Application

for

Individual Life Insurance

Use for all fully underwritten life products

Do not use for Workplace products
FAIR CREDIT REPORTING ACT

In compliance with 15 USC 1681 et. seq., this notice is to inform you that:

In making this application for insurance it is understood that an investigative consumer report may be made whereby information is obtained through personal interviews with third parties, such as family members, business associates, financial sources, friends, neighbors or others with whom you are acquainted. This inquiry includes information as to your character, general reputation, personal characteristics and mode of living, whichever may be applicable. You have the right to make a written request to EMC National Life Company, PO Box 9144, Des Moines, IA 50306-9144, within a reasonable period of time for a complete and accurate disclosure of additional information concerning the nature and scope of the investigation.

NOTIFICATION REGARDING THE MIB, INC.

Information regarding your insurability will be treated as confidential. EMC National Life Company or its reinsurer(s) may, however, make a brief report thereon to MIB, Inc., a not-for-profit membership organization of insurance companies, which operates an information exchange on behalf of its Members. If you apply to another MIB Member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, MIB, upon request, will supply such company with the information about you in its file.

Upon receipt of a request from you, MIB will arrange disclosure of any information in your file. Please contact MIB at 866-692-6901. If you question the accuracy of the information in MIB’s file, you may contact MIB and seek a correction in accordance with the procedures set forth in the federal Fair Credit Reporting Act. The address of MIB’s information office is 50 Braintree Hill Park, Suite 400, Braintree, Massachusetts 02184-8734.

EMC National Life Company or its reinsurer(s) may also release information from its file to other insurance companies to whom you may apply for life or health insurance, or to whom a claim for benefits may be submitted. Information for consumers about MIB may be obtained on its website at www.mib.com.

CONDITIONAL COVERAGE RECEIPT

RECEIVED FROM ___________________________, this _________ day of ___________ the sum of $ ____________, subject to the terms and conditions of the policy, as full (check one) □ annual □ semiannual □ quarterly □ check plan premium, along with the application bearing the date of this Receipt, for coverage on __________________________, the Proposed Insured(s).

TERMS AND CONDITIONS

“Effective Date” as used herein means the later of a) the date the application is signed; b) the date of completion of all medical examinations, if required; or c) the requested Effective Date shown on the application.

Coverage may become effective prior to the policy delivery if and when all of the following conditions are met:

1. The amount of the payment is equal to the first full premium selected and the payment is taken with the application;
2. The Proposed Insured(s) must be, on the Effective Date as defined above, a risk acceptable to EMC National Life Company under its rules, standards and practices for the exact contract of insurance and premium applied for, without any modifications; and
3. The contract is issued exactly as applied for within 60 days from the date of the application. If the application is declined or disapproved or if the contract is not issued within 60 days from the date of application, then this condition has not been fulfilled, no coverage is or has been provided under the terms of this Conditional Receipt, and any premium paid will be returned.
4. The maximum amount of coverage which may become effective under this Conditional Receipt, including any Riders applied for, cannot exceed $250,000.

If any of the above conditions are not met, there shall be no liability on the part of EMC National Life Company except to return the premiums collected with the application.

This Receipt shall be rendered void if it is modified or altered, or if a check or draft given in payment is not honored. No agent or broker of EMC National Life Company, PO Box 9144, Des Moines, IA 50306-9144, is authorized to waive or alter any of the above conditions.

X Applicant’s Signature X Agent’s Signature X Date

ALL PREMIUM CHECKS OR DRAFTS MUST BE MADE PAYABLE TO EMC NATIONAL LIFE COMPANY.
DO NOT MAKE CHECKS PAYABLE TO THE AGENT. DO NOT LEAVE THE PAYEE BLANK.
# INDIVIDUAL LIFE INSURANCE APPLICATION

**PRINT IN BLACK INK**

### 1. Proposed Insured Name

<table>
<thead>
<tr>
<th>Proposed Insured Name (First, M.I., Last)</th>
<th>Age</th>
<th>Birthdate Mo-Day-Yr</th>
<th>Birth State</th>
<th>Social Security / TIN #</th>
<th>Driver’s License #</th>
<th>Sex</th>
<th>Height</th>
<th>Weight</th>
</tr>
</thead>
<tbody>
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</table>

**COMPLETE FOR FAMILY / BUSINESS COVERAGE**

- **Spouse / Other Insured Name**
  - SS#
  - DL#

- **Child / Other Insured Name**
  - SS#
  - DL#

- **Child / Other Insured Name**
  - SS#
  - DL#

**Mailing Address:**

- Address
- City
- State
- Zip

Proposed Insured’s phone numbers (include area codes):

- Home (_____)_________
- Business / Cell (_____)_________

If we need to contact you, we should call:

- Home
- Business / Cell

- Time ______________
- A.M.  P.M.

