Clear Form Clear Kit

North American Company
for Life and Health Insurance
Principal Office: 4601 Westown Parkway, Suite 300
West Des Moines, IA 50266
A Member of the Sammons Financial Group

O21322

POLICY CHANGE REQUEST

Part 1

PLEASE PRINT LEGIBLY OR USE TYPEWRITER **If additional space is required, use "OTHER" section below**	NEW ADDRESS GIVEN BELOW? ☐ NO ☐ INSURED'S ☐ OWNER'S	POLICY NUMBER

INSURED 1	ADDRESS	CITY	STATE	ZIP CODE
INSURED 2	ADDRESS	CITY	STATE	ZIP CODE

SECTION A — Change Request (New policy specifics)

NEW PLAN	UNDERWRITING CLASS	DEATH BENEFIT OPTION
		☐ Option A ☐ Option B ☐ Option C _____% increase ☐ Option D _____% increase_____years

TYPE OF CONVERSION	CARRY BENEFITS OVER TO THE NEW POLICY ☐ Yes ☐ No
☐ Basic Plan ☐ Term Rider ☐ Full ☐ Partial	REMAINING INSURANCE AFTER PARTIAL CONVERSION TO BE ☐ Continued ☐ Discontinued

CHANGE EXISTING POLICY

CHANGE FACE AMOUNT (If increasing, complete reverse side)	☐ Increase to $ ☐ Decrease to $	☐ FREEZE ☐ THAW
☐ RE-ENTRY (Complete reverse side)	☐ CONSIDER CLASS CHANGE TO ☐ CONSIDER RATE REDUCTION TO (complete reverse side)	

☐ EXERCISE OPAI
(If original plan does not have smoking classification, answer question #7 on reverse side)

SUPPLEMENTARY BENEFITS CHANGE (If adding complete reverse side)

ADD	DELETE		ADD	DELETE	State # of units
☐	☐	WAIVER OF PREMIUM	☐	☐	FAMILY PROTECTION (S & C)
☐	☐	ACCIDENTAL DEATH BENEFIT	☐	☐	FAMILY PROTECTION (C ONLY)
☐	☐	OPAI	☐	☐	SPOUSE COVERAGE

☐ CHANGE DEATH BENEFIT OPTION TO:
☐ Option A (increasing) ☐ Option C_____% increase
☐ Option B (level) ☐ Option D_____% increase for _____ years
(complete reverse side when going to A, C, D)

OTHER:

PAYMENT SUBMITTED WITH THIS CHANGE REQUEST $

PLANNED PERIODIC PREMIUM $	☐ ANNUAL ☐ SEMI-ANNUAL ☐ QUARTERLY ☐ LIST BILL ☐ MGA

☐ PAC	COMPLETED REQUEST FOR PRE-AUTHORIZED CHECK (PAC) PLAN FORM OR L-1683 WITH A VOIDED SAMPLE CHECK, MUST BE SUBMITTED WITH THIS CONVERSION/CHANGE REQUEST.	DRAFT START DATE

SECTION C — Home Office Endorsement (change made by the Company)

Continuation of Application for Policy Change - Evidence of Insurability — Part 2

SECTION D - Questions for the Insured - complete fully (If policy insures more than one life, complete Part 2 on each insured)

1. INSURED: (Print full name) ☐ Male ☐ Female	2. BIRTHDATE	3. BIRTHPLACE	4. OCCUPATION: (Give title/Duties)

5. a. Height: _____ft. _____ in. Weight:_____ lbs. b. Weight loss of more than 10 lbs. in last 12 months? ☐ Yes ☐ NO

c. Name and address of personal physician/health care facility: (If none, check here_____ and omit d, e, and f)

d. Date last consulted:_____ e. Reason _____

f. Any medication or treatment? ☐ Yes ☐ No If Yes, describe_____

6. Other than this policy, state your total amount of life insurance inforce? ☐ None ☐ $ _____

7. Tobacco use — Have you used tobacco in any form during the past 12 months? ☐ Yes ☐ No (Answer a or b below)

a. If Yes, forms used ? ☐ Cigarettes ☐ Other:_____ No. per day? _____ For how long? _____ years.

b. If No, ☐ Never used ☐ Quit — give month year If cigarettes, used _____ per day for years.

SECTION E - Complete if other persons are proposed for insurance

1. Spouse and children: Note - for family or children insurance include all dependent natural children, legally adopted and stepchildren under age 24.

Proposed	Print full name	Sex	Age	Birthdate	Birthplace	Height	Weight
Spouse						ft. in.	lbs.
Child #1						ft. in.	lbs.
Child #2						ft. in.	lbs.
Child #3						ft. in.	lbs.
Child #4						ft. in.	lbs.

