



Instructions/Information

1. Answer non-medical questions if: (a) reinstating (b) increasing face amount (c) adding benefits or riders (d) requesting change to non-smoker status (or if original plan did not distinguish between smokers and non-smokers and non-smoker rates are desired.) (e) Death Benefit Option Change (f) rating reduction/removal (g) Exchanging. 2. Remit full modal premium. 3. Be certain to obtain owner's signature.

Section A – To be completed for all requests. Check appropriate box.

Change Reinstatement Conversion Exchange

EXISTING COVERAGE: UNIVERSAL LIFE WHOLE LIFE TERM MIZER RIDER

2. Policy Number	3. Occupation of Insured (Describe and give exact duties.)	3a. Income
4. Full Name of Insured – Please Print		
4a. Full Name AND Social Security Number of Owner (If other than Insured.) of new policy.		5. Home Telephone Number ()
		6. Business Telephone Number ()
7. Address of Owner	8a. Address of Insured	8b. How long at this address? If less than 2 years, complete Years Months previous address section.
		9. Previous Address
		10. Contact The Proposed Insured At: <input type="checkbox"/> Residence <input type="checkbox"/> Business <input type="checkbox"/> A.M. <input type="checkbox"/> P.M. Time
11. Will this request replace any existing life insurance or annuity, with the exception of contractual changes made without evidence of insurability and conversions. <input type="checkbox"/> Yes <input type="checkbox"/> No		
12a. New Premium Amount	12c. FOR CHECK-O-MATIC ONLY: DRAW DATE _____ (1ST-28TH) Month Day	ACCOUNT TYPE <input type="checkbox"/> Checking (enclose void check) <input type="checkbox"/> Savings (must complete 12b)
		AUTHORIZED SIGNATURE(S) OF ACCOUNT HOLDER(S)
12b. New Premium Mode	ROUTING/TRANSIT NUMBER	ACCOUNT NUMBER
		FINANCIAL INSTITUTION NAME AND ADDRESS

Section B – To be completed for Changes and Conversions.

13. Convert/change the present: plan, and/or rider The balance of the Plan or Rider is to be continued in force
 Option 1 Option 2 terminated

Name of New Plan	New Policy Date Mo. Yr.	\$ Amount of Insurance	Telemed <input type="checkbox"/> YES Commission Option A <input type="checkbox"/> <input type="checkbox"/> NO B <input type="checkbox"/>
<input type="checkbox"/> Preferred Plus-Non	<input type="checkbox"/> Preferred Smoker	Corrections and Amendments (For Home Office Use Only)	
<input type="checkbox"/> Preferred-Non	<input type="checkbox"/> Smoker		
<input type="checkbox"/> Non-Smoker	<input type="checkbox"/> Review Rating		

14. In the boxes below, enter the amount of changes only. NOTE: The Total Amount/Units column should reflect the new TOTAL after the change.

RIDER/BENEFIT	ADD	DELETE	TRANSFER	INCREASE BY	DECREASE BY	CONVERT	OTHER	Total Amount/Units
Base Plan								
FIR								
CIR								
COLR2/ABI								
LNR/ABR								
OIR/AIR								
WP								
ADB								
APL								
Other								

Section C – To be completed for requests requiring evidence of insurability.										
15. PROPOSED INSURED	OCCUPATION	BIRTH DATE			STATE OF BIRTH	AGE	SEX	SOCIAL SECURITY # and DRIVERS LICENSE #	HEIGHT (FT. IN.)	WEIGHT (LBS.)
		MO.	DAY	YEAR						
LAST NAME	FIRST	M.I.						STATE		
SPOUSE PROPOSED for INSURANCE (or premium payer for juvenile policy)	OCCUPATION							STATE		
PROPOSED INSUREDS	RELATIONSHIP							STATE		
	RELATIONSHIP							STATE		
16a. Primary Beneficiary	RELATIONSHIP	16b. Primary Beneficiary (OIR/AIR)						RELATIONSHIP		
17a. Contingent Beneficiary	RELATIONSHIP	17b. Contingent Beneficiary (OIR/AIR)						RELATIONSHIP		
Beneficiary designations do not apply to others covered under Family/Children's Provision Riders.										
18. WITHIN THE PAST 12 MONTHS, HAS ANY PERSON PROPOSED FOR INSURANCE:						If changing from Smoker to Non-Smoker, indicate date stopped smoking				
a. SMOKED CIGARETTES? <input type="checkbox"/> YES <input type="checkbox"/> NO (If yes, provide details.)						___/___/___				
b. USED TOBACCO IN ANY OTHER FORM? <input type="checkbox"/> YES <input type="checkbox"/> NO (If yes, provide details.)						Details				

