NATIONAL WESTERN LIFE INSURANCE COMPANY

APPLICATION FOR OTHER INSURED RIDER

850 East Anderson Lane • Austin, Texas 78752-1602

(Complete an application for each Other Insured)

Proposed Primary Insured _____

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

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

❒ Male ❒ Female ❒ Tobacco Use ❒ Tobacco Free

Residence Address (street and number)	City	State	Zip	Home Phone	Business Phone

Face Amount	Annual Income	Net Worth	Relationship to Primary Insured

Occupation and Duties _____

Citizenship ❒ U.S. Citizen ❒ Foreign National Type of Visa _____ Exp date _____

Country of Citizenship _____ Drivers License # and State _____

II. TOBACCO / NICOTINE USE

1. In the last five years has the Proposed Other 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, provide details:

Type of product used _____ Frequency and amount used _____ Month/Year last used _____

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

Primary Beneficiaries

Full Name	Relationship	% Share
1.		
2.		

Contingent Beneficiaries

Full Name	Relationship	% Share
1.		
2.		

IV. NON MEDICAL QUESTIONS (Provide details below to all Yes answers in this section)

1. Has the Proposed Other 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   a. Ever had an application or reinstatement request for life or disability insurance declined, postponed, cancelled, withdrawn, or charged an extra premium?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. Any intention to travel or reside outside the United States in the next 2 years? (if Yes, state, where, when and how long) ..... ❒ Yes ❒ No
   d. Been convicted of more than 1 moving violation in the last 3 years? ..... ❒ Yes ❒ No
   e. 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
   f. 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
2. In the last 5 years has the Proposed Other Insured been convicted of driving under the influence of alcohol or drugs, reckless driving, or had their drivers license revoked or suspended? ..... ❒ Yes ❒ No
3. In the last 5 years has the Proposed Other 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
4. In the last 10 years, has the Proposed Other 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
5. Does the Proposed Other 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
6. Is the Proposed Other Insured a member of the military, military reserve, or National Guard, whether active or inactive? If Yes, provide details such as military duties and responsibilities, rank, and dates and locations of service. ..... ❒ Yes ❒ No
7. Has the Proposed Other Insured entered into a written agreement to become a member of the military, military reserve, or National Guard, whether active or inactive, at a future date?If Yes, provide details such as date, location and duties of anticipated service. .. ❒ Yes ❒ No

Proposed Primary Insured _____

Provide details to any Yes answers to questions 1 thru 7 in IV. Non Medical Questions.

V. MEDICAL HISTORY (To be completed even if an exam will be done)

1. What is the height and weight of Proposed Other Insured? Height _____ft _____in Weight _____lbs
2. Has Proposed Other 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. Provide name and address of personal physician, and the date and reason last seen
   _____
   _____
4. Has the Proposed Other Insured ever been diagnosed, treated, tested positive for, or been given medical advice by a member of the medical profession for a disease or disorder such as:
   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
5. Has the Proposed Other 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
6. In the past 5 years, has the Proposed Other Insured been treated or diagnosed by a member of the medical profession for any disease, disorder or condition not stated previously?..... ❒ Yes ❒ No
7. Has the Proposed Other Insured ever been diagnosed by a member of the medical profession or tested positive for Human Immunodeficiency Virus (AIDS virus) or Acquired Immune Deficiency Syndrome (AIDS)? ..... ❒ Yes ❒ No
8. Have any of the Proposed Other Insured's parents or siblings died from cardiovascular disease or cancer, prior to age 65? (If Yes, provide relationship to the Proposed Other Insured, age at death, cause of death, and if cancer, provide type) ..... ❒ Yes ❒ No

Details to #1 thru 8. (Provide full details including, condition, treatment, dates, doctor's name and address and medications)

Proposed Primary Insured _____

VI. OTHER COVERAGE AND REPLACEMENT

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

5. Insured	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

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.

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 PRESENTS A FALSE STATEMENT IN AN APPLICATION FOR INSURANCE MAY BE GUILTY OF A CRIMINAL OFFENSE AND SUBJECT TO PENALTIES UNDER STATE LAW.

Signed at _____ Date _____
City and State

_____ _____
Signature of Proposed Other Insured Signature of Owner

_____ _____
Agent Name (please print) License No. Signature of Agent