



National Life Company

4095 NW Urbandale Drive • Urbandale, Iowa 50322

Employee Number

1 COMPLETE INFORMATION AT RIGHT

LAST NAME	FIRST NAME	MIDDLE INITIAL	Social Security Number	
ADDRESS				
CITY		STATE	ZIP	<input type="checkbox"/> Male <input type="checkbox"/> Female
Telephone Number (home)			Date of Birth	
Telephone Number (work)			Birth State	
Send Secondary Premium Notice (notification of possible lapse to):				
Name		Address	City	State
Zip+4				

2 DEPENDENT COVERAGE

I desire coverage for my: <input type="checkbox"/> Spouse <input type="checkbox"/> Children	Spouse's Social Security Number	
Spouse's Full Name	Spouse's Date of Birth	Spouse's Birth State
Spouse's Telephone Number (home)	Spouse's Occupation	
Spouse's Telephone Number (work)		
Children (please print) Name	Birthdate	Name
		Birthdate

3 SMOKER/NONSMOKER

Has any person to be insured smoked any cigarettes within the last 12 months? Yes No
 If "Yes," list name(s) _____

4 INDICATE YOUR CHOICE OF COVERAGE

Version 1.0 Version 2.0 Other _____

BENEFIT AMOUNT - PRIMARY _____ Accelerated Benefit Rider - Primary
 0% 25% 50% 100%

BENEFIT AMOUNT - SPOUSE _____ Accelerated Benefit Rider - Spouse
 0% 25% 50% 100%

Children's term rider
 \$2,500 \$5,000 \$10,000

WAIVER OF PREMIUM ACCIDENTAL DEATH: BENEFIT AMOUNT
 Primary Coverage (Available through issue age 55) Primary Coverage \$ _____
 Spouse Coverage Spouse Coverage \$ _____

5 CALCULATE PREMIUM PAYMENT

PREMIUM MODE Annual Semi-annual Quarterly Monthly
 BILLING METHOD List Bill Check Plan Direct (EXCEPT MONTHLY)

Special Billing Instructions: _____

Proposed Effective Date: ____/____/____

Make all checks payable to **EMC National Life Company.**

PREMIUM CALCULATOR

Life Coverage Primary	\$ _____
ADB Premium	\$ _____
Life Coverage Spouse	\$ _____
ADB Premium	\$ _____
Children's term coverage	\$ _____
Total	\$ _____

6 REPLACEMENT

Is this policy being purchased to replace any existing insurance? YES NO
 (If "Yes," complete Replacement Notice if applicable.)

7 INTERIM COVERAGE

APPLIES ONLY TO PAYROLL DEDUCTION

Is interim coverage being applied for? YES NO
 If "Yes," effective immediately, interim coverage will be provided as applied for until the date the policy becomes effective; or until the owner is notified that no insurance policy will be issued. Interim coverage does not apply to the Accelerated Benefit Rider. In no event will interim coverage be provided for more than 60 days from the date of this application.

8 BENEFICIARY DESIGNATION

Beneficiary - Full Name & Relationship _____

Contingent Beneficiary - Full Name & Relationship _____

IF SPOUSE COVERAGE IS APPLIED FOR, THE PRIMARY BENEFICIARY OF THE SPOUSE COVERAGE IS THE PRIMARY INSURED.

THE CONTINGENT BENEFICIARY IS THE ESTATE OF THE PRIMARY INSURED.



