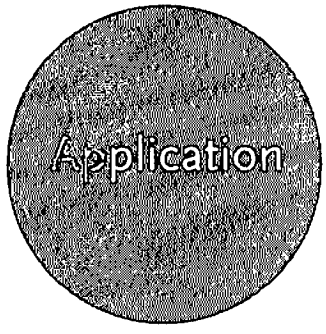
National Life Group®

- Sample paper App -



Our Vision

To Bring Peace of Mind To Everyone We Touch.

Our Mission

Keeping Our Promises.

Life Insurance Products Issued by
Life Insurance Company of the Southwest®

Experience Life

Centralized Mailing Address: One National Life Drive, Montpelier, VT 05604 | Home Office: Addison, TX
800-732-8939 | www.NationalLifeGroup.com

8121TX(1014)K
Cat. No. 46557

National Life Group®

Life Insurance Company of the Southwest®

Agent's Report

Part 1 - Proposed Primary Insured Information - Please PRINT

1. Proposed Insured's Name: John Doe
2. Did you meet with the Proposed Insured in person to complete the application? ☒ Yes ☐ No
3. How long have you known the Proposed Insured(s)? I Quit
4. Are you related? ☐ Yes ☒ No
   (If 'Yes', relationship?) _____
5. Proposed Primary Insured's
   Net Worth $ 500000
   Household Income $ 120000
   Household Net Worth $ 500000
6. Are there existing life, disability or annuity contracts? ☐ Yes ☒ No
7. To the best of your knowledge, is this insurance intended to replace any existing coverage? ☐ Yes ☒ No
8. List any sales materials, including illustrations, used relating to the new application: Compete illustration
9. Which rate class was quoted?
   Proposed Primary Insured STD NON TOBACCO
   Proposed 2nd/Other Insured _____
10. Indicate underwriting requirement(s)

PI	2nd/OIR	
☐	☐	Oral Fluid (Agent collected)*
☐	☐	Blood & Urine
☐	☐	Blood, Urine & Paramed Exam
☐	☐	Blood, Urine, Paramed Exam & EKG

   Exam service ordered from: MIB Medical
   *Non-preferred classes only for Harbor, Foundation, Provider & LSW Term.
11. What is the purpose of this insurance? Mortgage Protection
12. How was the face amount determined? Mortgage Amount
13. If business insurance, please complete Business Insurance Questionnaire Form 20098.

Part 2 - Proposed Insured / Owner Information

1. To your knowledge is any Proposed Insured or the Owner receiving any loans, cash, promises of future benefit, free insurance, or other valuable consideration as an inducement to apply for or become an insured under this life insurance policy? ☐ Yes ☒ No
2. Are you aware that any Proposed Insured or the Owner has been involved in any discussions regarding transfer of ownership of the policy being applied for to a third party, such as (but not limited to) a life settlement company or investor group? ☐ Yes ☒ No

Part 3 - Owner's Information

1. Annual Income $ 80000
   Net Worth $ 500,000
2. If Owner is a **Corporation**, what % of stock is owned by Proposed Primary Insured? _____ %
3. If Owner is a **Limited** Partnership, give name of **all** general partners *(Print names)*

Part 4 - Notes

If your Agent Number is pending, please provide your email address.

Part 5 - Agent's Signature

Licensed Agent	Licensed Agent's Name *(Print)*	Percent	Agent No./Suffix	Phone & Email
	Nate Affort	100%	123456	555-121-1212 John.doe@gmail
Additional Agent	Name of Additional Agent *(Print)*	Percent	Agent No./Suffix	Phone & Email
Additional Agent	Name of Additional Agent *(Print)*	Percent	Agent No./Suffix	Phone & Email

National Life Group®

Life Insurance Company of the Southwest®

Individual Life Insurance Application

Part A - Proposed Insured Information

1. Name *(print first, middle, last)*	2. Place of Birth - State/Country	3. Sex
John Doe	TX USA	☒ M ☐ F

4. Home Address *(Street, City, State & Zip. If mailing address different, provide in Remarks)*	5. Date of Birth	6. Issue at Age	7. SS No.
55 Main Street Dallas TX 75055	01/01/1969	45	343-62-4111

8. Home Phone	Cell Phone	Work Phone	9. E-Mail Address	10a. Driver's License #	10b. State
(555) 555 1212	(555) 654 1313	(555) 4236489	johndoe@gmail	U4685724	Tx

11. Are you a citizen of	11a. Perm. Res. Card # *(include copy)*	11b. Type of VISA *(include copy)*
☒ USA ☐ Other Country _____		

12. Employer & time employed	13. Occupation *(w/specific duties)*	14a. Annual Income	14b. Net Worth
Acme Corp 10 years	Acct Executive	80,000	500,000

Part B - Owner Information - *Relationship, Address, Telephone #, E-Mail, DOB & SSN (If different than Proposed Insured)*

Or the survivor(s); while living; thereafter the First Proposed Insured (FPI), unless otherwise provided.

Part C - Beneficiary Information *(If a trust - include trustees, trustor, date and tax ID#.)*

Primary: The beneficiary is the Owner, unless otherwise provided. *(Name, Relationship, Address, Telephone #, E-mail, DOB & SSN)*

MUST HAVE THIS INFO → ALL OF IT! Sally Doe - wife 12/3/1978
555-654-1213 phone 654-44-4444 - SS#
sallydoe@gmail.com
Address: 55 Main ST Dallas TX 75055

Contingent: *(Name, Relationship, Address, Telephone #, E-mail, DOB & SSN)*

A deceased beneficiary's share shall be paid equally to the surviving beneficiaries of the same class, unless otherwise provided.

Part D - Policy Information

(Only EIUL)

1. Product Name	2. Face Amount	3. Universal Life Death Benefit Option
Provider or Flex Life or Term	200,000	☒ A - Level ☐ B - Increasing

4. Definition of Life Insurance Test *(Applies to IUL & UL only except Foundation.)*	5. Use of Dividends: *(Whole Life only) (Choose only one.)*
☒ GPT ☐ CVAT *(Illustration needed.)*	☐ Cash ☐ Additions ☐ Applied *(N/A with EFT)* ☐ Deposits

6. Riders and Amounts (No Ryders)

- ☐ Accelerated Benefits (ABR) *(Complete ABR Disclosure form)*
- ☐ Additional Paid Up *(Whole Life)*
  - Rider Modal Premium $ _____
  - Rider Single Premium (SPAR) $ _____
- ☐ Additional Protection Benefit (APB) *(Adv 79, FlexLife, Horizon)* $ _____
- ☐ Automatic Conversion Rider *(Whole Life)* $ _____
  - ☐ 10 Years ☐ 20 Years
- ☐ Children's Term (CTR) *(IUL & UL except IncomeBuilder)* $ _____
- ☐ Guaranteed Insurability (GIR) *(IUL & UL)* $ _____
- ☐ Disability Income (DIR) ☐ 2 Yr ☐ 5 Yr $ _____
  - a. Do you have any disability insurance, including employer sponsored short or long-term coverage? *(If yes, give details in Remarks)* ☐ Yes ☐ No
- ☐ Waiver of Premiums (WP) *(All products)* $ _____ *(Annual Premium Waived if applicable)*
- ☐ Other _____ $ _____
- ☐ Other _____ $ _____

The Death Benefit Protection Rider is automatically added, if eligible. *(FlexLife, IncomeBuilder, Provider)*

☐ Please check this box if you do NOT want this rider. Otherwise, it will be added. There is a minimum premium associated with this rider, and the IncomeBuilder product will have a monthly charge if issue age is over 50.

Part E - Children's Term Rider (CTR) - Applicable for ages 0-16 only *(Complete HIPAA for each child.)*

1. Complete the following questions for Children's Term Rider only. *(Provide Names, Dates of Birth, and SS Numbers of all Children to be covered.)*

Name:	Date of Birth	Social Security No.

