NATIONAL WESTERN LIFE INSURANCE COMPANY®

APPLICATION FOR INDIVIDUAL LIFE INSURANCE

850 East Anderson Lane • Austin, Texas 78752-1602

I. PRIMARY INSURED (Please Print Clearly Using Black Ink)

Name of Proposed Insured (First, Middle, Last) _____ Date of Birth (mm/dd/yyyy) _____ Age _____ Place of Birth (State and Country) _____

❒ Male ❒ Female Marital Status ❒ Married ❒ Single ❒ Widowed ❒ Divorced ❒ Tobacco Use ❒ Tobacco Free

Home Address (number and street) _____ City _____ State _____ Zip _____

Social Security Number or Tax ID _____ Drivers License Number and State _____ Home Phone Number _____ Best time and place to call ❒ Home_____ ❒AM ❒PM ❒ Work _____ ❒AM ❒PM

Citizenship ❒ U.S. Citizen ❒ Foreign National Email _____

If Non US Citizen: Type of Visa_____ Exp date _____ Country of Citizenship _____

Current Employer _____ Occupation and Duties _____ Work Phone Number _____

Employer Address (number and street) _____ City _____ State _____ Zip _____

II. COVERAGE APPLIED FOR

Plan of Insurance (Name of Product) _____ **Face Amount** _____

If Universal Life: ❒ Option I ❒ Option II

If Term, Select Period ❒ 10 Yrs ❒ 15 Yrs ❒ 20 Yrs ❒ 25 Yrs ❒ 30 Yrs ❒ Other_____ Yrs

Riders: (Not all riders are available with all plans or in all states)

❒ Term Insurance Rider $_____

❒ Supplemental Life Insurance Endorsement $_____

❒ Other Insured Rider (complete Other Insured application)

❒ Accidental Death Benefit $_____

❒ Spouse Term Life Rider (complete Spouse Term/Child Rider application)

❒ Child Term Rider (complete Spouse Term/Child Rider application)

❒ Return of Premium

❒ Total Disability Premium Payment rider

❒ Waiver of Monthly Deduction rider

❒ Critical Illness Rider (complete Critical Illness application)

❒ Disability Income Rider $_____ monthly (complete Disability Income application)

❒ Waiver of Premium Disability Benefit Rider

❒ Waiver of Premium for Disability or Unemployment Rider

❒ Other _____

III. PREMIUMS

Annual Premium $_____ One Time Deposit $ _____ Planned Modal Premium $ _____ Cash with app $_____

Mode: ❒ Annual ❒ Semi-annual ❒ Quarterly ❒ Monthly ❒ Single Pay ❒ Other _____

Method: ❒ Direct ❒ Bank Draft ❒ Allotment ❒ Salary Deduction ❒ Other _____

Source of Premium: ❒ Salary ❒ Savings ❒ Investments ❒ 1035 Exchange ❒ Loan (premium financing) ❒ Other (specify)_____

Who will pay the premium? _____ Relationship to Proposed Insured _____

IV. OWNERSHIP INFORMATION (Complete only if Owner is other than the Proposed Insured)

Owner / Applicant / Trust Name _____ Date of Birth (mm/dd/yyyy) _____ SSN / TIN _____

Phone Number _____ Relationship to Proposed Insured _____

Address (number and street) _____ City _____ State _____ Zip Code _____

If the owner is a trust, please submit the Trust Information Form.

The proposed insured or owner may designate a secondary addressee to receive notification of a possible lapse in coverage.

Secondary Addressee Name_____ Address _____

V. BENEFICIARY INFORMATION (If percentages are not given, the shares will be divided equally)

Primary Beneficiaries

Full Name	Relationship	% Share
1.		
2.		
3.		

Contingent Beneficiaries

Full Name	Relationship	% Share
1.		
2.		
3.		

