



# LSW

## LIFE INSURANCE APPLICATION

## 8121 Application Instructions

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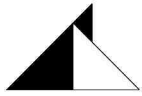
### California Kit Instructions:

- Use this application kit to apply for any LSW Life policy.
- Fax applications to: (802) 229-7592, or e-mail nbapplicationimages@nationallife.com.
- Any alterations or corrections on the application must be initialed by the policy owner, including corrections made using white out.
- Dates, agents and participation percentages must not be whited out or altered on applications and agent reports.
- Issue Age calculation for SecurePlus Paragon, Advantage 79, Harbor & Horizon should be age as of nearest birthday. All other products use age last birthday.
- The election box in Part 7 (**Sales Illustration Certification**) must be checked if a signed illustration of the policy applied for is NOT enclosed with this application. This applies to Universal Life and Non-Guaranteed Term products.
- **Signatures** - make sure that you, the Proposed Insured and the Applicant/Owner sign and date Part 9 (**Agreement and Authorization**). If the Proposed Insured is a minor between ages 0 and 14, we must have a parent's signature in part 9 of the application and on the HIPAA form. Proposed Insured's age 15 and up need to sign the application as the Proposed Insured, the HIPAA form and the HIV consent form.
- **Agent Report** - 8121G must be completed and signed by you, the Agent. Be sure to include class quoted for both Proposed Primary Insured and Proposed Other Insured.
- **Bank draft** - Please attach a voided check or deposit slip to the New Business Checklist (in addition to the correct premium payment) when applying for Check-O-Matic or bank draft.
- **ABR disclosure** - Send one signed copy with the application and leave the other signed copy with the Applicant.
- **HIPAA Authorization** - form must be completed on the top and signed by the Proposed Insured if the Proposed Insured. If under age 15, the parent or guardian needs to sign and enter relationship to the Proposed Insured below signature. One signed copy should be sent with the application. The other signed copy of the HIPAA form should remain with the Applicant. HIPAA forms are required for all CTR Insured's.
- **HIV consent** - send one copy with the application. The other signed copy of the consent form should remain with the Applicant. No HIV consent form is needed for ages 0-14.
- **Interest Crediting Strategies form, 8613** - required for SecurePlus Provider, Paragon and Advantage 79.
- **Pension or Profit Sharing Plans** - Harbor/Horizon, SecurePlus Provider, Paragon and Advantage 79, please submit Supplemental Application for Qualified Pension or Profit Sharing Trust, form 8533.

### Additional Forms Required when applicable:

- Avocation, Aviation & Foreign Travel Supplemental Application, 1480
- Replacement forms
- Transfer/1035 Exchange forms
- For NAIC states, if there is insurance in force, submit form 8027
- Long Term Care forms
- Employer Owned Notification & Consent Form, 8453
- California Financial Advice Disclosure for Elders Form, 8196 - needs to be signed by the client and agent and left with all clients 65 and older when applying for life insurance.

Thank you for your business!



**Part 1 - Proposed Primary Insured Information - Please PRINT**

- How long have you known the Proposed Insured(s)?  
\_\_\_\_\_
- Are you related?  Yes  No  
(If 'Yes', relationship?) \_\_\_\_\_
- Proposed Primary Insured's  
Net Worth \$ \_\_\_\_\_  
Household Income \$ \_\_\_\_\_  
Household Net Worth \$ \_\_\_\_\_
- Which rate class was quoted?  
Proposed Primary Insured \_\_\_\_\_  
Proposed Other Insured \_\_\_\_\_
- Indicate underwriting requirement(s)  
 Oral Fluids taken  Exam ordered (indicate examiner)  
 Blood/HOS ordered \_\_\_\_\_
- Are there existing life, disability or annuity contracts?  
(If 'Yes', provide Replacement Forms.)  Yes  No
- To the best of your knowledge, is this insurance intended to replace any existing coverage?  Yes  No
- List any sales materials, including illustrations, used relating to the new application: \_\_\_\_\_

**Part 2 - Owner's Information**

- Annual Income \$ \_\_\_\_\_  
Net Worth \$ \_\_\_\_\_
- If a **Partnership** involved, give full legal name or title  
\_\_\_\_\_  
\_\_\_\_\_  
If the above Partnership is a **Limited Partnership**, give name of all general partners (Print names)  
\_\_\_\_\_  
\_\_\_\_\_
- If a **Corporation** involved, give full legal name or title  
\_\_\_\_\_  
\_\_\_\_\_  
State of incorporation \_\_\_\_\_  
% of stock owned by Proposed Primary Insured \_\_\_\_ %
- To your knowledge is the Proposed Primary Insured or Owner receiving any loans, cash, promises of future benefit, free insurance, or other valuable consideration as an inducement to apply for or become an insured under this life insurance policy?  
 Yes  No
- Are you aware that the Proposed Primary Insured or Owner has been involved in any discussions regarding transfer of ownership of the policy being applied for to a third party, such as (but not limited to) a life settlement company or investor group?  
 Yes  No

**Part 3 - Notes**

**Part 4 - Agent's Signature**

Signature of Licensed Agent	Licensed Agent's Name (Print)	Percent	Agent Number/Suffix	Phone
Signature of Additional Agent	Name of Additional Agent (Print)	Percent	Agent Number/Suffix	Phone

Application for Life Insurance

**Part 1 - Proposed Primary Insured (PPI) and Plan Information - Please PRINT**

1. Name _____	2. Place of Birth - State/Country _____	3. Date of Birth _____	4. Issue at Age _____
5. Home Address (if mailing address different, provide in Remarks) _____			
6. Sex <input type="checkbox"/> M <input type="checkbox"/> F	7. Soc. Sec. # _____	8. Telephone #'s and best time to call H ( ) W ( ) C ( )	
9. Are you a citizen of <input type="checkbox"/> USA <input type="checkbox"/> Other Country _____ Type of VISA _____ Alien Registration # _____			
10. Employer and time employed _____		11. Occupation (w/specific duties) _____	
12. Annual Income \$ _____		13. Are you actively at work full time (30 hours per week) and able to perform all your regular duties? <input type="checkbox"/> Yes <input type="checkbox"/> No	
14a. Driver's License # _____	14b. State _____	15. Riders and Amounts (Check website for rider availability)	
16. Product Name _____		<input type="checkbox"/> Accelerated Benefits (ABR) (Complete ABR Disclosure form)	
17. Face Amount \$ _____		<input type="checkbox"/> Waiver of Premium (WP)	
18. Death Benefit Option (IUL/UL only) <input type="checkbox"/> A - Level <input type="checkbox"/> B - Increasing		<input type="checkbox"/> Waiver of Specified Premium (WSP) (Harbor, Horizon, Adv79) (Annual Premium Waived) \$ _____	
19. Definition of Life Insurance Test (Applies to IUL/UL only.) <input type="checkbox"/> Guideline Premium Test (GPT) <input type="checkbox"/> Cash Value Accumulation Test (CVAT)		<input type="checkbox"/> Additional Protection Benefit (APB) (Paragon, Horizon, Adv79) \$ _____	
20. Premium Information		<input type="checkbox"/> Children's Term Rider (CTR) \$ _____	
a. Premium Mode _____		<input type="checkbox"/> Disability Income (DIR) <input type="checkbox"/> 2 Yr <input type="checkbox"/> 5 Yr \$ _____	
b. Planned Periodic Premium \$ _____		a. Do you have any disability insurance, including employer sponsored short or long-term coverage? (If Yes, give details in Remarks) <input type="checkbox"/> Yes <input type="checkbox"/> No	
c. Cash with Application \$ _____		<input type="checkbox"/> Long Term Care (LTC) (Complete 8099 LTC kit)	
21. Identify the source of funds for premium payment		<input type="checkbox"/> Extension of Benefits (EB) <input type="checkbox"/> w/Inflation Protection (IP) (Complete 8099 LTC Kit)	
<input type="checkbox"/> Income/Savings <input type="checkbox"/> Home equity		<input type="checkbox"/> Accidental Death Benefit (ADB) \$ _____	
<input type="checkbox"/> Payment by third party <input type="checkbox"/> Loan/Premium Finance		<input type="checkbox"/> Guaranteed Insurability (GIR) \$ _____	
<input type="checkbox"/> Other _____		<input type="checkbox"/> Death Benefit Protection (DBP)	
22. Primary Beneficiary, Relationship, Date of Birth, S.S. # and Address (if different than PPI) _____		<input type="checkbox"/> No-Lapse Guarantee (NLG) (Horizon only) (OIR, APB & BSB N/A if NLG elected)	
		<input type="checkbox"/> Balance Sheet Benefit (BSB) (Paragon & Horizon) (% Waived) _____ %	
		<input type="checkbox"/> Other Insured (Complete 8122)	
		23. Owner, Relationship, Address, Date of Birth, & S.S.# (if other than PPI) _____	

**Part 2 - General Information for Proposed Primary Insured (If 'Yes', provide details in Remarks)**

1. Have you used any type of product containing tobacco or nicotine within the last 24 months? _____	<input type="checkbox"/> Yes <input type="checkbox"/> No
Product Type: _____ Frequency: _____ Date Last Used: _____	
2. Have you ever applied for life, health, or disability insurance or reinstatement of same, which was declined, postponed, rated or modified in any way? _____	<input type="checkbox"/> Yes <input type="checkbox"/> No
3. Are you or do you have any intention of becoming a member of a military organization? _____	<input type="checkbox"/> Yes <input type="checkbox"/> No
4. Have you had any moving vehicle violations in the last 3 years, or a suspended license or DUI in the last 5 years? _____	<input type="checkbox"/> Yes <input type="checkbox"/> No
5. Have you ever been convicted of a felony or misdemeanor? _____	<input type="checkbox"/> Yes <input type="checkbox"/> No
6. Have there been any bankruptcy proceedings against you within the last 7 years? _____	<input type="checkbox"/> Yes <input type="checkbox"/> No
7. Within the past 6 months have you applied for or do you have any applications pending for life or disability insurance? _____	<input type="checkbox"/> Yes <input type="checkbox"/> No
8. Have you received or applied for disability or worker's compensation? _____	<input type="checkbox"/> Yes <input type="checkbox"/> No
9. Within the last 3 years, have you participated in or do you intend to participate in any type of racing, scuba, skin, sport or sky diving; competition sport; parachuting or hang gliding; BASE or bungee cord jumping; big game hunting; mountain climbing; cave exploring; rodeos or snowmobiling? (If 'Yes', complete form 1480) _____	<input type="checkbox"/> Yes <input type="checkbox"/> No
10. Do you participate in any aviation activity other than as a fare paying passenger? (If 'Yes', complete form 1480) _____	<input type="checkbox"/> Yes <input type="checkbox"/> No
11. Do you intend to travel or reside outside of the USA for more than 2 weeks in a year? (If 'Yes', complete form 1480) _____	<input type="checkbox"/> Yes <input type="checkbox"/> No
12. Have you been offered any cash incentive or other consideration (such as free insurance) as an inducement to apply for or become an insured under this life insurance policy, or have you been involved in any discussions about the possible sale or transfer of this policy to an unrelated third party, such as (but not limited to) a life settlement company or investor group? _____	<input type="checkbox"/> Yes <input type="checkbox"/> No