2. To the best of your knowledge: *(If 'Yes', give details, including the name and address of any physician in Remarks)*

a. Has a licensed member of the medical profession diagnosed any Child as having Attention Deficit Disorder, dyslexia, autism, mental retardation, or any psychiatric disease? ☐ Yes ☐ No

b. Has a licensed member of the medical profession diagnosed or treated any Child for seizures, juvenile diabetes, scoliosis, hemophilia, cancer, or a heart, lung, or respiratory disease? ☐ Yes ☐ No

c. Does the Proposed Insured/child live with parent? ☐ Yes ☐ No

d. Does any Child take medication prescribed by a doctor? ☐ Yes ☐ No

Part F - Premium Information

1. Planned Periodic/Modal Premium $ 280.17

2. Premium Mode ☐ Annual ☐ Semi-Annual ☐ Quarterly ☒ Monthly *(Electronic Funds Transfer (EFT))*

If EFT was selected, you may choose a draft date from the 1st - 28th _____ *(If EFT is chosen in #4 below, advanced dating will occur to align the requested draft date with the effective date of your policy.)*

If no day is selected, recurring drafts will be initiated on the day of issue. *(Policy effective date current)*

☐ Single Premium ☐ Group Bill No.: _____

3. Automatic Payment of Premium ***(Whole life only, also known as APL.)*** ☐ Yes ☐ No

4. Initial Premium Payment Method ***(Choose one.)***

☐ Check/Cash with application *(Cash equivalent payment must be accompanied by form 7953.)*

☐ COD *(collect payment on delivery of policy.)*

☒ Draft initial premium *(EFT - only available if Monthly is selected in #2.)*

If Draft initial premium is selected, the draft will be initiated on the day chosen above in #2, the policy effective date will be advanced dated to this requested day and commissions will not be generated until this advanced date. If no option is selected, coverage under the Conditional Receipt is not available and coverage under a policy (if one is issued to you) will not be effective until we receive your initial premium.

5. Identify the source of funds for premium payment

☒ Income/Savings ☐ Home equity ☐ Payment by third party ☐ Loan/Premium Finance ☐ Other: _____

6. Send premium notices to: ☐ Owner ☒ Proposed Insured ☐ Other: *(street, city, state & zip)* _____

7. Bank Information ***(Complete if Monthly EFT is selected)***

I authorize the National Life Group to draft payments from my account ☒ Checking ☐ Savings

Name of Bank: Bank of Texas Name on Account: John Doe

Bank Routing No. *(9 digits)*

⑆	4	5	4	6	6	3	2	1	0

Customer Account No. *(Do not include check number)*

⑆	1	7	7	8	5	5	4	3	2								

☒ Please check this box if you agree that premiums may be deducted if the premium amount increases by $25 of the amount included above. You will be given prior notification for any draft amounts that exceed this $25 limit.

I understand that recurring premiums will be initiated on my chosen draft date, however, they may take several days to clear my account.

Depositor's Mailing Address: 55 Main Street Dallas Tx 75055

Depositor's Email Address: johndoe@Gmail.com Depositor's Phone No: 555 654 1313

Depositor Signature: *(If not Applicant/Owner) (Exactly as it appears on bank records)* _____

Part G - Juvenile Coverage - *Applicable for Ages 0-17 only* *(Complete HIPAA for each child. The entire application must be completed for minor age applicants.)*

Complete the following questions for Juvenile Coverage only: (Complete on Child u/a 18)

1. Does the Proposed Insured/child live with parent? ☐ Yes ☐ No
   (If 'No', explain in Remarks. Give name & relationship of person with whom the PI lives.)

2. Amount of Insurance in force on Proposed Insured, the Applicant and other members of Proposed Insured's family:

	Age	Company	Amount In-Force	Amount Applied for
Applicant			$	$
Proposed Insured's father			$	$
Proposed Insured's mother			$	$
Brothers and sisters of Proposed Insured *(If none, so state)*			$	$
			$	$
			$	$

Part H - Recent Applications, Inforce Coverage, and Replacement Information ***(All questions must be answered.)***

1. Do you have any inforce life insurance or annuity contracts including long term care insurance or riders? *(If yes, provide details)* ☐ Yes ☒ No

Company	Policy Number	Date Issued	Amount of Coverage	ADB Coverage	To be Replaced	1035 Exchange
					☐ Yes ☐ No	☐
					☐ Yes ☐ No	☐
					☐ Yes ☐ No	☐
					☐ Yes ☐ No	☐

2. Have you ever applied for life, health, or disability insurance or reinstatement of same, which was declined, postponed, rated or modified in any way? ☐ Yes ☒ No
3. Within the past 12 months have you applied for or do you have any applications pending for life or disability insurance? ☐ Yes ☒ No
4. Is the policy or rider being applied for intended to replace any inforce life insurance or annuity contract(s) including long term care insurance or riders? Replacement includes surrender, lapse, reissue, conversion, reduction in coverage, premium or period of coverage of any life, disability income or annuity contract. *(If yes, replacement forms must be provided)* ☐ Yes ☒ No
5. Is the Proposed Insured or Owner considering using funds from an inforce life or annuity contract to fund the policy or rider being applied for? *(If yes, replacement forms must be provided)* ☐ Yes ☒ No

Part I - General Information about the Proposed Insured *(If yes, provide details in Remarks)*

1. During the last 5 years have you plead guilty to or been convicted of any moving vehicle violations or DUI or have you had a suspended license? ☐ Yes ☒ No
2. Have you ever been convicted of a felony or misdemeanor? *(If 'Yes', complete form 20087.)* ☐ Yes ☒ No
3. Have you been or are you currently involved in any bankruptcy proceedings that have not been discharged? *(If 'Yes', provide type & date discharged)* ☐ Yes ☒ No
4. Do you participate in any type of racing, scuba diving, aerial sports, mountain climbing, BASE or bungee jumping, or cave exploration? *(If 'Yes', complete form 1480)* ☐ Yes ☒ No
5. Do you participate in any aviation activity other than as a fare paying passenger? *(If 'Yes', complete form 1480)* ☐ Yes ☒ No
6. During the next 2 years do you intend to travel or reside outside of the USA for more than 2 weeks in a year? *(If 'Yes', complete form 1480)* ☐ Yes ☒ No
7. Have you been offered any cash incentive or other consideration (such as free insurance) as an inducement to apply for or become an insured under this life insurance policy? ☐ Yes ☒ No
8. Have you been involved in any discussions about the possible sale or transfer of this policy to an unrelated third party, such as (but not limited to) a life settlement company or investor group? ☐ Yes ☒ No

Part J - Health History of the Proposed Insured ***(Give details, dates & results for any 'Yes' questions in Remarks). Complete Part J if money was collected with the application or an exam is not being done.***

1. Name and Address of Personal Physician and all other medical specialists seen, *(If none, so state)*	Date last Seen	Reason consulted & outcome
Dr Feel Good 48 Feel Good Dr Ste 101 DAMS TX 75068	08/2014 - OR - (10/2014)	Had a Sinus infection Given Antibiotics took for 7 days (Routine Checkup - All Good)

2. Height 6 Weight 185 Have you gained or lost weight during the last 12 months? *(If yes, provide details below.)* ☐ Yes ☒ No

Remarks: _____

3. Are you taking any medications? *(If yes, list type, dose, frequency and reason/diagnosis in the Remarks section.)* ☒ Yes ☐ No

4. Have you used any type of product containing tobacco or nicotine within the last five years? ☐ Yes ☒ No

Product Type: _____ Frequency: _____ Date Last Used: _____

5. Within the past 5 years have you worked less than full time, received or applied for disability or worker's compensation? ☐ Yes ☒ No

