒ Tobacco Use ❒ Non-Tobacco Use ❒ Male ❒ Female (Sex) ❒ Married ❒ Single ❒ Widowed ❒ Divorced (Marital Status)

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

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

Address (if different from Insured) _____ City _____ State _____ Zip Code _____

Phone Number: ❒ Home ❒ Work ❒ Cell (____)_____ Email Address _____

Relationship to Proposed Insured _____

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

III. COVERAGE APPLIED FOR

Plan: ❒ 15 Year Term ❒ 20 Year Term ❒ 30 Year Term **Face Amount $**_____

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

❒ Accidental Death Benefit $ _____ ❒ Waiver of Premium for Disability ❒ Child Rider _____ # of units (Complete Section XI for Children.)

IV. PREMIUMS AND FINANCES

Mode: ❒ Annual ❒ Semi-Annual ❒ Monthly (Not available for Direct Billing)

Premium Amount $_____ ❒ Premium Submitted with App

Method: ❒ Bank Draft/EFT ❒ Credit Card ❒ Direct Billing ❒ Other _____

Source of Premium: ❒ Salary ❒ Savings ❒ Investments ❒ Loan (premium financing) ❒ Other (Specify) _____

Payor (If other than Owner/Insured) _____ Relationship to Proposed Insured _____

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

Primary Beneficiaries

Full Name	Relationship	SSN	% Share
1.			
2.			

Contingent Beneficiaries

Full Name	Relationship	SSN	% Share
1.			
2.			

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 life insurance or annuity policy 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

VII. HEIGHT AND WEIGHT (If height and weight are not within product guidelines, no coverage can be issued)

What is your height? _____ Ft. _____ In. What is your weight? _____Lbs

Has your weight changed by more than 10 lbs in the past 12 months? ..... ❒ Yes ❒ No

VIII. APPLICATION QUESTIONS

1. Are you currently employed? ..... ❒ Yes ❒ No
   Annual Income $ _____ Occupation _____Employer _____
   If not employed, please explain reason for unemployment _____
2. Do you currently have a driver's license? ..... ❒ Yes ❒ No
   If yes, provide DL Number. _____ State of Issue _____
   If no, have you ever been issued a driver's license? _____ ❒ Yes ❒ No
   If yes, explain why you no longer have a valid DL. _____

IX. MEDICAL QUESTIONS

If any question from 3 to 7 is answered "Yes", no coverage can be issued.

3. Are you currently:
   a. Hospitalized, confined to a bed or nursing facility, residing in an assisted living facility, or receiving hospice care? ..... ❒ Yes ❒ No
   b. Using a walker, wheelchair, electric scooter, oxygen, dialysis machine, or do you have a defibrillator implanted? ..... ❒ Yes ❒ No
4. 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
5. Have you ever:
   a. Been diagnosed by a member of the medical profession as having, or tested positive for, Human Immunodeficiency Virus (HIV) or Acquired Immune Deficiency Syndrome (AIDS)? ..... ❒ Yes ❒ No
   b. Been diagnosed, tested positive, or been given medical advice by a member of the medical profession for diabetes prior to age 30, been treated by a member of the medical profession for insulin shock, diabetic coma, retinopathy, nephropathy (kidney), neuropathy (nerve, circulation) disorder, amputation, or diabetes not under control? ..... ❒ Yes ❒ No
6. Have you ever been medically diagnosed, treated for, tested positive for, or taken medication for:
   a. Alzheimer's disease, dementia, organic brain disease, memory loss, mental incapacity, Down's Syndrome, schizophrenia, bipolar disorder, Lou Gehrig's disease (ALS), Huntington's disease, muscular dystrophy, Cystic Fibrosis, pulmonary fibrosis, Parkinson's, Multiple Sclerosis, or multiple myeloma? ..... ❒ Yes ❒ No
   b. Congestive heart failure, cardiomyopathy, cirrhosis of the liver, liver failure, kidney (renal) failure, chronic kidney disease, or renal insufficiency? ..... ❒ Yes ❒ No

IX. MEDICAL QUESTIONS (CONTINUED)

7. Within the past 5 years have you:
   a. Had or been advised by a licensed member of the medical profession to have an organ or bone marrow transplant or have you been medically diagnosed as having a terminal illness or life expectancy of 12 months or less? ..... ❒ Yes ❒ No
   b. Been diagnosed by a licensed member of the medical profession with leukemia, lymphoma, melanoma, or any cancer, or, have you received chemotherapy, radiation, or any type of treatment, or had surgery for any cancer (other than basal, or squamous cell cancer of the skin), or been diagnosed for more than one occurrence of any cancer, or had an amputation caused by cancer or any other disease? ..... ❒ Yes ❒ No
   c. Been diagnosed, treated, or advised to receive treatment by a licensed member of medical profession, or been hospitalized for respiratory failure, chronic hepatitis, liver disease, pancreatitis, stroke, transient ischemic attack (TIA), cerebral palsy, grand mal epilepsy, systemic lupus (SLE) disease, or do you have paralysis of 2 or more extremities? ..... ❒ Yes ❒ No
   d. Been diagnosed, treated, or advised to receive treatment by a licensed member of the medical profession, or been hospitalized for; heart disease, heart attack, angina (chest pain), 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
   e. Been diagnosed, treated, or advised to receive treatment by a licensed member of medical profession, or been hospitalized for Chronic Obstructive Pulmonary or Lung Disease (COPD/COLD), emphysema, chronic bronchitis or had asthma attack(s) requiring visit(s) to the emergency room or hospitalization(s)? ..... ❒ Yes ❒ No
   f. Been diagnosed, treated, or advised to receive treatment by a licensed member of medical profession, or been hospitalized, for major depression, attempts of suicide or suicidal thoughts? ..... ❒ Yes ❒ No
8. Are you presently taking any medications for any medical condition(s) that you have not already disclosed? (Excluding Human Immunodeficiency Virus (HIV) infection, Acquired Immune Deficiency Syndrome (AIDS), or AIDS Related Complex (ARC))? ..... ❒ Yes ❒ No
   Provide condition(s) _____
9. Name and Address of Personal Physician _____
   _____

X. NON-MEDICAL QUESTIONS

If any question 10 to 14 is answered "Yes", no coverage can be issued.

