APPLICATION FOR INDIVIDUAL LIFE INSURANCE FOR YOUTH PRODUCTS
EMC NATIONAL LIFE COMPANY • P.O. Box 9144 Des Moines, Iowa 50306-9144

1. PROPOSED INSURED **PRINT IN BLACK INK**

FIRST NAME	MIDDLE NAME	LAST NAME	SOCIAL SECURITY #	
MAILING ADDRESS		❑ FEMALE ❑ MALE	DATE OF BIRTH	AGE
CITY	STATE	ZIP + 4 DIGIT	TELEPHONE # ( )	
Is the Proposed Insured a U.S. citizen? ❑ YES ❑ NO		If no, provide details on a separate sheet and send copy of permanent resident visa card.		

2. PRIMARY BENEFICIARY

NAME (First, M.I., Last)	DATE OF BIRTH	SOCIAL SECURITY #	RELATIONSHIP	%

CONTINGENT BENEFICIARY

NAME (First, M.I., Last)	DATE OF BIRTH	SOCIAL SECURITY #	RELATIONSHIP	%

3. OWNER

FIRST NAME	MIDDLE NAME	LAST NAME	SOCIAL SECURITY #
MAILING ADDRESS			DATE OF BIRTH
CITY	STATE	ZIP + 4 DIGIT	RELATIONSHIP TO INSURED

4. AMOUNT OF INSURANCE Youth Plus Term: ❑ $5,000 ❑ $7,500 ❑ $10,000 ❑ $20,000

Youth Whole Life: $_____ ($2,000 - $50,000)

Additional Paid-Up Insurance Rider (Youth Whole Life Only): $ _____

5. PREMIUM OPTIONS Youth Plus Term: ❑ Single Premium ❑ 2-Year Payment Plan

Youth Whole Life: ❑ Single Premium ❑ 5 Pay ❑ Continuous

6. MODE ❑ Single Premium $ _____

❑ Planned Premium $ _____ ❑ Annual ❑ Semiannual ❑ Quarterly ❑ Monthly (not available on Direct Bill)

Form: ❑ Check Plan ❑ Direct Bill ❑ List Bill ❑ ABS# _____

Additional Paid-Up Insurance Rider / Single Premium (Youth Whole Life only): $_____

7. LIFE INSURANCE / ANNUITIES IN FORCE (List below, including any existing EMCNL policies.) ❑ **Check if none in force**

Person Insured	Company	Policy #	Life Amount	ADB	To Be Replaced
					❑ Yes ❑ No
					❑ Yes ❑ No
					❑ Yes ❑ No

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.

8. PAYOR (specify one) ❑ Insured ❑ Owner ❑ Other

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

9. ADDITIONAL PERSON TO RECEIVE LAPSE NOTIFICATION (if desired)

Full Name | Address / City / State / Zip | Relationship

10. IMPORTANT! GIVE COMPLETE DETAILS BELOW FOR EACH "YES" ANSWER SPECIFYING DATES AND RESULTS OF TREATMENT, DOCTORS AND COMPLETE ADDRESSES.

	Yes	No
A. Within the past 10 years, has the Proposed Insured been diagnosed or treated by a medical practitioner for:		
(1) Cancer in any form?	❑	❑
(2) Heart disorder or defect, coronary disease, rheumatic fever, stroke or disorder of blood vessels?	❑	❑
(3) Mental illness requiring hospitalization or inpatient treatment, diabetes, disorder of the lung, kidney, stomach, liver, intestine, epilepsy or brain or nervous system disorder?	❑	❑
(4) Tested positive for exposure to the Human Immunodeficiency Virus (HIV) or been diagnosed as having Acquired Immune Deficiency Syndrome (AIDS)?	❑	❑
B. Within the past 5 years, has the Proposed Insured:		
(1) Been hospitalized?	❑	❑
(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)?	❑	❑

Give complete details below to all Yes answers. Use Section 12 if additional space is needed.

Ques. #	Dates	Symptom(s), Condition(s), Diagnosis	Treatment / Medication	Complete Name(s) & Address(es) of Doctors, Hospitals or Clinics

11. FOR THE PROPOSED INSURED, PLEASE PROVIDE:

Name and Address of Personal Physician	Date and Reason Last Seen

12. PROVIDE DETAILS OR SPECIAL REQUESTS: _____

REPRESENTATIONS AND ACKNOWLEDGEMENTS

I/we, the undersigned, represent, agree to and understand the following:

A. All of the answers and statements in this application are true and complete to the best of my knowledge and belief, that the statements and answers in the application are the basis for any policy issued by the Company and that no information about me or the Proposed Insured will be considered to have been given to the Company unless it is stated in the application. I agree that this application and any policy, amendments and riders shall constitute the entire contract.

B. The agent is not authorized to waive answers to any questions, modify the contract or grant acceptability of insurance and that notice to or knowledge of the agent, or any other person concerning the health or insurability of any Proposed Insured shall not be notice to or knowledge of the Company unless it is fully disclosed in writing in this application or as a signed and dated attachment.

C. The Effective Date and any insurance coverage are subject to the terms of the Conditional Coverage Receipt. I have received a copy of the Fair Credit Reporting Act and MIB, Inc. notices.

D. FRAUD NOTICE/WARNING: **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.**

E. **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.

X _____ _____ _____

Parent or Guardian's Signature | Signed at City / State | Date

X _____ X _____

Owner's Signature | Proposed Insured's (age 18 and over) Signature

REQUIRED AGENT'S REPORT

	Yes	No
A. Have you personally asked the questions on this application of the Proposed Insured or parent of Proposed Insured, if a minor?	❑	❑
B. Have you accurately recorded information given to you by all persons proposed for coverage?	❑	❑
C. To the best of your knowledge, will the insurance applied for replace any existing annuity/life policy(ies)?	❑	❑
D. As applicable, have you given disclosure/replacement notices as required by your state?	❑	❑
E. As applicable, have you given the Conditional Coverage Receipt?	❑	❑
F. Were the notices regarding MIB, Inc. and the Fair Credit Reporting Act given?	❑	❑

G. **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 by me to the Proposed Insured/Owner, a fully compliant illustration conforming to the policy as issued will be provided no later than at the time of policy delivery.

_____ X _____

Agent's Printed Name | Agent's Signature (witness)

_____ _____ _____

Agent's Contract # | Commission % | Date

Commission Split, if applicable:

_____ _____ _____

Agent's Name | Agent's Contract # | Commission %

AUTHORIZATION TO OBTAIN AND DISCLOSE INFORMATION
Life Insurance Application
This Authorization Complies with the HIPAA Privacy Rule.

I, the undersigned, 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, P.O. 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 authorize EMCNL to obtain an investigative consumer report on me, if required.

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

X _____	_____	_____
Signature of Parent or Guardian or Personal Representative	Printed Name	Date
X _____	_____	_____
Proposed Insured's (age 18 and over) Signature	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

ALWAYS DETACH AND GIVE TO APPLICANT

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, P.O. 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.

COMPLETE, DETACH AND GIVE TO APPLICANT ONLY WHEN FULL FIRST PREMIUM IS PAID WITH APPLICATION

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.

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, P.O. Box 9144, Des Moines, IA 50306-9144, is authorized to waive or alter any of the above conditions.

X_____	X_____	X_____
Applicant's Signature	Agent's Signature	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.

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.

	Existing EMCNL POLICY # (if any)	NAME (Insured)
1.		
2.		
3.		

X

Signature of Account Holder / Policy Payor

Date

ATTACH VOIDED CHECK HERE
No Deposit Slips, Please!