6. In the past 10 years have you ever been diagnosed, treated, tested positive for, or been given medical advice by a member of the medical profession for: *(If yes, provide details including treating physician contact information.)*

a. Any disease or abnormal condition of the heart, circulatory system, high blood pressure, high cholesterol, irregular heartbeat, murmur, rheumatic fever, coronary artery disease, chest pain, angina, transient ischemic attack or stroke? ☐ Yes ☒ No

b. Any disease of the lungs or respiratory system, sleep apnea, emphysema, asthma, bronchitis, tuberculosis, allergies or disorder of the nose or throat? ☐ Yes ☒ No

c. Any digestive system disease, including ulcer, chronic indigestion, liver, stomach, intestine or pancreas disorder, hepatitis, cirrhosis, jaundice, esophagus disorder, gallbladder disorder, or colon disorder? ☐ Yes ☒ No

d. Any disorder of the nervous system, epilepsy, convulsions, paralysis, brain or eye disorders? ☐ Yes ☒ No

e. Any spine, hip, knee, shoulder, back, bones, muscles, arthritis, rheumatism, joints, skin, thyroid, gout or other gland disorder? ☐ Yes ☒ No

f. Any urinary system disease including protein, sugar or blood in urine, kidney infection or stones, disorder or disease of the breast, prostate or bladder, or pelvic organs? ☐ Yes ☒ No

g. Any depression, anxiety, bipolar, schizophrenia, attention deficit disorder (ADD), or any other developmental or psychological condition including Alzheimer's, Dementia, or Post Traumatic Stress Disorder (PTSD)? ☒ Yes ☐ No

h. Any anemia, hemophilia or disorders of the blood other than Acquired Immune Deficiency Syndrome (AIDS), Human Immunodeficiency Virus (HIV)? ☐ Yes ☒ No

i. Human Immunodeficiency Virus (HIV), Acquired Immune Deficiency Syndrome (AIDS), or have you tested positive for exposure to or been diagnosed with HIV or AIDS? ☐ Yes ☒ No

j. Any cancer, polyp, other tumors? ☐ Yes ☒ No

k. Diabetes or high blood sugar? ☐ Yes ☒ No

l. For the past 5 years only: any shortness of breath, dizzy spells, unconsciousness, headaches, or memory loss? ☐ Yes ☒ No

7. Amputation due to disease or other medical condition? ☐ Yes ☒ No

8. Ataxia, transverse Myelitis, Myasthenia Gravis, Autoimmune Disorder such as Lupus, Blindness, or Post Polio Syndrome? ☐ Yes ☒ No

9. Parkinson's disease, Muscular Dystrophy, Huntington's Chorea, Motor Neuron Disease, Lou Gehrig's Disease (ALS), or Multiple Sclerosis? ☐ Yes ☒ No

10. In the past 10 years have you used marijuana, cocaine, heroin, or any other illicit drug or controlled substance, been advised by a physician to discontinue or reduce alcohol or drug intake, used drugs not prescribed by a physician, or been a member of a support group such as NA or AA? ☐ Yes ☒ No

11. Within the past 5 years have you:

a. Consulted with a physician other than your personal physician or had x-rays, electrocardiograms, heart catheterization or other diagnostic tests, except those related to the Human Immunodeficiency Virus (AIDS Virus)? ☐ Yes ☒ No

b. been admitted to a hospital, or been advised or plan to enter a hospital for observation, operation or treatment of any kind? ☐ Yes ☒ No

12. Do you have any pending appointments with any medical professional? ☐ Yes ☒ No

Part J - Health History of the Proposed Insured *(Continued)*

13. Has a parent or sibling been diagnosed or treated by a health professional for cancer, heart disease, Huntington's Disease or polycystic kidney disease? ☐ Yes ☒ No

14. Do you currently:

a. Use or require the use of any mechanical or medical devices such as: a wheelchair, walker, multi-prong cane, hospital bed, dialysis machine, respirator oxygen, motorized cart or stair lift? ☐ Yes ☒ No

b. Need help, assistance or supervision for: bathing, eating, dressing, toileting, walking, transferring, or maintaining continence? ☐ Yes ☒ No

c. Need help, assistance or supervision in: taking medication, doing housework, laundry, shopping or meal preparation? ☐ Yes ☒ No

15. During the past 5 years have you been diagnosed, treated, tested positive for, or been given medical advice by a member of the medical profession for: Falls, Paralysis, Numbness, Tremors, Imbalance, or any condition which causes limited motion? ☐ Yes ☒ No

16. During the past 5 years have you been diagnosed, treated, tested positive for, or been given medical advice by a member of the medical profession for: memory loss, confusion, amnesia? ☐ Yes ☒ No

17. Family History

	Age if alive	Age at death	Cause of death
Father		72	Natural Causes
Mother	68		

Part K - Remarks *(Provide the details to questions as requested.)*

Section & Number:	Additional Information:
3a.	Takes 35 mg Simvastatin once A Day for Cholesterol Under Control
3g.	Takes Zoloft for depression diagnosed in 2009 After Mother Died Takes As Need
	See Depression Questionnaire

National Life Group®

Life Insurance Company of the Southwest™

Supplemental Information to the Application for Life Insurance

Insured's Name: John Doe Social Sec. #: 343-62-4111

Application Form Number: _____

Question Number:

Application Information: *(Specify if this information applies to the Proposed Insured, Second Proposed Insured, or Proposed Other Insured)*

Use For Additional Medications or illnesses If you ran out of Space on other Page 5

Signed at *(City and State)*: Dallas TX on this day of: 01/01/2015

Signature of Insured(s): John Doe

Signature of Applicant *(If different than Proposed Insured)*: _____

Signature of Agent: _____

Part L - Sales Illustration Certification *(Please check one of the following boxes if applicable.)*

☐ An illustration was not used corresponding to the policy as applied for and will be provided upon policy delivery.

☐ An illustration was used and signed which corresponds with the policy as applied for and is attached.

☒ An illustration was **viewed** on a computer screen; and if use is allowed in this state, the "Computer View Illustration Certification" form is attached. An illustration corresponding to the policy as issued will be provided upon policy delivery. *(The Computer View Illustration Certification form is not allowed in: HI, ID, IL, MD, MI, MN, NE, NV and WA.)* – ALWAYS MARK THIS –

Part M - Agreement & Authorization

I understand and agree that all answers given above and in any medical exam are to the best of my knowledge and belief complete and true. All such answers and this application shall be part of any contract issued. I have read the IMPORTANT NOTICES, including the notices required by the Fair Credit Reporting Act and MIB, Inc. ("MIB"). To the extent allowed by law, I waive all rights governing disclosure of medical exams or treatment. I authorize any medical practitioner or facility, insurer, MIB and any other organization or person that has any records or knowledge of me or my health to give such information to LSW or its reinsurers. I authorize LSW to request a copy of my driving record(s) from the state motor vehicle department. I understand and I authorize LSW, or its reinsurers, to make a brief report of my personal health information to MIB. This authorization is valid for 30 months (or the length of time as per state regulation) from the date signed and a photocopy shall be as valid as the original. I also certify, under the penalties of perjury, that the Social Security Number of the Proposed Insured and Applicant/Owner (if different) is correct.

The Agent taking this application has no authority to make, change or discharge any contract hereby applied for. The Agent may not extend credit on behalf of the Company. No statement made to or information acquired by any representative of the Company shall bind the Company unless set out in writing in this application.

Any person who knowingly presents a false statement in an application for insurance may be guilty of criminal offense and subject to penalties under state law.

Part N - Signatures

Signed at *(City & State)* Plano TX Date *(mm/dd/yyyy)* 01/01/2015

Proposed Insured age 18 & up ***(Note: AL - Age 19, MS - Age 21)***
(Under 18, Parent or Legal Guardian)

Applicant/Owner *(If Owner is other than Proposed Insured or a Minor.)*

Soliciting Agent/Representative *(Sign name in full)*

(Witness)

(Exercise of AIO Only)
Owner of Base Policy

National Life Group®

Life Insurance Company of the Southwest℠

Disclosure Statement for Accelerated Benefits Rider 1

Accelerated Benefits are payments made to the Owner while the Insured is living in lieu of payment of all or a portion of the death benefit that would otherwise be paid at the Insured's death. The Owner must apply for the Accelerated Benefits and must show the required proof stated in the Accelerated Benefits Rider attached to the policy that the Insured has a Terminal Illness.

