



9301

GENERAL PURPOSE LIFE APPLICATION (Please Print and Use Black Ink)

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|--|------------|-----|------|----------------|-----|-----|------------------|---------------|
| 1. PRIMARY PROPOSED INSURED <input type="checkbox"/> SINGLE <input type="checkbox"/> MARRIED LAST NAME _____ FIRST _____ M.I. _____ | BIRTH DATE | | | STATE OF BIRTH | AGE | SEX | HEIGHT (FT. IN.) | WEIGHT (LBS.) |
| | MO. | DAY | YEAR | | | | | |

1a. Are you a U.S. Citizen, or do you have a permanent Visa? Yes No (If no, complete Foreign Travel and Residence Questionnaire)

| | | |
|-------------------------|--------------------------|-------|
| Social Security Number: | Driver's License Number: | State |
|-------------------------|--------------------------|-------|

| | | | |
|-------------|-------------------------------------|---------------|-----------|
| Occupation: | Employer (Company Name and Address) | Annual Income | Net Worth |
|-------------|-------------------------------------|---------------|-----------|

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|--|------------|-----|------|----------------|-----|-----|------------------|---------------|
| 2. ADDITIONAL INSURED/SPOUSE PROPOSED for INSURANCE (or premium payer for juvenile policy) LAST NAME _____ FIRST _____ M.I. _____ | BIRTH DATE | | | STATE OF BIRTH | AGE | SEX | HEIGHT (FT. IN.) | WEIGHT (LBS.) |
| | MO. | DAY | YEAR | | | | | |

2a. Are you a U.S. Citizen, or do you have a permanent Visa? Yes No (If no, complete Foreign Travel and Residence Questionnaire)

| | | |
|-------------------------|--------------------------|-------|
| Social Security Number: | Driver's License Number: | State |
|-------------------------|--------------------------|-------|

| | | |
|-------------|-------------------------------------|---------------|
| Occupation: | Employer (Company Name and Address) | Annual Income |
|-------------|-------------------------------------|---------------|

| DEPENDENT CHILDREN PROPOSED for INSURANCE | BIRTH DATE | | | STATE OF BIRTH | AGE | SEX | SOCIAL SECURITY NUMBER | HEIGHT (FT. IN.) | WEIGHT (LBS.) |
|---|------------|-----|------|----------------|-----|-----|------------------------|------------------|---------------|
| | MO. | DAY | YEAR | | | | | | |
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| 3. RESIDENCE ADDRESS (Street, City, State, Zip) | 3a. How long at this address? _____ Years _____ Months If less than 2 years, provide previous address. |
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3b. MAILING ADDRESS (If other than residence)

| | | |
|---|--|---|
| 4. CONTACT THE PROPOSED INSURED AT: <input type="checkbox"/> RESIDENCE _____ (CST) <input type="checkbox"/> A.M. <input type="checkbox"/> P.M. <input type="checkbox"/> BUSINESS Time | RESIDENCE TELEPHONE NUMBER Primary Insured () Spouse () Cell Phone () | BUSINESS TELEPHONE NUMBER Primary Insured () Spouse () Cell Phone () |
|---|--|---|

5. Has anyone proposed for insurance ever smoked cigarettes, cigars, pipes, or used tobacco in any form, including smokeless tobacco, nicotine patch, gum or other substitutes?

5a. **Primary Insured:** Yes No If 'yes', provide: Type of product(s) used _____
 Amount Used: _____ How often: Daily _____ Weekly _____ Monthly _____ Date of last use mm/yy _____

5b. **Additional Insured Rider/Spouse:** Yes No If 'yes', provide: Type of product(s) used _____
 Amount Used: _____ How often: Daily _____ Weekly _____ Monthly _____ Date of last use mm/yy _____

| | | | |
|--------------|------------------------|--|---|
| 6. AMOUNT \$ | PLAN OF PRIMARY POLICY | Agent Use Only A <input type="checkbox"/> B <input type="checkbox"/> C <input type="checkbox"/> | Type of Underwriting <input type="checkbox"/> Traditional <input type="checkbox"/> X-Press |
|--------------|------------------------|--|---|

| | | |
|---|---|---|
| 7. For UL/VUL: (check if applicable) <input type="checkbox"/> Option I <input type="checkbox"/> Option II <input type="checkbox"/> Rebalance <input type="checkbox"/> Minimum Premium <input type="checkbox"/> Target Premium | <input type="checkbox"/> Automatic Premium Loan (Whole Life Only) | Enhanced Corridor Percentage SVUL <input type="checkbox"/> Yes <input type="checkbox"/> No |
|---|---|---|

