# LifeShield National Insurance Co.

**Administrative Office: 815 W. Ash Ave., Duncan, Oklahoma 73533**

## Individual Whole Life Application - Survivor Life Application

**(If applying for Joint Life, please complete both Applicant 1 and Applicant 2 information)**

**Please Print Clearly**

| APPLICANT 1 | APPLICANT 2 |
|---|---|
| Proposed Insured's Name:<br>First Middle Last | Proposed Insured's Name:<br>First Middle Last |
| Address<br>City State Zip Code | Address<br>City State Zip Code |
| Home Phone: ( )<br>Cell Phone: ( ) | Home Phone: ( )<br>Cell Phone: ( ) |
| Email Address:_____ | Email Address:_____ |
| Sex: ☐ M ☐ F<br>Date of Birth / /<br>Height:<br>Weight: | Sex: ☐ M ☐ F<br>Date of Birth / /<br>Height:<br>Weight: |
| Social Security Number - -<br>State or Country of Birth:<br>Occupation: | Social Security Number - -<br>State or Country of Birth:<br>Occupation: |
| _____ %<br>Primary Beneficiary 1 Relationship<br>_____ %<br>Primary Beneficiary 2 Relationship | _____ %<br>Primary Beneficiary 1 Relationship<br>_____ %<br>Primary Beneficiary 2 Relationship |
| _____ %<br>Contingent Beneficiary 1 Relationship<br>_____ %<br>Contingent Beneficiary 2 Relationship | _____ %<br>Contingent Beneficiary 1 Relationship<br>_____ %<br>Contingent Beneficiary 2 Relationship |
| Do you have any existing life insurance or annuity contract(s) with the company or any other company? ☐ Yes ☐ No | Do you have any existing life insurance or annuity contract(s) with the company or any other company? ☐ Yes ☐ No |
| Do you intend to replace or change any existing life insurance or annuity contract: ☐ Yes ☐ No If "Yes," complete section below | Do you intend to replace or change any existing life insurance or annuity contract: ☐ Yes ☐ No If "Yes," complete section below |
| Existing Coverage Insurer's Name:<br>Policy/Certificate Number:<br>Termination Date:<br>Benefit Amount: | Existing Coverage Insurer's Name:<br>Policy/Certificate Number:<br>Termination Date:<br>Benefit Amount: |
| Within the past 12 months, have you used tobacco in any form (including Marijuana, Vapes, or E-cigs)?<br>☐ Yes ☐ No | Within the past 12 months, have you used tobacco in any form (including Marijuana, Vapes, or E-Cigs)?<br>☐ Yes ☐ No |

