MIDLAND NATIONAL® Life Insurance Company

ICC139936

INDIVIDUAL LIFE INSURANCE APPLICATION PART 2

PROPOSED INSURED PERSONAL INFORMATION

1a. Last Name	First Name	Middle Initial

1b. Are you a U.S. Citizen or do you have a permanent Visa? ☐ Yes ☐ No

1c. Have you ever used a different name? ☐ Yes ☐ No If yes, give name used and time period. _____

2. Employer

Occupation (Title and Duties)	Are you actively employed? ☐ Yes ☐ No	Annual Income	Net Worth

TO BE COMPLETED FOR MILITARY PERSONNEL (Including National Guard and Reserves)

3. Job Duties

4. Are you currently drawing extra duty or hazard pay? ☐ Yes ☐ No

5. Military Information ☐ USA ☐ USN ☐ USAF ☐ USMC ☐ USCG ☐ Other (Specify) _____
Military ID _____
Pay Grade: Rotation Date: Expected Discharge Date:

6. Has the Proposed Insured applied to be a member of, or been a member of, a special forces or special or hazardous duty organization? ☐ Yes ☐ No
If Yes, provide specific details.

7. Has the Proposed Insured been alerted to, volunteered for, or received formal orders to a hazardous area or overseas assignment? ☐ Yes ☐ No
If Yes, provide specific details.

UNDERWRITING AND LIFESTYLE INFORMATION

8. Has the Proposed Insured ever used cigarettes, nicotine patches, nicotine gum, or other nicotine substitutes? ☐ Yes ☐ No
If yes, what product? ☐ Cigarettes ☐ Nicotine patches ☐ Nicotine gum ☐ Other: _____
If yes, was use of the product within: ☐ last 12 months ☐ last 24 months ☐ last 36 months ☐ last 60 months ☐ 60+ months

9. Has the Proposed Insured used tobacco in pipe or cigar form in the last 12 months? ☐ Yes ☐ No
If yes, how often: ☐ Daily ☐ Weekly ☐ Monthly ☐ Less than monthly

Please provide Details to "Yes" answers for Q 10. through 15. and "No" answer to Q 16. in the Details Section on the following page.

10. In the past 10 years, has the Proposed Insured:

a. Used barbiturates, hallucinatory drugs, narcotics, including crack, ecstasy, opium derivatives, marijuana, LSD, PCP, or any derivatives of these drugs, or been advised by a licensed medical professional to get medical treatment or undergone any medical treatment, counseling or hospitalization for drug abuse? ..... ☐ Yes ☐ No

b. Been advised by a licensed medical professional to limit your alcohol use or been advised to get medical treatment or undergone any medical treatment, counseling or hospitalization for alcoholism, excessive alcohol use or abuse? Or, have you subsequently consumed alcohol after receiving counseling or medical treatment for alcohol use? Or, do you drink on average more than three alcoholic drinks per day? ..... ☐ Yes ☐ No

c. Pled guilty to or been convicted of a felony or misdemeanor? If yes, provide details on the nature of the plea or conviction, the date and state where the plea or conviction occurred, and whether time was served in prison. ..... ☐ Yes ☐ No

d. Been refused life insurance or charged an extra premium for life insurance? ..... ☐ Yes ☐ No

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11. Has the Proposed Insured:

a. Within the past five years, had his/her driver's license revoked or suspended or been convicted of reckless driving, driving without a valid license, or for driving while under the influence of alcohol and/or drugs (DWI, DUI)? ☐ Yes ☐ No

b. Within the past five years, pled guilty or been convicted of any speeding or motor vehicle moving violation, been involved in any accident in which he/she was found to be at fault, or pled guilty or been convicted for driving under the influence of alcohol and/or drugs? ☐ Yes ☐ No

c. Flown a plane in the past 24 months or plan to fly in the next 12 months as a pilot, copilot, student pilot, military pilot, engineer or in any other capacity except as a regularly scheduled commercial airline pilot or fare-paying passenger? ☐ Yes ☐ No