TO PREVENT DELAYS, PLEASE ANSWER ALL QUESTIONS ON THE APPLICATION.

Non-Medical Questions

<p>19. Has any person proposed for insurance on reverse side:</p> <p>(a) Used marijuana, narcotic, hallucinogenic or habit forming drugs not prescribed by a physician? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>(b) Had any motor vehicle moving violations or accidents within the last two years? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>(c) Been arrested for any reason other than moving traffic violations? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>(d) Flown other than as a fare-paying passenger within the last two years, or contemplate such flying in the future? (If yes, complete Aviation Questionnaire.) <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>(e) Any past, present or expected activity in racing, skin or sky diving, or any other hazardous sport or hobby? (If yes, complete Hazardous Activities Questionnaire.) <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>(f) Ever had an application for insurance or reinstatement of insurance declined, postponed, rated up or modified? Why? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>(g) Traveled or resided outside the U.S. or intends to travel or reside outside the U.S.? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>20. Has any person proposed for insurance on reverse side ever had or been treated for</p> <p>(a) Chest pain, heart murmur, high blood pressure, or any other disease of the heart, blood, or blood vessels? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>(b) Peptic ulcer, indigestion, or any other disease of the stomach, intestines, gall bladder or liver? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>(c) Emphysema, bronchitis, asthma, pleurisy, or any other disease of the chest or lungs? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>(d) Kidney stone, diabetes; albumin, pus, blood or sugar in urine; venereal disease, or any other disease of the kidneys, bladder or reproductive organs? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>(e) An immune deficiency disorder, AIDS, ARC (AIDS related complex) or been told test results indicate exposure to the AIDS virus? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>(f) Severe headaches, fainting spells, epilepsy, paralysis, nervousness, mental disorder, or any other disease of the brain or nervous system? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>(g) Any impairment of sight or hearing? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>(h) Alcoholism or been treated or counselled for the use of alcohol? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>(i) Cancer, tumor or any other illness or injury not mentioned above? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>21. Other than indicated above, has any person proposed for insurance on reverse side</p> <p>(a) Ever applied for or received a pension or disability benefit? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>(b) Been hospitalized in the past 5 years? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>(c) Consulted a physician during the past 5 years? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>(d) Had a change of weight in the past year? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>(e) Had an immediate family member with a history of diabetes, mental, nervous, heart or circulatory disorder? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>22. Is any person proposed for insurance on reverse side now under observation or taking treatment or been advised to have any tests, hospitalization or surgery which has not been completed? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>23. Are medical records under any other name (maiden name, etc.)? If yes, please indicate name <input type="checkbox"/> Yes <input type="checkbox"/> No</p>	<p>Details of questions answered "yes" in Section 19 through 23. Include question number, full names and addresses of physicians and names of individuals to whom history pertains.</p>		
<p>Name and Address of Primary Physician (if not specified above, date last consulted)</p>		<p>Telephone Number of Primary Physician</p> <p>()</p>	<p>APS Pre-Payment Amount</p> <p>\$</p>