VI. OTHER COVERAGE AND REPLACEMENT

1. Does the Proposed Insured have any existing life insurance or annuity policies with this company or any other company? (If yes provide details in #5) ❒ Yes ❒ No
2. Does the Proposed Insured have an application pending with any other company? ❒ Yes ❒ No
   If yes, give company name, amount applied for, and total amount to be place in force in all companies. _____
3. Is this policy intended to replace any existing life insurance or annuity with this company or any other? ❒ Yes ❒ No
   (If yes, please submit appropriate state replacement forms and provide company name and details in #5)
4. Is the Proposed Owner or Proposed Insured considering using funds from an existing policy or contract to pay premiums on the Policy being applied for? (If Yes, complete the appropriate state replacement forms and provide company name and details in #5).... ❒ Yes ❒ No

5. Company	Policy Number	Type of Coverage	Amt of Coverage	To be Replaced	1035 Exchange
				❒ Yes ❒ No	❒ Yes ❒ No
				❒ Yes ❒ No	❒ Yes ❒ No
				❒ Yes ❒ No	❒ Yes ❒ No
				❒ Yes ❒ No	❒ Yes ❒ No

VII. INSURANCE NEEDS / FINANCES

❒ **Personal Insurance**

1. Purpose of Insurance ❒ Income Replacement ❒ Estate Conservation ❒ Other (specify) _____
2. Annual Earned Income _____ Annual Unearned Income _____ Total Annual Income _____
3. Assets _____ Liabilities _____ Net worth _____
4. Within the last 5 years, has the Proposed Insured filed for bankruptcy or had any judgments or liens filed against him/her?
   ❒ Yes (date of discharge)_____ ❒ No

❒ **Business Insurance**

5. Purpose of Insurance ❒ Buy-Sell ❒ Key employee ❒ Cross Purchase ❒ Secure credit ❒ Other (specify) _____
6. Is the business a: ❒ Corporation ❒ Partnership ❒ Proprietorship ❒ Other (specify) _____
7. Type of Business _____ 8. How long has the business been established? _____
9. Total Assets_____ 10. Total Liabilities_____ 11. Net Worth _____
10. What percentage of the business do you own? _____
11. Within the past 5 years, has the business filed for bankruptcy or had any liens or judgments filed against it?
    ❒ Yes (date of discharge)_____ ❒ No
12. Is business insurance being applied for or in force on other key members of the business? ❒ Yes ❒ No

VIII. TOBACCO USE

1. In the last five years has the Proposed Insured used any tobacco or nicotine products, such as smoking cigarettes, pipes or cigars; using snuff, chewing tobacco, or a nicotine delivery device such as a patch, gum or lozenge? ❒ Yes ❒ No

If yes, indicate:
Type of product _____ Frequency and amount used _____ Month/Year last used _____

IX. NON MEDICAL QUESTIONS (Provide details to all Yes answers in #9)

1. Has the Proposed Owner or Proposed Insured taken or been offered any economic incentive, free life insurance, money or any other inducement to purchase this policy? ❒ Yes ❒ No
2. Will any portion of the initial or future premiums be borrowed, loaned or otherwise financed, or paid by someone other than the Proposed Owner or Proposed Insured? ❒ Yes ❒ No
3. Does the Proposed Owner or Proposed Insured have a current agreement or commitment to sell, transfer, assign or release this policy to a Life Settlement company, Viatical company, bank, investor or other third party? ❒ Yes ❒ No
4. Has the Proposed Insured:
   a. Ever had an application or reinstatement request for life or disability insurance declined, postponed, cancelled, withdrawn, or charged an extra premium? ❒ Yes ❒ No
   b. Ever plead guilty or been convicted of a felony, have such charges currently pending, or currently on parole or probation? ❒ Yes ❒ No
   c. Been convicted of more than 1 moving violation in the last 3 years? ❒ Yes ❒ No
   d. Flown in the last 2 years, or intend to fly in the next 2 years, as a pilot, student pilot or crew member, other than as a fare paying passenger on a scheduled commercial airline? (If Yes, complete Aviation Questionnaire) ❒ Yes ❒ No
   e. Within the last 2 years, participated in, or in the next 2 years, intend to participate in, auto, motorboat or motorcycle racing, skydiving, hang gliding, hot air ballooning, mountain climbing, scuba diving? (If Yes, complete Sports and Avocation Questionnaire) ❒ Yes ❒ No
5. In the last 5 years has the Proposed Insured been convicted of driving under the influence of alcohol or drugs, reckless driving, or had their drivers license revoked or suspended? ❒ Yes ❒ No
6. In the last 5 years has the Proposed Insured used cocaine, amphetamines, barbiturates, hallucinogens, narcotics, or any other drugs other than as prescribed by a member of the medical profession? (If Yes, complete Drug and Alcohol Questionnaire) ❒ Yes ❒ No
7. In the last 10 years, has the Proposed Insured ever received medical treatment or counseling for, or been advised by a physician to discontinue, the use of alcohol or prescribed or non-prescribed drugs? (If Yes, complete Drug and Alcohol Questionnaire) ❒ Yes ❒ No
8. Does the Proposed Insured currently use alcoholic beverages? ❒ Yes ❒ No
   If Yes, what is the average number of drinks per day? ❒ 2 or less ❒ 3-5 ❒ 6 or more
9. Are you a member, or in the next four years do you intend to become a member of the armed forces, including the reserves or national guard? ❒ Yes ❒ No
10. Details to Yes answers for questions 1 thru 7 (Identify question number and include all details)