**Part 3 - Inforce & Replacement Information**

1. Do you have any existing life insurance policies or annuity contracts? (Include face & ADB amounts, company name & year of issue) If none - check this box:
  
2. Has there been or will there be a lapse, surrender, replacement, reissue, conversion, or change to reduce amount, premium, or period of coverage of any existing life, disability or annuity contract if the applied for policy or rider is issued?  Yes  No  
*(If Yes, Replacement forms must be provided)*
  
3. Will there be any substantial borrowing on any life insurance policy if the applied for policy or rider is issued?  Yes  No  
*(List company name(s) and policy number(s) in Remarks)*

**Part 4 - Health History of the Proposed Primary Insured** (Give details, dates & results for any 'Yes' questions 1-10 in Remarks)  
 Complete Part 4 if money was collected with the application or an LSW exam is not being done.

1. Name, Address and Phone No. of Personal Physician <i>(If none, so state)</i>	Date last seen	Reason consulted & outcome
2. Height	Weight	Change in last year? <input type="checkbox"/> Yes <input type="checkbox"/> No
Details: _____		
3. Are you taking any medication? <i>(If 'Yes', list type, dose and frequency in the Remarks section.)</i> <span style="float: right;"><input type="checkbox"/> Yes <input type="checkbox"/> No</span>		
4. In the last 10 years have you been diagnosed, treated, taken medication for, or know of having any indication of any:		
a. Heart Murmur, Rheumatic Fever or Anemia <input type="checkbox"/> Yes <input type="checkbox"/> No b. Chest Pain, Heart Disease/Disorder or Heart Surgery <input type="checkbox"/> Yes <input type="checkbox"/> No c. Sleep Apnea, Emphysema, Asthma or Lung Disease <input type="checkbox"/> Yes <input type="checkbox"/> No d. Ulcer, Jaundice, Hepatitis or Chronic Indigestion <input type="checkbox"/> Yes <input type="checkbox"/> No e. Eyes, Ears, Nose, or Throat Disorder <input type="checkbox"/> Yes <input type="checkbox"/> No f. Diseases of the Central Nervous System or Headaches <input type="checkbox"/> Yes <input type="checkbox"/> No g. Spine, Bones, Muscles, Joints, Skin or Thyroid Disorder <input type="checkbox"/> Yes <input type="checkbox"/> No h. Stroke, Dizzy Spells, Epilepsy, Convulsions, Paralysis or Unconsciousness <input type="checkbox"/> Yes <input type="checkbox"/> No i. Veins, Blood, or other Circulatory System Disorder <input type="checkbox"/> Yes <input type="checkbox"/> No j. Protein, Sugar, or Blood in the Urine <input type="checkbox"/> Yes <input type="checkbox"/> No k. Alzheimer's or Dementia <input type="checkbox"/> Yes <input type="checkbox"/> No	l. Kidney Stone, Kidney or Bladder Disorder <input type="checkbox"/> Yes <input type="checkbox"/> No m. Depression, Anxiety, or other Psychological Condition <input type="checkbox"/> Yes <input type="checkbox"/> No n. Gout, Arthritis, Back Pain or Back Disorder <input type="checkbox"/> Yes <input type="checkbox"/> No o. Diabetes or High Blood Sugar <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, is it controlled by diet alone? <input type="checkbox"/> Yes <input type="checkbox"/> No p. Cancer, Polyp, or Other Tumor <input type="checkbox"/> Yes <input type="checkbox"/> No q. Esophagus, Stomach, Intestinal, Liver or Gall Bladder Disorder <input type="checkbox"/> Yes <input type="checkbox"/> No r. Prostate, Pelvic Organs, or Breast Disease <input type="checkbox"/> Yes <input type="checkbox"/> No s. Alcohol or Drug Abuse <input type="checkbox"/> Yes <input type="checkbox"/> No t. High Blood Pressure or High Cholesterol <input type="checkbox"/> Yes <input type="checkbox"/> No	
5. Within the past 10 years has a physician or other medical professional diagnosed you as having Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC)? <span style="float: right;"><input type="checkbox"/> Yes <input type="checkbox"/> No</span>		
6. In the past 10 years have you used narcotic drugs, amphetamines, cocaine, marijuana or drugs not prescribed by a doctor? <span style="float: right;"><input type="checkbox"/> Yes <input type="checkbox"/> No</span>		
7. Within the past 5 years have you:		
a. had x-rays, electrocardiograms, heart catheterization or other diagnostic tests (excluding tests for HIV)? <span style="float: right;"><input type="checkbox"/> Yes <input type="checkbox"/> No</span>		
b. been admitted to a hospital or been advised or plan to enter a hospital for observation, operation or treatment of any kind? <span style="float: right;"><input type="checkbox"/> Yes <input type="checkbox"/> No</span>		
c. consulted any medical professional other than your personal physician? <span style="float: right;"><input type="checkbox"/> Yes <input type="checkbox"/> No</span>		
8. Do you have any pending appointments with any medical professional within the next 30 days? <span style="float: right;"><input type="checkbox"/> Yes <input type="checkbox"/> No</span>		
9. Do you have any family history of diabetes, cancer, heart disease, Huntington's Disease or polycystic kidney disease? <span style="float: right;"><input type="checkbox"/> Yes <input type="checkbox"/> No</span>		
10. Family History	Age if alive	State of Health
Father	_____	_____
Mother	_____	_____
Siblings	_____	_____

**Part 5 - Children's Term Rider Information** (Complete only if CTR is requested. Complete HIPAA for each Child)

1. Names and Dates of Birth of all Children to be covered
  
2. To the best of your knowledge: *(If 'Yes', give details in Remarks)*
  - a. Is any Child's health impaired in any way?  Yes  No
  - b. Has any Child shown any signs of abnormal physical or mental development?  Yes  No
  - c. Does any Child not reside with you?  Yes  No
  - d. Does any Child take medication prescribed by a doctor?  Yes  No

**Part 6 - Bank Authorization** (Complete for Check-O-Matic or automatic bank draft & include voided check or deposit slip)

I authorize LSW to draft monthly payments from my account:  Checking  Savings  Money Market  
 Draft 1st premium, no money collected

Draft on the  1st  8th  15th  22nd day each month **or**  Draft on the next available date after policy issue.



**Application for Life Insurance - Continued**

**Conditional Receipt** (to be given to applicant upon premium payment to agent) (Not to be used for Qualified Pension or Profit Sharing Trust.)

NOTE: All premium checks should be made payable to LSW. Do not make a check payable to the agent or leave the payee blank.

This receipt should not be issued (and will be deemed void) and premium should not be paid if Parts 1, 2, 3 and 5 of the application are not completely answered. No agent or medical examiner may waive a complete answer to any question in the application.

\$ \_\_\_\_\_ has been received from \_\_\_\_\_ as payment for the life insurance applied for on this date, subject to the following.

Coverage under this policy receipt, not to exceed the face amount(s) applied for or \$300,000, whichever is less, will take effect as described below.

Coverage under this receipt will begin on the LATER of: **a)** the date the application is signed, **b)** the date the first full modal premium has been paid, **c)** the date the last medical requirement requested by LSW is completed, or **d)** the effective date, if any, requested on the application.

Prior to delivery of the policy, coverage will be effective if:

1. the first full modal premium has been paid, and the check or draft is honored when presented for payment, and
2. LSW receives all medical examinations, tests and records within 60 days from the date of the application, and
3. LSW determines that each Proposed Insured is acceptable to it, under applicable underwriting standards, for the plan, benefits, amount and rate class applied for, and
4. there is no material misrepresentation in the application or in any medical information furnished to LSW.

**Termination of Coverage.** Coverage under this receipt will end on the FIRST of: **a)** insurance beginning under the policy applied for, **b)** LSW declines the application or offers the applicant a policy other than the one applied for, **c)** 60 days from the date coverage under this receipt begins, or **d)** LSW notifies the applicant in writing that coverage is ended. If LSW terminates coverage under this receipt or declines the application, or if the applicant refuses a policy issued other than as applied for, LSW will refund the full amount paid under this receipt. If a Proposed Insured dies by suicide, LSW's liability under this receipt is limited to a full refund of the premium paid. (Suicide clause not applicable to Missouri.)

Licensed Agent's Signature: \_\_\_\_\_ Licensed Agent's Name: (Print) \_\_\_\_\_

Signed at: (City & State) \_\_\_\_\_ on this day of: (mm/dd/yyyy) \_\_\_\_\_

Detach

**Important Notices** (to be given to the Applicant and Proposed Insured(s))

**Insurance Information Practices:** We must collect certain amounts of necessary and helpful personal information in order to properly underwrite and administer your insurance coverage. The amount and type of information collected may vary depending on the amount and type of insurance for which you have applied. Our information practices provide that:

1. Personal information may be collected from sources other than yourself;
2. Such information as well as other personal or privileged information subsequently collected by us or our agent, may, in certain circumstances be disclosed to third parties without your authorization; and
3. You have a right of access and correction with respect to all personal information collected.

If you would like to obtain a more detailed explanation of our information practices, including your rights of access to and correction of personal information, please contact our Administrative Office (1 National Life Drive, Montpelier, VT 05604).