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|---|--|
| 8. RIDERS <input type="checkbox"/> Waiver of Premium/Waiver of Charges <input type="checkbox"/> Children's Insurance Rider _____ Units <input type="checkbox"/> Flexible Disability \$ _____ <input type="checkbox"/> Guaranteed Insurability _____ Units <input type="checkbox"/> Living Needs Rider <input type="checkbox"/> Estate Preservation Rider <input type="checkbox"/> Pro Term Rider <input type="checkbox"/> NLG-Option Period to Age _____ <input type="checkbox"/> IPGR <input type="checkbox"/> Guaranteed Death Benefit to Maturity Rider <input type="checkbox"/> Other Rider (Plan) _____ (Amount) | Individual Life Rider First <input type="checkbox"/> Amount \$ _____ Second <input type="checkbox"/> Amount \$ _____ |
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9. PREMIUM FREQUENCY: Annual Semi-Annual Quarterly Monthly
 PREMIUM MODE: EFT List Billing Direct Billing (A, SA, Q) only Civil Service Allotment Military Government Allotment
 List Bill Code _____
 Make all checks payable to MIDLAND NATIONAL LIFE INSURANCE COMPANY

Amount of Modal Premium \$ _____ Amount Paid with Application \$ _____ (Receipt valid only if amount paid with application is entered here.)

| | | |
|---|---|--|
| 10. FOR EFT ONLY: DRAW DAY _____ (1ST-28TH) Month _____ Day _____ 10a. Initial Draft <input type="checkbox"/> Yes <input type="checkbox"/> No | ACCOUNT TYPE <input type="checkbox"/> Checking (attach voided check) <input type="checkbox"/> Savings (must complete 10b) | AUTHORIZED SIGNATURE(S) OF ACCOUNT HOLDER(S) X X |
| | 10b. Routing Transit Number | Account Number |

11. Please list all life insurance and annuities currently in force or pending on the life of any of the proposed insureds. This includes policies that have or will be sold, assigned or otherwise placed via life settlement, viatical or other agreements, or that you intend to replace, cancel, or sell: **If None, check here:**

| Name | Company | Policy # | Pending | Issue Yr. | Basic Amount | ADB Amount | WP Amount | Intention of Replacement or Change* |
|------|---------|----------|--------------------------|-----------|--------------|------------|-----------|---|
| | | | <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.

12. Are any of the above policies being used to fund this policy? Yes No

13. Have you or will you be compensated in any way to purchase this policy? Yes No

14. Are you paying for this policy with your own funds? Yes No

15. Have you financed or do you intend to finance all or a portion of the premiums for this policy? Yes No
 (If yes, complete applicable Disclosure and Acknowledgement Form and submit with application)

16. Have you entered into or are you considering any other agreement in regard to this policy including but not limited to an agreement to sell, transfer or assign any rights in the policy? Yes No

If the answer is 'Yes' to questions 12, 13, or 16 please provide details below. If answer to question 14 is 'No' please provide details below.

17. OWNER IF OTHER THAN PROPOSED INSURED (Include relationship to proposed insured.)

| | | | |
|------|---------|------------------------|--------------|
| Name | Address | Social Security Number | Relationship |
|------|---------|------------------------|--------------|