Are all Proposed Insureds U.S. citizens?  Yes  No

If no, provide details in Section 7 and send copy of permanent resident visa.

### 2. Beneficiary: Primary Applicant (If a trust is the beneficiary, record name and date of the trust.)

<table>
<thead>
<tr>
<th>Name (First, M.I., Last)</th>
<th>Birthdate</th>
<th>Social Security / TIN #</th>
<th>Relationship</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Primary</td>
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<tr>
<td>Contingent</td>
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</table>

**Beneficiary: Spouse / Other Insureds (If a trust is the beneficiary, record name and date of the trust.)**

<table>
<thead>
<tr>
<th>Name (First, M.I., Last)</th>
<th>Birthdate</th>
<th>Social Security / TIN #</th>
<th>Relationship</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Primary</td>
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<tr>
<td>Contingent</td>
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</tbody>
</table>

### 3. Owner (Complete only if Owner is other than Proposed Insured. If Joint Ownership, specify details in Section 7. If a trust is the owner, provide a copy of the trust.)

- **Name (First, M.I., Last) | Mailing Address | Birthdate | Soc. Sec. / TIN # | Relationship**

- First Owner

- Contingent
4. **Payor** (specify one):  
   - Insured  
   - Owner  
   - Other  

   If Other, provide:  
   - Full Name  
   - Address / City / State / Zip  
   - Relationship

5. **Additional Person to Receive Lapse Notification** (if desired):  

   Full Name  
   Address / City / State / Zip  
   Relationship

6. **Life Insurance / Annuities In Force** (List below, including any existing EMCNL policies.)  
   - Check if none in force  

<table>
<thead>
<tr>
<th>Person Insured</th>
<th>Company</th>
<th>Policy #</th>
<th>Life Amount</th>
<th>ADB</th>
<th>To Be Replaced</th>
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<tr>
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<td></td>
<td>Yes</td>
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<td>Yes</td>
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<td>Yes</td>
</tr>
</tbody>
</table>

Is this policy being purchased to replace any existing life insurance policy or annuity contract?  
   - Yes  
   - No  

If yes, complete any replacement form required by your state and send with the application.

7. **Special Requests:**  

8. **Life Plan:**  
   - Amount of Primary Coverage: $  

   Please use marketing name. See agent website or product guide for product options and rider specifications.

   **Term Life Options and Riders**  
   - Primary Insured Level Term for _______ Years  
   - Spouse / Other Insured Term Rider Amt. $ _______/_____ Years  
   - Disability Income Rider (must complete Section 14)  
   - Primary Insured Critical Illness Life Rider Amt. $ ____________ (must complete disclosure form)  
   - Spouse / Other Insured Critical Illness Life Rider Amt. $ ____________ (must complete disclosure form)  
   - Waiver of Premium  
   - Children’s Term Amt. $ ____________________  
   - Accidental Death Benefit Amt. $ ____________

   **Universal Life Options and Riders**  
   - Option 1 – Level Death Benefit  
   - Option 2 – Increasing Death Benefit  
   - Primary Insured Term Rider Amt. $ ____________ /_____ Years  
   - Spouse / Other Insured Term Rider Amt. $ _______/_____ Years  
   - Disability Income Rider (must complete Section 14)  
   - Primary Insured Critical Illness Life Rider Amt. $ ____________ (must complete disclosure form)  
   - Spouse / Other Insured Critical Illness Life Rider Amt. $ ____________ (must complete disclosure form)  
   - Waiver: (specify one)  
     - Monthly Deductions  
     - Stipulated Amt. $ ____________  
     - Minimum Premium  
   - Children’s Term Amt. $ ____________________  
   - Accidental Death Benefit Amt. $ ____________