**Investigative Consumer Report Notice:** In compliance with the Fair Credit Reporting Act (FCRA), this is to notify you that as part of our underwriting process an investigative consumer report may be obtained through personal interviews with neighbors, friends, associates or others concerning your character, general reputation, personal characteristics and mode of living. You have the right to be personally interviewed if we order an investigative consumer report. Please notify us if this is your wish. You may contact our Administrative Office for additional information regarding the nature and scope of this inquiry and a summary of your rights under FCRA. On written request, we will inform you whether a report was requested and provide additional information. LSW may telephone you directly to obtain the information described above. An interviewer in the Administrative Office may ask you to review and clarify information provided on the application or may ask additional questions. Whenever possible, calls will be made at your convenience and to the telephone number you provided.

**Medical Information Bureau Notice:** Information regarding your insurability will be treated as confidential. LSW or its reinsurers may, however, make a brief report thereon to the Medical Information Bureau (MIB, Inc.), a non-profit membership organization of life insurance companies which operates an information exchange on behalf of its members. If you apply to another insurance company, the Bureau, on request, will supply such company with the information in its file. On receipt of a request from you, the Bureau will arrange disclosure of any information it may have in your file. (Medical information will be released only to your attending physician.) If you question the accuracy of information in the Bureau's file, you may contact the Bureau and make a correction in accordance with procedures set forth in the Fair Credit Reporting Act. The address of the Bureau's information office is 50 Braintree Hill, Suite 400, Braintree, MA 02184-8734, telephone number (866) 692-6901, website: www.mib.com.

LSW may release information in its files to other life insurance companies to whom you may apply for life or health insurance, or to whom a claim for benefits may be submitted.

**Supplemental Other Insured Rider Application for Life Insurance**

**Part 1 - Proposed Other Insured (POI) and Plan Information**

1. Name	2. Place of Birth - State/Country	3. Date of Birth	4. Issue at Age
5. Home Address (street, city, state and zip)			
6. Sex <input type="checkbox"/> M <input type="checkbox"/> F	7. Soc. Sec. #	8. Telephone #'s and best time to call H ( ) W ( ) C ( )	
9. Are you a citizen of <input type="checkbox"/> USA <input type="checkbox"/> Other Country _____ Type of VISA _____ Alien Registration # _____			
10. Employer and time employed		11. Occupation (w/specific duties)	
12. Annual Income \$	13a. Driver's License #	13b. State	14. Face Amount \$
15. Primary Insured, Relationship and S.S. #	17. Riders and Amounts		
	<input type="checkbox"/> Accidental Death Benefit (ADB) \$ _____ <input type="checkbox"/> Disability Income (DIR) <input type="checkbox"/> 2 Year <input type="checkbox"/> 5 Year \$ _____ a. Do you have any disability insurance, including employer sponsored short or long-term coverage? <input type="checkbox"/> Yes <input type="checkbox"/> No (If Yes, give details in Remarks)		
16. Primary Beneficiary, Relationship and S.S. #	<input type="checkbox"/> Guaranteed Insurability (GIR) \$ _____ <input type="checkbox"/> Long Term Care (LTC) \$ _____ <input type="checkbox"/> Extension of Benefits (EB) <input type="checkbox"/> with Inflation Protection (IP) (Complete 8099 LTC kit when applying for LTC and/or EB) <input type="checkbox"/> Other _____ \$ _____		

**Part 2 - Inforce & Replacement Information**

1. Do you have any existing life insurance policies or annuity contracts? (Include face & ADB amounts, company name & year of issue). If none, check this box:

2. Has there been or will there be a lapse, surrender, replacement, reissue, conversion, or change to reduce amount, premium, or period of coverage of any existing life, disability or annuity contract if the applied for policy or rider is issued?  Yes  No  
(If Yes, Replacement forms must be provided.)

3. Will there be any substantial borrowing on any life insurance policy if the applied for policy or rider is issued?  Yes  No  
(List Company Name(s) and Policy Number(s) in Remarks)

**Part 3 - General Information for Proposed Other Insured (If 'Yes', provide details in Remarks)**

1. Have you used any type of product containing tobacco or nicotine within the last 24 months?  Yes  No  
Product Type: \_\_\_\_\_ Frequency: \_\_\_\_\_ Date Last Used: \_\_\_\_\_

2. Are you actively at work full time (30 hours per week) and able to perform all your regular duties?  Yes  No

3. Have you ever applied for life, health, or disability insurance or reinstatement of same, which was declined, postponed, rated or modified in any way?  Yes  No

4. Are you or do you have any intention of becoming a member of a military organization?  Yes  No

5. Have you had any moving vehicle violations in the last 3 years, or a suspended license or DUI in the last 5 years?  Yes  No

6. Have you ever been convicted of a felony or misdemeanor?  Yes  No

7. Have there been any bankruptcy proceedings against you within the last 7 years?  Yes  No

8. Within the past 6 months have you applied for or do you have any applications pending for life or disability insurance?  Yes  No

9. Have you received or applied for disability or worker's compensation?  Yes  No

10. Within the last 3 years, have you participated in or do you intend to participate in any type of racing; scuba, skin, sport or sky diving; competition sport; parachuting or hang gliding; BASE or bungee cord jumping; big game hunting; mountain climbing; cave exploring; rodeos or snowmobiling? (If 'Yes', complete form 1480)  Yes  No

11. Do you participate in any aviation activity other than as a fare paying passenger? (If 'Yes', complete form 1480)  Yes  No

12. Do you intend to travel or reside outside of the USA for more than 2 weeks in a year? (If 'Yes', complete form 1480)  Yes  No

13. Have you been offered any cash incentive or other consideration (such as free insurance) as an inducement to apply for or become an insured under this life insurance policy, or have you been involved in any discussions about the possible sale or transfer of this policy to an unrelated third party, such as (but not limited to) a life settlement company or investor group?  Yes  No

**Supplemental Other Insured Rider**  
**Application for Life Insurance - Continued**

**Part 4 - Health History of the Proposed Other Insured** (Give details, dates, and results for any 'Yes' answer to questions 1-10 in Remarks.)  
 Complete Part 4 if money was collected with the application or an LSW exam is not being done.

1. Name, Address and Phone No. of Personal Physician (If none, so state)	Date last seen	Reason consulted & outcome
2. Height      Weight      Change in last year? <input type="checkbox"/> Yes <input type="checkbox"/> No    Details:		
3. Are you taking any medication? (If 'Yes', list type, dose and frequency in the Remarks section.) <input type="checkbox"/> Yes <input type="checkbox"/> No		
4. In the last 10 years have you been diagnosed, treated, taken medication for, or know of having any indication of any:		
a. Heart Murmur, Rheumatic Fever or Anemia <input type="checkbox"/> Yes <input type="checkbox"/> No b. Chest Pain, Heart Disease/Disorder or Heart Surgery <input type="checkbox"/> Yes <input type="checkbox"/> No c. Sleep Apnea, Emphysema, Asthma or Lung Disease <input type="checkbox"/> Yes <input type="checkbox"/> No d. Ulcer, Jaundice, Hepatitis or Chronic Indigestion <input type="checkbox"/> Yes <input type="checkbox"/> No e. Eyes, Ears, Nose, or Throat Disorder <input type="checkbox"/> Yes <input type="checkbox"/> No f. Diseases of the Central Nervous System or Headaches <input type="checkbox"/> Yes <input type="checkbox"/> No g. Spine, Bones, Muscles, Joints, Skin or Thyroid Disorder <input type="checkbox"/> Yes <input type="checkbox"/> No h. Stroke, Dizzy Spells, Epilepsy, Convulsions, Paralysis or Unconsciousness <input type="checkbox"/> Yes <input type="checkbox"/> No i. Veins, Blood, or other Circulatory System Disorder <input type="checkbox"/> Yes <input type="checkbox"/> No j. Protein, Sugar, or Blood in the Urine <input type="checkbox"/> Yes <input type="checkbox"/> No k. Alzheimer's or Dementia <input type="checkbox"/> Yes <input type="checkbox"/> No	l. Kidney Stone, Kidney or Bladder Disorder <input type="checkbox"/> Yes <input type="checkbox"/> No m. Depression, Anxiety, or other Psychological Condition <input type="checkbox"/> Yes <input type="checkbox"/> No n. Gout, Arthritis, Back Pain or Back Disorder <input type="checkbox"/> Yes <input type="checkbox"/> No o. Diabetes or High Blood Sugar <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, is it controlled by diet alone? <input type="checkbox"/> Yes <input type="checkbox"/> No p. Cancer, Polyp, or Other Tumor <input type="checkbox"/> Yes <input type="checkbox"/> No q. Esophagus, Stomach, Intestinal, Liver or Gall Bladder Disorder <input type="checkbox"/> Yes <input type="checkbox"/> No r. Prostate, Pelvic Organs, or Breast Disease <input type="checkbox"/> Yes <input type="checkbox"/> No s. Alcohol or Drug Abuse <input type="checkbox"/> Yes <input type="checkbox"/> No t. High Blood Pressure or High Cholesterol <input type="checkbox"/> Yes <input type="checkbox"/> No	
5. Within the past 10 years has a physician or other medical professional diagnosed you as having Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC)? <input type="checkbox"/> Yes <input type="checkbox"/> No		
6. In the past 10 years have you used narcotic drugs, amphetamines, cocaine, marijuana or drugs not prescribed by a doctor? <input type="checkbox"/> Yes <input type="checkbox"/> No		
7. Within the past 5 years have you:		
a. had x-rays, electrocardiograms, heart catheterization or other diagnostic tests (excluding tests for HIV)? <input type="checkbox"/> Yes <input type="checkbox"/> No		
b. been admitted to a hospital or been advised or plan to enter a hospital for observation, operation or treatment of any kind? <input type="checkbox"/> Yes <input type="checkbox"/> No		
c. consulted any medical professional other than your personal physician? <input type="checkbox"/> Yes <input type="checkbox"/> No		
8. Do you have any pending appointments with any medical professional within the next 30 days? <input type="checkbox"/> Yes <input type="checkbox"/> No		
9. Do you have any family history of diabetes, cancer, heart disease, Huntington's Disease or polycystic kidney disease? <input type="checkbox"/> Yes <input type="checkbox"/> No		
10. Family History	Age if alive	State of Health
Father	_____	_____
Mother	_____	_____
Siblings	_____	_____

**Part 5 - Remarks** (Provide the details to questions as requested. Use form 8123 if additional space is needed.)

Section & Number:	Additional Information:
_____	_____
_____	_____
_____	_____

**Part 6 - Agreement and Authorization**

I understand and agree that all answers given above and in any medical exam are to the best of my knowledge and belief complete and true. All such answers and this application shall be part of any contract issued. I have read the IMPORTANT NOTICES, including the notices required by the Fair Credit Reporting Act and the Medical Information Bureau (MIB). To the extent allowed by law, I waive all rights governing disclosure of medical exams or treatment. For purposes of underwriting this risk and verifying answers on this application, I authorize any medical practitioner or facility, insurer, the MIB, or credit bureau to give such information to LSW or its reinsurers. I understand and agree that any such information may be reported to the MIB. This authorization is valid for 30 months from the date signed and a photocopy shall be as valid as the original. This authorization is subject to revocation by the applicant at any time. I also certify, under the penalties of perjury, that the Social Security Number of the Proposed Other Insured, Primary Insured, and Primary Beneficiary are correct.