Benefits may be elected under this rider if the Insured is Terminally Ill. Terminally Ill means that the Insured has been certified by a Physician as having an illness or chronic condition which can reasonably be expected to result in death in 24 months or less from the date of the certification.

The Owner may elect to accelerate all or a portion of the Insured's death benefit in force on the election date. **The Company reserves the right to set a maximum death benefit that may be accelerated under all Accelerated Benefits Riders on the life of the Insured. This maximum limit will be no less than $500,000.**

Accelerated Benefits are paid as a lump sum. The amount paid is calculated as the present value of the death benefit accelerated, less an adjustment for future premiums, and less an administrative fee. The benefit will first be used to pay a pro rata share of any outstanding debt to us. The benefit will never exceed the death benefit being accelerated. It will never be less than the cash surrender value, if any, that corresponds to the death benefit accelerated.

The Insured's death benefit in force will be reduced each time an Accelerated Benefit is paid. The reduction will equal the portion of the death benefit that is accelerated on the election date. The face amount, and any accumulated value, cash surrender value, and outstanding debt will also be reduced. Each of these will be reduced in the same proportion as the reduction in the death benefit. The premiums and charges for any remaining life coverage will be determined as if the contract had been originally issued at the reduced face amount.

Death benefits, cash values and loan values (for policies with such values) will be reduced if an Accelerated Benefit is paid.

The Accelerated Benefits offered under this rider may or may not qualify for favorable tax treatment under the Internal Revenue Code of 1986. Whether such benefits qualify depends on factors such as your life expectancy at the time benefits are accelerated or whether you use the benefits to pay for necessary long-term care expenses, such as nursing home care. If the Accelerated Benefits qualify for favorable tax treatment, the benefits will be excludable from your income and not subject to federal taxation. Tax laws relating to Accelerated Benefits are complex. You are advised to consult with a qualified tax advisor about circumstances under which you could receive Accelerated Benefits excludable from income under federal law.

Receipt of Accelerated Benefits may affect you, your spouse or your family's eligibility for public assistance programs such as medical assistance (Medicaid), Aid to Families with Dependent Children (AFDC), supplementary social security income (SSI), and drug assistance programs. You are advised to consult with a qualified tax advisor and with social service agencies concerning how receipt of such a payment will affect you, your spouse and your family's eligibility for public assistance.

Signed at: *(City & State)* Dallas TX Date: *(mm/dd/yyyy)* 01/01/2015

Licensed Agent: *(Sign name in full)* _____

Applicant/Owner: *(Sign name in full)* John Doe

Copies to the Company, the Customer, and the Agent

National Life Group®

Life Insurance Company of the Southwest℠

Disclosure Statement for Accelerated Benefits Rider 2

Accelerated Benefits are payments made to the Owner while the Insured is living in lieu of payment of all or a portion of the death benefit that would otherwise be paid at the Insured's death. The Owner must apply for the Accelerated Benefits and must show the required proof stated in the Accelerated Benefits Rider attached to the policy.

Benefits may be elected under this rider if the Insured has been certified, within the last 12 months, by a Licensed Health Care Practitioner as:

1. being unable to perform (without substantial assistance from another person) at least two Activities of Daily Living for a period of at least 90 consecutive days due to a loss of functional capacity; or
2. requiring substantial supervision for a period of at least 90 consecutive days by another person to protect oneself from threats to health and safety due to Severe Cognitive Impairment.

The Activities of Daily Living are:

- Bathing means washing oneself by sponge bath, or in a tub or shower, including the task of getting into and out of the tub or shower.
- Continence means the ability to maintain control of bowel and bladder function, or when unable to maintain control of bowel or bladder function, the ability to perform associated personal hygiene (including caring for a catheter or colostomy bag).
- Dressing means putting on and taking off all items of clothing and any necessary braces, fasteners, or artificial limbs.
- Eating means feeding oneself by getting food into the body from a receptacle (such as a plate, cup, or table) or by a feeding tube or intravenously.
- Toileting means getting to and from the toilet, getting on and off the toilet, and performing associated personal hygiene.
- Transferring means having sufficient mobility for moving into or out of a bed, chair, or wheelchair or for moving from place to place, either via walking, a wheelchair, or other means.

Severe Cognitive Impairment means deterioration or loss in intellectual capacity that is measured by clinical and standardized tests which reliably measure impairment in:

1. short-term or long-term memory; or
2. orientation to people, places, or time; or
3. deductive or abstract reasoning.

Substantial Supervision means continual supervision (which may include cueing by verbal prompting, gestures, or other demonstrations) by another person that is necessary to protect a cognitively impaired individual from threats to the individual's health or safety.

The Owner may elect to accelerate all or a portion of the Insured's death benefit in force on the election date. **The Company reserves the right to set a maximum death benefit that may be accelerated under all Accelerated Benefits Riders on the life of the Insured. This maximum limit will be no less than $500,000.**

Accelerated Benefits are paid as a lump sum. The amount paid is calculated as the present value of the death benefit accelerated, less an adjustment for future premiums, and less an administrative fee. The benefit will first be used to pay a pro rata share of any outstanding debt to us. The benefit will never exceed the death benefit being accelerated. It will never be less than the cash surrender value, if any, that corresponds to the death benefit accelerated.

The Insured's death benefit in force will be reduced each time an Accelerated Benefit is paid. The reduction will equal the portion of the death benefit that is accelerated on the election date. The face amount, and any accumulated value, cash surrender value, and outstanding debt will also be reduced. Each of these will be reduced in the same proportion as the reduction in the death benefit. The premiums and charges for any remaining life coverage will be determined as if the contract had been originally issued at the reduced face amount.

Death benefits, cash values and loan values (for policies with such values) will be reduced if an Accelerated Benefit is paid.

The Accelerated Benefits offered under this rider may or may not qualify for favorable tax treatment under the Internal Revenue Code of 1986. Whether such benefits qualify depends on factors such as your life expectancy at the time benefits are accelerated or whether you use the benefits to pay for necessary long-term care expenses, such as nursing home care. If the Accelerated Benefits qualify for favorable tax treatment, the benefits will be excludable from your income and not subject to federal taxation. Tax laws relating to Accelerated Benefits are complex. You are advised to consult with a qualified tax advisor about circumstances under which you could receive Accelerated Benefits excludable from income under federal law.

Receipt of Accelerated Benefits may affect you, your spouse or your family's eligibility for public assistance programs such as medical assistance (Medicaid), Aid to Families with Dependent Children (AFDC), supplementary social security income (SSI), and drug assistance programs. You are advised to consult with a qualified tax advisor and with social service agencies concerning how receipt of such a payment will affect you, your spouse and your family's eligibility for public assistance.

Signed at: *(City & State)* DALLAS TX Date: *(mm/dd/yyyy)* 01/01/2015

Licensed Agent: *(Sign name in full)* _____

Applicant/Owner: *(Sign name in full)* John Doe

Copies to the Company, the Customer, and the Agent

National Life Group®

LS7077545

Life Insurance Company of the Southwest®

Disclosure Statement for Accelerated Benefits Rider (Critical Illness)

Accelerated Benefits are payments made to the Owner while the Insured is living in lieu of payment of all or a portion of the death benefit that would otherwise be paid at the Insured's death. The Owner must apply for the Accelerated Benefits and must show the required proof stated in the Accelerated Benefits Rider attached to the policy.

The Critical Illness Qualifying Events covered under this rider are:

1. **Aorta Graft Surgery:** A definite diagnosis by a Specialist that surgery is medically necessary for disease or trauma to the aorta requiring excision and surgical replacement of the diseased or traumatized aorta with a graft. Aorta refers to the thoracic and abdominal aorta but not its branches. The Insured must survive for 30 days following the Date of Diagnosis.