**If any question in Section A is answered "Yes", the proposed insured is not eligible for any coverage.**

| **Section A** | **Applicant 1** | **Applicant 2** |
|---|---|---|
| 1. Is the Proposed Insured currently a resident of a nursing home or skilled nursing facility; a patient in a hospital or psychiatric facility; confined to a correctional facility, receiving or been advised by a member of the medical professional to receive skilled nursing care, hospice care, or home health care within the past 5 years? | ☐ Yes ☐No | ☐Yes ☐No |
| 2. Has the Proposed Insured ever been diagnosed or treated by a member of the medical profession for (including prescription medications) congestive heart failure, peripheral neuropathy, epilepsy, schizophrenia, ALS (Lou Gehrig's disease), or does the Proposed Insured have a cardiac defibrillator? | ☐ Yes ☐No | ☐Yes ☐No |
| 3. Has the Proposed Insured ever been diagnosed by a member of the medical profession with an un-operated aneurysm? | ☐ Yes ☐No | ☐Yes ☐No |
| 4. Has the Proposed Insured ever been diagnosed or treated by a member of the medical profession for Alzheimer's disease or dementia or been prescribed Aricept, Cognex, Donepezil, Exelon, Razadyne, or Namenda? | ☐ Yes ☐No | ☐Yes ☐No |
| 5. Has the Proposed Insured ever been diagnosed or treated by a member of the medical profession for Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC), or tested positive for the Human Immunodeficiency Virus (HIV)? | ☐ Yes ☐No | ☐Yes ☐No |
| 6. Does the Proposed Insured use a wheelchair, or does the Proposed Insured require assistance (from anyone) with Activities of Daily Living: bathing, dressing, eating, toileting, walking, moving about, getting in or out of bed or chairs or taking medication? | ☐ Yes ☐No | ☐Yes ☐No |
| 7. Has the Proposed Insured ever been diagnosed or treated by a member of the medical profession for internal cancer or melanoma? | ☐ Yes ☐No | ☐Yes ☐No |
| 8. Has the Proposed Insured ever been diagnosed, treated for (including prescription medications), or advised to receive treatment by a member of the medical profession for Parkinson's disease, multiple sclerosis, lupus, liver failure, Hepatitis C, cirrhosis of the liver, or kidney disease requiring dialysis? | ☐ Yes ☐No | ☐Yes ☐No |
| 9. Has the Proposed Insured ever had or been advised by a member of the medical profession to have an organ transplant or bone marrow transplant? | ☐ Yes ☐No | ☐Yes ☐No |
| 10. Has the Proposed Insured been diagnosed or treated by a member of the medical profession for diabetes and use or been advised by a member of the medical profession to use insulin; or has the Proposed Insured ever had an amputation due to diabetes or other disease? | ☐ Yes ☐No | ☐Yes ☐No |
| 11. Within the past 24 months, has the Proposed Insured had any diagnostic testing excluding those related to the Human Immunodeficiency Virus (AIDS virus) or any medical procedure recommended by a member of the medical profession that hasn't been completed, or test results excluding those related to the Human Immunodeficiency Virus (AIDS virus) the Proposed Insured hasn't yet received? | ☐ Yes ☐No | ☐Yes ☐No |
| 12. Within the past 12 months, has the Proposed Insured been diagnosed, hospitalized, treated or advised by a member of the medical profession to have treatment for (including prescription medications): heart attack, stroke or Transient Ischemic Attack (TIA), aneurysm, angina pectoris, any cardiovascular surgery, or has the Proposed Insured been advised by a member of the medical profession to have an implanted pacemaker? | ☐Yes ☐No | ☐Yes ☐No |
| 13. Within the past 12 months, has the Proposed Insured used or been advised by a member of the medical profession to use **OXYGEN** in connection with treatment for Chronic Obstructive Pulmonary Disease (COPD), Chronic bronchitis, emphysema, asthma or other lung disease? | ☐Yes ☐No | ☐Yes ☐No |
| 14. Within the past 12 months, has the Proposed Insured been treated for or advised by a member of the medical profession to receive treatment for alcohol or drug use? | ☐Yes ☐No | ☐Yes ☐No |
| 15. Is the Proposed Insured under age 65 AND receiving social security disability benefits? | ☐ Yes ☐No | ☐Yes ☐No |
| 16. Within the past 12 months, has the Proposed Insured CHEWED TOBACCO, or SMOKED AND been diagnosed, treated (including prescription medications) or advised by a member of the medical profession to have treatment for Heart Disease, Chronic Obstructive Pulmonary Disease (COPD), Chronic bronchitis, emphysema, asthma or other lung disease? | ☐ Yes ☐No | ☐Yes ☐No |
| 17. Does your weight fall outside the guidelines for your height on the Weight Table below? | ☐Yes ☐No | ☐Yes ☐No |

**Weight Table**

| HGT | 4'11 | 5'0 | 5'1 | 5'2 | 5'3 | 5'4 | 5'5 | 5'6 | 5'7 | 5'8 | 5'9 | 5'10 | 5'11 | 6'0 | 6'1 | 6'2 | 6'3 | 6'4 | 6'5 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Min | 88 | 90 | 93 | 95 | 98 | 101 | 104 | 106 | 110 | 113 | 117 | 120 | 125 | 129 | 133 | 136 | 140 | 143 | 148 |
| Max | 206 | 213 | 220 | 227 | 234 | 241 | 248 | 256 | 263 | 271 | 279 | 287 | 295 | 303 | 312 | 320 | 329 | 337 | 346 |

