NORTH AMERICAN℠

ICC20L3236B

Administered for the Company by: bestow | **Bestow Agency, LLC**
bestow.com
(833) 300-0603

Individual Life Insurance Application
For Reinstatements – Existing Policy #_____

Term Length Applied for: ☐ 2 Years ☐ 10 Years ☐ 15 Years ☐ 20 Years ☐ 25 Years ☐ 30 Years

Proposed Insured's Basic Information

Coverage Amount $_____

Legal First Name	Middle Initial	Legal Last Name
Date of Birth	State/ Birth	Gender ☐ Male ☐ Female
Height Feet	Inches	Weight Pounds
Street Address		Apt #
City	State	Zip Code
Annual Income	Total Household Income	Social Security #
[Driver's License #]	[State of Issue]	Mobile Phone #
Email	Citizenship ☐ U.S. ☐ Other	☐ Proposed insured is owner

Proposed Owner's Basic Information

Relationship to Proposed Insured		
Legal First Name	Middle Initial	Legal Last Name
Date of Birth	State/Country of Birth	Gender ☐ Male ☐ Female
Street Address		Apt #
City	State	Zip Code
[Driver's License #]	[State of Issue]	Mobile Phone #
Email	Citizenship ☐ U.S. ☐ Other	Social Security[/Tax ID] #

1. In the past [10] years, have you been convicted, pleaded guilty to or have charges pending for a: (select all that apply)

☐ [Misdemeanor]

☐ [Felony]

☐ [DUI/DWI for alcohol or drugs]

☐ None of the above

2. In the past [12] months, have you used cigarettes, E-cigarettes, pipes, vapor products, snuff, chewing tobacco, nicotine gum or nicotine patches?

☐ Yes ☐ No

2. Have you ever used any form of tobacco or nicotine?

☐ Yes ☐ No

3. Have you ever tested positive for HIV?

☐ Yes ☐ No

4. In the next [2] years, do you plan to: (select all that apply)

☐ [Pilot an aircraft]

☐ [Scuba dive]

☐ [Race a motor vehicle]

☐ [Mountain or rock climb]

☐ [Skydive]

☐ None of the above

5. In the past [10] years, have you used cocaine, methamphetamines, heroin, opioids, hallucinogens or any controlled substance not prescribed to you by a physician?

☐ Yes ☐ No

6. Are you: [(select all that apply)]

☐ [Working full-time]

☐ [Working part-time]

☐ [A full-time student]

☐ [A part-time time student]

☐ [A stay at home spouse or partner]

☐ [Retired]

☐ [Not working]

7. Do you have any life insurance [or annuities] currently in force or pending?

☐ Yes ☐ No

8. In the past [2] years, have you been declined for life insurance?

☐ Yes ☐ No

9. In the past [12] months, has a medical professional advised you to have: (select all that apply)

☐ Surgery

☐ Any test or procedure (other than for HIV)

☐ None of the above

10. In the past [12] months, have you received disability payments [(except for maternity leave)]?

☐ Yes ☐ No

11. In the past [6] months, have you lost more than [10] pounds?

☐ Yes ☐ No

12. In the past [10] years, have you been diagnosed or treated by a medical professional for: (select all that apply)

☐ [Alcohol abuse]

☐ [Aneurysm]

☐ [Cancer]

☐ [Chest pain]

☐ [Chronic kidney disease]

☐ [Chronic obstructive pulmonary disease (COPD)]

☐ [Depression or other mental health disorder]

☐ [Diabetes]

☐ [Heart disease or failure]

☐ [Liver cirrhosis]

☐ [Organ transplant]

☐ [Peripheral arterial disease]

☐ [Seizure disorder]

☐ [Stroke or mini-stroke/TIA]

☐ [Huntington's disease]

☐ [Amyotrophic lateral sclerosis (ALS)]

☐ [Cardiomyopathy]

☐ [Chronic hepatitis]

☐ [Multiple sclerosis]

☐ [Sickle cell anemia (not trait)]

☐ [Systemic Lupus]

☐ None of the above

13. In the next [12] months, do you plan to reside or travel outside of the United States?

☐ Yes ☐ No

14. Have you had a biological parent die before age [60] from any of the following:

☐ [Heart Disease]

☐ [Melanoma]

☐ [Colon cancer]

☐ [Ovarian or breast cancer]

☐ None of the above

15. Are you currently admitted to a:

☐ [Hospital]

☐ [Long-term care facility]

☐ [Hospice]