2. **Aplastic Anemia:** A definite diagnosis of a chronic persistent bone marrow failure, confirmed by biopsy, which results in anemia, neutropenia and thrombocytopenia requiring blood product transfusion, and treatment with at least one of the following: a) Marrow stimulating agents; b) Immunosuppressive agents; c) Bone marrow transplantation. The diagnosis of Aplastic Anemia must be made by a Specialist. The Insured must survive for 30 days following the Date of Diagnosis.

3. **Blindness:** The total and permanent loss of sight in both eyes as a result of disease or injury. Total loss of sight in an eye is defined as corrected vision of 20/200 or worse.

4. **Cancer:** A definite diagnosis of a disease manifested by the presence of one or more malignant tumors and characterized by the uncontrolled growth and spread of malignant cells and the invasion of normal tissue.

   Diagnosis of Cancer must be established according to the criteria of malignancy established by The American Board of Pathology after a study of the histocytologic architecture or pattern of the suspect tumor, tissue, or specimen. The Insured must survive for 90 days following the Date of Diagnosis.

   Exclusion: No benefit will be payable under this condition for: a) Any non-melanoma skin cancer, except those with distant lymph node metastasis; or b) Pre-malignant lesions, benign tumors, or dysplasias; or c) Carcinoma in-situ; or d) Localized non-invasive cancers such as, but not limited to: i. Thyroid cancers less than Stage 4; or ii. Early prostate cancer diagnosed as T1N0M0 or equivalent staging including T2a unless the Gleason score is higher than 6; or iii. Chronic lymphocytic leukemia classified as Rai Stage 0; or iv. Noninvasive papillary cancer of the bladder AJCC TaN0M0.

5. **Cystic Fibrosis:** A definitive diagnosis of Cystic Fibrosis with evidence of chronic lung disease and pancreatic insufficiency. The diagnosis must be made by a Specialist and must be made before the Insured's 20th birthday. The Insured must survive 30 days following the Date of Diagnosis.

6. **Diagnosis of ALS (Amyotrophic Lateral Sclerosis):** A definite diagnosis of ALS made by a Specialist. There must be permanent clinical impairment. Permanent clinical impairment is the situation in which the clinical specialist notes that the impairment caused by the condition is not reversible and hence permanent. The Insured must survive for 30 days following the Date of Diagnosis.

7. **End Stage Renal Failure:** A definite diagnosis of chronic irreversible failure of both kidneys to function, which necessitates regular haemodialysis or peritoneal dialysis continuously for a period of at least 6 months or result in renal transplantation. The diagnosis of Kidney Failure must be made by a Specialist. The Insured must survive 30 days following the Date of Diagnosis.

8. **Heart Attack:** A definite diagnosis of the death of a portion of the heart muscle resulting from inadequate blood supply to the relevant area. The diagnosis of Heart Attack must be made by a Specialist, supported by symptoms clinically accepted as consistent with the diagnosis of an acute myocardial infarction and at least one of the following conditions: a) New characteristic electrocardiographic changes; or b) The characteristic rise above laboratory accepted normal values of biochemical cardiac specific markers such as CK-MB or cardiac troponins; or c) An abnormal myocardial perfusion or other scan showing characteristic findings of new heart muscle death; or d) An echocardiogram with new wall abnormalities indicating new heart muscle death. The Insured must survive for 30 days following the Date of Diagnosis.

   Exclusion: No benefit will be payable under this condition for other acute coronary syndromes including but not limited to angina.

9. **Heart Valve Replacement:** A definite diagnosis determined by a Specialist that surgery is medically necessary to replace any heart valve with either a natural or mechanical valve. The Insured must survive 30 days following the Date of Diagnosis.

10. **Major Organ Transplant:** A definite diagnosis of the irreversible failure of any of the following organs or tissues: heart, both lungs, liver, both kidneys, pancreas, or bone marrow, and transplantation must be medically necessary. To qualify under Major Organ Transplant, a Transplant specialist must document that transplantation is necessary and the Insured must be placed on a transplant list as the recipient of a heart, lung, liver, kidney, pancreas or bone marrow, and limited to these entities. The Insured must survive 30 days following the Date of Diagnosis.

Copies to the Company, the Customer, and the Agent

11. **Motor Neuron Disease:** A definite diagnosis of one of the following conditions and is limited to these conditions: a) Primary lateral sclerosis; or b) Progressive spinal muscular atrophy; or c) Progressive bulbar palsy; or d) Pseudo bulbar palsy. There must be permanent clinical impairment. Permanent clinical impairment is the situation in which the clinical specialist notes that the impairment caused by the condition is not reversible and hence permanent. The diagnosis of Motor Neuron Disease must be made by a Specialist. The Insured must survive for 30 days following the Date of Diagnosis.

12. **Stroke:** A definite diagnosis of an acute cerebrovascular accident or infarction (death) of brain tissue caused by hemorrhage, embolism, or thrombosis resulting in neurological deficit with persistent clinical symptoms for at least 30 consecutive days following the occurrence of the Stroke, and also resulting in either: a) Permanent Neurological Deficit with Persisting Clinical Symptoms that are expected to last throughout the Insured's life; or b) Definite evidence of death of brain tissue or hemorrhage on a brain scan. The diagnosis of Stroke must be made by a Specialist. The Insured must survive for 30 days following the Date of Diagnosis.

    Exclusion: No benefit will be payable under this condition for: a) Transient ischemic attacks; or b) Intracerebral vascular events due to trauma; or c) Lacunar infarcts which do not meet the definition of Stroke as described above; or d) Asymptomatic silent stroke found on imaging.

13. **Sudden Cardiac Arrest:** Defined as the sudden loss of heart function with interruption of blood circulation around the body resulting in unconsciousness and requiring resuscitation. After resuscitation, treatment may include: a) Surgical implantation of an Implantable Cardioverter-Defibrillator (ICD); or b) Surgical implantation of a Cardiac Resynchronization Therapy with Defibrillator (CRT-D); or c) Electrophysiological mapping with radio frequency ablation; or d) Cardiac surgery; or e) Long-term medication therapy.

    Exclusion: No benefit will be payable under this condition for: a) Insertion of a pacemaker; or b) Insertion of a defibrillator without cardiac arrest; or c) Cardiac arrest resulting directly from alcohol or drug abuse. The Insured must survive for 30 days following the date of Sudden Cardiac Arrest.

No Accelerated Benefit will be paid under this rider for any Critical Illness Qualifying Event that directly results from self-inflicted injury or attempted suicide. This benefit is underwritten and may not be available on your policy.

The Owner may elect to accelerate all or a portion of the Insured's death benefit in force on the election date. **The Company reserves the right to set a maximum death benefit that may be accelerated under this and any other Accelerated Benefits Rider on the life of any Insured person. This maximum limit will be no less than $500,000.**

Accelerated Benefits will be paid as a lump sum. The amount paid is calculated as the present value of the death benefit accelerated, less an adjustment for future premiums, and less an administrative fee. The benefit will first be used to pay a pro rata share of any outstanding debt to us. The benefit will never exceed the death benefit being accelerated. It will never be less than the cash surrender value, if any, that corresponds to the death benefit accelerated.

The Insured's death benefit in force will be reduced each time an Accelerated Benefit is paid. The reduction will equal the portion of the death benefit that is accelerated on the election date. The face amount, and any accumulated value, cash surrender value, and outstanding debt will also be reduced. Each of these will be reduced in the same proportion as the reduction in the death benefit. The premiums and charges for any remaining life coverage will be determined as if the contract had been originally issued at the reduced face amount.

Death benefits, cash values and loan values (for policies with such values) will be reduced if an Accelerated Benefit is paid.