18. PRIMARY BENEFICIARY--(Class 1) (Include relationship to proposed insured.)

19. CONTINGENT BENEFICIARY--(Class 2) (Include relationship to proposed insured.)

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

20. SPECIAL REQUESTS OR DETAILS

For Military Personnel (Including National Guard and Reserves)

| | |
|--|--|
| 21. PERMANENT HOME OF RECORD (Street, City, State, Zip) | 22. MILITARY ADDRESS |
| 23. JOB DUTIES | 24. Are you currently drawing extra duty or hazard pay? <input type="checkbox"/> YES <input type="checkbox"/> NO |
| 25. MILITARY INFORMATION <input type="checkbox"/> USA <input type="checkbox"/> USN <input type="checkbox"/> USAF <input type="checkbox"/> Other (Specify) | |
| Pay Grade _____ | Rotation Date _____ Expected Discharge Date _____ |
| 26. Has the Proposed Insured been a member of a special forces, special or hazardous duty organization? <input type="checkbox"/> YES <input type="checkbox"/> NO If yes, provide specific details. | |
| 27. Has the Proposed Insured been alerted to, volunteered for, or received formal orders to a hazardous area or overseas assignment? <input type="checkbox"/> YES <input type="checkbox"/> NO If yes, provide specific details. | |

Must be completed for all proposed insureds, including CIR.

Must be completed for all proposed insureds, including CIR, not subject to Tele-Underwriting or a Paramed exam.

28. Has any person proposed for insurance:

- (a) In the past 10 years used barbiturates, hallucinatory drugs, narcotics including cocaine, crack, ecstasy, opium derivatives, marijuana, LSD, PCP, or any derivatives of these drugs, or been advised by a medical professional to get, or undergone any treatment, counseling or hospitalization for drug abuse? . . . Yes No
- (b) In the past 10 years been advised by a medical professional to get, or undergone any treatment, counseling or hospitalization for alcoholism, excessive alcohol use or abuse? Or, drink on average more than 3 alcoholic drinks per day? Yes No
- (c) Had any motor vehicle moving violations or accidents or been arrested for driving under the influence of alcohol or drugs within the last five years? . . Yes No
- (d) In the past 10 years been convicted of any criminal activity, or been held or served time in any type of incarceration, jail, penitentiary, prison, probation, or parole program? Or, have any criminal charges pending against them at this time? Yes No
- (e) Flown a plane in the past 24 months or plan to fly in the next 12 months as a pilot, copilot, student pilot, military pilot, engineer or in any other capacity except as a regularly scheduled commercial airline pilot or fare-paying passenger? If yes, complete Aviation Questionnaire Yes No
- (f) Any past, present or expected activity in racing, scuba or sky diving, or any other hazardous sport or hobby? (If yes, complete Hazardous Activities Questionnaire.) Yes No
- (g) In the past 10 years been refused for life insurance or charged an extra premium for life insurance? Yes No
- (h) Traveled to or resided for more than 30 days outside of the U.S., U.S. territories, Canada, or Japan within the past 12 months or plan to travel to or reside outside of the U.S., U.S. territories, Canada, or Japan in the next 12 months? If yes, complete the Foreign Travel and Residence Questionnaire Yes No
- (i) Have any bankruptcy pending or expect to file bankruptcy in the next 12 months? Yes No

Details of questions answered "yes" in Section 28 through 33. Include question number, full names and addresses of physicians and names of individuals to whom history pertains.

29. Within the last ten years, has any person proposed for insurance ever had or been treated by a medical professional for:

- (a) Chest pain, heart murmur, stroke, high blood pressure, or any other disease of the heart, blood, or blood vessels? Yes No
- (b) Peptic ulcer, indigestion, or any other disease of the stomach, intestines, gall bladder or liver? Yes No
- (c) Emphysema, bronchitis, asthma, pleurisy, or any other disease of the chest or lungs? Yes No
- (d) Kidney stone, diabetes; albumin, pus, blood or sugar in urine; venereal disease, or any other disease of the kidneys, bladder or reproductive organs? Yes No
- (e) An immune deficiency disorder [Acquired Immune Deficiency Syndrome (AIDS), AIDS related complex (ARC)] or been told test results indicate exposure to the AIDS virus? Yes No
- (f) Severe headaches, fainting spells, epilepsy, paralysis, nervousness, mental disorder, or any other disease of the brain or nervous system? Yes No
- (g) Cancer, tumor, or any other illness or injury not mentioned above? Yes No