The Agent taking this application has no authority to make, change or discharge any contract hereby applied for. The Agent may not extend credit on behalf of the Company. No statement made to or information acquired by any representative of the Company shall bind the Company unless set out in writing in this application.

I wish to receive a copy of the investigative consumer report if one is prepared as stated in the IMPORTANT NOTICES.

Signature of Proposed Other Insured age 15 & up (or Parent or Guardian)	Date	Signature of Applicant/Owner (if other than POI)
Signed at (City and State)	Signature of Licensed Agent	Licensed Agent Name & Number (Print)

# Supplemental Application for Qualified Pension or Profit Sharing Trust

Proposed Insured Name: \_\_\_\_\_

Policy No.: \_\_\_\_\_

## Part A - Owner Information

1. Qualified Pension or Profit Sharing Trust (Name of Trust Agreement) \_\_\_\_\_
2. Tax Identification Number for the Qualified Pension or Profit Sharing Trust: \_\_\_\_\_
3. Address: (Street, City, State, Zip) \_\_\_\_\_
4. Telephone Number: (        ) \_\_\_\_\_

## Part B - Beneficiary Information (Do Not Write in Section B)

The Owner is always the Beneficiary for a Qualified Pension or Profit Sharing Trust.

**Note:** If the policy is owned by a qualified pension or profit sharing plan, all payments are protected by the Spendthrift Provision. The right to change the beneficiary is reserved.

## Part C - Underwriting Information

1. Issue Date: \_\_\_\_\_ 2. (Check one.)  Sex Neutral  Sex Distinct
- (Answer a & b only for Simplified Underwriting)**
3.  Full Underwriting  Guaranteed Issue  Automatic Issue  
 Simplified Underwriting (If either questions a or b are answered 'Yes', give the following details in the space provided. Nature of ailment, date, duration and names and addresses of attending physicians.)
    - a. Have you been admitted to, or been advised to be admitted to a hospital or medical facility in the past 90 days by a member of the medical profession?  Yes  No
    - b. In the past two years have you been treated for or advised by a member of the medical profession to seek treatment for heart problems (including angina), stroke, or cancer, or been treated for or diagnosed as having AIDS or AIDS Related Complex (ARC)?  Yes  No
  4. Are you actively at work at the customary workplace, doing the usual duties and functions required by the position during the normal work hours and weekly period?  Yes  No\*  
\*Reason: \_\_\_\_\_

## Part D - Agreement & Authorization

I understand and agree that all answers given above and in any medical exam are to the best of my knowledge and belief complete and true. All such answers and this application shall be part of any contract issued. I have read the IMPORTANT NOTICES, including the notices required by the Fair Credit Reporting Act and the Medical Information Bureau (MIB). To the extent allowed by law, I waive all rights governing disclosure of medical exams or treatment. For purposes of underwriting this risk and verifying answers on this application, I authorize any medical practitioner or facility, insurer, the MIB, or credit bureau to give such information to LSW or its reinsurers. I understand and agree that any such information may be reported to the MIB. This authorization is valid for 30 months from the date signed and a photocopy shall be as valid as the original. This authorization is subject to revocation by the applicant at any time. I also certify, under the penalties of perjury, that the Social Security Number of Applicant/Owner (if different) is correct.

The Agent taking this application has no authority to make, change or discharge any contract hereby applied for. The Agent may not extend credit on behalf of the Company. No statement made to or information acquired by any representative of the Company shall bind the Company unless set out in writing in this application.

I wish to receive a copy of the investigative consumer report if one is prepared as stated in the IMPORTANT NOTICES.

**Part E - Owner's Taxpayer ID Number Certification**

Under penalties of perjury, I certify that (1) the number shown on this application is my correct taxpayer identification number; (2) the IRS has never notified me that I am subject to backup withholding, or has notified me that I am no longer subject to such withholding or I am exempt from such withholding; and (3) I am a U.S. person (including a U.S. resident alien). You must cross out item 2 if you have been notified by the IRS that you are currently subject to backup withholding because of underreporting interest or dividends on your tax return.

**Part F - Signatures**

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

Signed at (City & State) \_\_\_\_\_ Date (mm/dd/yyyy) \_\_\_\_\_

**Proposed Insured** (Sign name in full)

**Applicant/Trustee**

(Print name of Pension/Profit Sharing Trust)

\_\_\_\_\_

**Licensed Agent** (Sign name in full)

\_\_\_\_\_

\_\_\_\_\_  
(Trustee)

**Conditional Life Insurance Receipt** (For use if a plan or trust applies for life insurance)

**Conditional Life Insurance Receipt** (Send completed copy to the Company upon receipt of premium payment by agent.)

**Receipt**

1. IF ANY PREMIUM IS PAID WITH AN APPLICATION MADE BY A PLAN OR TRUST APPLYING FOR LIFE INSURANCE, THIS RECEIPT MUST BE USED.
2. PLEASE READ CAREFULLY.
3. THIS RECEIPT IS SUBJECT TO THE TERMS AND CONDITIONS WHICH FOLLOW BELOW.

Received from \_\_\_\_\_,  
Applicant, the sum of \$ \_\_\_\_\_ with the application made today  
to Life Insurance Company of the Southwest for:

- \$ \_\_\_\_\_ of guaranteed issue life insurance.
- \$ \_\_\_\_\_ of simplified underwritten life insurance.
- \$ \_\_\_\_\_ of underwritten life insurance.
- \$ \_\_\_\_\_ of automatic issue life insurance.

on the life of \_\_\_\_\_,  
Proposed Insured.

Signed at (City & State) \_\_\_\_\_  
on this day of: (mm/dd/yyyy) \_\_\_\_\_

Agent's Signature: \_\_\_\_\_

8533CA(0707)

**Company's Copy of Receipt**  
Separate here

Page 3

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on the life of \_\_\_\_\_,  
Proposed Insured.

Signed at (City & State) \_\_\_\_\_  
on this day of: (mm/dd/yyyy) \_\_\_\_\_

Agent's Signature: \_\_\_\_\_

8533CA(0707)

**Applicant's Copy of Receipt**

Page 3

**Terms & Conditions**

The following terms and conditions apply as if a separate and identical receipt were given with respect to each policy applied for in the application and as if each policy were the only one for which payment was made.

**A. Effective Date of Receipt.** With respect to any life insurance applied for, the Effective Date of Receipt shall be the date of the application.

**B. If Policy Cannot Be Issued.** If as of the Effective Date of Receipt the underwriting rules of the Company do not permit a policy to be issued either as applied for or on a modified basis, no insurance of any type whatever will take effect.

**C. If Policy Can Be Issued But Not As Applied For.** If as of the Effective Date of Receipt the underwriting rules of the Company prevent issuance of a policy for the plan, amount, additional benefits or rate class applied for but permit the issuance of a policy on a modified basis, then **subject to the following conditions** the policy with the needed changes, called the Issuable Policy, shall take effect subject to all its terms and conditions, as of the Effective Date of Receipt.

1. The applicant must accept the Issuable Policy.
2. The applicant must complete payment of at least one premium for the Issuable Policy.
3. The Insured must be living at the time of such acceptance and payment.

If the Proposed Insured dies within 90 days after the Effective Date of Receipt and before the Issuable Policy takes effect, then it shall be deemed to be effective subject to its terms and conditions.

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If the Proposed Insured dies within 90 days after the Effective Date of Receipt and before the Issuable Policy takes effect, then it shall be deemed to be effective subject to its terms and conditions.

**Conditional Life Insurance Receipt** (Send completed copy to the Company upon receipt of premium payment by agent.)

However, it shall be for an amount which the first premium for the policy applied for, exclusive of premium for any additional benefits not available in the Issuable Policy, would purchase when applied as the first premium with the same premium interval as the Issuable Policy. If the plan of insurance applied for is not available, the Issuable Policy shall be deemed to be on a plan which would not violate the terms of the plan or trust document.

**D. If Policy Can Be Issued As Applied For.** If as of the Effective Date of Receipt the underwriting rules of the Company permit a policy to be issued for the plan, amount, additional benefits and rate class applied for, such policy shall take effect subject to all its terms and conditions as of the Effective Date of Receipt.

**E. Termination and Limitation.** This Conditional Receipt will TERMINATE ON AND BE OF NO FORCE OR EFFECT AFTER the earlier of:

1. 90 days from the Effective Date of Receipt; or
2. The issuance of a policy of insurance pursuant to this application.

**F. Evidence of Insurability.** The Company may require additional evidence of insurability. If the Proposed Insured dies within 90 days after the Effective Date of Receipt and before insurability has been determined, insurability shall be determined as of the Effective Date of Receipt. Facts available at date of death and any additional facts which can be obtained from other sources will be used to determine insurability.

**G. Maximum Death Benefits.** Any death benefits under this Receipt for death occurring prior to termination of this Receipt SHALL NOT exceed the lesser of:

1. the amount applied for, or
2. \$250,000.00

If death should occur while more than one receipt is in effect with respect to applications for life insurance made to Life Insurance Company of the Southwest, the maximum under (2) above shall apply to total death benefits under all policies pursuant to all such receipts. This maximum shall be prorated on the basis of the amounts which would have been paid in the absence of this Section G.

