


**General Purpose  
Life Application**

1. PRIMARY PROPOSED INSURED <input type="checkbox"/> SINGLE <input type="checkbox"/> MARRIED  LAST NAME _____ FIRST _____ M.I. _____		BIRTH DATE			STATE OF BIRTH	AGE	SEX	SOCIAL SECURITY NUMBER and DRIVERS LICENSE NUMBER		HEIGHT (FT. IN.)	WEIGHT (LBS.)	
		MO.	DAY	YEAR						STATE		
ADDITIONAL INSURED/SPOUSE PROPOSED for INSURANCE (or premium payer for juvenile policy)										STATE		
DEPENDENT CHILDREN PROPOSED for INSURANCE												
2. RESIDENCE ADDRESS (Street, City, State, Zip)		TELEPHONE NUMBER Primary Insured ( ) Spouse ( )										
2a. How long at this address? _____ Years _____ Months If less than 2 years, provide previous address.		3. CONTACT THE PROPOSED INSURED AT:					BUSINESS TELEPHONE NUMBER					
		<input type="checkbox"/> RESIDENCE <input type="checkbox"/> BUSINESS					<input type="checkbox"/> A.M. <input type="checkbox"/> P.M. Time					
4. OCCUPATION (Give exact duties)		EMPLOYER (Company Name, Address)					ANNUAL INCOME Primary Proposed Insured: _____ Spouse Proposed Insured: _____					
5. ADDITIONAL INSURED/SPOUSE OCCUPATION (Give exact duties)		EMPLOYER (Company Name, Address)					SEND MAIL TO: <input type="checkbox"/> RESIDENCE <input type="checkbox"/> BUSINESS					
6. Has anyone proposed for insurance used any tobacco product within the last 36 months? . . . . <input type="checkbox"/> Yes <input type="checkbox"/> No Has anyone proposed for insurance used cigarettes within the last 12 months? . . . . <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, number per day.....		Primary Insured <input type="checkbox"/> Yes <input type="checkbox"/> No Spouse <input type="checkbox"/> Yes <input type="checkbox"/> No										
7. AMOUNT	PLAN OF PRIMARY POLICY	Agent Use Only A <input type="checkbox"/> B <input type="checkbox"/> C <input type="checkbox"/>	Type of Underwriting <input type="checkbox"/> Standard <input type="checkbox"/> X-Press <input type="checkbox"/> Tele-Underwriting	<input type="checkbox"/> Non-Smoker <input type="checkbox"/> Smoker	If UL/VUL <input type="checkbox"/> Option I <input type="checkbox"/> Option II	If Sell Premium UL/VUL <input type="checkbox"/> Minimum Premium <input type="checkbox"/> Target Premium	<input type="checkbox"/> Automatic Premium Loan					
8. RIDERS <input type="checkbox"/> Waiver of Premium <input type="checkbox"/> Living Needs Rider <input type="checkbox"/> Pro Term Rider		<input type="checkbox"/> Accidental Death Benefit _____ Amount	<input type="checkbox"/> Children's Insurance Rider _____ Units	<input type="checkbox"/> NLG-Option Period to Age _____	<input type="checkbox"/> Other Rider _____ Plan _____ Amount							
9a. PREMIUM FREQUENCY: <input type="checkbox"/> Annual <input type="checkbox"/> Semi-Annual <input type="checkbox"/> Quarterly <input type="checkbox"/> Monthly PREMIUM MODE: <input type="checkbox"/> EFT <input type="checkbox"/> Direct Billing (A, SA, Q) only <input type="checkbox"/> List Billing <input type="checkbox"/> Military Government Allotment <input type="checkbox"/> Civil Service Allotment Amount of Modal Premium _____ Amount Paid with Application _____ (Receipt valid only if amount paid with application is entered here.)												
9b. FOR EFT ONLY: DRAW DAY _____ (1ST-28TH) Month _____ Day _____		ACCOUNT TYPE <input type="checkbox"/> Checking (enclose voided check) <input type="checkbox"/> Savings (must complete 9c)			AUTHORIZED SIGNATURE(S) OF ACCOUNT HOLDER(S) X _____ X _____							
9c. ROUTING/TRANSIT NUMBER		ACCOUNT NUMBER			FINANCIAL INSTITUTION NAME AND ADDRESS							

10a. WILL THE INSURANCE BEING APPLIED FOR REPLACE OR CHANGE ANY EXISTING LIFE INSURANCE OR ANNUITY CONTRACT?  YES  NO

(If Yes, complete applicable Replacement Notice form and submit with application)

10b. IS THERE ANY INSURANCE IN FORCE OR APPLICATION PENDING ON THE LIFE/LIVES OF ANY PROPOSED INSURED(S)?  YES  NO

(If yes, please complete 10c.)

