North American Company
for Life and Health Insurance
Principal Office: West Des Moines, IA

ICC18L3236TR

Administered for the Company by: bestow
Bestow Agency, LLC
www.bestow.life
(800) 555-5555

Individual Life Insurance Application For Reinstatements – Existing Policy #:_____

Plan of Insurance Applied for: ☐ 10 Year Term ☐ 20 Year Term

Your Basic Information

1a. Legal First Name of Proposed Insured/Owner	1b. Middle Initial	1c. Legal Last Name of Proposed Insured/Owner
2a. Date of Birth	2b. State/Country of Birth	2c. Sex ☐ Male ☐ Female
3a. Height Feet Inches		3b. Weight Pounds
4a. Street Address		4b. Suite/Apt #
4c. City	4d. State	5. Zip Code
6. Email	7. Primary Telephone Number	8. Social Security Number

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

9. Are you a U.S. citizen, or do you have a U.S. permanent resident card (green card)?
   ☐ Yes ☐ No
10. Have you:
   ☐ Ever been convicted of a felony?
   ☐ Ever been convicted of a DUI/DWI for alcohol or drugs in the past 5 years?
   ☐ Had a suspended or revoked license in the past 3 years?
11. In the past 12 months, have you used any tobacco or nicotine products (excluding less than 24 cigars)?
   ☐ Yes ☐ No
12. In the past 5 years, have you been declined for life insurance?
   ☐ Yes ☐ No
13. In the past 2 years or within the next year, have you or do you plan to (1) pilot an airplane (other than as a regularly scheduled commercial airline pilot), or participate in (2) scuba diving deeper than 100 feet, (3) automobile racing over 100 miles per hour, or (4) outdoor climbing requiring specialized equipment?
   ☐ Yes ☐ No
14. In the past 2 years, have you received disability payments for a period in excess of 3 months?
   ☐ Yes ☐ No
15. Have you ever tested positive for HIV or been medically diagnosed as having AIDS?
   ☐ Yes ☐ No

16. In the past 10 years, have you been medically diagnosed or medically treated for: (Select all that apply)

☐ Heart disease

☐ Cancer (excluding basal and squamous cell skin cancer)

☐ Organ transplant

☐ Peripheral arterial disease

☐ Chronic kidney disease

☐ Liver cirrhosis or drug abuse

☐ None of the above

17. Other than routine care, in the past 12 months, have you been advised by a licensed medical professional to have surgery, hospitalization, any diagnostic test (other than for HIV) or any procedure which has not been completed or the results are unknown?

☐ Yes ☐ No

18. In the past 3 months, have you unintentionally lost more than 15 pounds [female only]? 20 pounds [male only]?

☐ Yes ☐ No

19. In the past 10 years, have you been medically diagnosed or medically treated for: (Select all that apply)

☐ Depression or other mental disorder

☐ Alcohol abuse

☐ Chest pain

☐ Diabetes

☐ Stroke or mini-stroke/TIA

☐ Seizure disorder

☐ None of the above

20. Are you: (Select only one)

☐ A full time student

☐ A homemaker

☐ Working 30 hours or more per week

☐ Working less than 30 hours per week or unemployed

21. My annual income is $_____.

22. Do you have any life insurance or annuities currently in force or pending?

☐ Yes ☐ No

23. In the next 12 months, do you plan to travel outside of the United States, Canada, or Mexico?

☐ Yes ☐ No

24a. Do you have a U.S. valid driver's license?

☐ Yes (next question) ☐ No

24b. Driver's License Number	24c. State of Issue (If applicable)

Primary Beneficiaries

25. 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 *
Address		Apt/Suite #	City	
State	Zip Code	Telephone Number	Social Security Number	%
Name *		Relationship *	Date of Birth	Share *
Address		Apt/Suite #	City	
State	Zip Code	Telephone Number	Social Security Number	%
Name *		Relationship *	Date of Birth	Share *
Address		Apt/Suite #	City	
State	Zip Code	Telephone Number	Social Security Number	%
				Total %

Contingent Beneficiaries (optional)

26. 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 *
Address		Apt/Suite #	City	
State	Zip Code	Telephone Number	Social Security Number	%
Name *		Relationship *	Date of Birth	Share *
Address		Apt/Suite #	City	
State	Zip Code	Telephone Number	Social Security Number	%
				Total %

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 me in any medical questionnaire or supplement that become part of this application, are complete and true to the best of my knowledge and belief. 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 me. I FURTHER AGREE to immediately advise the Company's Administrative Office [(Bestow Agency, LLC, 1920 McKinney Avenue, Dallas, TX 75201)] of any change to any of my responses contained in the application, including any change in my health or habits that arises or is discovered after completing this application, but before the policy or reinstatement 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 you while you are living and in the state of health and financial condition 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 you are living and in the same state of health as stated in all parts of this application.]

Authorization

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

Additionally, for the Company to determine eligibility for insurance, you authorize it to collect information about you from public and non-public sources, including your Social Security number, financial and credit history, employment, general character and reputation, personal characteristics and mode of living.

You further authorize: (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 your 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 my 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 your 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. You 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. You understand that you 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 you. The Company is not responsible for determining whether there are any marital interests in this policy that may be affected by your requested purchase or any policy change. By signing below, you agree 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.

Electronic Signature Notice and Consent

By signing this application, I voluntarily consent to submission of this application electronically and use of my electronic signature, including voice signatures, on this application and related forms. I understand that I will be provided an electronic copy of the completed application bearing my electronic signature at policy delivery. I agree to provide the Company's Administrative Office with a current Internet email address and I have 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. I understand I also have a right to receive a paper copy of the completed application by contacting the Company's Administrative Office. I understand and agree that if coverage is declined, a copy of the application will not be provided, unless requested.

Payment Method

Modal Premium Frequency:

☐ Annual ☐ Monthly

Payment Type:

☐ Direct Bill/EFT ☐ Credit Card

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

Third Party Billing Notification

Do you want to designate an additional person to receive Grace Period notices for insufficient premium and lapse notices?

☐ Yes, complete information below ☐ No

Name		Telephone Number with Area Code
Street Address		Suite/Apt #
City	State	Zip Code

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.

Your Signature

Signed At (Resident City and State)
Signature of Owner / Date **X**