The Accelerated Benefits offered under this rider may or may not qualify for favorable tax treatment under the Internal Revenue Code of 1986. If the Accelerated Benefits qualify for such favorable tax treatment, the benefits will be excludable from your income and not subject to federal taxation. Tax laws relating to Accelerated Benefits are complex. You are advised to consult with a qualified tax advisor about circumstances under which you could receive Accelerated Benefits excludable from income under federal law.

Receipt of Accelerated Benefits may affect eligibility for public assistance programs such as medical assistance (Medicaid), Aid to Families with Dependent Children (AFDC), supplementary social security income (SSI), and drug assistance programs. You are advised to consult with a qualified tax advisor and with social service agencies concerning how receipt of such a payment will affect your eligibility, your spouse's eligibility, and your family's eligibility for public assistance.

Signed at: *(City & State)* TX Date: *(mm/dd/yyyy)* as of 04/20/2015

Licensed Agent: *(Sign name in full)* Nathan R Auffort

Applicant/Owner: *(Sign name in full)* Carla R Kraft

Please Sign

National Life Group®

LS7077545

Life Insurance Company of the Southwest®

Disclosure Statement for Accelerated Benefits Rider (Critical Injury)

Accelerated Benefits are payments made to the Owner while the Insured is living in lieu of payment of all or a portion of the death benefit that would otherwise be paid at the Insured's death. The Owner must apply for the Accelerated Benefits and must show the required proof stated in the Accelerated Benefits Rider attached to the policy.

The Critical Injury Qualifying Events covered under this rider are:

1. **Coma:** A definite diagnosis of a state of unconsciousness with no reaction to external stimuli or response to internal needs for a continuous period of at least 96 hours, which: a) Has a Glasgow Coma score of 4 or less; and b) Requires the use of life support systems; and c) Results in Permanent Neurological Deficit with Persisting Clinical Symptoms that are expected to last throughout the Insured's life. The diagnosis of Coma must be made by a Specialist.

   Exclusion: No benefit will be payable under this condition for: a) A medically induced Coma; or b) A Coma which results directly from alcohol or drug abuse.

2. **Paralysis:** Defined as Quadriplegia, Paraplegia or Hemiplegia that has been present for 90 days from the Date of Diagnosis confirmed by a Specialist and which is expected to be permanent without expectation of recovery. a) Quadriplegia means the complete and irreversible Paralysis of both upper and lower Limbs. b) Paraplegia means the complete and irreversible Paralysis of both lower Limbs. c) Hemiplegia means the complete and irreversible Paralysis of the upper and lower Limbs of the same side of the body. d) Limb means entire arm or entire leg.

3. **Severe Burns:** A definite diagnosis of third degree burns covering at least 30% of the body's surface area or 30% of the area of the face or head. The diagnosis of Severe Burns must be made by a Specialist. The Insured must survive for 30 days following the Date of Diagnosis.

4. **Traumatic Brain Injury:** A definite diagnosis of damage to brain tissue due to Traumatic Brain Injury, which: a) Has a Glasgow Coma score of 12 or less in the first 48 hours after injury; and b) Has skull fracture, brain contusion or hemorrhage on CT scan of head; and c) Results in a Permanent Neurological Deficit with Persisting Clinical Symptoms that are expected to last throughout the Insured's life.

   The diagnosis of Traumatic Brain Injury must be made by a Specialist. The Insured must survive for 60 days following the Date of Diagnosis.

   Exclusion: No benefit will be payable under this condition for: a) Mild Traumatic Brain Injury; or b) Traumatic Brain Injury due to repetitive head trauma; or c) Traumatic Brain Injury which results directly from intentional self-inflicted injury.

No Accelerated Benefit will be paid under this rider for any Critical Injury Qualifying Event that directly results from self-inflicted injury or attempted suicide. This benefit is underwritten and may not be available on your policy.

The Owner may elect to accelerate all or a portion of the Insured's death benefit in force on the election date. **The Company reserves the right to set a maximum death benefit that may be accelerated under this and any other Accelerated Benefits Rider on the life of any Insured person. This maximum limit will be no less than $500,000.**

Accelerated Benefits will be paid as a lump sum. The amount paid is calculated as the present value of the death benefit accelerated, less an adjustment for future premiums, and less an administrative fee. The benefit will first be used to pay a pro rata share of any outstanding debt to us. The benefit will never exceed the death benefit being accelerated. It will never be less than the cash surrender value, if any, that corresponds to the death benefit accelerated.

The Insured's death benefit in force will be reduced each time an Accelerated Benefit is paid. The reduction will equal the portion of the death benefit that is accelerated on the election date. The face amount, and any accumulated value, cash surrender value, and outstanding debt will also be reduced. Each of these will be reduced in the same proportion as the reduction in the death benefit. The premiums and charges for any remaining life coverage will be determined as if the contract had been originally issued at the reduced face amount.

Death benefits, cash values and loan values (for policies with such values) will be reduced if an Accelerated Benefit is paid.

The Accelerated Benefits offered under this rider may or may not qualify for favorable tax treatment under the Internal Revenue Code of 1986. If the Accelerated Benefits qualify for such favorable tax treatment, the benefits will be excludable from your income and not subject to federal taxation. Tax laws relating to Accelerated Benefits are complex. You are advised to consult with a qualified tax advisor about circumstances under which you could receive Accelerated Benefits excludable from income under federal law.

Receipt of Accelerated Benefits may affect eligibility for public assistance programs such as medical assistance (Medicaid), Aid to Families with Dependent Children (AFDC), supplementary social security income (SSI), and drug assistance programs. You are advised to consult with a qualified tax advisor and with social service agencies concerning how receipt of such a payment will affect your eligibility, your spouse's eligibility, and your family's eligibility for public assistance.

Signed at: *(City & State)* TX Date: *(mm/dd/yyyy)* 04/20/2015

Licensed Agent: *(Sign name in full)* Nathan R Auffart

Applicant/Owner: *(Sign name in full)* Carla R Kraft

Please Sign

Copies to the Company, the Customer, and the Agent

National Life Group®

Life Insurance Company of the Southwest™

Interest Crediting Strategies
Indexed Universal Life

Do Not Need This Page for A Term Product

Insured Information (*If joint, list both Insureds)

Insured's Name*: John Doe Policy Number: _____

Instructions

The Net Premiums you pay are put into the Basic Strategy. There is a Basic Strategy Value Minimum amount which must remain within the Basic Strategy. If the Basic Strategy Value exceeds the Basic Strategy Value Minimum, the excess will be transferred into the other Strategies subject to a selection specified by you. Please specify this selection below.

Whole percentages must be used. A percentage must be at least 5%, and the total of all percentages must equal 100%.

For After Issue business, send to: Customer Relations - M330 *(for non-pension business)*
Contract Change - M305 *(for pension business)*

Section 1 - SecurePlus Provider Strategy Selection - Five-Year Crediting Periods

(Fixed-Term Strategy) (105) _____ %

Point-to-Point, Cap Focus
(Equity Indexed Strategy 1) (107) (151) 100 % Mugs this one on Provider

Point-to-Average, No Cap
(Equity Indexed Strategy 2) (106) _____ %

Point-to Point, High Participation Rate Focus
(Equity Indexed Strategy 3) (154) _____ %

Point-to-Point, Cap Focus, Emerging Markets
(Equity Indexed Strategy 4) (156) _____ %

Total 100%

☐ Use Monthly Basic Strategy Value Minimum
☐ Activate Systematic Allocations on New Premium Payments
☐ Activate Systematic Allocations on Renewing Index Segments**
☐ Terminate Systematic Allocations for future premiums and Renewing Index Segments
☐ Terminate all existing Systematic Allocation accounts

Section 2 - SecurePlus Paragon, SecurePlus Advantage 79 and LifeCycle Solution Strategy Selection - One-Year Crediting Periods