*** If all questions in Section A are answered "NO", proceed to Section B**

**If all questions in Section A are answered "NO", and any question in Section B is answered "Yes", the Proposed Insured is only eligible for the Graded Death Benefit, Form Number ICC16 LN-1001 GDB.**

| **Section B** | **Applicant 1** | **Applicant 2** |
|---|---|---|
| 1. Within the past 24 months was the Proposed Insured diagnosed, treated for, or advised by a member of the medical profession to receive treatment for heart attack, stroke, Transient Ischemic Attack (TIA), aneurysm, angina pectoris, or any cardiovascular surgery? | ☐ Yes ☐ No | ☐ Yes ☐ No |
| 2. Within the past 24 months were you diagnosed, treated for (including prescription medications and inhalers), or advised to receive treatment by a member of the medical profession for Chronic bronchitis, emphysema, asthma, Chronic Obstructive Pulmonary Disease (COPD), or any other lung disease or disorder? | ☐ Yes ☐ No | ☐ Yes ☐ No |
| 3. Within the past 24 months was the Proposed Insured diagnosed, treated for, or advised by a member of the medical profession to receive treatment for liver disorder or kidney disease without dialysis? | ☐ Yes ☐ No | ☐ Yes ☐ No |
| 4. Within the past 24 months has the Proposed Insured had or been advised by a member of the medical profession to receive treatment for alcohol and/or drug use? | ☐ Yes ☐ No | ☐ Yes ☐ No |
| 5. Within the past 24 months did the Proposed Insured receive treatment by a member of the medical profession or have a surgery for an aneurysm? | ☐ Yes ☐ No | ☐ Yes ☐ No |
| 6. Does the Proposed Insured have a pacemaker that was implanted more than 12 months prior to the date of the application? | ☐ Yes ☐ No | ☐ Yes ☐ No |

**If all questions in sections A and B are answered "No", the proposed insured qualifies for the Survivor Level Benefit Plan, Form Number LN-1001.**

**Please list all physicians and hospitals used by the applicant(s) in the last 24 months:**

| **Applicant Name** | **Physician/Hospital Name** | **Address** | **Phone Number** |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

**1. Owner** (Complete only if other than Proposed Insured)

| | | |
|---|---|---|
| Name:<br><br>First Middle Last | | |
| Address:<br><br>Street Address City State Zip Code | | |
| Phone Number:<br>( ) | Social Security Number:<br>/ / | Date of Birth:<br>/ /<br>MM/ DD /YYYY |
| Relationship to Insured: | | |

**2. Insurance Applied For**

**Policy Type:**

☐ LifeShield Individual Survivor (Level Benefit)

☐ LifeShield Individual Survivor (Graded Death Benefit)

☐ LifeShield Joint Survivor (Level Benefit)

☐ LifeShield Joint Survivor (Graded Death Benefit)

**Insurance Amount:** $ _____ **Initial Premium Amount:** $ _____

**Automatic selection and insurance amount adjustment** – Owner agrees that if: (i) selecting but not qualifying for, based on the information in this application, LifeShield Survivor (Level Benefit) the owner is instead automatically applying this application for LifeShield Survivor (Graded Death Benefit).

**Automatic premium loan provision elected?** ("Yes" or "No" must be selected) ☐ Yes ☐ No

If "Yes", overdue premium will be paid through a loan against, and for as long as there is, available cash value, if any. If "No", the certificate's Non-forfeiture provision will automatically apply, if premium is overdue at the end of the grace period, resulting in either reduced coverage or surrender.

**3. Settlement Options (Please select between Supplemental Income and One Time Payout.)**

**Supplemental Income:** Equal monthly payments for the number of months elected.

☐ $_____ in Monthly Income for _____ months.

**One Time Payout:** One lump sum payout of the death benefit.

☐ $_____ Death Benefit

*** Unless otherwise stated by the owner prior to the death of the Insured, the beneficiary at claim time can choose to have the face amount of the policy paid in cash or monthly income for selected monthly periods or combination of income and cash.**

**4. Payment Information**

Payor Name *(first, middle, last)* _____

Payor Address *(Street, City, State, Zip)* _____

Relationship if other than applicant _____

**First Premium Payment Provided by** ☐ Pre-Authorized Check (PAC) (Complete Payment Form)

**Subsequent Premium Payments Made by:** ☐ Pre-Authorized Check (PAC) (Complete Payment Form) ☐ Direct Bill

**Payment Mode:** ☐ Monthly (PAC Only) ☐ Quarterly ☐ Semi-Annual ☐ Annual

**Draft date being requested:** Draft on the _____ day (choose between 1st and 28th) of the month, beginning in _____(month and year).