d. In the past 12 months or in the next 12 months, engaged in, or plan to engage in, the following recreational activities: hang gliding, skydiving, motor vehicle/cycle racing, rock climbing, ballooning, bungee jumping, mountain climbing, motor boat racing, snowmobile racing, ultra light aircraft flying, scuba diving to more than 50 feet in depth, or in caves, ship wrecks or deep seas? ☐ Yes ☐ No

e. Traveled to or resided for more than 30 days outside of the U.S., U.S. territories, Canada, or Japan within the past 12 months or plan to travel to or reside outside of the U.S., U.S. territories, Canada, or Japan in the next 12 months? ☐ Yes ☐ No

f. Filed for bankruptcy that is pending or expect to file bankruptcy in the next 12 months? ☐ Yes ☐ No

12. Has, or will, the Proposed Insured or Owner of this policy been, or be, compensated in any way to purchase this policy? ☐ Yes ☐ No

13. Will the proceeds of a home equity loan or reverse mortgage transaction be used to pay the premiums on this policy? ☐ Yes ☐ No

14. Has the Proposed Insured or Owner of this policy financed, or intend to finance, all or a portion of the premiums for this policy? ☐ Yes ☐ No

15. Has the Proposed Insured, Owner, or Beneficiary entered into or are they considering entering into any other agreement with a third party, trust, or other entity, in regard to this policy, including, but not limited to, an agreement to sell, transfer or assign the policy or any policy rights or beneficial interests? ☐ Yes ☐ No

16. Is the Proposed Insured or Owner of this policy paying for this policy with his/her own funds? ☐ Yes ☐ No

DETAIL SECTION FOR 'YES' ANSWERS FOR QUESTIONS 10. THROUGH 15. AND "NO" ANSWER TO QUESTION 16. If more space is needed, attach additional sheet, identify question(s), sign and date.

Question #	Details

17. Who is your primary physician or health care provider? If None, check here ☐

Physician or Health Care Provider Name/Address/Telephone	Date Last Consulted	Reason Seen and Results of Visit (include diagnosis, treatment given, medication prescribed)

18a. What is your current height and weight? _____ FT. _____ IN. _____ LBS

18b. Have you gained or lost more than 15 pounds in the last year? ☐ Yes ☐ No

Please provide Details to "Yes" answers for Questions 19. through 22. in Details section following these questions.

19. In the past 10 years, has the Proposed Insured been diagnosed by a licensed medical professional, treated or advised to get treatment from a licensed medical professional, hospitalized, or presently taking prescription(s) or medication(s) or had any medical procedures for any of the following:

a. Angina, chest pain, heart attack, heart failure, heart surgery, irregular heartbeat, abnormal EKG, coronary artery bypass, angioplasty, stents, peripheral vascular disease, poor circulation, valvular heart disease, cardiomyopathy or heart murmur? ☐ Yes ☐ No

b. High blood pressure, hypertension or abnormal cholesterol levels? ☐ Yes ☐ No

c. Stroke, seizures, epilepsy, dizziness, fainting, memory disorder or any other neurological or brain disorder? ☐ Yes ☐ No

d. Multiple Sclerosis, neuritis, neuropathy, paralysis, muscular dystrophy, Parkinson's disease or any other disorder of the muscles? ☐ Yes ☐ No

e. Arthritis, chronic pain, fibromyalgia, connective tissue disease, lupus or scleroderma? ☐ Yes ☐ No

f. Cancer, malignancy, tumor, melanoma, lymphoma, Hodgkin's disease or leukemia? ☐ Yes ☐ No

g. Chronic obstructive pulmonary or lung disease, chronic bronchitis, emphysema, sarcoidosis, asthma, shortness of breath, tuberculosis or sleep apnea? ☐ Yes ☐ No

h. Diabetes, abnormal blood sugar, sugar in the urine, disease or disorders of the adrenal, parathyroid, pituitary or thyroid glands? ☐ Yes ☐ No

i. Disorder of the kidney, bladder or urinary system, abnormal PSA, abnormal pap smear without subsequent normal pap smear or protein or blood in the urine? ☐ Yes ☐ No

