



10321

Instructions/Information

1. Answer Medical/Insurability 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 (f) rating reduction/removal (g) Exchanging. 2. Must remit full modal premium or check-o-matic authorization to complete the change. 3. Be certain to obtain owner's signature.

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

- Change Review Rating Reinstatement Conversion Class Change
 Increase Add Rider Decrease Option Change
 Exchange Exchange Commission Option: A B

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 previous address section. 9. Previous Address 10. Contact The Proposed Insured At: Residence Business A.M. P.M. Time

11. New Premium Amount 12. FOR CHECK-O-MATIC ONLY: DRAW DATE (1ST-28TH) Month Day ACCOUNT TYPE Checking (enclose void check) Savings (must complete 12b) AUTHORIZED SIGNATURE(S) OF ACCOUNT HOLDER(S)

11a. 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 terminated decreased
 Level DB Option Increasing DB Option

Name of New Plan New Policy Date Mo. | Yr. \$ Amount of Insurance Telemed YES NO Product Commission Option A B C

Preferred Plus-Non Preferred Smoker Preferred Tobacco
 Preferred-Non Smoker Non Tobacco
 Non-Smoker Tobacco Preferred Non Tobacco Preferred Plus Non Tobacco

14a. 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
Base Plan								
FIR								
CIR								
LNR								
OIR/AIR								
WP								
ADB								
APL								
IPGR								
GIR/OPAI								
Other								

14b. LIFE INSURANCE AND ANNUITIES IN FORCE AND PENDING: If None, check here: <input type="checkbox"/>								Intention of Replacement or Change*
Name	Company	Policy #	Pending	Issue Yr.	Basic Amount	ADB Amount	WP Amount	
			<input type="checkbox"/>					<input type="checkbox"/> Y <input type="checkbox"/> N
			<input type="checkbox"/>					<input type="checkbox"/> Y <input type="checkbox"/> N
			<input type="checkbox"/>					<input type="checkbox"/> Y <input type="checkbox"/> N
			<input type="checkbox"/>					<input type="checkbox"/> Y <input type="checkbox"/> N

* If Yes, complete applicable Replacement Form. Use Additional sheet, if necessary.
If this is a 1035 Exchange, also complete 1035 Exchange paperwork and submit with application.

Section C – To be completed for changes requiring evidence of insurability.

15. PROPOSED INSURED										
			BIRTH DATE			STATE OF BIRTH	AGE	SEX	HEIGHT (FT. IN.)	WEIGHT (LBS.)
MO.	DAY	YEAR								
LAST NAME	FIRST	M.I.								
Occupation:	Social Security Number:		Driver's License Number:				State			

SPOUSE PROPOSED for INSURANCE (or premium payer for juvenile policy)										
			BIRTH DATE			STATE OF BIRTH	AGE	SEX	HEIGHT (FT. IN.)	WEIGHT (LBS.)
MO.	DAY	YEAR								
Occupation:	Social Security Number:		Driver's License Number:				State			

PROPOSED INSUREDS										
			BIRTH DATE			STATE OF BIRTH	AGE	SEX	HEIGHT (FT. IN.)	WEIGHT (LBS.)
MO.	DAY	YEAR								
RELATIONSHIP	Social Security Number:		Driver's License Number:				State			

PROPOSED INSUREDS										
			BIRTH DATE			STATE OF BIRTH	AGE	SEX	HEIGHT (FT. IN.)	WEIGHT (LBS.)
MO.	DAY	YEAR								
RELATIONSHIP	Social Security Number:		Driver's License Number:				State			

16a. Primary Beneficiary (For Conversions & Exchanges Only)								RELATIONSHIP

17a. Contingent Beneficiary								RELATIONSHIP

Beneficiary designations do not apply to others covered under Family/Children's Provision Riders.

18. Has anyone proposed for insurance smoked cigarettes, cigars, pipes, or used tobacco or nicotine in any form, including smokeless tobacco, nicotine patch, gum or other substitutes within the past 36 months?						Primary Insured	Add'l. Insured/Spouse
						<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
18a. If the answer to question 18 is "yes", has anyone proposed for insurance smoked cigarettes, cigars, pipes, or used tobacco or nicotine in any form, including smokeless tobacco, nicotine patch, gum or other substitutes within the last 12 months?						<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
18b. If the answer to question 18a is "yes", has anyone proposed for insurance used cigarettes within the last 12 months?						<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
18c. If 18b is "yes", please indicate number of cigarettes smoked per day						_____	_____

If changing from Smoker to Non-Smoker, indicate date stopped smoking or using tobacco related products ____/____/____	Details
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Special Instructions:

IT IS DECLARED that statements 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 of the Company; (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 9 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:

1. 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**
2. I am not subject to backup withholding because: (a) I am exempt from backup withholding, or (b) I have not been notified by the Internal Revenue Service that I am subject to backup withholding as a result of a failure to report all interest or dividends, or (c) the IRS has notified me that I am no longer subject to backup withholding. **(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, health care professional, hospital, clinic, or other medically related facility, laboratory, pharmacy or pharmacy benefit manager, insurance or reinsuring company, the Medical Information Bureau, Inc., consumer reporting agency, insurance support organization, independent administrator, or other organization, institution, or person, or employer having information available as to diagnosis, prescription history, medications prescribed, 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 WARNING - AR, LA, NM, and OH Residents: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison..

CO Residents: It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete or misleading facts or information to a contractholder or claimant for the purpose of defrauding or attempting to defraud the contractholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

DC and TN Residents: Warning: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.

PA Residents: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such a person to criminal and civil penalties.

VA Residents: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the Company. Penalties include imprisonment, fines and denial of insurance benefits.

SIGNED AT (City, State)				DATE	
SIGNATURE OF PROPOSED INSURED if 15 YEARS OR OLDER X			SIGNATURE OF PROPOSED ADDITIONAL INSURED/SPOUSE X		
SIGNATURE OF OWNER, (If other than Proposed Insured)					
SPOUSE SIGNATURE, IF COMMUNITY PROPERTY LAWS APPLY (AK, AZ, CA, ID, LA, NM, NV, TX, WA, WI)			COLLATERAL ASSIGNEE		
Soliciting Agent: Does the applicant(s) have any existing life insurance or annuities? <input type="checkbox"/> Yes <input type="checkbox"/> No					
Is any insurance applied for in this application intended to replace any life insurance or annuity now in force? <input type="checkbox"/> Yes <input type="checkbox"/> No					
If a replacement is involved, submit a copy of this application and applicable Replacement Notice to the existing insurer.					
SIGNATURE OF SOLICITING AGENT X		PRINT AGENT'S LAST NAME	CODE NO.	% CREDIT	TELEPHONE NUMBER ()
					CELL PHONE NUMBER ()
OTHER AGENT (Please Print)	% CREDIT	CODE NO.	GENERAL AGENT (Please Print)		CODE NO.