   **Whole Life Options and Riders**  
   - Level Whole Life  
   - Single Premium  
   - 5-Pay  
   - Continuous Pay  
   - Increasing Whole Life  
   - Primary Insured Term Rider Amt. $ ____________ /_____ Years (available on continuous pay only)  
   - Spouse / Other Insured Term Rider Amt. $ ____________ /_____ Years (available on continuous pay only)  
   - Disability Income Rider (must complete Section 14) (available on continuous pay only)  
   - Primary Insured Critical Illness Life Rider Amt. $ ____________ (must complete disclosure form)(available on continuous pay only)  
   - Spouse / Other Insured Critical Illness Life Rider Amt. $ ____________ (must complete disclosure form) (available on continuous pay only)  
   - Waiver of Premium (available on continuous pay only)  
   - Children’s Term Amt. $ __________________ (available on continuous pay only)  
   - Accidental Death Benefit Amt. $ ____________ (available on continuous pay only)  
   - Additional Paid-Up Insurance Rider Amt. $ ____________ (available on Level Whole Life continuous pay only)
9. Premium Options

Mode: ☐ Annual ☐ Semiannual ☐ Quarterly ☐ Monthly (not available on Direct Bill) ☐ Single Premium
Form: ☐ Check Plan ☐ Direct Bill ☐ List Bill ☐ ABS# _______________________

Premium: Planned Periodic $ __________ Extra Single / Lump Sum $ ________Estimated 1035 / Lump Sum $ ________
Amount Paid with Application $ __________________

10. Has any person proposed for coverage: Yes No
   A. Have any other application for personal insurance pending? ................................................................. ☐ ☐
   B. Applied for life, health, or disability insurance or reinstatement which was declined, postponed, rated, restricted or modified? ................................................................. ☐ ☐
   C. Engaged in aviation activity other than as a passenger? (If yes, complete 1, 2, 3, 4, 5 and 6.)............. ☐ ☐
      (1) Number of hours flown last 12 months __________
      (2) Number of hours contemplated over next 12 months __________
      (3) Total number of hours flown __________
      (4) License type ________________
      (5) Type of flying ________________
      (6) Instrument Flight Rating (IFR)? .............................................................................................................. ☐ ☐
   D. Engaged in ballooning, sky diving, hang gliding, rock or mountain climbing, rodeo competition, SCUBA diving (max. depth _________) or any form of organized motorized racing? Intentions to engage in such activities over next 12 months: activity ___________________________frequency________________ .... ☐ ☐
   E. Within the past 5 years, had a driver's license suspended or revoked for any reason, or been charged with or convicted of driving while intoxicated or under the influence of a controlled substance or with any moving violation involving a motor vehicle? (If yes, list below the name(s), date(s) and details.) ................................................................. ☐ ☐
   F. Have any charges pending, plead guilty or been convicted of or are awaiting trial for any crime other than a misdemeanor, including currently being on parole or probation? .......................................................................................................................... ☐ ☐
   G. Currently a member of the military, military reserve or National Guard, whether active or inactive, or has the Proposed Insured entered into a written agreement to enter the armed services? (If yes, list below name, branch, rank and duties.) ................................................................................................................................................................................................................................................................................................................. ☐ ☐
   H. Do you intend to travel outside the U.S. or Canada or change your country of residence in the next 24 months? (If yes, list countries, cities, duration and purpose of travel in the details section below.) ............................... ☐ ☐
   I. (1) Now use tobacco or any nicotine substitute? ............................................................................................. ☐ ☐
      (2) Ever used tobacco or any nicotine substitute? (If yes, provide date when stopped.) ______________________ .... ☐ ☐
      If yes to I. (1) or (2), indicate below name of person and type of tobacco or nicotine substitute used (cigarettes, pipe, cigar, chew, patch, gum, other).

Specify person's name and give details to all yes answers. Also, use this area to provide any other information.

11. Family History: Has any person proposed for coverage had a parent / sibling who was diagnosed with or died of heart disease, kidney disease, diabetes, cancer, stroke or other hereditary disease?