X. MEDICAL INFORMATION

1. What is the height and weight of the Proposed Insured? Height _____ft _____in Weight _____lbs
2. Has the Proposed Insured lost or gained more than 10 pounds in the last year? ❒ Yes ❒ No
   If Yes, amount of weight change _____ Lbs ❒ Gain ❒ Loss Reason _____
3. Personal Physician:

Name _____ Phone number _____

_____	_____	_____	_____
Address (number and street)	City	State	Zip Code

Date last seen _____ Reason _____

XI. MEDICAL HISTORY (To be completed even if an exam is being done)

1. Has the Proposed Insured ever had, or been treated for or diagnosed by a member of the medical profession as having any of the following?
   a. Coronary artery disease, chest pain, angina, heart attack, angioplasty, heart surgery, congestive heart failure, heart murmur, atrial fibrillation, irregular heart beat, cardiomyopathy or any other disease or disorder of the heart or circulatory system? .. ❒ Yes ❒ No
   b. High blood pressure, stroke, transient ischemic attack(TIA), carotid artery or peripheral vascular disease, aneurysm, anemia, or other disease or disorder of the blood or arteries? ..... ❒ Yes ❒ No
   c. Diabetes, disease or disorder of the thyroid, pancreas, endocrine glands or immune system? ..... ❒ Yes ❒ No
   d. Cancer, tumors, leukemia, lymphoma, Hodgkin's disease, Multiple Myeloma or other malignant disease or disorder? ..... ❒ Yes ❒ No
   e. Asthma, emphysema, chronic bronchitis, chronic obstructive lung disease (COPD), sleep apnea, or any other disease or disorder of the lung or respiratory system?..... ❒ Yes ❒ No
   f. Headaches, seizures, epilepsy, multiple sclerosis, Alzheimer's disease, dementia, memory loss, Parkinson's disease or any other disease or disorder of the brain or nervous system? ..... ❒ Yes ❒ No
   g. Depression, psychosis, neurosis, affective disorder, anxiety or any other psychiatric or mental health disease or disorder?.. ❒ Yes ❒ No
   h. Crohn's disease, ulcerative colitis, hepatitis, cirrhosis of the liver, or any other disease or disorder of the stomach, liver, colon, rectum or intestines?..... ❒ Yes ❒ No
   i. Disease of the kidney, bladder, prostate, breast, urinary tract or reproductive system, sugar, blood or protein in the urine, or any sexually transmitted disease or organ transplant?..... ❒ Yes ❒ No
   j. Arthritis, osteoporosis, lupus, paralysis, muscular dystrophy, or other disease or disorder of the muscles, bones, joints or skin? ..... ❒ Yes ❒ No
   k. Any disease or disorder of the eyes, ears, nose or throat? ..... ❒ Yes ❒ No
2. Has the Proposed Insured been advised by a member of the medical profession to get specified medical care which was not completed, such as any hospitalization, surgery or diagnostic test, except those tests related to Human Immunodeficiency Virus (AIDS virus)? ..... ❒ Yes ❒ No
3. In the past 5 years, has the Proposed Insured been treated or diagnosed by a member of the medical profession for any disease, disorder or condition not stated previously?..... ❒ Yes ❒ No
4. To the best of your knowledge, have any of the Proposed Insured's parents or siblings died from cardiovascular disease or cancer prior to age 65? (If Yes, provide relationship to the Proposed Insured, age at death, cause of death, and if cancer, provide type) ..... ❒ Yes ❒ No
5. Has the Proposed Insured tested positive for exposure to the HIV infection or been diagnosed as having ARC or AIDS caused by the HIV infection or other sickness or condition derived from such infection? ..... ❒ Yes ❒ No

Details to #1 thru #4. (Provide full details including, condition, dates, doctor's name and address and medications)

Proposed Insured _____

Each of the undersigned: Declares that all answers in this application are true and complete to the best of their knowledge and belief, and understands that: (a) all statements and answers in this application will be relied upon by the Company to determine insurability and to issue the policy; (b) no information will be considered given to the company unless it is stated in an application; (c) the Company's agent does not have the Company's authorization to accept risk, pass on insurability, or make, void, waive, or change any conditions or provisions in the application, policy or receipt, as applicable; and (d) a material misrepresentation may void the policy during the contestable period. This policy will take effect when: (1) the application is approved at National Western's Office in Austin, Texas; (2) National Western delivers the policy; (3) the initial premium has been paid; and (4) each of the prior three conditions is satisfied while the proposed insureds are alive and their health and insurability are as described herein.

