MIDLAND NATIONAL®
Life Insurance Company
A Member of the Sammons Financial Group

8806RMA

TELE-UNDERWRITING LIFE INSURANCE APPLICATION-PART 1 (Please Print and Use Black Ink)

1. PRIMARY PROPOSED INSURED ☐ SINGLE ☐ MARRIED

LAST NAME	FIRST	M.I.	BIRTH DATE MO.	DAY	YEAR	STATE OF BIRTH	AGE	SEX	HEIGHT (FT. IN.)	WEIGHT (LBS.)

Social Security Number:	Driver's License Number:	State

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

2. ADDITIONAL INSURED/SPOUSE PROPOSED for INSURANCE (or premium payer for juvenile policy)

LAST NAME	FIRST	M.I.	BIRTH DATE MO.	DAY	YEAR	STATE OF BIRTH	AGE	SEX	HEIGHT (FT. IN.)	WEIGHT (LBS.)

Social Security Number:	Driver's License Number:	State

Occupation:	Employer (Company Name and Address)	Annual Income

DEPENDENT CHILDREN PROPOSED for INSURANCE	BIRTH DATE MO.	DAY	YEAR	STATE OF BIRTH	AGE	SEX	SOCIAL SECURITY NUMBER	HEIGHT (FT. IN.)	WEIGHT (LBS.)

3. RESIDENCE ADDRESS (Street, City, State, Zip)

3a. How long at this address? ________ Years ________ Months
If less than 2 years, provide previous address.

3b. MAILING ADDRESS (If other than residence)

4. CONTACT THE PROPOSED INSURED AT:
☐ RESIDENCE
☐ BUSINESS ________ Time (CST) ☐ A.M. ☐ P.M.

RESIDENCE TELEPHONE NUMBER
Primary Insured ( )
Spouse ( )
Cell Phone ( )

BUSINESS TELEPHONE NUMBER
Primary Insured ( )
Spouse ( )
Cell Phone ( )

	Primary Insured	Additional Insured/ Spouse
5a. 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?	☐Yes ☐No	☐Yes ☐No
5b. If the answer to question 5a 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?	☐Yes ☐No	☐Yes ☐No
5c. If the answer to question 5b is "yes", has anyone proposed for insurance used cigarettes within the last 12 months?	☐Yes ☐No	☐Yes ☐No
5d. If 5c is "yes", please indicate number of cigarettes smoked per day	________	________

NOTE: IF APPLYING FOR VARIABLE LIFE INSURANCE: THE DEATH BENEFIT MAY BE VARIABLE OR FIXED UNDER CERTAIN CONDITIONS, CASH VALUES MAY INCREASE OR DECREASE, EVEN TO THE EXTENT OF BEING REDUCED TO ZERO, IN ACCORDANCE WITH THE EXPERIENCE OF THE SEPARATE ACCOUNT (SUBJECT TO ANY SPECIFIED MINIMUM GUARANTEES). ILLUSTRATIONS OF BENEFITS CONFORMING TO THE REQUIREMENTS OF 211 CMR 95(1)(i), INCLUDING DEATH BENEFITS AND CASH SURRENDER VALUES, ARE AVAILABLE UPON REQUEST.

6. AMOUNT
$

PLAN OF PRIMARY POLICY

Agent Use Only
A ☐ B ☐ C ☐

7. For UL/VUL: (check if applicable)
☐ Option I ☐ Option II ☐ Rebalance
☐ Minimum Premium ☐ Target Premium

☐ Automatic Premium Loan

Enhanced Corridor Percentage SVUL
☐ Yes ☐ No

8. RIDERS
☐ Waiver of Premium
☐ Living Needs Rider
☐ IPGR
☐ Accidental Death Benefit $ ____________
☐ Children's Insurance Rider ____________ Units
☐ Guaranteed Death Benefit to Maturity Rider
☐ Estate Preservation Rider
☐ NLG-Option Period to Age ________
☐ Other Rider (Plan) ________ | ________ (Amount)
Individual Life Rider
First ☐ Amount $ ____________
Second ☐ Amount $ ____________

9. PREMIUM FREQUENCY: ☐ Annual ☐ Semi-Annual ☐ Quarterly ☐ Monthly
PREMIUM MODE: ☐ EFT ☐ List Billing ☐ Direct Billing (A, SA, Q) only ☐ Civil Service 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
☐ Yes ☐ No

ACCOUNT TYPE
☐ Checking (enclose voided check)
☐ Savings (must complete 10b)

AUTHORIZED SIGNATURE(S) OF ACCOUNT HOLDER(S)
X ____________________
X ____________________

10b. Routing Transit Number	Account Number	Financial Institution Name and Address

11. LIFE INSURANCE AND ANNUITIES INFORCE AND PENDING: If None, check here: ☐

Name	Company	Policy #	Pending	Issue Yr.	Basic Amount	ADB Amount	WP Amount	Intention of Replacement or Change*
			☐					☐ Y ☐ N
			☐					☐ Y ☐ N
			☐					☐ Y ☐ N
			☐					☐ Y ☐ N
			☐					☐ Y ☐ N
			☐					☐ Y ☐ 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. PRELIMINARY HEALTH QUESTION
Within the past 10 years, has any Proposed Insured been diagnosed or treated by a medical professional for diabetes, cancer, heart disease, stroke, alcoholism, drug abuse or high blood pressure or does any Proposed Insured have any health problems, habits, or hobbies that may affect insurability?
(if yes, preferred rates are unlikely) .... ☐ YES ☐ NO

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

Name	Address	Social Security Number	Relationship

14. PRIMARY BENEFICIARY–(Class 1) (Include relationship to proposed insured.)

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

15. CONTINGENT BENEFICIARY–(Class 2) (Include relationship to proposed insured.)

16. SPECIAL REQUESTS OR DETAILS

PREFERRED PARAMED SERVICES

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 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, 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.

SIGNED AT (City, State)	DATE

SIGNATURE OF PROPOSED INSURED if 15 YEARS OR OLDER	SIGNATURE OF PROPOSED ADDITIONAL INSURED/SPOUSE
X	X

SIGNATURE OF OWNER (If other than Proposed Insured)	SPOUSE SIGNATURE, IF BENFICIARY IS OTHER THAN SPOUSE AND COMMUNITY PROPERTY LAWS APPLY

Soliciting Agent: Does the applicant(s) have any existing life insurance or annuities? . . . . ☐ Yes ☐ No

Is any insurance applied for in this application intended to replace any life insurance or annuity now in force? . . ☐ Yes ☐ No

If a replacement is involved, submit a copy of this application and applicable Replacement Notice to the existing insurer. Leave the applicant a copy of all sales materials used in the sales presentation.

SIGNATURE OF SOLICITING AGENT	PRINT AGENT'S LAST NAME	CODE NO.	TELEPHONE NUMBER ( )
X			CELL PHONE NUMBER ( )

OTHER AGENT (Please Print)	% CREDIT	CODE NO.	GENERAL AGENT (Please Print)	CODE NO.