**H. Refund of Amount Received.** After 90 days from the Effective Date of Receipt if no policy of insurance has been issued and taken effect, the amount received will be refunded.

**I. General.** This Receipt is not valid unless signed by an agent of the Company. No agent has authority to modify or alter the provisions of this Receipt.

**Notice to Applicant**

If you do not hear from the Company about your application within 60 days from the date of this Receipt, write our Administrative Office at, One National Life Drive, Montpelier, Vermont 05604, or call (800) 732-8939. Please state the facts about your application for insurance.

**Make all premium checks payable to Life Insurance Company of the Southwest: Do Not make check payable to the agent or leave the payee blank.** Checks and drafts are accepted only subject to collection.

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Separate here

Page 4

**Conditional Life Insurance Receipt** (Send completed copy to the Company upon receipt of premium payment by agent.)

However, it shall be for an amount which the first premium for the policy applied for, exclusive of premium for any additional benefits not available in the Issuable Policy, would purchase when applied as the first premium with the same premium interval as the Issuable Policy. If the plan of insurance applied for is not available, the Issuable Policy shall be deemed to be on a plan which would not violate the terms of the plan or trust document.

**D. If Policy Can Be Issued As Applied For.** If as of the Effective Date of Receipt the underwriting rules of the Company permit a policy to be issued for the plan, amount, additional benefits and rate class applied for, such policy shall take effect subject to all its terms and conditions as of the Effective Date of Receipt.

**E. Termination and Limitation.** This Conditional Receipt will TERMINATE ON AND BE OF NO FORCE OR EFFECT AFTER the earlier of:

1. 90 days from the Effective Date of Receipt; or
2. The issuance of a policy of insurance pursuant to this application.

**F. Evidence of Insurability.** The Company may require additional evidence of insurability. If the Proposed Insured dies within 90 days after the Effective Date of Receipt and before insurability has been determined, insurability shall be determined as of the Effective Date of Receipt. Facts available at date of death and any additional facts which can be obtained from other sources will be used to determine insurability.

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**Insured Information**

Insured's Name \_\_\_\_\_ Policy Number \_\_\_\_\_

**Instructions**

Complete Section 1 for SecurePlus Provider.  
Complete Section 2 for SecurePlus Paragon and SecurePlus Advantage 79.

The Net Premiums you pay are put into the Basic Strategy. There is a Basic Strategy Value Minimum amount must remain within the Basic Strategy. If the Basic Strategy Value exceeds the Basic Strategy Value Minimum, the excess will be transferred into the other Strategies subject to a selection specified by you. Please specify this selection.

Whole percentages must be used. A percentage must be at least 5%, and the total of all percentages must equal 100%.

For After Issue business, send to: Customer Relations - M330 (for non-pension business)

**Section 1 - SecurePlus Provider**

Strategy Selection	Percent	
Five-Year Crediting Period (Fixed-Term Strategy) (105)	_____ %	
Five-Year Crediting Period, Point-to-Point (Indexed Strategy 1) (107)	_____ %	<input type="checkbox"/> HPR option <i>(The HPR option is only available at time of issue)</i>
Five-Year Crediting Period, Point-to-Average (Indexed Strategy 2) (106)	_____ %	
<b>Total 100%</b>		

**Section 2 - SecurePlus Paragon and SecurePlus Advantage 79**

Strategy Selection	Percent
One-Year Crediting Period (Fixed-Term Strategy) (105)	_____ %
One-Year Crediting Period, Point-to-Point, Cap Focus (Indexed Strategy 1) (107)	_____ %
One-Year Crediting Period, Point-to-Point, Participation Rate Focus (Indexed Strategy 2) (108)	_____ %
One-Year Crediting Period, Point-to-Point, No Cap (Indexed Strategy 3) (109)	_____ %
One-Year Crediting Period, Point-to-Average, No Cap (Indexed Strategy 4) (106)	_____ %
<b>Total 100%</b>	

**Sign and Date**

Owner's Signature \_\_\_\_\_ Date: \_\_\_\_\_



**Disclosure Statement for Accelerated Benefits  
(ABR 1, ABR 2, ABR 3)**

Accelerated Benefits are payments made to the Owner while the Insured is living in lieu of payment of all or a portion of the death benefit that would otherwise be paid at the Insured's death. The Owner must apply for the Accelerated Benefits and must show the required proof stated in the Accelerated Benefits Rider attached to the policy. The condition under which accelerated benefits may be elected varies by rider as described below.

**NOTE: Your policy may not be eligible for coverage under all the Accelerated Benefits Riders described below. Please check your policy for details on each Accelerated Benefits Rider that is included in your policy and the insured(s) covered under each rider.**

**Accelerated Benefits Rider 1**

Benefits may be elected under this rider if the Insured is Terminally Ill. Terminally Ill means that the Insured has been certified by a Physician as having an illness or chronic condition which can reasonably be expected to result in death in 24 months or less from the date of the certification.

**Accelerated Benefits Rider 2**

Benefits may be elected under this rider if the Insured is Chronically Ill. Chronically Ill means that the Insured has been certified, within the last 12 months, by a Licensed Health Care Practitioner as:

1. being unable to perform without substantial assistance from another person at least two Activities of Daily Living for a period of at least 90 consecutive days; or
2. requiring substantial supervision for a period of at least 90 consecutive days by another person to protect oneself from threats to health and safety due to severe cognitive impairment.

The Activities of Daily Living are bathing, continence, dressing, eating, toileting, and transferring.

No Application for Election of Accelerated Benefits will be accepted under Accelerated Benefits Rider 2 during the first two years that it is in effect.

**Accelerated Benefits Rider 3**

Benefits may be elected under this rider if the Insured has experienced a covered Qualifying Event. The Qualifying Events covered under this rider are:

1. **Heart Attack (myocardial infarction):** The death of a portion of the heart muscle resulting from inadequate blood supply to the relevant area. Heart attack does not include angina or the chance finding of electrocardiographic (EKG) changes indicative of a previous heart attack. The diagnosis of heart attack must be based on the presence of chest pain, associated new EKG changes which support the diagnosis, and elevation of cardiac (heart) enzymes above standard laboratory levels.
2. **Stroke:** A cerebrovascular accident or infarction (death) of brain tissue caused by hemorrhage, embolism, or thrombosis lasting more than 24 hours and producing measurable neurological deficit which persists for at least 30 consecutive days following the occurrence of the Stroke. Stroke does not include transient ischemic attacks.
3. **Diagnosis of Cancer:** Cancer means a disease manifested by the presence of one or more malignant tumors and characterized by the uncontrolled growth and spread of malignant cells and the invasion of normal tissue. Cancer does not include: any skin cancer, except invasive malignant melanoma into the dermis or deeper; pre-malignant lesions, benign tumors, or polyps; and Carcinoma in-situ.
4. **Diagnosis of End Stage Renal Failure:** End Stage Renal Failure means the irreversible and total failure of both kidneys which requires the undergoing of renal transplantation or regular renal dialysis.
5. **Major Organ Transplant:** The receipt by transplant of any of the following organs or tissues: heart, lung, liver, kidney, pancreas, or bone marrow.
6. **Diagnosis of ALS:** (Amyotrophic Lateral Sclerosis) by a qualified Physician.
7. **Blindness:** The total and permanent loss of sight in both eyes as a result of disease or injury. Total loss of sight in an eye is defined as corrected vision of 20/200 or worse.

No Accelerated Benefit will be paid under Accelerated Benefits Rider 3 for any Qualifying Event that occurs on or before the 30th day following its effective date unless such Qualifying Event directly results from accidental injury. No Accelerated Benefit will be paid under this rider for any Qualifying Event that directly results from self-inflicted injury or attempted suicide.

**Copies to the Company, the Customer, and the Agent**

**Disclosure Statement for Accelerated Benefits (ABR 1, ABR 2, ABR 3) - Continued**

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The Owner may elect to accelerate all or a portion of the Insured's death benefit in force on the election date. **The Company reserves the right to set a maximum death benefit that may be accelerated under all Accelerated Benefits Riders on the life of the Insured. This maximum limit will be no less than \$500,000. If the Insured becomes eligible for benefits under Accelerated Benefits Rider 2, the death benefit that may be accelerated in any year will also be subject to a maximum amount.**

Accelerated Benefits are paid as a lump sum. The amount paid is calculated as the present value of the death benefit accelerated, less an adjustment for future premiums, and less an administrative fee. The benefit will first be used to pay a pro rata share of any outstanding debt to us. The benefit will never exceed the death benefit being accelerated. It will never be less than the cash surrender value, if any, that corresponds to the death benefit accelerated.

The Insured's death benefit in force will be reduced each time an Accelerated Benefit is paid. The reduction will equal the portion of the death benefit that is accelerated on the election date. The face amount, and any accumulated value, cash surrender value, and outstanding debt will also be reduced. Each of these will be reduced in the same proportion as the reduction in the death benefit. The premiums and charges for any remaining life coverage will be determined as if the contract had been originally issued at the reduced face amount.

**Payment of Accelerated Benefits will reduce the death benefit otherwise payable under the policy. Receipt of Accelerated Benefits may be a taxable event. Please consult your personal tax advisor to determine the tax status of any benefits paid under this rider.**

Signed at: *(City & State)* \_\_\_\_\_ Date: *(mm/dd/yyyy)* \_\_\_\_\_

Licensed Agent: *(Sign name in full)* \_\_\_\_\_

Applicant/Owner: *(Sign name in full)* \_\_\_\_\_

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(ABR 1, ABR 2, ABR 3)**

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The Activities of Daily Living are bathing, continence, dressing, eating, toileting, and transferring.

No Application for Election of Accelerated Benefits will be accepted under Accelerated Benefits Rider 2 during the first two years that it is in effect.