**5. Agreements**

I, the proposed insured and/or owner, declare that I have reviewed all of the statements and answers as they pertain to me, and that they are true and complete to the best of my knowledge and belief. The statements and answers in this application are the basis for an insurance contract (defined as a policy), if any, issued by LifeShield National Insurance Co. A Material Misrepresentation, or untrue declaration, or failure to disclose all material facts, may result in loss of coverage or cancellation of the insurance contract. No producer, medical examiner, or any other person, except LifeShield National Insurance Co.'s President or Vice-President, has power on behalf of LifeShield National Insurance Co. to make, modify, or discharge an insurance contract. No person is authorized to advise me that any untrue or incomplete answer or information is acceptable. LifeShield National Insurance Co. will have no liability until the policy date of the policy issued based on this application, the first premium due is paid in full on the policy date, and provided that there has been no change in either an answer to an application question or the proposed insured's health between the date this application was signed and the policy date of the insurance contract. This application shall form part of the entire contract with LifeShield National Insurance Co. This application and related documents may be sent by electronic means. If I have chosen to provide an email address in this application or choose to provide one in the future. LifeShield National Insurance Co. may use that address to send messages or documents to me electronically. LifeShield National Insurance Co. may require and obtain information about me to validate my identification.

**FRAUD NOTICE/WARNING: Any person who knowingly presents a false statement in an application for insurance may be guilty of a criminal offense and subject to penalties under state law.**

## 6. Authorization to Obtain and Disclose Information

"Authorized persons" means reinsurers, insurance agents and agencies and those performing services in relation to an application for insurance, insurance product or benefit claim. For purposes of assessing insurance coverage eligibility, coverage and/or benefit claim, I, the proposed insured, authorize LifeShield National Insurance Co. and its authorized persons, to obtain information, including previously restricted information, about me from any: physician, medical practitioner, hospital, clinic, or medical facility; employer, benefit plan, other insurer, or institution; consumer reporting agency; public records, pharmacy, pharmacy benefits manager, or other pharmacy related services organization; or MIB, Inc. This includes records or other information as to past, current, or future: diagnosis, treatment and prognosis of a physical or mental condition, drug, physical and mental health, and alcohol-related information that may be protected by federal or state laws and regulations. I, the proposed insured, authorize LifeShield National Insurance Co. and its authorized persons, to make a brief report of my personal and/or protected health information to MIB, Inc. Information may be disclosed: between and among LifeShield National Insurance Co. and its authorized persons; companies that I have applied or may apply to for life or health insurance, or benefits; as required or permitted by law. Obtained or disclosed information may no longer be protected by federal privacy laws. This authorization shall remain valid from the date this application is signed for the time limit permitted by the applicable law in the state where the policy is issued or delivered. A copy of this authorization shall be valid as the original. This authorization may be revoked at any time by written notice to LifeShield National Insurance Co., except that action(s) taken before receipt of notice will not be affected. A copy of this authorization will be provided upon request. I have been provided the Notices.

## 7. Signature Section (Review entire Application before signing)

**X** _____ Signed on: _____ Signed at: _____
Applicant 1's Signature | Date (mm/dd/yyyy) | (City, State)

**X** _____ Signed on: _____ Signed at: _____
Applicant 2's Signature | Date (mm/dd/yyyy) | (City, State)

**X** _____ Signed on: _____ Signed at: _____
Owner's Signature (If other than Proposed Insureds) | Date (mm/dd/yyyy) | (City, State)

## 8. Producer Certification

**I certify the following**: I am not aware of undisclosed information about the health, personal information, or lifestyle of the proposed insured(s) that might affect insurability. All questions, to which an answer is shown, were asked as written in this application, by me in person. The answers given by the proposed insured(s) were recorded as shown on this application which was reviewed with him/her before it was signed.