10c.	Proposed Insured Name	Company	Amount	Status	ADB	Proposed Insured Name	Company	Amount	Status	ADB
				<input type="checkbox"/> Pending <input type="checkbox"/> Issued Yr. _____	<input type="checkbox"/> Y <input type="checkbox"/> N				<input type="checkbox"/> Pending <input type="checkbox"/> Issued Yr. _____	<input type="checkbox"/> Y <input type="checkbox"/> N
				<input type="checkbox"/> Pending <input type="checkbox"/> Issued Yr. _____	<input type="checkbox"/> Y <input type="checkbox"/> N				<input type="checkbox"/> Pending <input type="checkbox"/> Issued Yr. _____	<input type="checkbox"/> Y <input type="checkbox"/> N

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

NAME \_\_\_\_\_ ADDRESS \_\_\_\_\_ Soc. Sec. No. or Fed. Tax I.D. No. \_\_\_\_\_

12. PRIMARY BENEFICIARY--(Class 1) (Include relationship to proposed insured.)

14. SPECIAL REQUESTS OR DETAILS

PRINCIPAL REVIEW (For Variable Products)

13. CONTINGENT BENEFICIARY--(Class 2) (Include relationship to proposed insured.)

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

Premium checks must be payable to Midland National Life Insurance Company. Do not make checks payable to the Agent or leave the Payee blank.

**Application to MIDLAND NATIONAL LIFE INSURANCE COMPANY**

Must be completed for all proposed insureds, including CIR.	15. Has any person proposed for insurance:	Yes	No	Details of questions answered "yes" in Section 15 through 18. Include question number, full names and addresses of physicians and names of individuals to whom history pertains.
	(a) Received treatment for drug or alcohol use or used marijuana or narcotic, hallucinogenic or habit-forming drugs not prescribed by a physician; or is any such person currently using marijuana or such drugs? . . . . .	<input type="checkbox"/>	<input type="checkbox"/>	
	(b) Had any motor vehicle moving violations or accidents or been arrested for driving under the influence of alcohol or drugs within the last five years? . . . . .	<input type="checkbox"/>	<input type="checkbox"/>	
	(c) Been arrested for any reason other than moving traffic violations? . . . . .	<input type="checkbox"/>	<input type="checkbox"/>	
	(d) Flown other than as a fare-paying passenger within the last two years, or contemplated such flying in the future? (If yes, complete Aviation Questionnaire.) . . . . .	<input type="checkbox"/>	<input type="checkbox"/>	
	(e) Any past, present or expected activity in racing, scuba or sky diving, or any other hazardous sport or hobby? (If yes, complete Hazardous Activities Questionnaire.) . . . . .	<input type="checkbox"/>	<input type="checkbox"/>	
	(f) Ever had an application for insurance or reinstatement of insurance declined, postponed, rated, or modified? . . . . .	<input type="checkbox"/>	<input type="checkbox"/>	
	(g) Traveled or resided outside the U.S. or does any proposed insured intend to travel or reside outside the U.S.? . . . . .	<input type="checkbox"/>	<input type="checkbox"/>	
	16. Within the last ten years, has any person proposed for insurance ever had or been treated for:			
	(a) Chest pain, heart murmur, stroke, high blood pressure, or any other disease of the heart, blood, or blood vessels? . . . . .	<input type="checkbox"/>	<input type="checkbox"/>	
	(b) Peptic ulcer, indigestion, or any other disease of the stomach, intestines, gall bladder or liver? . . . . .	<input type="checkbox"/>	<input type="checkbox"/>	
	(c) Emphysema, bronchitis, asthma, pleurisy, or any other disease of the chest or lungs? . . . . .	<input type="checkbox"/>	<input type="checkbox"/>	
	(d) Kidney stone, diabetes; albumin, pus, blood or sugar in urine; venereal disease, or any other disease of the kidneys, bladder or reproductive organs? . . . . .	<input type="checkbox"/>	<input type="checkbox"/>	
	(e) An immune deficiency disorder [Acquired Immune Deficiency (AIDS), (AIDS related complex (ARC)] or been told test results indicate exposure to the AIDS virus? . . . . .	<input type="checkbox"/>	<input type="checkbox"/>	
	(f) Severe headaches, fainting spells, epilepsy, paralysis, nervousness, mental disorder, or any other disease of the brain or nervous system? . . . . .	<input type="checkbox"/>	<input type="checkbox"/>	
(g) Any impairment of sight or hearing? . . . . .	<input type="checkbox"/>	<input type="checkbox"/>		
(h) Cancer, tumor, or any other illness or injury not mentioned above? . . . . .	<input type="checkbox"/>	<input type="checkbox"/>		
17. Other than indicated above, has any person proposed for insurance:				
(a) Ever applied for or received a pension or disability benefit, or currently disabled? . . . . .	<input type="checkbox"/>	<input type="checkbox"/>		
(b) Been hospitalized in the past 5 years? . . . . .	<input type="checkbox"/>	<input type="checkbox"/>		
(c) Consulted a physician during the past 5 years? . . . . .	<input type="checkbox"/>	<input type="checkbox"/>		
(d) Had a change of weight in the past year? . . . . .	<input type="checkbox"/>	<input type="checkbox"/>		
(e) Had an immediate family member with a history of cancer, diabetes, mental, nervous, heart or circulatory disorder? If yes, show age at onset, current age if living. If deceased, age at death. . . . .	<input type="checkbox"/>	<input type="checkbox"/>		
18. Is any person proposed for insurance now under observation or taking treatment or been advised to have any tests, hospitalization, or surgery which has not been completed? . . . . .	<input type="checkbox"/>	<input type="checkbox"/>		