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Benefits may be elected under this rider if the Insured has experienced a covered Qualifying Event. The Qualifying Events covered under this rider are:

1. **Heart Attack (myocardial infarction):** The death of a portion of the heart muscle resulting from inadequate blood supply to the relevant area. Heart attack does not include angina or the chance finding of electrocardiographic (EKG) changes indicative of a previous heart attack. The diagnosis of heart attack must be based on the presence of chest pain, associated new EKG changes which support the diagnosis, and elevation of cardiac (heart) enzymes above standard laboratory levels.
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4. **Diagnosis of End Stage Renal Failure:** End Stage Renal Failure means the irreversible and total failure of both kidneys which requires the undergoing of renal transplantation or regular renal dialysis.
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**Disclosure Statement for Accelerated Benefits (ABR 1, ABR 2, ABR 3) - Continued**

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The Owner may elect to accelerate all or a portion of the Insured's death benefit in force on the election date. **The Company reserves the right to set a maximum death benefit that may be accelerated under all Accelerated Benefits Riders on the life of the Insured. This maximum limit will be no less than \$500,000. If the Insured becomes eligible for benefits under Accelerated Benefits Rider 2, the death benefit that may be accelerated in any year will also be subject to a maximum amount.**

Accelerated Benefits are paid as a lump sum. The amount paid is calculated as the present value of the death benefit accelerated, less an adjustment for future premiums, and less an administrative fee. The benefit will first be used to pay a pro rata share of any outstanding debt to us. The benefit will never exceed the death benefit being accelerated. It will never be less than the cash surrender value, if any, that corresponds to the death benefit accelerated.

The Insured's death benefit in force will be reduced each time an Accelerated Benefit is paid. The reduction will equal the portion of the death benefit that is accelerated on the election date. The face amount, and any accumulated value, cash surrender value, and outstanding debt will also be reduced. Each of these will be reduced in the same proportion as the reduction in the death benefit. The premiums and charges for any remaining life coverage will be determined as if the contract had been originally issued at the reduced face amount.

**Payment of Accelerated Benefits will reduce the death benefit otherwise payable under the policy. Receipt of Accelerated Benefits may be a taxable event. Please consult your personal tax advisor to determine the tax status of any benefits paid under this rider.**

Signed at: *(City & State)* \_\_\_\_\_ Date: *(mm/dd/yyyy)* \_\_\_\_\_

Licensed Agent: *(Sign name in full)* \_\_\_\_\_

Applicant/Owner: *(Sign name in full)* \_\_\_\_\_



**NOTICE AND CONSENT FOR BLOOD TESTING WHICH WILL INCLUDE AIDS VIRUS (HIV) ANTIBODY/ANTIGEN TESTING**

This HIV is submitted in conjunction with an application to a Company of the National Life Group:

**National Life Insurance Company**

**Home / Administrative Office:** One National Life Drive, Montpelier, VT 05604

**Life Insurance Company of the Southwest**

**Administrative Office:** One National Life Drive, Montpelier, VT 05604

**Home Office:** 1300 West Mockingbird Lane, Dallas, TX 75247-4921

To determine your insurability, the Insurer named above has requested that you provide a sample of your blood, oral fluid and/or urine for testing and analysis. All tests will be performed by a licensed laboratory. The consent you give by signing this form authorizes the Insurer to withdraw blood, oral fluid and/or urine and order laboratory tests only in regard to your present application for life or disability income insurance. The test or tests to be performed are used to determine the presence of antibodies or antigens to the Human Immunodeficiency Virus (HIV), also known as the AIDS virus. The HIV antibody test that we perform is actually a series of tests done by a medically accepted procedure. The HIV antigen test directly identifies AIDS viral particles. These tests are extremely reliable.

**TESTS TO BE PERFORMED**

We will use an ELISA test or a Western Blot Assay, or both. An ELISA test is an enzyme-linked immunosorbent assay serologic test which has been licensed by the Federal Food and Drug Administration to detect antibodies to the human immunodeficiency virus. A positive ELISA test means an ELISA test performed in accordance with the manufacturer's specifications which is reactive on an initial testing and on at least one of two additional tests of the same serum or plasma specimen. A Western Blot Assay is an assay which uses reagents consisting of HIV antigens separated by polyacrylamide-gel electrophoreses and then transferred to nitro-cellulose paper to detect antibodies to the human immunodeficiency virus. A reactive Western Blot Assay is a Western Blot Assay which is reactive according to the standards of performance and results specified in the manufacturer's Federal Food and Drug Administration approved product circular to the Western Blot Assay reagents and laboratory apparatus.

**MEANING OF POSITIVE TEST RESULT**

Positive HIV antibody/antigen test results do not mean that you have AIDS, but that you are at significantly increased risk of developing AIDS or AIDS-related conditions. Federal authorities say that persons who are HIV antibody/antigen positive should be considered infected with the AIDS virus and capable of infecting others.

Positive HIV antibody or antigen/screening results or other significant blood abnormalities will adversely affect your application for insurance. This means that your application may be declined, that an increased premium may be charged, or that other policy changes may be necessary.

**CONFIDENTIALITY OF TEST RESULTS**

All test results will be treated confidentially. They will be reported by the laboratory to the Insurer. When necessary for business reasons in connection with insurance you have or have applied for with the Insurer, the Insurer may disclose test results to others involved solely in the underwriting process such as its affiliates, reinsurers, employees or contractors. If the Insurer is a member of the Medical Information Bureau (MIB, Inc.), and if the test results for HIV antibodies/antigens are other than normal, the Insurer will report to the MIB, Inc., a generic code which signifies only a non-specific blood test abnormality. If your HIV test is normal, no report will be made about it to the MIB, Inc. The organizations described in this paragraph may maintain the test results in a file or data bank. There will be no other disclosure of test results or even that the tests have been done except as may be required or permitted by law or as authorized by you.

**COST OF TESTING**

The cost of any testing will be borne by the Insurer.

**NOTIFICATION OF TEST RESULTS**

If your HIV test results are normal, no routine notification will be sent to you. If the HIV test results are other than normal, the Insurer will contact your designated physician, or you if you have not designated a physician. The Insurer will ask you for the name of a physician or other health care provider to whom you may authorize disclosure and with whom you may wish to discuss the results. You may designate below the physician or other person to whom positive or indeterminate test results will be reported:

Name: *(Print or Type)* \_\_\_\_\_

Address: *(Street, City, State, Zip Code)* \_\_\_\_\_

**TIME LIMIT**

This Consent shall be valid for a period of 30 months from the date noted below.

**CONSENT**

I have read and I understand this Notice of Consent for Blood Testing Which Will Include HIV Antibody/Antigen Testing. I voluntarily consent to the withdrawal of blood from me by needle, the collection of oral fluid and/or urine samples, the testing of the samples, and the disclosure of the test results as described above. I understand that I have the right to request and receive a copy of this authorization. A photocopy of this form will be as valid as the original.

Proposed Insured's Name: *(Print or type)* \_\_\_\_\_ Date of Birth: *(mm/dd/yyyy)* \_\_\_\_\_ State of Residence: \_\_\_\_\_

Signature of Proposed Insured or Parent/Guardian: \_\_\_\_\_ Date: *(mm/dd/yyyy)* \_\_\_\_\_

**Copies to the Company, the Customer, the Examiner, and the Agent**

## COUNSELING RESOURCES LIST

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Public health authorities urge that everyone become educated about how to protect themselves from HIV infection. If you have questions or concerns, your own physician or health care provider is your best source of information. Other counseling services may also be available to you.

As required by California law, the following list of counseling resources is being provided to you. It was compiled from publicly available information, which is subject to change without notice to LSW. Therefore, LSW makes no representations or warranties that this information is accurate as of the date you receive this list. Also LSW makes no representations or warranties about the quality or nature of any services these resources may provide.

This is not a complete list of all resources that may be available to you. We suggest you contact your own physician or health care provider, your county health department, or your local chapter of the American Red Cross, for further information.

AIDS Hotline  
U.S. Public Health Service  
(800) 342-AIDS

Spanish AIDS Hotline  
(800) 222-SIDA

TTY Information  
Information and Referral for Hearing Impaired  
(213) 464-0029

Kern County AIDS Team - Bakersfield  
(805) 861-3631

Central Valley AIDS Team - Fresno  
(209) 264-2436

AIDS Project East Bay - Oakland  
(415) 420-8181

Sacramento AIDS Foundation - Sacramento  
(916) 448-2437

San Francisco AIDS Foundation - San Francisco  
(415) 846-5855

Santa Clara County ARIS Project - Campbell  
(408) 370-3272

Sonoma County AIDS Information Hotline  
(707) 579-AIDS

AIDS Hotline - Southern California  
(800) 922-AIDS

Hemophilia Foundation of Southern California Social Services  
Southern California Hemophilia AIDS Information  
(818) 792-6192  
(714) 740-2222

California Department of Health Services  
Statewide Services - Office of AIDS - Sacramento  
(916) 323-7415

AIDS Services Foundation of Orange County - Costa Mesa  
(714) 646-0411

AIDS Project - Los Angeles - West Hollywood  
(213) 876-8951

Inland AIDS Project  
Riverside/San Bernardino Counties  
(714) 784-2437

San Diego AIDS Project  
(619) 543-0300 - City of San Diego  
(619) 945-6000 - City of Vista

Santa Barbara County AIDS Hotline  
(805) 965-2925

Shasta County Helpline  
(916) 225-5252



National Life Insurance Company  
 Life Insurance Company of the Southwest

**NOTICE AND CONSENT FOR BLOOD TESTING WHICH WILL INCLUDE AIDS VIRUS (HIV) ANTIBODY/ANTIGEN TESTING**

This HIV is submitted in conjunction with an application to a Company of the National Life Group:

**National Life Insurance Company**

**Home / Administrative Office:** One National Life Drive, Montpelier, VT 05604

**Life Insurance Company of the Southwest**

**Administrative Office:** One National Life Drive, Montpelier, VT 05604

**Home Office:** 1300 West Mockingbird Lane, Dallas, TX 75247-4921

To determine your insurability, the Insurer named above has requested that you provide a sample of your blood, oral fluid and/or urine for testing and analysis. All tests will be performed by a licensed laboratory. The consent you give by signing this form authorizes the Insurer to withdraw blood, oral fluid and/or urine and order laboratory tests only in regard to your present application for life or disability income insurance. The test or tests to be performed are used to determine the presence of antibodies or antigens to the Human Immunodeficiency Virus (HIV), also known as the AIDS virus. The HIV antibody test that we perform is actually a series of tests done by a medically accepted procedure. The HIV antigen test directly identifies AIDS viral particles. These tests are extremely reliable.