<table>
<thead>
<tr>
<th>Proposed Insured</th>
<th>Spouse / Other Insured</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age if Living</td>
<td>Age at Death / Cause or if Living, Age at Diagnosis / Cause</td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td>Father</td>
<td></td>
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<tr>
<td>Mother</td>
<td></td>
</tr>
<tr>
<td>Sibling</td>
<td></td>
</tr>
</tbody>
</table>

12. IMPORTANT! GIVE COMPLETE DETAILS ON NEXT PAGE FOR EACH “YES” ANSWER SPECIFYING TO WHOM MEDICAL HISTORY APPLIES, DATES AND RESULTS OF TREATMENT, DOCTORS AND COMPLETE ADDRESSES.

A. Has any person proposed for coverage had any diagnosis or treatment for: Yes No
   (1) High blood pressure, elevated cholesterol, chest pain or angina, heart attack, disease or disorder of the heart or heart valves, blood clot, blood vessels, stroke, Transient Ischemic Attack (mini stroke), speech defect or paralysis? ................................................................. ☐ ☐
   (2) Cancer, tumor, melanoma, basal or squamous cell carcinoma, abnormal moles or lesions, polyps, dysplastic nevi, leukemia or blood disorder? .......................................................................................................................... ☐ ☐
(3) Nervous, emotional or mental disorder, dementia or Alzheimer’s? ............................................................  
(4) Diabetes, disease or disorder of the pancreas, thyroid or other endocrine disorder? ...............................  
(5) Stomach or intestines, hepatitis, liver, kidney, bladder, genito-urinary organs or breast? ..........................  
(6) Asthma, sleep apnea, emphysema, chronic bronchitis, Chronic Obstructive Pulmonary Disease (COPD) or other lung disorder? ........................................................................................................  
(7) Epilepsy, brain or nervous system disorder? .................................................................................................  
(8) Been diagnosed as having or been treated for Human Immunodeficiency Virus (HIV), Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC) by a member of the medical profession? ..........  
(9) Been diagnosed as having or been treated for any immune deficiency disorder, autoimmune disorder, or muscle or connective tissue disease or disorder (not HIV related)? ..................................................................................................................................................  
(10) Except as prescribed by a physician, ever used marijuana, heroin, cocaine, barbiturates or other illegal drugs, joined any organization, received or had treatment or counseling for drug or alcohol abuse? .........................................................  

B. Is any person proposed for coverage taking prescription medication? ............................................................  

C. Within the past 5 years, has any Proposed Insured:
   (1) Been treated, examined or advised by a member of the medical profession? ............................................  
   (2) Been advised by a member of the medical profession to get specified medical care which was not completed, such as any hospitalization, surgery or diagnostic tests, except those tests related to the Human Immunodeficiency Virus (AIDS Virus)? ...........................................................................................  
   (3) Had diagnostic tests such as an electrocardiogram (EKG), x-ray or other diagnostic tests, except those tests related to the Human Immunodeficiency Virus (AIDS Virus)? ......................................................................  
   (4) Been a patient in a hospital, clinic or other medical facility? ..........................................................................................................................  

Give complete details below to all yes answers. Use box on page 3 if additional space is needed.

<table>
<thead>
<tr>
<th>Ques. #</th>
<th>Person’s Name</th>
<th>Dates</th>
<th>Symptom(s), Condition(s), Diagnosis</th>
<th>Treatment / Medication</th>
<th>Complete Name(s) &amp; Address(es) of Doctors, Hospitals or Clinics</th>
</tr>
</thead>
</table>

13. For each Proposed Insured, please provide:

<table>
<thead>
<tr>
<th>Individual Insured</th>
<th>Other Insured</th>
<th>Children</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name and Address of Personal Physician</td>
<td></td>
<td></td>
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<tr>
<td>Date and Reason Last Seen</td>
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<td></td>
</tr>
</tbody>
</table>