9	ANSWER THE FOLLOWING QUESTIONS:	A. Are you actively at work now and have you worked at least 30 hours a week for the last 3 months except for minor illnesses of 1 week or less or pregnancy?	PRIMARY YES NO	SPOUSE/CHILD YES NO
		B. Has any person to be insured ever tested positive for exposure to the HIV infection or been diagnosed as having ARC or AIDS caused by the HIV infection or other sickness or condition derived from such infection?	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>
		C. Has any person to be insured been diagnosed or treated as a victim of a heart attack or stroke prior to this date?	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>
		If Yes, list name(s) of person(s): _____ <i>The person(s) named above will not be eligible for the Accelerated Benefit Rider.</i>		
		D. Has any person to be insured been diagnosed or treated for kidney failure, internal cancer, malignant melanoma, leukemia, lymphoma or any malignancy prior to this date?	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>
		If Yes, list name(s) of person(s): _____ <i>The person(s) named above will not be eligible for the Accelerated Benefit Rider.</i>		

10	Except for 9A, if any question in section 9 or 10 is answered "yes", give complete details below.	A. During the past 5 years has any person to be insured received medical care for or had:	PRIMARY YES NO	SPOUSE/CHILD YES NO
		1) any intestinal or urinary tract bleeding, heart disease, heart surgery, pacemaker implanted, or blood vessel surgery?	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>
		2) emphysema, chronic bronchitis, tuberculosis, asthma or lung disorders causing a decrease in normal or daily activity?	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>
		3) liver disease, hepatitis, diabetes requiring insulin or causing amputation or blindness, multiple sclerosis, or systemic disease such as lupus?	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>
		4) mental illness requiring medication or hospitalization, suicide attempted, more than two fainting episodes, medical treatment for alcoholism or drug abuse? . . .	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>
		5) been advised to have any diagnostic tests, hospitalization, or surgery which was not completed or for which results have not been received?	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>
		B. Have you ever applied for a life insurance policy and been declined coverage? . . .	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>
		C. Is there any reason you are not physically capable of full time employment?	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>
		D. Has any parent at age 50 or less died of colorectal, breast or other internal cancers, polycystic kidney disease, heart attack, or stroke?	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>

Question	Person to Whom it Applies	Names and Addresses of Physicians	Details of "yes" answer including date & treatment received

11 SIGN AND DATE THIS FORM BELOW WHERE INDICATED.

I have read, or had read to me, the above questions and my answers to them. To the best of my knowledge and belief, my answers are complete, true and correct.

No agent is authorized to extend, waive or change any terms, conditions or provisions of the Policy.

I understand EMC National Life Company, its reinsurers, insurance support organizations, and their authorized representative, may obtain medical and other information in order to evaluate my application for insurance. Any physician, practitioner, hospital, clinic, other medical or medically related facility, the Veterans Administration, the Medical Information Bureau, Inc., my employer and consumer reporting agency or insurance company who possesses information of care, treatment or advice of me, may furnish such information to EMC National Life Company or its reinsurers upon presenting this authorization or a photocopy. This information will not be released to others except as allowed by law or as I further authorize. I authorize EMC National Life Company to obtain an investigative consumer report on me, if required. I understand this authorization includes information about drugs, alcoholism or mental illness. This consent is subject to revocation at any time. EMC National Life Company or its reinsurers may make a brief report regarding me to other companies to whom I have applied or may apply. If applicable, automatic premium loan provision is elected. Any dividends will be paid in cash. I understand that the insurance will become effective on the date the application is approved by EMC National Life Company or the date elected in section 5. I have read the signature information and understand that my personal representative or I may receive a copy. I have also received a copy of the "Important Notice." I elect to be interviewed if any investigative consumer report is prepared in connection with this application. This authorization will be valid from the date signed for a period of two years.

Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

I, as agent, represent that to my knowledge the insurance applied for will not replace any insurance unless so stated in #6.
 Yes No

I, as agent, certify that no personalized sales illustration was used in my presentation. A fully compliant sales illustration will be provided to my client no later than the date the policy is delivered.

Applicant's Signature **X** _____ Date _____

Owner's Signature **X** _____ Date _____
(If other than Primary Insured)

Agent's Signature **X** _____ Dated at _____

Agent's Printed Name _____ Agent's Code Number _____

Agent's Phone Number _____ Florida License ID Number _____