**TESTS TO BE PERFORMED**

We will use an ELISA test or a Western Blot Assay, or both. An ELISA test is an enzyme-linked immunosorbent assay serologic test which has been licensed by the Federal Food and Drug Administration to detect antibodies to the human immunodeficiency virus. A positive ELISA test means an ELISA test performed in accordance with the manufacturer's specifications which is reactive on an initial testing and on at least one of two additional tests of the same serum or plasma specimen. A Western Blot Assay is an assay which uses reagents consisting of HIV antigens separated by polyacrylamide-gel electrophoreses and then transferred to nitro-cellulose paper to detect antibodies to the human immunodeficiency virus. A reactive Western Blot Assay is a Western Blot Assay which is reactive according to the standards of performance and results specified in the manufacturer's Federal Food and Drug Administration approved product circular to the Western Blot Assay reagents and laboratory apparatus.

**MEANING OF POSITIVE TEST RESULT**

Positive HIV antibody/antigen test results do not mean that you have AIDS, but that you are at significantly increased risk of developing AIDS or AIDS-related conditions. Federal authorities say that persons who are HIV antibody/antigen positive should be considered infected with the AIDS virus and capable of infecting others.

Positive HIV antibody or antigen/screening results or other significant blood abnormalities will adversely affect your application for insurance. This means that your application may be declined, that an increased premium may be charged, or that other policy changes may be necessary.

**CONFIDENTIALITY OF TEST RESULTS**

All test results will be treated confidentially. They will be reported by the laboratory to the Insurer. When necessary for business reasons in connection with insurance you have or have applied for with the Insurer, the Insurer may disclose test results to others involved solely in the underwriting process such as its affiliates, reinsurers, employees or contractors. If the Insurer is a member of the Medical Information Bureau (MIB, Inc.), and if the test results for HIV antibodies/antigens are other than normal, the Insurer will report to the MIB, Inc., a generic code which signifies only a non-specific blood test abnormality. If your HIV test is normal, no report will be made about it to the MIB, Inc. The organizations described in this paragraph may maintain the test results in a file or data bank. There will be no other disclosure of test results or even that the tests have been done except as may be required or permitted by law or as authorized by you.

**COST OF TESTING**

The cost of any testing will be borne by the Insurer.

**NOTIFICATION OF TEST RESULTS**

If your HIV test results are normal, no routine notification will be sent to you. If the HIV test results are other than normal, the Insurer will contact your designated physician, or you if you have not designated a physician. The Insurer will ask you for the name of a physician or other health care provider to whom you may authorize disclosure and with whom you may wish to discuss the results. You may designate below the physician or other person to whom positive or indeterminate test results will be reported:

Name: *(Print or Type)* \_\_\_\_\_

Address: *(Street, City, State, Zip Code)* \_\_\_\_\_

**TIME LIMIT**

This Consent shall be valid for a period of 30 months from the date noted below.

**CONSENT**

I have read and I understand this Notice of Consent for Blood Testing Which Will Include HIV Antibody/Antigen Testing. I voluntarily consent to the withdrawal of blood from me by needle, the collection of oral fluid and/or urine samples, the testing of the samples, and the disclosure of the test results as described above. I understand that I have the right to request and receive a copy of this authorization. A photocopy of this form will be as valid as the original.

Proposed Insured's Name: *(Print or type)* \_\_\_\_\_ Date of Birth: *(mm/dd/yyyy)* \_\_\_\_\_ State of Residence: \_\_\_\_\_

Signature of Proposed Insured or Parent/Guardian: \_\_\_\_\_ Date: *(mm/dd/yyyy)* \_\_\_\_\_

**Copies to the Company, the Customer, the Examiner, and the Agent**

## COUNSELING RESOURCES LIST

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Public health authorities urge that everyone become educated about how to protect themselves from HIV infection. If you have questions or concerns, your own physician or health care provider is your best source of information. Other counseling services may also be available to you.

As required by California law, the following list of counseling resources is being provided to you. It was compiled from publicly available information, which is subject to change without notice to LSW. Therefore, LSW makes no representations or warranties that this information is accurate as of the date you receive this list. Also LSW makes no representations or warranties about the quality or nature of any services these resources may provide.

This is not a complete list of all resources that may be available to you. We suggest you contact your own physician or health care provider, your county health department, or your local chapter of the American Red Cross, for further information.

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(800) 342-AIDS

Spanish AIDS Hotline  
(800) 222-SIDA

TTY Information  
Information and Referral for Hearing Impaired  
(213) 464-0029

Kern County AIDS Team - Bakersfield  
(805) 861-3631

Central Valley AIDS Team - Fresno  
(209) 264-2436

AIDS Project East Bay - Oakland  
(415) 420-8181

Sacramento AIDS Foundation - Sacramento  
(916) 448-2437

San Francisco AIDS Foundation - San Francisco  
(415) 846-5855

Santa Clara County ARIS Project - Campbell  
(408) 370-3272

Sonoma County AIDS Information Hotline  
(707) 579-AIDS

AIDS Hotline - Southern California  
(800) 922-AIDS

Hemophilia Foundation of Southern California Social Services  
Southern California Hemophilia AIDS Information  
(818) 792-6192  
(714) 740-2222

California Department of Health Services  
Statewide Services - Office of AIDS - Sacramento  
(916) 323-7415

AIDS Services Foundation of Orange County - Costa Mesa  
(714) 646-0411

AIDS Project - Los Angeles - West Hollywood  
(213) 876-8951

Inland AIDS Project  
Riverside/San Bernardino Counties  
(714) 784-2437

San Diego AIDS Project  
(619) 543-0300 - City of San Diego  
(619) 945-6000 - City of Vista

Santa Barbara County AIDS Hotline  
(805) 965-2925

Shasta County Helpline  
(916) 225-5252



National Life Insurance Company  
 Life Insurance Company of the Southwest

**Notice Regarding Replacement**

**Mailing Instructions:** *LSW Annuities* - Life Insurance Company of the Southwest  
*NL Annuities beginning with NG* - National Life Insurance Co  
*NL Annuities (New Issue)* - National Life Insurance Company  
PO Box 569080, Dallas, TX 75356  
Service: 800-579-2878 • Fax: 214-638-9371

*LSW Life Insurance* - Life Insurance of the Southwest  
*NL Life Insurance* - National Life Insurance Company  
*NL Annuities (Post Issue)* - National Life Insurance Company  
One National Life Drive, Montpelier, VT 05604  
Service: 802-229-3333 • Fax: 802-229-3868

**Replacing your Life Insurance Policy or Annuity?**

Are you thinking about buying a new life insurance policy or annuity and discontinuing or changing an existing one? If you are, your decision could be a good one - or a mistake. You will not know for sure unless you make a careful comparison of your existing benefits and the proposed benefits.

Make sure you understand the facts. You should ask the company or agent that sold you your existing policy to give you information about it.

Hear both sides before you decide. This way you can be sure you are making a decision that is in your best interest.

We are required by law to notify your existing company that you may be replacing their policy.

Applicant's Signature:

Date: (mm/dd/yyyy)

Agent's Signature:

Date: (mm/dd/yyyy)

**Policy Information:**

Name of Insured:

Date of Birth:

Address: (Street, City, State, Zip Code)

**Policies being replaced:**

Insurer:

Policy Number:

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8027CA(0210) National Life Group® is a trade name of National Life Insurance Company and its affiliates. Each company is solely responsible for its own financial condition and contractual obligations. Cat. No. 44998  
Life Insurance Company of the Southwest is licensed to do business in 49 states and the District of Columbia. It is not licensed to do business in New York. National Life Insurance Company is licensed to do business in all 50 states and the District of Columbia.



Mailing Instructions:  LSW Annuities - Life Insurance Company of the Southwest  
NL Annuities - National Life Insurance Company  
PO Box 569080, Dallas, TX 75356  
Service: 800-579-2878 • Fax: 214-638-9371

LSW Life Insurance - Life Insurance of the Southwest  
NL Life Insurance - National Life Insurance Company  
One National Life Drive, Montpelier, VT 05604  
Service: 802-229-3333 • Fax: 802-229-3868

To: \_\_\_\_\_  
Prospective California Client (please print)

From: \_\_\_\_\_  
Agent (please print)

Pursuant to California Insurance regulation, I am required to advise you of the following:

In the event I recommend that you sell or liquidate any stock, bond, IRA, certificate of deposit, mutual fund, annuity, or other asset to purchase a life insurance or annuity product you may be subject to any or all of the following:

1. Tax consequences
2. Early withdrawal penalties
3. Other costs or penalties as a result of the sale or liquidation

You or your agent may wish to consult independent legal or financial advice before selling or liquidating any assets and prior to the purchase of any life or annuity product being solicited, offered for sale, or sold.

I acknowledge receipt of this disclosure and understand its contents.

Signature of Prospective California Client:

Date: (mm/dd/yyyy)

\_\_\_\_\_

Agent Signature:

Date: (mm/dd/yyyy)

\_\_\_\_\_



HIPAA Compliant Authorization
for Release of Health-Related Information

Table with 2 columns: National Life Insurance Company and Life Insurance Company of the Southwest. Includes addresses for Home / Administrative Office and Home Office.

I authorize any health plan, physician, health care professional, hospital, clinic, laboratory, pharmacy, medical facility, or other health care provider that has provided payment, treatment or services to me or on my behalf within the past 10 years ("My Providers") to disclose my entire medical record and any other protected health information concerning me to National Life Insurance Company and Life Insurance Company of the Southwest (The Company) and its agents, employees, and representatives.

By my signature below, I acknowledge that any agreements I have made to restrict my protected health information do not apply to this authorization and I instruct any physician, health care professional, hospital, clinic, medical facility, or other health care provider to release and disclose my entire medical record without restriction.

This protected health information is to be disclosed under this Authorization so that The Company may: (1) underwrite my application for coverage, make eligibility, risk rating, policy issuance and enrollment determinations; (2) obtain reinsurance; (3) administer claims and determine or fulfill responsibility for coverage and provision of benefits; (4) administer coverage; and (5) conduct other legally permissible activities that relate to any coverage I have or have applied for with The Company.