☐ None of the above

16. In the past [12] months have you been:

☐ [Confined to a wheelchair]

☐ [Diagnosed or treated by a medical professional for memory impairment]

☐ [Required to use supplemental oxygen]

☐ [Assisted or supervised with dressing, eating, bathing, or walking]

☐ None of the above

17. Do you have a valid U.S. driver's license?

☐ Yes ☐ No

18. In the past [30] days, have you been diagnosed or treated by a medical professional for COVID-19?

☐ Yes ☐ No

19. In the past [12] months, have you used any form of marijuana?

☐ Yes ☐ No

20. How many alcoholic drinks do you typically have per week?

_____ (number of drinks per week)

Primary Beneficiaries

Share percentages must equal 100%. Use whole numbers only, no decimals. Provide Beneficiary(ies) Full Name(s).
* indicates Required Fields.

Name *		Relationship *	Date of Birth	Share 1* %
Address		Apt #	City	
State	Zip Code	Mobile Phone #	Social Security[/Tax ID] #	
Name *		Relationship *	Date of Birth	Share 2* %
Address		Apt #	City	
State	Zip Code	Mobile Phone #	Social Security[/Tax ID] #	
Name *		Relationship *	Date of Birth	Share 3* %
Address		Apt #	City	
State	Zip Code	Mobile Phone #	Social Security[/Tax ID] #	
Name *		Relationship *	Date of Birth	Share 4* %
Address		Apt #	City	
State	Zip Code	Mobile Phone #	Social Security[/Tax ID] #	
Name *		Relationship *	Date of Birth	Share 5* %
Address		Apt #	City	
State	Zip Code	Mobile Phone #	Social Security[/Tax ID] #	
				Total %

Contingent Beneficiaries (optional)

Share percentages must equal 100%. Use whole numbers only, no decimals. Provide Beneficiary(ies) Full Name(s).
* indicates Required Fields.

Name *		Relationship *	Date of Birth	Share 1* %
Address		Apt #	City	
State	Zip Code	Mobile Phone #	Social Security[/Tax ID] #	
Name *		Relationship *	Date of Birth	Share 2* %
Address		Apt #	City	
State	Zip Code	Mobile Phone #	Social Security[/Tax ID] #	
Name *		Relationship *	Date of Birth	Share 3* %
Address		Apt #	City	
State	Zip Code	Mobile Phone #	Social Security[/Tax ID] #	
Name *		Relationship *	Date of Birth	Share 4* %
Address		Apt #	City	
State	Zip Code	Mobile Phone #	Social Security[/Tax ID] #	
Name *		Relationship *	Date of Birth	Share 5* %
Address		Apt #	City	
State	Zip Code	Mobile Phone #	Social Security[/Tax ID] #	
				Total %

Supplemental Questions

The following questions and your responses will be used to determine your eligibility.

*Initiated by **Question 1:***
1.a. Please specify the date of the violation(s):
2011

*Initiated by **Question 2:***
2.a. When was the last time you used any of these products?
3 year(s) ago

Legal

IRS Substitute W-9 Social Security Number-Taxpayer Identification Number Certification

Under penalties of perjury, as Owner of this policy, I certify that:

1. The taxpayer identification number shown on this application is my correct taxpayer identification number;
2. I am not subject to backup withholding because: (a) I am exempt from backup withholding, or (b) I have not been notified by the Internal Revenue Service that I am subject to backup withholding as a result of a failure to report all interest or dividends, or (c) the IRS has notified me that I am no longer subject to backup withholding. Check this box if you ARE subject to backup withholding;
3. I am a U.S. citizen or other U.S. person as defined by the IRS for federal tax purposes.
4. I am exempt from Foreign Account Tax Compliance Act (FATCA) reporting.

It Is Declared That

Statements and answers in this application, including statements by the Proposed Insured in any medical questionnaire or supplement that become part of this application, are complete and true to the best knowledge and belief of the undersigned. IT IS AGREED THAT: (1) any waiver or modification of this application will not be effective unless in writing and signed by the President or the Secretary of North American Company for Life and Health Insurance (the Company); (2) the acceptance of any policy or policy change issued on this application shall constitute a ratification of any correction or amendment made by the Company; and (3) no change in amount, risk classification, plan of insurance, or benefits shall be effective unless agreed to in writing by the applicant(s). The undersigned FURTHER AGREES to immediately advise the Company's Administrative Office [,Bestow Agency, LLC, 750 North St. Paul Street - #1900, Dallas, TX 75201,] of any change to any of the responses contained in the application, including any change in the health or habits of any Proposed Insured, that arise or is discovered after completing this application, but before the policy is effective, as defined herein.