(Fixed-Term Strategy) (105) _____ %

Point-to-Point, Cap Focus
(Indexed Strategy 1) (107) _____ %

Point-to-Point, Participation Rate Focus
(Indexed Strategy 2) (108) _____ %

Point-to-Point, No Cap
(Indexed Strategy 3) (109) _____ %

Point-to-Average, No Cap
(Indexed Strategy 4) (106) _____ %

Point-to-Point, Cap Focus, Emerging Markets
(Indexed Strategy 5) (156) _____ %

Total 100%

☐ Activate Systematic Allocations on New Premium Payments
☐ Activate Systematic Allocations on Renewing Index Segments**
☐ Terminate Systematic Allocations for future premiums and Renewing Index Segments
☐ Terminate all existing Systematic Allocation accounts

Section 3 - FlexLife Strategy Selection - One-Year Crediting Periods

(Fixed-Term Strategy) (105) _____ %

Point-to-Point, Cap Focus
(Indexed Strategy 1) (301) _____ %

Point-to-Point, Participation Rate Focus
(Indexed Strategy 2) (302) 100 % Mugs this one for Flex Life

Point-to-Point, No Cap
(Indexed Strategy 3) (303) _____ %

Point-to-Average, No Cap
(Indexed Strategy 4) (300) _____ %

Point-to-Point, Cap Focus, Emerging Markets
(Indexed Strategy 5) (310) _____ %

Total 100%

☐ Activate Systematic Allocations on New Premium Payments
☐ Activate Systematic Allocations on Renewing Index Segments**
☐ Terminate Systematic Allocations for future premiums and Renewing Index Segments
☐ Terminate all existing Systematic Allocation accounts

**Only available after issue. Activation will be for both new premium payments and renewing index segments.

Sign and Date

Applicant/Owner's Signature: John Doe Date: 9/01/2015

National Life Group®

☐ National Life Insurance Company
☑ Life Insurance Company of the Southwest

NOTICE AND CONSENT FOR HIV RELATED BLOOD AND OTHER BODILY FLUID TESTING

This Notice is submitted in conjunction with an application to a Company of the National Life Group:

National Life Insurance Company
Home / Administrative Office: One National Life Drive, Montpelier, VT 05604

Life Insurance Company of the Southwest
Administrative Office: One National Life Drive, Montpelier, VT 05604
Home Office: 1300 West Mockingbird Lane, Dallas, TX 75247-4921

To evaluate your insurability, the Insurer named above (the Insurer) has requested that you provide a sample of your blood, oral fluid extracted from cheek and gum tissue, urine for testing and analysis to determine the presence of human immunodeficiency virus (HIV) antibodies. By signing and dating this form you agree that this test may be done and that underwriting decisions will be based on the test results. A series of tests will be performed by a licensed laboratory through a medically accepted procedure.

PRE TESTING CONSIDERATIONS

Many public health organizations have recommended that before taking an HIV related blood or other bodily fluid test a person seek counseling to become informed concerning the implications of such a test. You may wish to consider counseling, at your expense, prior to being tested.

MEANING OF POSITIVE TEST RESULTS

The test is not a test for AIDS. It is a test for antibodies to the HIV virus, the causative agent for AIDS, and shows whether you have been exposed to the virus. A positive test result does not mean that you have AIDS but that you are at a significantly increased risk of developing problems with your immune system. The test for HIV antibodies is very sensitive. Errors are rare, but they do occur. Your private physician, a public health clinic, or an AIDS information organization in your city might provide you with further information on the medical implications of a positive test.

Positive HIV antibody test results will adversely affect your application for insurance. This means that your application may be declined, that an increased premium may be charged, or that other policy changes may be necessary.

CONFIDENTIALITY OF TEST RESULTS

All test results are required to be treated confidentially. They will be reported by the laboratory to the Insurer. The test results may be disclosed as required by law or may be disclosed to employees of the Insurer who have the responsibility to make underwriting decisions on behalf of the Insurer or to outside legal counsel who needs such information to effectively represent the Insurer in regard to your application. The results may be disclosed to a reinsurer, if the reinsurer is involved in the underwriting process. The test may be released to an insurance medical information exchange under procedures that are designed to assure confidentiality, including the use of general codes that also cover results to tests for other diseases or conditions not related to AIDS, or for the preparation of statistical reports that do not disclose the identity of any particular person.

NOTIFICATION OF TEST RESULTS

If your test results are negative, no routine notification will be sent to you. If your test results are reported by the laboratory to the Insurer as being positive, you will receive written notification of such results from a physician you have designated or, in the absence of such designation, from the Texas Department of Health. Because a trained person should deliver that information so that you understand clearly what the test result means, please list your private physician so that the Insurer can have him or her tell you the test result and explain its meaning.

Name of physician for reporting a positive test result: *(Print or Type)* Dr Feel Good

Address: *(Street, City, State, Zip Code)* 48 Feel Good Dr Ste 101
Dallas TX 75068

In the event the test is positive and you are denied coverage because of that fact and you request the reason for the denial, the Insurer may require you to name a physician at that time in order to receive the information.

If the test indicates a positive result, but you do not designate a private physician, the test results will be provided to you by a representative of the Texas Department of Health.

Consent

I have read and I understand this Notice and Consent for HIV Related Blood and Other Bodily Fluid Testing. I voluntarily consent to the collection of a sample of blood, oral fluid extracted from cheek and gum tissue, or urine from me, the testing of the samples, and the disclosure of the test results as described above. I have read the information on this form about what a test result means.

I understand that I have the right to request and receive a copy of this authorization. A photocopy of this form will be as valid as the original.

Proposed Insured's Name: *(Print or type)* John Doe

Date of Birth: *(mm/dd/yyyy)* 01/01/1968

State of Residence: TX

Signature of Proposed Insured or Parent/Guardian: John Doe

Date: *(mm/dd/yyyy)* 01/01/2015

Copies to the Company, the Customer, the Examiner, and the Agent

National Life Group®

☐ National Life Insurance Company®
☒ Life Insurance Company of the Southwest™

Important Notice
Replacement of Life Insurance or Annuities

This document must be signed by the applicant and the producer, if there is one, and a copy left with the applicant.

You are contemplating the purchase of a life insurance policy or annuity contract. In some cases this purchase may involve discontinuing or changing an existing policy or contract. If so, a replacement is occurring. Financed purchases are also considered replacements.

A replacement occurs when a new policy or contract is purchased and, in connection with the sale, you discontinue making premium payments on the existing policy or contract, or an existing policy or contract is surrendered, forfeited, assigned to the replacing insurer, or otherwise terminated or used in a financed purchase.

A financed purchase occurs when the purchase of a new life insurance policy involves the use of funds obtained by the withdrawal or surrender of or by borrowing some or all of the policy values, including accumulated dividends, of an existing policy, to pay all or part of any premium or payment due on the new policy. A financed purchase is a replacement.

You should carefully consider whether a replacement is in your best interest. You will pay acquisition costs and there may be surrender costs deducted from your policy or contract. You may be able to make changes to your existing policy or contract to meet your insurance needs at less cost. A financed purchase will reduce the value of your existing policy and may reduce the amount paid upon the death of the insured.

We want you to understand the effects of replacements before you make your purchase decision and ask that you answer the following questions and consider the questions on page 2.

1. Are you considering discontinuing making premium payments, surrendering, forfeiting, assigning to the insurer, or otherwise terminating your existing policy or contract? ☐ Yes ☒ No
2. Are you considering using funds from your existing policies or contracts to pay premiums due on the new policy or contract? ☐ Yes ☒ No

If you answered 'Yes' to either of the above questions, list each existing policy or contract you are contemplating replacing (include the name of the insurer, the insured, and the contract number if available) and whether each policy will be replaced or used as a source of financing:

	INSURER NAME	CONTRACT OR POLICY NO.	INSURED	REPLACED (R) OR FINANCING (F)
1.				
2.				
3.				

The existing policy or contract is being replaced because: _____

Make sure you know the facts. Contact your existing company or its agent for information about the old policy or contract. If you request one, an in-force illustration, policy summary or available disclosure documents must be sent to you by the existing insurer. Ask for and retain all sales material used by the agent in the sales presentation. Be sure that you are making an informed decision.