30. Other than indicated above, has any person proposed for insurance:

- (a) Been hospitalized in the past 5 years? Yes No
- (b) Consulted a physician during the past 5 years? Yes No
- (c) Had a change of weight in the past year? Yes No
- (d) Had a parent or a brother or sister who before age 60 was diagnosed with or died from cardiovascular disease, stroke, cancer (except basal or squamous cell cancer of the skin), Huntington's Chorea, familial polyposis, or polycystic kidney disease? If yes, provide age at onset and current age if living. If deceased, age at death. Yes No

31. Is any person proposed for insurance now under observation, taking treatment or medication, or been advised to have any tests, hospitalization, or surgery which has not been completed? Yes No

32. Is any person proposed for insurance currently receiving or have an application pending for any illness or disability benefits or compensation? Yes No

Must be completed for all proposed insureds, including CIR.

33. Are medical records under any other name (maiden name, etc.)?
 Yes No
 If yes, please indicate full name.

Name and Address of Primary Physician and Facility Name (if not specified above, date last consulted)

Telephone Number of Primary Physician

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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; (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 any required examination and additional information. (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 FURTHER AGREE to immediately advise the Company of any change to any of the responses contained in the application, including any change in the health or habits of any Proposed Insured(s), that arises or is discovered after completing this application, but before the Policy is effective, as defined herein.

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, health care professional, hospital, clinic, or other medical-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, 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 person to criminal and civil penalties.

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 BENEFICIARY IS OTHER THAN SPOUSE AND COMMUNITY PROPERTY LAWS APPLY | |
| 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. |
| | | | TELEPHONE NUMBER () |
| | | | CELL PHONE NUMBER () |
| OTHER AGENT (Please Print) | % CREDIT | CODE NO. | GENERAL AGENT (Please Print) |
| | | | CODE NO. |



Authorization for Release of Health-Related Information

This Authorization complies with the HIPAA Privacy Rules

| | | | |
|---|------------|-----|------|
| Name of Proposed Insured (Please print) | Birth Date | | |
| | Month | Day | Year |

I authorize any health plan, physician, dental practitioner, 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 Midland National Life Insurance Company and its agents, employees, and representatives. This includes information on the diagnosis or treatment of Human Immunodeficiency Virus (HIV) infection and sexually transmitted diseases. This also includes information on the diagnosis and treatment of mental illness and the use of alcohol, drugs, and tobacco, but excludes psychotherapy notes.

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 My Providers to release and disclose my entire medical record without restriction.

This protected health information is to be disclosed under this Authorization so that Midland National Life Insurance Company may: 1) underwrite my application for coverage, determine 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 Midland National Life Insurance 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 Midland National Life Insurance Company at One Midland Plaza, Sioux Falls SD, 57193-0001, Attention: New Business. I understand that a revocation is not effective to the extent that any of My Providers has relied on this Authorization or to the extent that Midland National Life Insurance Company has a legal right to contest a claim under an insurance policy or to contest the policy itself. I understand that any information that is disclosed pursuant to this Authorization may be redisclosed and no longer covered by federal rules governing privacy and confidentiality of health information.

I understand that My Providers cannot deny me treatment or payment for health care services if I refuse to sign this authorization. I further understand that if I alter, revoke, or refuse to sign this Authorization to release my complete medical record, Midland National Life Insurance 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 by my signature below, that I have a right to receive, and have in fact received, a copy of this authorization

| | |
|--|-------------------|
| Signature of Proposed Insured or Personal Representative | Date (MM/DD/YYYY) |
|--|-------------------|

If you are the Personal Representative of the Proposed Insured, describe the scope and/or basis of your authority to act on the Insured's behalf:

SEND ORIGINAL WITH APPLICATION – GIVE A COPY TO PROPOSED INSURED

MIDLAND NATIONAL LIFE INSURANCE COMPANY • ONE MIDLAND PLAZA • SIOUX FALLS, SD 57193-0001

Phone: (605) 335-5700 • New Business Fax - Red Team: (605) 373-8571 Blue Team: (605) 335-7583 Green Team: (605) 373-8573 • Fax Center: (605) 335-3621 • Internet: www.MNLife.com