j. Anemia, hemophilia, clotting disorder or any other disorder of the blood? ☐ Yes ☐ No

k. Immune Deficiency disorder (Acquired Immune Deficiency Syndrome (AIDS), AIDS related complex (ARC) or been told test results indicate exposure to the AIDS virus? ☐ Yes ☐ No

l. Colitis, ulcerative colitis, Crohn's, esophageal varices, peptic or gastric ulcer, intestinal or rectal bleeding, diverticulitis, colon polyps, cirrhosis, hepatitis, liver failure, liver impairment, loss of bowel function or other disease or disorder of the liver or pancreas? ☐ Yes ☐ No

m. Depression, anxiety, stress, eating disorder or any other nervous, mental or emotional condition? ☐ Yes ☐ No

20. In the past 5 years, has the Proposed Insured been diagnosed, treated or advised to get medical treatment from a licensed medical professional for any mental or physical disorder or medically or surgically treated condition not listed above? ☐ Yes ☐ No

21. Other than indicated above, in the past 12 months, has the Proposed Insured been advised by a licensed medical professional to:

a. Except for tests related to Human Immunodeficiency Virus (AIDS virus), have a check up, EKG, X-ray, blood or urine test or any other diagnostic test, or get medical advice or treatment for any reason? ☐ Yes ☐ No

b. Be admitted to a hospital, medical facility, nursing home or assisted living facility? ☐ Yes ☐ No

22. Is the Proposed Insured currently taking any prescription medications, herbal remedies or non-prescription medications for any condition, disease or disorder not listed above? ☐ Yes ☐ No
If yes, list the medications and remedies and the reasons for which they are taken.

23. Is the Proposed Insured currently receiving or have an application pending for any illness or disability benefits or compensation? ..... ☐ Yes ☐ No

DETAILS SECTION FOR 'YES' ANSWERS FOR QUESTIONS 19. THROUGH 22. If more space is needed, attach additional sheet, identify question(s), sign and date.

Question #	Date, Diagnosis, Treatment, Results and Duration	Name, Address and Phone # of Attending Physician & Hospital

24. If not previously listed, please provide full name, address and phone numbers of personal physician(s) and any other physician(s) consulted in the past five years below. If more space is needed, attach additional sheet, identify question, sign and date.

Name, Address and Phone # of Attending Physician	Date and Findings of Last Visit	Tests performed and treatment received

25. Do you have medical records under any other name? ☐ Yes ☐ No

If yes, provide details: _____

FAMILY HISTORY

26. Does the Proposed Insured have or did have a parent or brother or sister who, before age 60, was diagnosed with or died from cardiovascular disease, cancer (except basal or squamous cell cancer of the skin), Huntington's Chorea, familial polyposis, or polycystic kidney disease? ☐ Yes ☐ No

If yes, provide details in Family Health Chart below, including age at onset, if still living. If more space is needed, attach additional sheet, identify question(s), sign and date.

Family Health Chart

Relationship to Proposed Insured	Condition or Cause of Death	Current Age	Age at Onset	Age at Death

AGREEMENT

By my signature affixed below or my electronic signature, which I understand is attached to this application electronically, I acknowledge that this Agreement has been read in full to me and that statements 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) the acceptance of any policy or policy change issued on this application shall constitute a ratification of any correction or amendment made by the Midland National Life Insurance Company (the Company); and (3) No change in amount, issue age, risk classification, plan of insurance, or benefits shall be effective unless agreed to in writing by the applicant(s). The undersigned FURTHER AGREES to immediately advise the Company of any change to any of the responses contained in the application, including any change in the health or habits of any Proposed Insured(s), that arises or is discovered after completing this application, but before the policy or policy change is effective, as defined herein.

Check appropriate box:

☐ No Exceptions or Corrections
☐ See Exceptions or Corrections in Details section below.

DETAILS: _____

FRAUD 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.

SIGNATURE

Signature of **Proposed Insured** (Signature of Parent/Legal Guardian if Proposed Insured is a Minor) **X**	Date
Signature of **Witness**, if applicable **X**	Date
Name of Witness (Print Full Name):	