NATIONAL TEACHERS ASSOCIATES LIFE INSURANCE COMPANY
[P.O. Box 802207, Dallas, Texas 75380]
Phone [(888) 671-6771] Fax [(972) 532-2180]

Check if applicable:
☐ Name Change
☐ Policy Reinstatement
☐ Plan Change:
Policy #_____
☐ Other _____

APPLICATION FOR INDIVIDUAL SIMPLETERM™ LIFE INSURANCE

APPLICANT: Please supply all of the following important information. It will be used to determine your eligibility for coverage, including age, height, weight, occupation, and responses to medical information below.

Name of Proposed Primary Insured (Last, First, Middle Initial)					Social Security No. - -
Sex	Date of Birth	Age (Maximum 64)	Height	Weight	(For Statistics Only) ☐Smoker ☐Non-Smoker
Address					E-mail Address

City	County or Parish	State	Zip -	CODES	St.	Cnty.	City	Bldg.

Home Phone ( )	Work Phone ( )	Cell Phone ( )

Best place and time to call (before 5 pm) ☐HM ☐WK ☐CELL / ☐AM_____ ☐PM_____	School System	School or Business

Current Annual Pre-tax Income $	Occupation

Primary Death Benefit Beneficiary	Relationship	Contingent Death Benefit Beneficiary	Relationship
Address	Date of Birth	Address	Date of Birth

☐ Application for SimpleTerm™ Life Insurance Policy

☐ Term Life Face Amount Applied for $_____	☐ $5,000 Child Rider Face Amount	☐ AD&D Rider Face Amount $_____

FOR CHILD LIFE INSURANCE RIDER	Names of Dependent Children (Last, First, Middle) (use additional paper if necessary)	Social Security No.	Birthdate	Sex

☐ Owner and/or ☐ Payor of Policy if Other than Proposed Insured	Relationship	Address

City	State	Zip	Social Security Number

COVERAGE WILL BE AUTOMATICALLY DECLINED FOR ANY "YES" RESPONSE TO QUESTIONS 1-3.

1. ☐ No ☐ Yes Are you currently **not working** because of sickness or an injury; **on leave** from work; **disabled**; or **under the care of a hospital, long term care facility, or nursing home**?
2. ☐ No ☐ Yes Have you been diagnosed with **Type I diabetes;** or, within the past 5 years, have you been **prescribed insulin** or **insulin refills**?
3. Within the past 5 years, have you: (i) **received medical advice for**, (ii) **been diagnosed with**, (iii) **received treatment or surgery for**, or (iv) **been prescribed medication for**:
   - ☐ No ☐ Yes a. **Cancer** (including internal / in situ / melanoma Cancer, but excluding other skin cancers)?
   - ☐ No ☐ Yes b. Any disease, disorder, or abnormality of the **cardiovascular system or heart,** such as coronary artery disease, heart disease, heart attack, diagnostic heart catheterization, or any heart surgery (excluding: mitral valve prolapse; heart murmur; and an irregular heartbeat not treated with medication or surgery)?

A

I have reviewed all responses provided in this application for accuracy. _____ Initial

☐ No ☐ Yes c. Any disease, disorder, or abnormality of the **circulatory system** (including arteries, veins and vessels; excluding high blood pressure if controlled)?

☐ No ☐ Yes d. **Stroke**, **transient ischemic attack** (TIA or mini-stroke), or any disease of the **brain**?

☐ No ☐ Yes e. **Kidney** (renal) **failure or insufficiency**, **liver failure**, or **cirrhosis** of the liver?

☐ No ☐ Yes f. **Emphysema**, chronic obstructive pulmonary disease (**COPD**) or Sarcoidosis?

☐ No ☐ Yes g. **Psychosis** (including schizophrenia, manic depression (bipolar), and severe/major depression)?

☐ No ☐ Yes h. Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC), or tested positive for antibodies to the AIDS virus (**HIV positive**)?

4. ☐ No ☐ Yes In the past 3 years, have you been hospitalized or undergone surgery for any disease, disorder, or abnormality of the **back, neck, spine, bones, or joints** (including rheumatoid arthritis**,** osteoarthritis or degenerative joint disease)? If yes, explain: _____.

5. ☐ No ☐ Yes Have you ever received an organ transplant? If yes, please provide details including type of organ transplant, diagnosis, and date:_____
_____.

6. Name, city, and phone number of your primary care physician: _____.

7. ☐ No ☐ Yes Is the policy for which you are applying intended to replace or change any of your existing policies? If yes, identify company and benefit amount:
_____ $_____.

MODE OF PAYMENT

Initial Premium with Application:
☐ Check Attached *
☐ Credit Card Payment
☐ Other _____

Recurring Payments:
☐ **Monthly** ☐ **Other** _____
☐ Bank Draft ☐ Credit Card
☐ Payroll Deduction ☐ Other_____

Policy and Optional Riders:
Life Ins. $ _____
Total Premium $ _____

* When a check is provided as a payment, National Teachers Associates Life Insurance Company (NTA) may use the information from the check to make a one-time electronic funds transfer (EFT) from your account or to process the payment as a check transaction. If we use information from the check to make an EFT, funds may be withdrawn from your account the same day that NTA receives your check. You may not receive the cancelled check from your financial institution.

BANK DRAFT AUTHORIZATION

USE ACCOUNT INFO. FROM: ☐Initial Premium Check **OR** ☐Specimen Check (attached)

I request and authorize National Teachers Associates Life Insurance Company to make withdrawals against the bank account selected above, or any account subsequently named by me, and such bank(s) to process these withdrawals as if I had signed them for the purpose of collecting premiums under the policy. If the said account is replaced by an account in another bank, this request and authorization shall also apply to such other bank. I understand that I have the right to receive notice of each electronic debit entry that varies in amount from the previous entry, but I elect to receive such notice only when such entry differs from the previous entry by more than $200.

X _____ _____/_____/_____
Signature exactly as it appears on bank records — Date Signed

Requested first draft date (1-28 only)

WARNING: **Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.**

I, (or we) certify that I have read or had read to me the completed application and submit it as my offer for the purchase of insurance. I understand that I have no coverage unless and until the policy is issued by the Company. I represent that the answers are true and correct to the best of my knowledge and belief, and realize that any fraudulent statement or material misrepresentation in the application may result in a loss of coverage. I authorize the Company to call me on a recorded phone call to clarify or verify certain information in this application and agree that a transcript of such recording can be made a part of my application for insurance. I authorize National Teachers Associates Life Insurance Company or its reinsurers to make a brief report of my protected health information to MIB, Inc. No oral statement between the agent and me will be binding on the Company. A copy of this application will be valid as if it were an original. I also certify that I have received a copy of the Company's privacy notice and privacy practices.

DATED AT _____, THIS _____ DAY OF _____ _____
City and State — Day — Month — Year

X _____
Signature of Proposed Primary Insured

X_____
Signature of Owner/Payor if other than Proposed Primary Insured

I certify that I have truly and accurately recorded on this Application the information supplied by the applicant.

_____ _____ _____ _____
Licensed Agent Signature — Printed agent name — License ID No. — Agent No.

[4949 Keller Springs Road, Addison, TX 75001] — Address

[1-800-TALK-NTA] — Phone

ICC13 75-402 (6/13)