Proposed Insured: Authorizes any licensed physician, medical practitioner, hospital, other health care provider, insurance company or the MIB, Inc., formerly known as Medical Information Bureau, or other organization or person to give any information about me or my mental or physical health to the Company and/or its authorized agents to determine my eligibility for life insurance coverage. The Company may disclose such information to its reinsurers and the MIB, Inc. National Western or its reinsurers may also release such information to other life or health insurance companies to whom an application for insurance or to whom a claim for benefits is submitted. This authorization also applies to any member of my family proposed for coverage in the application and is valid for 2 years after the date shown below. A photocopy of this form is as valid as the original. I may have a copy of this form upon request. I understand that I may revoke this authorization by notifying the company in writing and that such revocation will be effective upon the date received by the company.

Each of the undersigned acknowledges receipt of the Notice under the Fair Credit Reporting Act (Consumer Report Notice), MIB Disclosure Notice, and Notice of Information Practices (if applicable).

ANY PERSON WHO KNOWINGLY AND WITH INTENT TO INJURE, DEFRAUD, OR DECEIVE ANY INSURER FILES A STATEMENT OF CLAIM OR AN APPLICATION CONTAINING ANY FALSE, INCOMPLETE, OR MISLEADING INFORMATION IS GUILTY OF A FELONY OF THE THIRD DEGREE.

Signed at _____ Date_____
City and State

_____ _____
Signature of Proposed Insured (parent if age 17 or less)

Signature of Owner if other than Proposed Insured
(If a Trust, signature of trustee)
(If business or corporation, officer, other than Proposed insured, and Title)

_____ _____
Agent Name (please print) License No.

Signature of Agent

AGENT REPORT

1. How long have you known the Proposed Insured?_____ Are you related? ❒ Yes ❒ No If yes, How _____
2. Proposed Insured's estimated Income $ _____ Estimated Net Worth $ _____

   Purpose of Insurance _____
3. Is the Proposed Insured married? ❒ Yes ❒ No If yes, indicate the amount of Insurance in force on spouse $ _____

   If spouse is not insured, give reason: _____
4. Is any Proposed insured a minor? ❒ Yes ❒ No If yes, indicate the amount of Insurance in force on parents and all siblings:

   Father $_____ Mother $_____ Siblings (name and amount) _____

   If parents and all siblings are not insured, give reason: _____
5. Did you personally see the Proposed Insured(s) and complete the application in his and/or her presence? ..... ❒ Yes ❒ No

   If No, please explain: _____
6. Are you aware of any information about any of the Proposed Insured(s) that might affect his/her insurability? ..... ❒ Yes ❒ No

   If Yes, give details: _____
7. Will the policy applied for replace or change any existing life insurance or annuity? ..... ❒ Yes ❒ No
8. Do you have any knowledge or reason to believe:
   a. that the Proposed Insured or Owner is considering assigning or transferring any rights or interest in this policy to an unrelated third party such as a Life Settlement company, Viatical, Investor, trust, bank, lending institution or other third party? ..... ❒ Yes ❒ No
   b. that any of the initial or future premiums will be borrowed, loaned or otherwise financed? ..... ❒ Yes ❒ No
   c. that the Proposed Insured or Owner has taken or been offered any incentive, financial or other, or been offered free insurance as an inducement to purchase this policy? ..... ❒ Yes ❒ No
9. Did you accept money with this application? ..... ❒ Yes ❒ No

   If yes, was the Temporary Insurance Agreement $ receipt completed and given to the Proposed Insured or Proposed Owner? .. ❒ Yes ❒ No

USA PATRIOT Act Notice

1. The USA PATRIOT Act requires that we establish an Anti-Money Laundering (AML) Compliance Program, and as part of our Program, National Western Life Insurance Company® requires that its agents/brokers/consultants verify the identity of the proposed owner(s) of our contracts and collect documents and/or information sufficient to provide such verification. Please refer to your company-specific AML training materials for more detailed information.