Producer's Full Name: _____ Producer's Number: _____

Producer's Signature: _____ Date: _____

## Notices

For purposes of these Notices the following words are defined: "Application" means the Application for Life Insurance to which this notice relates; "Producer" means the licensed individual who signed that application as the producer; "LifeShield National Insurance Co.", "we", "our", and "us" mean LifeShield National Insurance Co.; "You" and "Your" mean the proposed insured. If you have questions, discuss them with your producer or contact us directly by writing to LifeShield National Insurance Co. PO Box 1626, Duncan, OK 73534

Privacy - Personal information we obtain about you is confidential. As permitted by privacy laws, we may disclose information without further authorization to insurance companies to which you have applied for coverage or benefits, those providing services for us and those conducting bona fide actuarial, marketing or scientific studies or audits. We may also disclose information to your physician and MIB, Inc. ("MIB"). You can make a written request to review personal information about you in our file. However, we will not disclose information to you that was prepared for an anticipated claim, civil or criminal proceeding. You may request correction of information which you believe to be inaccurate or irrelevant. Upon written request, we will provide more information about these procedures.

Medical and Personal Information - The Underwriting process evaluates information about you to see if you qualify for the requested insurance. Answers in the Application are our principal source of information. We may contact other sources, such as a doctor, clinic, hospital, other insurers, or a lending institution. No adverse underwriting decision will be made based upon an individual's implied or confirmed sexual orientation or an individual's concern or consultation for AIDS information.

MIB PRE-NOTICE - Information regarding your insurability will be treated as confidential. LifeShield National Insurance Co., or its reinsurers, may, however, make a brief report thereon to the MIB, Inc., a non-profit membership organization of life insurance companies, which operates an information exchange on behalf of its members. If you apply to another MIB, Inc. member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, the MIB, Inc., upon request, will supply such company with the information in its file. Upon receipt of a request form from you, MIB, Inc. will arrange disclosure of any information it may have in your file. Please contact MIB, Inc. at 866-692-6901 (TTY 866-346-3642). If you question the accuracy of information to the MIB, Inc.'s file, you may contact MIB, Inc. and seek a correction in accordance with the procedures set forth in the federal Fair Credit Reporting Act. The address of MIB, Inc.'s information office is 50 Braintree Hill Park, Suite 400, Braintree, Massachusetts 02184-8734. Information for consumers about MIB, Inc. may be obtained on its website at: www.mib.com. LifeShield National Insurance Co., or its reinsurers, may also release information in its file to other life insurance companies to whom you may apply for life or health insurance, or to whom a claim for benefits may be submitted.


**Administrative Office: 815 W Ash, Duncan, OK 73533**
**US Mailing Address: PO Box 1627, Duncan, OK 73534-1627**
**1-800-366-8354**

## Acknowledgement of First Premium (This page must be given to the owner.)

It is acknowledged that an amount of $_____ will be provided as the 1st premium payment for the policy issued, if any, in response to the Application for Life insurance on the life of_____.
Proposed insured's Name

There is no conditional or temporary insurance coverage as no amount was provided or collected for the initial premium.

Insurance will only come into effect on the policy date of the policy issued, if any, and subject to the terms of that policy, provided a) that first premium payment is honored when presented to the financial institution from which it is to be collected, and b) that there has been no change in either an answer to the application questions or the proposed insured's health or habits between the date the application was signed and the policy date of that insurance contract.

Producer's signature: X_____ Date (mm/dd/yyyy) _____

Applicant 1's signature: X_____ Date (mm/dd/yyyy) _____

Applicant 2's signature: X_____ Date (mm/dd/yyyy) _____

**Call 1-800-366-8354 if you have not received your LifeShield National Insurance Co. policy within 30 days from the date of this receipt.**

**PRE-AUTHORIZATION AGREEMENT FOR ELECTRONIC FUNDS TRANSFER**

**LIFESHIELD NATIONAL INSURANCE CO.®**

*THIS FORM MUST BE COMPLETELY FILLED OUT TO BE ACCEPTED*

| Proposed Insured's Name | Policy Number(Home Office Only) |
|---|---|
| | |

If the account to be drafted is a Dedicated (Checking or Savings) or Savings account, fill in the shaded boxes. If this is a **Personal/Business Checking Account, you must attach a voided check for processing.** Staple voided checks on the box below.