Effective Date

Any insurance issued as a result of this application will not take effect until the full first premium is paid and the contract is delivered to and accepted by the Owner during the lifetime of any person proposed for insurance and while such person is in the financial condition and state of health described in all parts of this application. [For Reinstatements, the reinstatement is effective as of the date approved by the Company, all required premium is paid and while the Proposed Insured is living and in the same state of health as stated in all parts of this application.]

Authorization

In the HIPAA Authorization, the Proposed Insured provided consent that North American Company for Life and Health Insurance (the Company) and our third party partners could obtain and use his/her medical records.

Additionally, for the Company to determine eligibility for insurance, the Proposed Insured authorized it to collect information about him/her from public and non-public sources, including his/her Social Security number, financial and credit history, employment, general character and reputation, personal characteristics and mode of living.

The Proposed Insured further authorizes: (1) the Company to release any such data to its reinsurers, MIB, or other persons or organizations performing business or legal services in connection with this application, or to persons or organizations performing services on behalf of the Company for other business or marketing purposes, or as required by law when given a copy of this authorization; and (2) the Company's Administrative Office or its reinsurers to make a brief report of the Insured's personal health information to MIB.

To the extent required by law, the information gathered under this authorization will be maintained as confidential. The Company will not share any personal information except as stated within this authorization.

This authorization is valid from the date signed for the length of time permitted by applicable law in the state where the policy is delivered or issued for delivery. The Proposed Insured may revoke this authorization for information not then obtained by notifying the Company in writing. Such revocation will not be effective until received by the Company. The Proposed Insured understands that he/she or an authorized representative will receive a copy of this authorization upon request.

Community Property

The Company assumes there is no marital property interest in the policy unless the Company is notified otherwise in writing by the Owner. The Company is not responsible for determining whether there are any marital interests in this policy that may be affected by the Owner's requested purchase or any policy change. By signing below, the Owner agrees to indemnify and hold the Company harmless as to any marital property claims that are made in connection with this purchase or any policy change.

Accelerated Death Benefits

If the policy being applied for includes an accelerated death benefit(s) endorsement, the Owner understands and acknowledges: (1) Receipt of such benefits may affect eligibility for public assistance programs and benefits may be taxable; (2) Payment of this benefit will reduce the Insured's death benefit; (3) There is no additional premium for this benefit; and (4) an Accelerated Death Benefit Summary and Disclosure Statement(s) will be provided to the Owner prior to or concurrent with this application.

Electronic Signature Notice and Consent

By signing this application, the undersigned applicant(s) voluntarily consents to submission of this application electronically and use of his/her electronic signature, including voice signatures, on this application and related forms. The applicant(s) understands: his/her consent will be as legally binding and enforceable as if he/she had signed a paper application and that he/she will be provided an electronic copy of the completed application bearing his/her electronic signature at policy deliver. He/she agrees to provide the Company's Administrative Office with a current Internet email address and he/she has access to the Internet for the purpose of accepting electronic delivery of the document and a computer with Adobe Acrobat Reader and a Windows Operating System to view the completed application. He/she understands that he/she has the right to receive a paper copy of the completed application by contacting the Company's Administrative Office. He/she understands and agrees that if coverage is declined, a copy of the application will not be provided, unless requested.

Payment Method

Modal Premium Frequency:

☐ Monthly ☐ Annual

Payment Type:

☐ Direct Bill ☐ ETF ☐ Credit Card ☐ Mobile Payment

Account Holder's Name _____

Amount paid with application: $_____

Billing Address

☐ Check this box if billing address is same as residence, otherwise list below.
(If P.O. Box, also include Street Address below)

Street Address		Suite/Apt #
City	State	Zip Code

Secondary Billing Notification
Do you want to designate an additional address or person to receive Grace Period notices for insufficient premium and lapse notices?

☐ Yes, complete information below ☐ No

Name		Mobile Phone #
Street Address		Suite/Apt #
City	State	Zip Code

Signature

☐ *I verify, as the proposed insured that I am personally completing this application without any assistance or supervision, while physically located in the United States.*

I acknowledge receipt of the Consumer Protection Notice that includes the Fair Credit Reporting Act Notice/MIB, Inc., Notice and Notice of Insurance of Information Practices.

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.

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

Signature of Proposed Insured	Date
Signed At (Resident City and State)	

Signature of Proposed Owner (if different than proposed insured)	Date
Signed At (Resident City and State)	