   Owner/Trustee Verification - In order to satisfy such obligations, we require that you review and verify a current driver's license or government-issued photo ID for the proposed Owner/Trustee associated with the contract.
2. Do you certify that you personally met with the proposed Owner/Trustee and reviewed his or her identification document (driver's license or government-issued photo ID) and that to the best of your knowledge, it accurately reflects the identity of the proposed Owner/Trustee? ..... ❒ Yes ❒ No

   If no, please explain_____

   _____

I certify that:

a. the insurance being applied for is suitable for the Proposed Insured's needs and financial objectives
b. the consumer notices were delivered to the Proposed Insured or Owner;
c. all questions on the application were asked of each Proposed Insured, and the answers were recorded as given, prior to the application being signed;
d. the temporary insurance agreement was explained fully and (if applicable), the receipt was given.
e. the answers given in this application and Agent's Report are complete and accurate to the best of my knowledge and belief

Date _____ Agent Signature _____ Print Agent Name_____

Licensed agent(s) to receive commissions (please print) **Florida License Number** _____

Name of Agent	Agent No.	Percent of commission	Agent phone #	Agent Email address
1.				
2.				
3.				

TEMPORARY INSURANCE AGREEMENT & RECEIPT

This agreement shall be void if altered or modified. • Premium checks must be made payable to National Western Life.
Proposed Insured _____ Amount Paid $ _____ Application Date_____
Subject to all terms and conditions of the insurance policy applied for in this application, this Temporary Insurance Agreement & Receipt (TIA) provides Temporary Insurance in the amount of the lesser of: (a) the amount of insurance applied for; or (b) $50,000 on each proposed insured; or (c) $250,000 in the aggregate for all insureds listed on the application. This Temporary Insurance will take effect on the effective date and end as defined below.
I have read this Temporary Insurance Agreement & Receipt and it has been explained to me by the agent. I understand and agree to all conditions and limitations. Proposed owner's signature _____ Date _____

I explained and witnessed the signing of this Agreement.
01-9058FL-14 Receipt Agent's signature _____ Date _____

Temporary Insurance will take effect on the date that the following four requirements are met: (1) the application is fully completed, including any amendments required by National Western; (2) the initial premium has been paid; and (3) all medical exams or tests required by National Western are completed; and (4) as of the date of this Agreement, the proposed insured must be insurable at standard rates for the type and amount of insurance applied for.

Temporary Insurance will end on the earliest of the following dates: (1) the date insurance begins under the policy applied for; (2) the date this application is cancelled or declined; or (3) 60 days have passed since the date of this application.

DETACH AND KEEP THIS NOTICE

Date_____

NOTICE UNDER THE FAIR CREDIT REPORTING ACT. This is to inform you that, as part of our procedure for processing your application for insurance, an investigative consumer report may be prepared whereby information is obtained through personal interviews with your neighbors, friends, or others with whom you are acquainted. This inquiry includes information as to your character, general reputation, personal characteristics and mode of living. None of the information described in this paragraph will be used to establish, or aid in establishing, the proposed insured's sexual orientation. 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.

MIB DISCLOSURE NOTICE. Information regarding your insurability will be treated as confidential; however, we or our reinsurers may make a brief report thereon to the MIB, Inc., formerly known as Medical Information Bureau, a not-for-profit membership of insurance companies which operates an information exchange on behalf of its members. If you apply to another MIB member company for life or health insurance coverage, or a claim for benefits is submitted to such company, MIB, upon request, will supply such company with the information about you in its file. Upon receipt of a request from you, MIB will arrange disclosure of any information in your file. Please contact MIB at 866 692-6901 (TTY 866 346-3642). If you question the accuracy of information in MIB's file, you may contact MIB and seek a correction in accordance with the procedures set forth in the federal Fair Credit Reporting Act. The address of MIB's information office is 50 Braintree Hill Park, Suite 400, Braintree, Massachusetts 02184-8734. We or our reinsurers may also release information to other life or health insurance companies to whom you may (1) apply for life or health insurance, or (2) submit a claim for benefits. Information for consumers about MIB may be obtained on its website at www.mib.com.

NOTICE OF INFORMATION PRACTICES. Residents of Arizona, California, Georgia, Illinois, Maine, Minnesota, Montana, Nevada, North Carolina, Ohio, Oregon and Virginia must be given and sign an Authorization to Obtain and Disclose Information and Notice of Information Practice [SU-6412(Rev.9/00)].