I do not want this notice read aloud to me. _____
(Applicants must initial only if they do not want the notice read aloud.)

I certify that the responses herein are, to the best of my knowledge, accurate:

Applicant's Signature: John Doe	Date: *(mm/dd/yyyy)* 01/01/2015
Applicant's Name: *(Print.)* John Doe	Date: *(mm/dd/yyyy)* 01/01/2015
Producer's Signature:	Date: *(mm/dd/yyyy)* 01/01/2015
Producer's Name: *(Print.)* Nathan Affleck	Date: *(mm/dd/yyyy)* 01/01/2015

Copies to the Company, the Customer, and the Agent

National Life Group®

☐ National Life Insurance Company®
☑ Life Insurance Company of the Southwest™

HIPAA Compliant Authorization
for Release of Health-Related Information

I authorize any health plan, physician, health care professional, hospital, clinic, laboratory, pharmacy, medical facility, prescription benefit manager, or other health care provider that has provided payment, treatment or services to me or on my behalf within the past 10 years (collectively, "My Providers") to disclose my entire medical record, prescription drug information, and any other protected health information concerning me to National Life Insurance Company and Life Insurance Company of the Southwest (collectively, "The Company") and The Company's agents, employees, reinsurers, and representatives. This includes information on the diagnosis or treatment of Human Immunodeficiency Virus (HIV) infection and sexually transmitted diseases. This also includes information on the diagnosis and treatment of mental illness and the use of alcohol, drugs, and tobacco, but excludes psychotherapy notes. I further authorize The Company to redisclose any protected health information concerning me to The Company's reinsurers and to MIB, Inc., which operates an information exchange on behalf of life and health insurance companies.

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 My Providers to release and disclose my entire medical record without restriction.

This protected health information is to be disclosed under this Authorization so that The Company may: (1) underwrite my application for coverage, make eligibility, risk rating, policy issuance and enrollment determinations; (2) obtain reinsurance; (3) administer claims and determine or fulfill responsibility for coverage and provision of benefits; (4) administer coverage; and (5) conduct other legally permissible activities that relate to any coverage I have or have applied for with The Company.

This Authorization shall remain in force for 30 months following the date of my signature below, and a copy of this Authorization is as valid as the original. I understand that I have the right to revoke this Authorization in writing, at any time, by sending a written request for revocation to National Life Insurance Company or Life Insurance Company of the Southwest, Centralized Mailing Address, One National Life Drive, Montpelier, VT 05604, Attention: Privacy Officer. I understand that a revocation is not effective to the extent that any of My Providers has relied on this Authorization or to the extent that The Company has a legal right to contest a claim under an insurance policy or to contest the policy itself. I understand that any information that is disclosed pursuant to this Authorization may be redisclosed and no longer covered by federal rules governing privacy and confidentiality of health information.

I understand that My 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 to release my complete medical record, The Company may not be able to process my application, or if coverage has been issued, may not be able to make any benefit payments. I acknowledge that I have received a copy of this Authorization.

Proposed Insured/Patient: *(Print)* John Doe — Date of Birth: 01/01/1969

Signature of Proposed Insured/Patient or Personal Representative: John Doe — Today's Date: *(mm/dd/yyyy)* 01/01/2015

Description of Personal Representative's Authority or Relationship to Patient:

National Life Group®

Life Insurance Company of the Southwest®

Conditional Receipt

Complete for Single Life and Survivorship Life

Conditional Receipt *(to be given to applicant only upon (a) premium payment to agent or (b) completion of Part F of the application in good order and checking "EFT" as the Initial Premium Payment Method) (Not to be used for Qualified Pension or Profit Sharing Trust.)*

NOTE: ALL PREMIUM CHECKS SHOULD BE MADE PAYABLE TO LIFE INSURANCE COMPANY OF THE SOUTHWEST.
Do not make a check payable to the agent or leave the payee blank.

This receipt may not be used (and will be deemed void) if (a) either at least the first full modal premium does not accompany the application or Part F of the application is not completed in good order with "EFT" checked as the Initial Premium Payment Method or (b) the application is not accurately and fully completed in good order, including (without limitations) Parts A-J of the application. No agent or medical examiner may waive a complete answer to any question in the application.

Check one:

☐ $ _____ has been submitted by the applicant with the application, subject to the terms of this receipt.

☑ Part F of the application has been completed by the applicant in good order with "EFT" checked as the Initial Premium Payment Method, subject to the terms of this receipt.

If the check or draft, as applicable, when processed is returned as insufficient funds, no coverage is provided under this receipt.

Coverage under this receipt shall not exceed the face amount(s) applied for or $1,000,000, whichever is less. If a Proposed Insured dies by suicide, Life Insurance Company of the Southwest's (LSW) liability under this receipt is limited to a full refund of the premium paid. If applicant directed LSW to draft the initial premium payment and LSW had not yet done so, no refund will be due.

Coverage under this receipt will begin on the LATER of:

a) either (i) the date the application in good order is signed, including Part F of the application with "EFT" checked as the Initial Premium Payment Method, or (ii) the date the application in good order is signed and the first full modal premium has been received by LSW in good funds,

b) the date the last medical requirement requested by LSW is completed; provided no coverage under this receipt will begin if medical requirements requested by LSW have not been received by LSW within 90 days of the date of the application, or

c) LSW determines that each Proposed Insured is acceptable to it, under applicable underwriting standards, for the plan, benefits, amount and rate class for which the applicant applied.

Termination of Coverage. Coverage under this receipt will end on the FIRST of:

a) insurance beginning under the policy for which the applicant applied,

b) LSW declines the application or offers the applicant a policy for other than the one for which the applicant applied,

c) 90 days from the date coverage under this receipt begins, or

d) LSW notifies the applicant in writing that coverage is ended. If LSW terminates coverage under this receipt or declines the application, or if the applicant refuses a policy issued other than that for which the applicant applied, LSW will refund the full amount paid under this receipt. If applicant directed LSW to draft the first premium payment and LSW had not yet done so, no refund will be due.

Signed at: *(City & State)* DALLAS TX on this day of: *(mm/dd/yyyy)* 01/01/2015

Licensed Agent's Signature: _____ Licensed Agent's Name: *(Print)* Nate Alford

P: 800-732-8939 | www.NationalLifeGroup.com
Centralized Mailing Address: One National Life Drive, Montpelier, VT 05604 | Home Office: Addison, TX

National Life Group®

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☑ Life Insurance Company of the Southwest™

Computer View Illustration Certification

Complete one form for each application

Name of primary Proposed Insured: *(print title, first, middle, last name and suffix, as applicable)*
John Doe

Name of Owner if other than Proposed Insured:

I certify that I displayed a computer screen illustration for (name) John Doe

that complies with state requirements and for which no paper copy was furnished. The illustration was based on the following personal and contract information:

Plan of insurance: Provider

Underwriting or rating class: STD NON TOBACCO NON MED

Gender	Age	Initial death benefit	Annual Premium	Dividend option/death benefit option
☒M ☐F	45	200,000	280.17	

Signature of Licensed Agent

Date Signed: *(mm/dd/yyyy)* 01/01/2015

Licensed Agent Name & Number *(Print)*
Nate Auffort 123456

I acknowledge that I viewed a computer screen illustration based on the information as stated above. No paper copy of the illustration was furnished. I understand that an illustration conforming to the contract as issued will be provided to me no later than at the time the contract is delivered.

Signature of Primary Proposed Insured age 15 & up *(or Parent or Guardian)*
John Doe

Date Signed: *(mm/dd/yyyy)* 01/01/2015

Signature of Other Proposed Insured

Date Signed: *(mm/dd/yyyy)*

Signature of Applicant/Owner *(if other than First Proposed Insured)*

Date Signed: *(mm/dd/yyyy)*