Must be completed for all proposed insureds, including CIR.	19. Are medical records under any other name (maiden name, etc.)? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please indicate full name.	Name and Address of Primary Physician (if not specified above, date last consulted)	Telephone Number of Primary Physician (      )
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IT IS DECLARED that statement and answers in this application, including statements by the Proposed Insured(s) in any medical questionnaire or supplement that become part of this application, are complete and true to the best knowledge and belief of the undersigned. IT IS AGREED THAT: (1) any waiver or modification of this application will not be effective unless in writing and signed by the President, or the Secretary; (2) **no insurance shall be in effect under this application (except as may be provided in the receipt bearing the same date as this application) unless and until the application has been approved and accepted by the Company at its Executive Office and the policy is delivered to and accepted by the Owner and the full first premium has been paid while each person proposed for insurance is alive and while the state of health and other conditions affecting insurability are as stated in this application and examination, if required. (If a List Billing Authorization or Government Allotment is indicated in section 9a and has actually been signed and delivered for the correct amount, this shall be considered the same as payment of the full first premium);** (3) the acceptance of any policy issued on this application shall constitute a ratification of any correction or amendment made by the Company. No change in amount, classification, plan of insurance, or benefits shall be effective unless agreed to in writing by the applicant.

I also acknowledge receipt of Fair Credit Reporting Act and Medical Information Bureau Notifications.

**TAX PAYER IDENTIFICATION NUMBER CERTIFICATION** - Under penalties of perjury, I certify that:

1. The number shown on this form is my correct taxpayer identification number (or I am waiting for a number to be issued to me), **and**
2. I am not subject to backup withholding because: (a)  I am exempt from backup withholding, or (b)  I have not been notified by the Internal Revenue Service that I am subject to backup withholding as a result of a failure to report all interest or dividends, or (c)  the IRS has notified me that I am no longer subject to backup withholding. **(Please check appropriate response.)**

**FINANCIAL INSTITUTION DISCLOSURE** - Insurance products and annuities are not a deposit or other obligation of, or guaranteed by a bank, any affiliate of a bank, or savings association and are not insured by the Federal Deposit Insurance Corporation (FDIC) or any other agency of the United States, a bank, any affiliate of a bank, or savings association, and involve investment risk, including possible loss of value. The approval or disapproval of any extension of credit by the bank or an affiliate is not based on whether or not this insurance is purchased through the bank or through any particular source.

**AUTHORIZATION:** To determine eligibility for insurance, I authorize any physician, medical practitioner, hospital, clinic, other medically related facility, insurance or reinsuring company, the Medical Information Bureau, Inc., consumer reporting agency or employer having information available as to diagnosis, treatment and prognosis with respect to information regarding alcoholism, drug abuse, and psychiatric care or any physical or mental condition and/or treatment of me or my minor children and any other nonmedical information of me or my minor children to give to Midland National Life Insurance Company (the Company) or its legal representative, any and all such information. I also authorize the Company to conduct a personal telephone interview in connection with my application; and to release any such data to its reinsurers, the Medical Information Bureau, or other persons or organizations performing business or legal services in connection with my application, or as required by law when given a copy of this authorization. I understand that I may request to be interviewed in connection with the preparation of an investigative consumer report. I understand that I am entitled to receive a copy of the investigative consumer report upon request. This authorization is valid for 30 months from the date signed. I may revoke this authorization for information not then obtained by notifying the Company in writing. Such revocation will not be effective until received by the Company. I understand that I or any authorized representative will receive a copy of this authorization upon request.

<b>PROPOSED INSURED if 15 YEARS OR OLDER (Signature)</b> <small>Make all checks payable to Midland National Life Insurance Company.</small> <b>X</b>	SIGNED AT (City, State)		DATE
	OWNER (Signature)		
<b>Soliciting Agent:</b> The applicant(s) <input type="checkbox"/> has <input type="checkbox"/> does not have any existing life insurance or annuities. To the best of my knowledge, this application <input type="checkbox"/> is <input type="checkbox"/> is not involved in replacement of life insurance or annuities. If a replacement is involved, submit a copy of this application an Replacement Notice to the replacing insurer. Leave the applicant a copy of all sales materials used in the sales presenta- <b>SOLICITING AGENT (Signature)</b>	PRINT AGENT'S LAST NAME	CODE NO.	TELEPHONE NUMBER (     )
	OTHER AGENT (Please Print)		% CREDIT CODE NO.
	GENERAL AGENT (Please Print)		CODE NO.