2. Spouse's occupation: (give title and duties)

SECTION F — Questions for the insured and all other persons proposed for insurance on this application

	Yes	No
1. Has any person proposed for insurance:		
a. Any intention of traveling or residing outside of the continental United States?_____	☐	☐
b. Any other application for new life insurance or changes to any existing policy pending or contemplated? _____	☐	☐
c. Had an application for life or health insurance or reinstatement declined, rated, or modified in any way? _____	☐	☐
d. Been convicted within the last 3 years for a moving violation, or driving while under the influence, or had a driver's license suspended or revoked? (If yes, give driver's license number and state issued in REMARKS)_____	☐	☐
e. Within the last 3 years, flown as a pilot or crewmember of any aircraft, done any underwater diving, parachuting, mountain climbing, vehicle racing of any kind or intend to do so?_____	☐	☐
2. Has any person proposed for insurance ever been diagnosed as having, been treated for or been told by any physician or other medical professional that they had:		
a. Cancer, tumor, or other malignancy, high blood pressure, heart or circulatory disease, heart murmur, stroke, epilepsy, brain, nervous or mental disorder, ulcers, hepatitis, or other disorder of the stomach, liver or intestines, tuberculosis, lung or other respiratory disorder, kidney, bladder or venereal disease, blood or glandular disorder, arthritis or other bone or joint disorder or diabetes? ____	☐	☐
b. AIDS (Acquired Immune Deficiency Syndrome) or HIV infection or disease _____	☐	☐
3. Within the past five years has any person proposed for insurance:		
a. Consulted, been examined or treated by any physician or medical professional, or been admitted to or treated at a hospital or other facility for any disease or condition not indicated in question #2 above? _____	☐	☐
b. Had an X-ray, EKG or other heart study, laboratory test, or been advised to have a surgical operation?_____	☐	☐
c. Been treated for alcoholism or substance (drug) abuse, or been a regular or frequent user of cocaine or other stimulants, hallucinogens or narcotics not prescribed by a physician? _____	☐	☐

4. REMARKS: Give details of Yes answers above including dates, durations, treatment, names and address of physicians and medical facilities and give the names of the person(s) they apply to:

SECTION G — Agreement, Authorization and Disclosure Information

IT IS UNDERSTOOD AND AGREED THAT:

1. This application shall be considered an amendment to the original application and shall form a part of the policy.
2. The change requested shall not be effective until approved and any required additional premium has been paid.
3. That acceptance of premium DOES NOT create coverage or imply that the change requested is in effect.
4. The same ownership and beneficiary designation on the original policy will remain in effect unless otherwise requested on title change request form L-2402.

I(We) agree that: (1) all statements and answers recorded on this policy change application and any required supplement or amendment are true and complete to the best of my(our) knowledge and belief and that they shall be the basis of any changes made to the policy(s); (2) if evidence of insurability is required for the policy change, the Suicide Exclusion and/or Incontestability Provisions of the policy will be amended by endorsement based upon the type of change approved; (3) if I am applying for an increase in coverage to a life insurance plan with flexible premium and adjustability provisions, expense and/or surrender charges may be assessed as to the increase on the same basis as the initial coverage.

AUTHORIZATION — For the purpose of determining the insurability of the persons proposed for insurance on this application, I(we) authorize any licensed physician, medical practitioner, hospital, clinic or other medical or medically related facility, insurance company, the Medical Information Bureau or any other organization, institution or person, that has any records or knowledge of me(us) or my(our) health to give to the North American Company for Life and Health Insurance, or its reinsurers, any such information. A photographic copy of this authorization shall be as valid as the original. This authorization is effective for thirty months from the date it is signed.

SECTION H — Signatures

SIGNED AT TOWN/CITY	STATE	DATE
PROPOSED INSURED/APPLICANT		
*POLICYOWNER (Include owner ID)		
SPOUSE CONSENT (AK, AZ, CA, ID, LA, NM, NV, TX, WA, WI)	COLLATERAL ASSIGNEE	
WITNESS	AGENTS SIGNATURE	WRITING AGENT NO.

**When owner is a corporation, trust, or other entity, write the title of the signee next to the signature.*

SECTION I — Consumer Protection Notice (Detach, read and retain for your record)

CONSUMER PROTECTION NOTICES FOR THE PROPOSED INSURED/APPLICANT

Investigative Consumer Report Notice — In connection with your application for insurance, an investigative consumer report may be prepared, in which information is obtained from public records and through personal interviews with your neighbors, friends, employers, business associates, financial sources, or others with whom you are acquainted. This inquiry includes information as to your character, general reputation, personal characteristics and mode of living, except as may be related directly or indirectly to your sexual orientation. You may make a written request to be interviewed in connection with the preparation of this report. You have the right to make a written request within a reasonable period of time to receive additional, detailed information about the nature and scope of this investigation. Either of these written requests should be directed to the Underwriting Department, North American Company for Life and Health Insurance, P.O. Box 5089, Sioux Falls, SD 57117-5089.

MIB, Inc. Notice — Information regarding your insurability will be treated as confidential. North American Company for Life and Health Insurance, or its reinsurers, may, however, make a brief report thereon to the Medical Information Bureau, a non-profit membership organization of life insurance companies, which operates an information exchange on behalf of its members. If you apply to another Bureau member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, the Bureau, upon request, will supply such company with the information in its file.

Upon receipt of a request from you, the Bureau will arrange disclosure of any information it may have in your file. If you question the accuracy of information in the Bureau's file, you may contact the Bureau and seek a correction in accordance with the procedures set forth in the Federal Fair Credit Reporting Act. The address of the Bureau's information office is 50 Braintree Hill, Braintree, MA 02184-8734, telephone number (617) 426-3660.

North American Company for Life and Health Insurance, 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.