This authorization shall remain in force for 30 months following the date of my signature below, and a copy of this authorization is as valid as the original. I understand that I have the right to revoke this authorization in writing, at any time, by sending a written request for revocation to National Life Insurance Company or Life Insurance Company of the Southwest, Administrative Office, One National Life Drive, Montpelier, VT 05604, Attention: Privacy Official.

I understand that My Providers may not refuse to provide treatment or payment for health care services if I refuse to sign this authorization. I further understand that if I refuse to sign this authorization to release my complete medical record, The Company may not be able to process my application, or if coverage has been issued, may not be able to make any benefit payments. I acknowledge that I have received a copy of this Authorization.

Proposed Insured/Patient: (Print)

Date of Birth:

Signature of Proposed Insured/Patient or Personal Representative:

Today's Date: (mm/dd/yyyy)

Description of Personal Representative's Authority or Relationship to Patient:

**Questions & Answers about Release of Protected Health Information to a Life or Disability Income Insurer.**

**1. May I release complete personal medical information to a life or disability income insurance company?**

Yes. As you did before the Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule became effective, a medical care provider may disclose complete Protected Health Information (PHI) to organizations not subject to the Privacy Rule as long as the applicant has signed a HIPAA compliant authorization.

**2. Does the "minimum amount necessary" rule apply to this release to a life or disability income insurer?**

No. The "minimum amount necessary" rule does not apply as long as a HIPAA compliant authorization is signed. This question was specifically addressed by Health and Human Services (HHS) in a Q and A published December 4, 2002: "Uses and disclosures that are authorized by the individual are exempt from the minimum necessary requirements. For example, if a covered health care provider receives an individual's authorization to disclose medical information to a life insurer for underwriting purposes, the provider is permitted to disclose the information requested on the authorization without making any minimum necessary determination. The authorization must meet the requirements of 45 CFR 164.508."

**3. Can an insurer request disclosure of a person's "entire" medical record or does it have to refer to specific items in a medical file only?**

Yes. HIPAA allows insurers to seek and providers to disclose a person's entire medical record, if the authorization used clearly states that the entire medical record is to be disclosed (e.g., "I authorize you to disclose my entire medical record.")

**4. Does HIPAA mandate the use of one specified form of authorization by everyone?**

No. HIPAA requires that certain specified "elements" be included in a valid authorization to disclose protected health information. HIPAA does not mandate that a specific form be used. Both covered and non-covered entities are free to use any format they wish so long as it is compliant with HIPAA's requirements. The signed authorization contains all of the elements required by HIPAA.

**5. What should I do if I had previously agreed to a restriction and now receive an authorization to release the "entire medical record?" Does the authorization cover PHI that was restricted?**

You may release all medical records, restricted and otherwise if a patient has previously requested a restriction and later signs an authorization which removes the restriction. The wording of this authorization specifically releases any restricted information.

**This HIPAA compliant authorization and Questions and Answers were created by the American Council of Life Insurers.**



HIPAA Compliant Authorization
for Release of Health-Related Information

Table with 2 columns: National Life Insurance Company and Life Insurance Company of the Southwest. Includes addresses for Home / Administrative Office and Home Office.

I authorize any health plan, physician, health care professional, hospital, clinic, laboratory, pharmacy, medical facility, or other health care provider that has provided payment, treatment or services to me or on my behalf within the past 10 years ("My Providers") to disclose my entire medical record and any other protected health information concerning me to National Life Insurance Company and Life Insurance Company of the Southwest (The Company) and its agents, employees, and representatives.

By my signature below, I acknowledge that any agreements I have made to restrict my protected health information do not apply to this authorization and I instruct any physician, health care professional, hospital, clinic, medical facility, or other health care provider to release and disclose my entire medical record without restriction.

This protected health information is to be disclosed under this Authorization so that The Company may: (1) underwrite my application for coverage, make eligibility, risk rating, policy issuance and enrollment determinations; (2) obtain reinsurance; (3) administer claims and determine or fulfill responsibility for coverage and provision of benefits; (4) administer coverage; and (5) conduct other legally permissible activities that relate to any coverage I have or have applied for with The Company.

This authorization shall remain in force for 30 months following the date of my signature below, and a copy of this authorization is as valid as the original. I understand that I have the right to revoke this authorization in writing, at any time, by sending a written request for revocation to National Life Insurance Company or Life Insurance Company of the Southwest, Administrative Office, One National Life Drive, Montpelier, VT 05604, Attention: Privacy Official.

I understand that My Providers may not refuse to provide treatment or payment for health care services if I refuse to sign this authorization. I further understand that if I refuse to sign this authorization to release my complete medical record, The Company may not be able to process my application, or if coverage has been issued, may not be able to make any benefit payments. I acknowledge that I have received a copy of this Authorization.

Proposed Insured/Patient: (Print)

Date of Birth:

Signature of Proposed Insured/Patient or Personal Representative:

Today's Date: (mm/dd/yyyy)

Description of Personal Representative's Authority or Relationship to Patient:

**Questions & Answers about Release of Protected Health Information to a Life or Disability Income Insurer.**

**1. May I release complete personal medical information to a life or disability income insurance company?**

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You may release all medical records, restricted and otherwise if a patient has previously requested a restriction and later signs an authorization which removes the restriction. The wording of this authorization specifically releases any restricted information.

**This HIPAA compliant authorization and Questions and Answers were created by the American Council of Life Insurers.**



National Life Insurance Company  
 Life Insurance Company of the Southwest

**Cash Equivalent Payment Receipt**  
 Use for cash equivalent remittance only

Policy No.: \_\_\_\_\_

To: (Agency or Office Name) \_\_\_\_\_

Received From: \_\_\_\_\_

Applicant/policy holder name if different then above \_\_\_\_\_

I hereby certify that I have given my Agent, (Name) \_\_\_\_\_

one of the following in the amount of \$ \_\_\_\_\_ to be submitted with my application and/or in satisfaction of my premium due.

- Cash                       Cashier's Check                       Official Bank Check  
 Money Order                       Treasurer's Check                       Traveler's Check

**Signatures:**

Applicant/Policyholder: \_\_\_\_\_ Last 4 SSN: \_\_\_\_\_ Date: \_\_\_\_\_

Received From: (Only needed \_\_\_\_\_ SSN: \_\_\_\_\_ Date: \_\_\_\_\_  
 if different then applicant/policyholder)

Agent: \_\_\_\_\_ Date: \_\_\_\_\_

**Note: Incomplete forms will be returned causing a delay in processing.**

7953(1010)                      Administrative Office: One National Life Drive • Montpelier, Vermont 05604 • Tel: 802 229-3333                      Cat. No. 47093  
 National Life Group® is a trade name of National Life Insurance Company, Life Insurance Company of the Southwest and their affiliates. Each company is solely responsible for its own financial condition and contractual obligations.

**Forward this portion to Treasury Operations Administrative Office with cash equivalent payment**



National Life Insurance Company  
 Life Insurance Company of the Southwest

**Cash Equivalent Payment Receipt**  
 Use for cash equivalent remittance only

Policy No.: \_\_\_\_\_

To: (Agency or Office Name) \_\_\_\_\_

Received From: \_\_\_\_\_

Applicant/policy holder name if different then above \_\_\_\_\_

I hereby certify that I have given my Agent, (Name) \_\_\_\_\_

one of the following in the amount of \$ \_\_\_\_\_ to be submitted with my application and/or in satisfaction of my premium due.

- Cash                       Cashier's Check                       Official Bank Check  
 Money Order                       Treasurer's Check                       Traveler's Check

**Signatures:**

Applicant/Policyholder: \_\_\_\_\_ Last 4 SSN: \_\_\_\_\_ Date: \_\_\_\_\_

Received From: (Only needed \_\_\_\_\_ SSN: \_\_\_\_\_ Date: \_\_\_\_\_  
 if different then applicant/policyholder)

Agent: \_\_\_\_\_ Date: \_\_\_\_\_

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**This portion retained by Client**



**For Processing Use Only**

Processing Center \_\_\_\_\_

Date: (mm/dd/yyyy) \_\_\_\_\_

Base # \_\_\_\_\_

Alt/Add'l #'s \_\_\_\_\_

Companion # \_\_\_\_\_

MGA/Agency Number \_\_\_\_\_

Agent Name & Number \_\_\_\_\_

Primary Insured \_\_\_\_\_

Other Insured(s) \_\_\_\_\_

Companion Name \_\_\_\_\_

**For use with all LSW Applications** (Check appropriate box to indicate form is accompanying application)

PI	OIR	CP		
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	HIV Consent Form	(Always Required, State specific)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	HIPAA Compliant Authorization (8164)	(Always Required for PI, OIR, and children under CTR, State specific)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	ABR Disclosure Form (8083)	(Always Required)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Initial Premium	(If Receipt is given)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Replacement Form (8027)	(Replacement cases or State requirement)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Transfer or 1035 Exchange Form (9685)	(1035 cases)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Previous Policy Pages	(Jump Start)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Interest Crediting Strategies (8613)	(SecurePlus Provider and all other Indexed UL Products)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Supplemental Application for Qualified Pension or Profit Sharing Trust (8533)	(Needed if policy will fund a Pension/Profit Sharing Plan)

**Underwriting Requirements**

Insured(s)	Requirement	Provider	When Needed		
PI	OIR	CP			
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Oral Fluids Taken (IFA/IPA only)	Agent	Refer to Life Underwriting Guide for qualifications, N/A to Paragon/Horizon
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Blood & HOS		See underwriting guidelines
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Para-med Exam		See underwriting guidelines
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Other		See underwriting guidelines

**Processing Center Only**

APS Ordered Insured: \_\_\_\_\_ Doctor \_\_\_\_\_ Date: (mm/dd/yyyy) \_\_\_\_\_

APS Ordered Insured: \_\_\_\_\_ Doctor \_\_\_\_\_ Date: (mm/dd/yyyy) \_\_\_\_\_

**Comments**

**Attach Void Check Here** (If premium frequency is COM, be sure to attach void check here or provide savings account information. Please attach check with glue or tape. Do not staple.)