| SEG Name(Selected Employer Group) if applicable: | |
|---|---|
| Name of Financial Institution | |
| Address & Phone Number of Financial Institution | |
| Transit No. & Routing | Savings or Dedicated Account No. |

Bank account is (Check appropriate box)

☐ Personal checking account
☐ Personal savings account
☐ Corporate/Business checking account
☐ Dedicated Draft checking account
☐ Dedicated Share savings account

Purpose for submitting this authorization (Check appropriate box/boxes):

☐ New pre-authorized payment plan
☐ Change in checking account
☐ Change in savings account
☐ Change in Dedicated account noted above
☐ Change in bank
☐ Addition of new policy to plan
☐ Change in existing coverage

Desired date for withdrawal from checking/savings account.(Any date between the 1st and 28th of each month) _____

**TOTAL AMOUNT OF PAYMENT FOR THIS POLICY $_____**

Withdraw My Payment: ____ Monthly ____ Quarterly ____ Semi-Annually ____ Annually

**APPLICANT INFORMATION FOR FINANCIAL INSTITUTIONS:**

As a convenience to me, I hereby request and authorize you to pay and charge to my account, drafts drawn on my account by and payable to LifeShield National Insurance Co. provided there are sufficient funds in said account to pay the same on presentation. Such drafts will bear my printed name. This authorization shall remain in effect until revoked by me in writing, and until you actually receive such notice. I agree that you shall be fully protected in honoring any such draft. I agree that your rights in respect to any such draft shall be the same as if it were a check signed personally by me. I further agree that if any such draft is dishonored, whether intentionally or inadvertently, you shall be under no liability whatsoever even though such dishonor results in the forfeiture of insurance.

**APPLICANT INFORMATION FOR LIFESHIELD NATIONAL INSURANCE CO.®:**

It is understood that the drafts will be drawn on or about the requested date each month. The presentation of such drafts to the above Financial Institution shall constitute notice of premiums being due upon the contract, and no other notice of premiums due will be given. No premium shall be deemed to have been paid unless and until actual payment of the draft drawn for such premium payment has been received by LifeShield. The cancelled draft will constitute receipt of premium payment. The privilege of paying premiums under this Plan may be revoked by LifeShield if any draft is not paid upon presentation. The payment of premiums under this Plan may be terminated by the Contract Owner, Financial Institution Depositor if other than Contract Owner, or by LifeShield upon 30 days written notice.

| Print name as it appears on account | Date |
|---|---|
| Signature of depositor | |

# LifeShield National Insurance Co.

Administrative Office: 815 W. Ash Ave, Duncan, Oklahoma, 73533
1-800-366-8354

## NOTICE REGARDING REPLACEMENT
## REPLACING YOUR LIFE INSURANCE POLICY

Are you thinking about buying a new life insurance policy and discontinuing or changing an existing one? If you are, your decision could be a good one—or a mistake. You will not know for sure unless you make a careful comparison of your existing benefits and the proposed benefits.

Make sure you understand the facts. You should ask the company or agent that sold you your existing policy to give you information about it. You are urged not to take action to terminate, assign or alter your existing life insurance coverage until you have been issued the new policy, examined it and have found it acceptable.

Hear both sides before you decide. This way you can be sure you are making a decision that is in your best interest.

**IF YOU SHOULD FAIL TO QUALIFY FOR THE LIFE INSURANCE FOR WHICH YOU HAVE APPLIED, YOU MAY FIND YOURSELF UNABLE TO PURCHASE OTHER LIFE INSURANCE OR ABLE TO PURCHASE IT ONLY AT SUBSTANTIALLY HIGHER RATES**.

We are required by law to notify your existing company that you may be replacing their policy.

| _____ | _____ | _____ |
|---|---|---|
| Applicant's Signature | Date | Agent's Signature |

Original - Send to Home Office with Application  Copy – Leave with Applicant

# LifeShield National Insurance Co.

Administrative Office: 815 W. Ash Ave, Duncan, Oklahoma, 73533
1-800-366-8354

## NOTICE REGARDING REPLACEMENT
## REPLACING YOUR LIFE INSURANCE POLICY

Are you thinking about buying a new life insurance policy and discontinuing or changing an existing one? If you are, your decision could be a good one—or a mistake. You will not know for sure unless you make a careful comparison of your existing benefits and the proposed benefits.