14. Disability Income Rider (Complete for each person applying for the Disability Income Rider.)
   A. Name of each person proposed for Rider coverage: _______________________     _______________________
   B. Monthly benefit amount applied for: Primary Insured $_________ Other Insured $_________
   C. Elimination Period (select 30, 60 or 90 days)
      Primary Insured: ☐ 30 days ☐ 60 days ☐ 90 days  Other Insured: ☐ 30 days ☐ 60 days ☐ 90 days
   D. Has any person proposed for coverage:
      (1) Within the past 5 years, received Disability, Workers’ Comp. or Pension Benefits? .................................... ☐ ☐
      (2) Within the past 5 years, received medical care for the muscles, bones, joints, including but not limited to the neck, back, spine, feet or nerve disorder or treatment of muscular or neuromuscular disorders?............. ☐ ☐
      (3) Within the past 5 years, received treatment or been diagnosed with arthritis, gout, bursitis or rheumatism? .... ☐ ☐
      (4) Had any physical or occupational therapy or had therapy recommended? .................................................. ☐ ☐
      (5) Had any prior complications of pregnancy or currently pregnant? .......................................................... ☐ ☐
E. Is each person proposed for coverage actively at work now and worked at least 30 hours a week for the last 3 months except for minor illnesses of one week or less or pregnancy? .................................................. □ □

F. Any other disability income policies in force? (Note: You do not need to include short-term disability policies of 26 weeks or less.) ........................................................................................................................... □ □

1) If yes, for every person proposed for coverage, note the amount of monthly coverage for each policy $_________ and maximum benefit periods __________.

2) If yes, is this coverage being purchased to replace any existing disability income coverage? ................................................................. □ □

G. Describe employment duties below for each person proposed for Rider coverage (what you do, types of machines used).

Specify person’s name and give details to all yes answers. Specify employment duties.

15. Taxpayer Identification Certification. Per Internal Revenue Service guidelines, use this area to report and certify the taxpayer identification number (typically this is your social security number or an employer identification number) of the owner of the policy.

Under penalties of perjury, by my signature on this form below, I certify that:

1. The number shown on this form on page 1 is my correct taxpayer identification number; and

2. I am not subject to backup withholding either because: (a) I am exempt from backup withholding, or (b) I have not been notified by the Internal Revenue Service (IRS) 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; and

3. I am a U.S. person (including a U.S. resident alien).

Note: You must cross out item 2 above if you have been notified by the IRS that you are currently subject to backup withholding because you have failed to report all interest and dividends on your tax return.

16. Statements and Agreements of All Applicants Undersigned Below

I understand all of the questions that I have read on this application. I am not currently taking and I am not under the influence of any medications or drugs that would affect my ability to fully understand and to fully and accurately complete this application.

All of the statements and answers in this application for life insurance are true and complete to the best of my knowledge and belief. I agree that this application will be the basis for, and will become part of, any policy that is issued by EMC National Life Company (the Company) and that no information about me will be considered to have been given to the Company unless it is stated in the application. I agree that the Effective Date of the policy and any insurance coverage are subject to the terms of the Conditional Coverage Receipt. I understand that the agent has no authority to approve the application, change the policy or waive any policy provisions. I understand no insurance will be effective until the date stated in the policy and all eligibility requirements are met. I am not being paid cash and have not been promised services as an inducement to enter into this application. The purpose of this application is not to sell or assign it to any type of viatical settlement, senior settlement or life settlement company. I acknowledge receipt of a copy of the Fair Credit Reporting Act and MIB, Inc. notices.

Illustration Certification. Applicable to a policy with non-guaranteed elements where required by law: I understand and agree that if a sales illustration was not provided to me by the agent, a fully compliant illustration conforming to the policy as issued will be provided to me no later than at the time of policy delivery.

WARNING

Fraud Notice
Any person who knowingly submits a false statement in an application or files a claim containing false or deceptive statements may be guilty of insurance fraud and subject to penalties under state law.

I understand and acknowledge this Fraud Notice.

Misrepresentation Notice
If your answers to the questions in the application are incorrect or untrue, EMC National Life Company may deny coverage by voiding or canceling your policy and returning your premium payments to you or your estate. Be aware that voiding or canceling your policy may have an adverse impact to your intended beneficiary(ies).

I understand and acknowledge this Misrepresentation Notice. I agree that the information on this application will be relied on to determine insurability and that incorrect or untrue information may result in coverage being voided, subject to the Incontestability provision in the policy.