IT IS DECLARED that statement and answers in this application, including statements by the Proposed Insured(s) in any medical questionnaire or supplement that become part of this application, are complete and true to the best knowledge and belief of the undersigned. IT IS AGREED THAT: (1) any waiver or modification of this application will not be effective unless in writing and signed by the President, or the Secretary; (2) **no insurance shall be in effect under this application (except as may be provided in the receipt bearing the same date as this application) unless and until the application has been approved and accepted by the Company at its Executive Office and the policy is delivered to and accepted by the Owner and the full first premium has been paid while each person proposed for insurance is alive and while the state of health and other conditions affecting insurability are as stated in this application and examination, if required. (If a List Billing Authorization or Government Allotment is indicated in section 9a and has actually been signed and delivered for the correct amount, this shall be considered the same as payment of the full first premium);** (3) the acceptance of any policy issued on this application shall constitute a ratification of any correction or amendment made by the Company. No change in amount, classification, plan of insurance, or benefits shall be effective unless agreed to in writing by the applicant.

I also acknowledge receipt of Fair Credit Reporting Act and Medical Information Bureau Notifications.

TAX PAYER IDENTIFICATION NUMBER CERTIFICATION - Under penalties of perjury, I certify that:

- The number shown on this form is my correct taxpayer identification number (or I am waiting for a number to be issued to me), and
- I am not subject to backup withholding because: (a) I am exempt from backup withholding, or (b) I have not been notified by the Internal Revenue Service that I am subject to backup withholding as a result of a failure to report all interest or dividends, or (c) the IRS has notified me that I am no longer subject to backup withholding. **(Please check appropriate response.)**

FINANCIAL INSTITUTION DISCLOSURE - Insurance products and annuities are not a deposit or other obligation of, or guaranteed by a bank, any affiliate of a bank, or savings association and are not insured by the Federal Deposit Insurance Corporation (FDIC) or any other agency of the United States, a bank, any affiliate of a bank, or savings association, and involve investment risk, including possible loss of value. The approval or disapproval of any extension of credit by the bank or an affiliate is not based on whether or not this insurance is purchased through the bank or through any particular source.

AUTHORIZATION: To determine eligibility for insurance, I authorize any physician, medical practitioner, hospital, clinic, other medically related facility, insurance or reinsuring company, the Medical Information Bureau, Inc., consumer reporting agency or employer having information available as to diagnosis, treatment and prognosis with respect to information regarding alcoholism, drug abuse, and psychiatric care or any physical or mental condition and/or treatment of me or my minor children and any other nonmedical information of me or my minor children to give to Midland National Life Insurance Company (the Company) or its legal representative, any and all such information. I also authorize the Company to conduct a personal telephone interview in connection with my application; and to release any such data to its reinsurers, the Medical Information Bureau, or other persons or organizations performing business or legal services in connection with my application, or as required by law when given a copy of this authorization. I understand that I may request to be interviewed in connection with the preparation of an investigative consumer report. I understand that I am entitled to receive a copy of the investigative consumer report upon request. This authorization is valid for 30 months from the date signed. I may revoke this authorization for information not then obtained by notifying the Company in writing. Such revocation will not be effective until received by the Company. I understand that I or any authorized representative will receive a copy of this authorization upon request.

FRAUD STATEMENT - Any person who, with the intent to defraud or knowing that he/she is facilitating a fraud against an insurer, submits an application or files a claim containing false or deceptive statements is/may be guilty of insurance fraud and may be subject to fines and penalties.

PROPOSED INSURED if 15 YEARS OR OLDER (Signature) <small>Make all checks payable to Midland National Life Insurance Company.</small> X	SIGNED AT (City, State)		DATE
OWNER (Signature)	ADDITIONAL INSURED/SPOUSE PROPOSED FOR INSURANCE (Signature)		
Soliciting Agent: The applicant(s) <input type="checkbox"/> has <input type="checkbox"/> does not have any existing life insurance or annuities. To the best of my knowledge, this application <input type="checkbox"/> is <input type="checkbox"/> is not involved in replacement of life insurance or annuities. SOLICITING AGENT (Signature)	PRINT AGENT'S LAST NAME	CODE NO.	TELEPHONE NUMBER ()
	OTHER AGENT (Please Print)		% CREDIT CODE NO.
	GENERAL AGENT (Please Print)		CODE NO.

Special Instructions:



A Member of the Sammons Financial Group