Make sure you understand the facts. You should ask the company or agent that sold you your existing policy to give you information about it. You are urged not to take action to terminate, assign or alter your existing life insurance coverage until you have been issued the new policy, examined it and have found it acceptable.

Hear both sides before you decide. This way you can be sure you are making a decision that is in your best interest.

**IF YOU SHOULD FAIL TO QUALIFY FOR THE LIFE INSURANCE FOR WHICH YOU HAVE APPLIED, YOU MAY FIND YOURSELF UNABLE TO PURCHASE OTHER LIFE INSURANCE OR ABLE TO PURCHASE IT ONLY AT SUBSTANTIALLY HIGHER RATES**.

We are required by law to notify your existing company that you may be replacing their policy.

| _____ | _____ | _____ |
|---|---|---|
| Applicant's Signature | Date | Agent's Signature |

Original - Send to Home Office with Application  Copy – Leave with Applicant

## LifeShield National Insurance Co.

## Effect of Accelerated Benefit Payment on Other Benefit Provisions

(a) Description of Benefit: Upon determining that, with reasonable medical certainty, a medical condition will result in the death of the Insured within 12 months or less, we will provide an accelerated death benefit. The amount of accelerated benefit provided shall be as requested by the Owner. The benefit may be up to 100% of the then current policy face amount, subject to a maximum of $100,000, limited to the actual death benefit payable at the time the request is made.

(b) Description of all Qualifying Events: The only qualifying event is that a physician states with reasonable medical certainty that a medical condition will result in the death of the Insured within 12 months or less from the date of the physician's statement. This statement must take into consideration the ordinary and reasonable medical care, advice and treatment available in the same or similar communities.

(c) Cost of Benefit: There is no separate premium for this Benefit, but the Benefit will be discounted for 12 months' interest. The interest rate used in the calculation will be the greater of: (a) The current yield on 90-day treasury bills available on the date of the request, and (b) The current maximum adjustable policy loan interest rate based on the Moody's Corporate Bond Yield Averages – Monthly Average Corporates, for the calendar month ending two months before the date of request and there will also be an administrative charge of not more than $100.

(d) Description of the Effects on the Remaining Policy: The face amount, guaranteed cash value, actual cash value and gross premium will be reduced by the benefit ratio times the respective amounts. **Benefit Ratio** means the result of dividing the requested accelerated death benefit by the policy face amount. Any outstanding loan and loan interest will be reduced by the portion repaid by any benefit payment under this rider. Any portion of the policy face amount remaining after payment of a benefit and related charges or interest will be paid upon the death of the insured subject to the terms and conditions of your policy.

(e) An administrative expense charge and an interest charge may apply at the time of acceleration.

(f) The acceleration of life insurance benefits (ALBR) offered under this rider are intended to qualify for favorable tax treatment under the Internal Revenue Code of 1986. If the ALBR qualify for such favorable tax treatment, the benefits will be excluded from your income and not subject to federal taxation. Tax laws relating to ALBR are complex. Consult with a qualified tax advisor about circumstances under which you could exclude ALBR from income under federal law.

(g) There are circumstances when receipt of accelerated benefit payment may be taxable and assistance should be sought from a personal tax advisor.

(h) Receipt of accelerated benefits may adversely affect the recipient's eligibility for Medicaid or other government benefits or entitlements.

(i) Accelerated benefits do not and are not intended to qualify as long-term care insurance.

**SAMPLE ACCELERATED DEATH BENEFIT CALCULATION**

If the request for the Accelerated Benefit payment is approved and paid:

- The death benefit, the Policy's base premium, the cash value, and any Policy loans will be reduced on a pro-rata basis.
- The payment will have the following effect on provisions of the policy:

| | **Before Accelerated Benefit Payment** | **After Accelerated Benefit Payment** |
|---|---|---|
| Death Benefit | $50,000 | $25,000 |
| Annual Base Premium for Policy: | $102.50 | $51.25 |
| Cash Value: | 6,200.00 | 3,100.00 |
| Policy Loan: | 3,000.00 | 1,500.00 |
| Accelerated Benefit Requested | $25,000.00 | *No longer in force* |
| *Less interest discount at 10%* | $2,272.73 | |
| *Less Administrative Charge* | $100.00 | |
| *Less Partial Policy Loan Payoff* | $1,500.00 | |
| *Net Payment* | $21,127.27 | |
| Annual Premium for Rider: | None | *No longer in force* |