X Proposed Insured’s Signature

Signed at City / State Date

X Owner’s Signature

(if other than Proposed Insured)

X Spouse’s / Other Insured’s Signature

(if applying for coverage)

X Joint Owner’s Signature

(if any)
### Required Agent’s Report

<table>
<thead>
<tr>
<th>Question</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>A. Have you seen all persons proposed for coverage?</td>
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<tr>
<td>If not, please explain.</td>
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<tr>
<td>B. Have you accurately recorded information given to you by all persons proposed for coverage?</td>
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<tr>
<td>C. To the best of your knowledge, will the insurance applied for replace any existing annuity/life policy(ies)?</td>
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<tr>
<td>D. As applicable, have you given disclosure/replacement notices as required by your state?</td>
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<tr>
<td>E. As applicable, have you given the Conditional Coverage Receipt?</td>
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<tr>
<td>F. Were the notices regarding MIB, Inc. and the Fair Credit Reporting Act given?</td>
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<tr>
<td>G. Illustration Certification. Applicable to a policy with non-guaranteed elements where required by law:</td>
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<td></td>
</tr>
<tr>
<td>I understand and agree that if a sales illustration was not provided by me to the Proposed Insured, a fully compliant illustration conforming to the policy as issued will be provided no later than at the time of policy delivery.</td>
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<tr>
<td>H. Purpose of Insurance:</td>
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<tr>
<td>Personal</td>
<td>q</td>
<td>Business - (circle one) Keyman, Buy-Sell, Creditor</td>
</tr>
<tr>
<td>I. Please choose only one if medical exam is required:</td>
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<td></td>
</tr>
<tr>
<td>Exam ordered by agent: Date Ordered ______________</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Exam to be ordered by the Home Office</td>
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</tbody>
</table>

I certify to the best of my knowledge that all persons proposed for coverage or any person or entity are not being paid cash or promised services as an inducement to enter into this insurance transaction and that this insurance transaction will not be sold or assigned for any type of viatical settlement, senior settlement, life settlement or other secondary market.

**Additional certification when Agent did see all persons proposed for coverage:** I certify that I have verified the personal information of the applicant(s) by viewing state issued driver’s license, state issued I.D. card, military I.D. card, Permanent U.S. Resident Card (Green Card), passport or other government issued picture I.D. card. I further certify that all persons proposed for coverage appeared to me to be lucid and able to fully understand all of the questions on this application.

---

Agent’s Printed Name ____________________________________________________________________________________________________________  
Agent’s Signature (witness) X

Agent’s Contract # Commission % Date

Commission Split, if applicable:

Agent’s Name __________________________________________________________________________ Agent’s Contract # Commission %

---

**REQUIRED: Complete Page 7 – Authorization and Page 8 (if applicable) – Check Plan**
AUTHORIZATION TO OBTAIN AND DISCLOSE INFORMATION

Life Insurance Application

This Authorization Complies with the HIPAA Privacy Rule.

I (person(s) signed below) understand EMC National Life Company (EMCNL), its reinsurers, insurance support organizations (such as MIB, Inc. or any of its members or affiliates) and their authorized representative, may obtain medical and other information in order to evaluate my application for insurance. I authorize any Medical Providers, as described below, to disclose or release Protected Health Information, as described below, to EMC National Life Company, PO Box 9144, Des Moines, Iowa 50306-9144, or its authorized representative.

- Medical Providers: All physicians, medical or dental practitioners, hospitals, clinics, pharmacies, pharmacy benefit managers, other medical care facilities and all other providers of medical or dental services who have provided treatment or other health care services to me or on my behalf.

- Protected Health Information: Any and all records and health information within such Medical Person’s possession, such as medical history, entire medical records, mental, psychiatric (excluding psychotherapy notes) and physical condition, prescription drug records, tobacco, drug and alcohol use and any other protected health information concerning me. This includes information which may be considered to be a communicable or a sexually transmitted disease, which may include, but are not limited to diseases such as hepatitis, syphilis, gonorrhea, the Human Immunodeficiency Virus (HIV) and the Acquired Immune Deficiency Syndrome (AIDS).

