Clear Form Clear Kit

9300MA

MIDLAND NATIONAL
Life Insurance Company

A Member of the Sammons Financial Group

Executive Office: One Midland Plaza • Sioux Falls, SD 57193-0001 • Principal Office: Des Moines, IA 50266

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

1. PRIMARY PROPOSED INSURED ☐ SINGLE ☐ MARRIED	BIRTH DATE MO.	DAY	YEAR	STATE OF BIRTH	AGE	SEX	HEIGHT (FT. IN.)	WEIGHT (LBS.)
LAST NAME FIRST M.I.								

Social Security Number:	Driver's License Number	State
Occupation:	Employer (Company Name and Address)	Annual Income

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

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:	TELEPHONE NUMBER	BUSINESS TELEPHONE NUMBER
☐ RESIDENCE ☐ BUSINESS _____ Time (CST) ☐ A.M. ☐ P.M.	Primary Insured ( ) Spouse ( )	Primary Insured ( ) Spouse ( )

	Primary Insured	Additional Insured/Spouse
5a. Has anyone proposed for insurance used any tobacco product within the last 36 months?	☐ Yes ☐ No	☐ Yes ☐ No
5b. If the answer to question 5a is 'yes', has anyone proposed for insurance used cigarettes within the last 12 months?	☐ Yes ☐ No	☐ Yes ☐ No
If yes, number per day	_____	_____

6. AMOUNT	PLAN OF PRIMARY POLICY	Agent Use Only	Type of Underwriting
$		A ☐ B ☐ C ☐	☐ Standard ☐ X-Press ☐ Non-Smoker ☐ Tele-Underwriting ☐ Smoker

7. For UL/VUL: (check if applicable)		Enhanced Corridor Percentage SVUL
☐ Option I ☐ Option II ☐ Minimum Premium ☐ Target Premium	☐ Automatic Premium Loan	☐ Yes ☐ No

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.

8. RIDERS

☐ Waiver of Premium
☐ Living Needs Rider
☐ IPGR
☐ Accidental Death Benefit $ _____
☐ Children's Insurance Rider _____ Units
☐ Guaranteed Death Benefit to Maturity Rider
☐ Pro Term Rider ☐ NLG-Option Period to Age _____
☐ Other Rider (Plan) _____ (Amount) _____
☐ Estate Preservation Rider

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 ☐ 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

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

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

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

11a. WILL THE INSURANCE BEING APPLIED FOR REPLACE OR CHANGE ANY EXISTING LIFE INSURANCE OR ANNUITY CONTRACT? ☐ YES ☐ NO
(If yes, complete applicable Replacement Notice form and submit with application)

11b. DOES ANY PROPOSED INSURED HAVE LIFE INSURANCE IN FORCE OR APPLICATIONS PENDING WITH ANY COMPANY? ☐ YES ☐ NO
(If yes, please provide information below.)

11c.

Insured Name	Company	Amount	Status	ADB	Insured Name	Company	Amount	Status	ADB
			☐ Pending ☐ Issued Yr. _____	☐ Y ☐ N				☐ Pending ☐ Issued Yr. _____	☐ Y ☐ N
			☐ Pending ☐ Issued Yr. _____	☐ Y ☐ N				☐ Pending ☐ Issued Yr. _____	☐ Y ☐ N

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

Name	Address	Social Security Number	Relationship

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

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

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

15. SPECIAL REQUESTS OR DETAILS

PREFERRED PARAMED SERVICES

PRINCIPAL REVIEW (For Variable Products)

For Military Use Only

16. PERMANENT HOME OF RECORD (Street, City, State, Zip)

TELEPHONE NUMBER ( )

17. MILITARY ADDRESS

18. JOB DUTIES

19. MILITARY INFORMATION

☐ USA ☐ USN ☐ USAF ☐ Other (Specify)

Pay Grade _____ Expected Rotation Date _____ Discharge Date _____

Are you currently drawing extra duty or hazard pay? ☐ YES ☐ NO

Must be completed for all proposed insureds, including CIR.

	Yes	No
20. Has any person proposed for insurance:		
(a) Received treatment for drug or alcohol use or used marijuana or narcotic, hallucinogenic or habit-forming drugs not prescribed by a physician; or is any such person currently using marijuana or such drugs?	☐	☐
(b) 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?	☐	☐
(c) Been arrested for any reason other than moving traffic violations?	☐	☐
(d) Flown other than as a fare-paying passenger within the last two years, or contemplated such flying in the future? (If yes, complete Aviation Questionnaire.)	☐	☐
(e) 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.)	☐	☐
(f) Ever had an application for insurance or reinstatement of insurance declined, postponed, rated, or modified?	☐	☐
(g) Traveled or resided outside the U.S. or does any proposed insured intend to travel or reside outside the U.S.? (Note: travel or residence to certain locations may result in denial of coverage)	☐	☐

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

	Yes	No
21. Within the last ten years, has any person proposed for insurance ever had or been treated for:		
(a) Chest pain, heart murmur, stroke, high blood pressure, or any other disease of the heart, blood, or blood vessels?	☐	☐
(b) Peptic ulcer, indigestion, or any other disease of the stomach, intestines, gall bladder or liver?	☐	☐
(c) Emphysema, bronchitis, asthma, pleurisy, or any other disease of the chest or lungs?	☐	☐
(d) Kidney stone, diabetes; albumin, pus, blood or sugar in urine; venereal disease, or any other disease of the kidneys, bladder or reproductive organs?	☐	☐
(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?	☐	☐
(f) Severe headaches, fainting spells, epilepsy, paralysis, nervousness, mental disorder, or any other disease of the brain or nervous system?	☐	☐
(g) Any impairment of sight or hearing?	☐	☐
(h) Cancer, tumor, or any other illness or injury not mentioned above?	☐	☐
22. Other than indicated above, has any person proposed for insurance:		
(a) Ever applied for or received a pension or disability benefit, or currently disabled?	☐	☐
(b) Been hospitalized in the past 5 years?	☐	☐
(c) Consulted a physician during the past 5 years?	☐	☐
(d) Had a change of weight in the past year?	☐	☐
(e) Had an immediate family member with a history of cancer, diabetes, mental, nervous, heart or circulatory disorder? If yes, show age at onset, current age if living. If deceased, age at death.	☐	☐
23. Is any person proposed for insurance now under observation or taking treatment or been advised to have any tests, hospitalization, or surgery which has not been completed?	☐	☐

Details of questions answered "yes" in Section 20 through 23. Include question number, full names and addresses of physicians and names of individuals to whom history pertains.

Must be completed for all proposed insureds, including CIR.

24. 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

( )

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, 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 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.

NJ Residents: Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

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 Required in [AK, AZ, CA, ID, LA, NV, NM, TX, WA, AND WI]

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 Replacement Notice to the replacing 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.