**I acknowledge receipt of a copy of the Accelerated Death Benefit disclosure and sample illustration**.

_____ _____

Applicant's Signature Date

_____ _____

Agent's Signature Date

## LifeShield National Insurance Co.

## Effect of Accelerated Benefit Payment on Other Benefit Provisions

(a) Description of Benefit: Upon determining that, with reasonable medical certainty, a medical condition will result in the death of the Insured within 12 months or less, we will provide an accelerated death benefit. The amount of accelerated benefit provided shall be as requested by the Owner. The benefit may be up to 100% of the then current policy face amount, subject to a maximum of $100,000, limited to the actual death benefit payable at the time the request is made.

(b) Description of all Qualifying Events: The only qualifying event is that a physician states with reasonable medical certainty that a medical condition will result in the death of the Insured within 12 months or less from the date of the physician's statement. This statement must take into consideration the ordinary and reasonable medical care, advice and treatment available in the same or similar communities.

(c) Cost of Benefit: There is no separate premium for this Benefit, but the Benefit will be discounted for 12 months' interest. The interest rate used in the calculation will be the greater of: (a) The current yield on 90-day treasury bills available on the date of the request, and (b) The current maximum adjustable policy loan interest rate based on the Moody's Corporate Bond Yield Averages – Monthly Average Corporates, for the calendar month ending two months before the date of request and there will also be an administrative charge of not more than $100.

(d) Description of the Effects on the Remaining Policy: The face amount, guaranteed cash value, actual cash value and gross premium will be reduced by the benefit ratio times the respective amounts. **Benefit Ratio** means the result of dividing the requested accelerated death benefit by the policy face amount. Any outstanding loan and loan interest will be reduced by the portion repaid by any benefit payment under this rider. Any portion of the policy face amount remaining after payment of a benefit and related charges or interest will be paid upon the death of the insured subject to the terms and conditions of your policy.

(e) An administrative expense charge and an interest charge may apply at the time of acceleration.

(f) The acceleration of life insurance benefits (ALBR) offered under this rider are intended to qualify for favorable tax treatment under the Internal Revenue Code of 1986. If the ALBR qualify for such favorable tax treatment, the benefits will be excluded from your income and not subject to federal taxation. Tax laws relating to ALBR are complex. Consult with a qualified tax advisor about circumstances under which you could exclude ALBR from income under federal law.

(g) There are circumstances when receipt of accelerated benefit payment may be taxable and assistance should be sought from a personal tax advisor.

(h) Receipt of accelerated benefits may adversely affect the recipient's eligibility for Medicaid or other government benefits or entitlements.

(i) Accelerated benefits do not and are not intended to qualify as long-term care insurance.

**SAMPLE ACCELERATED DEATH BENEFIT CALCULATION**

If the request for the Accelerated Benefit payment is approved and paid:

- The death benefit, the Policy's base premium, the cash value, and any Policy loans will be reduced on a pro-rata basis.
- The payment will have the following effect on provisions of the policy:

| | **Before Accelerated Benefit Payment** | **After Accelerated Benefit Payment** |
|---|---|---|
| Death Benefit | $50,000 | $25,000 |
| Annual Base Premium for Policy: | $102.50 | $51.25 |
| Cash Value: | 6,200.00 | 3,100.00 |
| Policy Loan: | 3,000.00 | 1,500.00 |
| Accelerated Benefit Requested | $25,000.00 | *No longer in force* |
| *Less interest discount at 10%* | $2,272.73 | |
| *Less Administrative Charge* | $100.00 | |
| *Less Partial Policy Loan Payoff* | $1,500.00 | |
| *Net Payment* | $21,127.27 | |
| Annual Premium for Rider: | None | *No longer in force* |

**I acknowledge receipt of a copy of the Accelerated Death Benefit disclosure and sample illustration**.

_____ _____

Applicant's Signature Date

_____ _____

Agent's Signature Date