In addition, I authorize the Veterans Administration, the MIB, Inc., my employer, consumer reporting agency, insurance company or other organization who possesses information, records or knowledge of me including information about drugs, alcoholism or mental illness, my health, other insurance coverage, employment, age, general character, finances or participation in hazardous activities to furnish such information to EMCNL, its reinsurers and their authorized representative upon presenting this authorization.

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 any Medical Provider to release and disclose my entire medical record without restriction.

The purpose of the release of the above information is for EMCNL to evaluate and underwrite an application for insurance coverage, to determine the rates and terms that apply to such insurance coverage, and/or to resolve any issues of incomplete, incorrect or misrepresented information on the application which may arise during the processing of the application.

I authorize EMCNL or its reinsurers to make a brief report of my Protected Health Information to MIB, Inc. EMCNL or its reinsurers may make a brief report regarding me or my children to other insurance companies to whom I have applied or may apply.

This authorization will remain in effect from the date signed below for a period of 24 months, and a copy of this authorization is as valid as the original. I understand that this authorization may be revoked at any time by sending written notice of such to EMCNL at the address above. The right to revoke this authorization is limited to the extent that EMCNL has taken action in reliance on the authorization or the law provides the Company with the right to contest a claim under the policy for which I have applied or to contest the policy itself. I understand that any information that is disclosed pursuant to this authorization may no longer be covered by federal rules governing privacy and confidentiality of health information, but it will not be redisclosed by the recipient except as authorized by me or as allowed by law.

I understand that my Medical Providers may not refuse to provide treatment or payment for health care services if I refuse to sign this authorization. I further understand that if I refuse to sign this authorization, EMCNL may not issue the insurance coverage for which I am applying or if coverage has been issued may not be able to make any benefit payments. I understand that any Personal Representative or I will receive a copy of this authorization upon request.

☐ I elect to be interviewed if any investigative consumer report is prepared in connection with this application.

Signature of Proposed Insured or Personal Representative

_________________________  ____________________________  _______________________
Printed Name                  Date

Signature of Spouse (if applying) or Personal Representative

_________________________  ____________________________  _______________________
Printed Name                  Date

Signature of Other Applicant (other than Proposed Insured or Spouse – if applying) or Personal Representative

_________________________  ____________________________  _______________________
Printed Name                  Date

Note: If the authorization is signed by a Personal Representative of an individual, a description of the Representative’s authority and relationship must be provided below.

Description of Personal Representative’s Authority and Relationship to the Individual
CHECK PLAN AUTHORIZATION (Complete if Paying by Check Plan.)

Name of Financial Institution

Name on the Account

City, State of Financial Institution

This must agree with the financial institution signature card. Include name of firm if checks are drawn on a business account.

TRANSIT NUMBER FIELD

ACCOUNT #

☐ Checking Account  OR  ☐ Savings Account

I hereby request the privilege of paying premiums to EMC National Life Company, its successors and assigns (hereinafter referred to as the Company) under the Company’s Check Plan and hereby authorize the Company to initiate variable entries to my checking/savings account for the purpose of paying said premiums from the above named account.

1) Please Note: A deduction will process immediately for any premium(s) that are past due. All subsequent deductions will correspond to the policy date.

2) The draft date will correspond to the policy date.

3) If this is your initial premium, do you want it drafted from your account upon approval of your application and activation of your policy?  ☐ Yes  ☐ No

4) The privilege of paying premiums under this plan may be revoked by the Company if any entry is not paid upon presentation.

5) This plan shall not be construed as a modification of grace periods or of any other provisions of the policies except that during the continuance of this plan, the Company shall not be required to give notice of monthly premiums becoming due on any of the policies issued to the undersigned.

6) The payment of premiums under this plan may be discontinued by the Company or the undersigned upon thirty (30) days written notice.

7) This plan shall apply to the applications or other policies listed below that are to be included on this payment.

<table>
<thead>
<tr>
<th>Existing EMCNL POLICY # (if any)</th>
<th>NAME (Insured)</th>
</tr>
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<tbody>
<tr>
<td>1.</td>
<td></td>
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<tr>
<td>2.</td>
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<td>3.</td>
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Signature of Account Holder/Policy Payor

Date

ATTACH VOIDED CHECK HERE

No Deposit Slips, Please!