10. Within the past 5 years have you:
    a. Pleaded guilty or been convicted of a felony, or are you currently incarcerated, on parole or on probation, or have pending charges but not gone to trial? ..... ❒ Yes ❒ No
    b. Been treated for, or been advised by a licensed member of the medical profession to have treatment for alcohol or drug abuse? ..... ❒ Yes ❒ No
    c. Been convicted of operating a vehicle while impaired or under the influence of alcohol or drugs? ..... ❒ Yes ❒ No
    d. Used cocaine, heroin, amphetamines, barbiturates, hallucinogens, or other habit forming drugs except as prescribed by a physician? ..... ❒ Yes ❒ No
11. Within the past two years have you had your driver's license suspended or revoked, or have you been found guilty or convicted of reckless or negligent driving? ..... ❒ Yes ❒ No
12. Are you not a U.S. citizen or lawful permanent resident (green card) who has lived in the U.S. for more than two years? ..... ❒ Yes ❒ No
13. Do you intend to live or work outside of the United States in the next two years? ..... ❒ Yes ❒ No
14. Within the past 3 years have you applied for life, health or disability insurance and been declined or postponed? ❒ Yes ❒ No
15. Within the past 2 years did you, or in the next 2 years do you intend to:
    a. Participate in any aviation activity other than as a passenger on a scheduled commercial airline? ..... ❒ Yes ❒ No
    b. Participate in any form of motorcycle, car, or boat racing, mountain, rock, or ice climbing, cave exploration, hang gliding, scuba or sky diving? ..... ❒ Yes ❒ No

X. NON-MEDICAL QUESTIONS (CONTINUED)

16. Are you an active duty Military, Military Reserve, or National Guard currently serving, have orders for, or anticipate orders in the next 2 years ?.....❒ Yes ❒ No
17. In the last 12 months, have you used any tobacco or nicotine products such as smoking cigarettes, cigars, pipes, cannabis, using electronic cigarettes, vapor, snuff, chewing tobacco, or used any nicotine delivery device such as a patch, gum, or lozenge? .....❒ Yes ❒ No

Please provide details to any "Yes" answers (questions 15-17).

Question #	**Details**
_____	_____
_____	_____
_____	_____

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 (First, Middle, Last) ❒ Male ❒ Female	Date of Birth (mm/dd/yyyy)	Social Security	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 (HIV) 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

XII. PAYMENT (Please select a payment option.)

Automatic Draft

❒ Checking ❒ Savings
Account Owner Name_____
Financial Institution_____
Routing Number _____
Account Number_____

Credit Card

❒ MasterCard ❒ Visa ❒ American Express ❒ Discover
Please see *Note* below
Name on Card _____
Card Number ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐
Expiration Date (mm/yyyy) _____/_____

Please draft my account on the _____ (number 1-28) day of the month, in accordance with the mode of payment indicated in section IV. **(Draft will be on the 1st of the month if left blank)**

***Note**: Payment by credit card may not be combined with any other payment option. If, for any reason, the credit card is declined, NWL® will deliver a notice to the policyholder and agent extending a 30-day grace period for substitute payment. NWL will make a single attempt to debit the credit card for premium. Any additional attempt must be authorized by the credit card holder in writing. If the debit is declined after a second attempt, the payment option will be converted to direct billing, and premium will be due immediately.*

Authorization: I, Card Holder/Account Holder, authorize NWL to draft from my account, or charge to my credit card, the initial premium and all future recurring renewal premiums in accordance with the mode of payment selected in this application. I acknowledge that the amount of premium charged by NWL will be the amount shown on the policy or as NWL shall otherwise notify the policyholder in writing. This authorization is valid indefinitely or until I provide written notice of cancellation to NWL. In the event there are any changes to the account information provided above, I am responsible for communicating the changes to NWL. NWL must receive notification of any account changes at least 30 days prior to my regularly scheduled billing date. NWL reserves the right to convert this authorization to direct billing at any time.

_____ _____
Signature Date Signature (if joint owner or account owner) Date

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 certify that I am not currently taking and not under the influence of any medications or drugs that would affect my ability to fully understand and fully complete this application. I authorize any licensed physician, medical practitioner, hospital, other health care provider, insurance company, consumer reporting agency, state motor vehicle agency, 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 reinsurers to determine my eligibility for life insurance coverage. I authorize all said sources, except MIB, to give such records or knowledge to any authorized agent of the Company. 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 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)

_____ _____ _____ _____
Agent Name (please print) Agent # 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-specificAML 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.

Print Agent Name_____ Agent Signature _____ Date _____

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

Name of Agent	Agent #	Agent Split %	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.
ICC17 01-9072-17 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. National Western Life Insurance Company may request and obtain a consumer report or an investigative consumer report for the purpose of processing your application for insurance. An investigative consumer report means a report in which information on a consumer's character, general reputation, personal characteristics, or mode of living is obtained through personal interviews with neighbors, friends, or associates of the consumer reported on or with others with whom he is acquainted or who may have knowledge concerning any such items of information. 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).