



CHANGE REQUEST

PLEASE PRINT LEGIBLY OR USE TYPEWRITER If additional space is required, use "OTHER" section below		NEW ADDRESS GIVEN BELOW? <input type="checkbox"/> NO <input type="checkbox"/> INSURED'S <input type="checkbox"/> OWNER'S		NUMBER	
INSURED 1	ADDRESS	CITY	STATE	ZIP CODE	
INSURED 2	ADDRESS	CITY	STATE	ZIP CODE	

SECTION A — Change Request (New Coverage specifics)

NEW PLAN	UNDERWRITING CLASS	DEATH BENEFIT OPTION	<input type="checkbox"/> Option A <input type="checkbox"/> Option B <input type="checkbox"/> Option C _____% increase <input type="checkbox"/> Option D _____% increase _____years		
TYPE OF CONVERSION	<input type="checkbox"/> Basic Plan <input type="checkbox"/> Term Rider <input type="checkbox"/> Full <input type="checkbox"/> Partial	CARRY BENEFITS OVER TO THE NEW COVERAGE <input type="checkbox"/> Yes <input type="checkbox"/> No REMAINING INSURANCE AFTER PARTIAL CONVERSION TO BE <input type="checkbox"/> Continued <input type="checkbox"/> Discontinued			
CHANGE EXISTING COVERAGE					
CHANGE FACE AMOUNT (If increasing, complete reverse side)	<input type="checkbox"/> Increase to \$ <input type="checkbox"/> Decrease to \$	<input type="checkbox"/> FREEZE <input type="checkbox"/> THAW			
<input type="checkbox"/> RE-ENTRY (Complete reverse side)	<input type="checkbox"/> CONSIDER CLASS CHANGE TO <input type="checkbox"/> CONSIDER RATE REDUCTION TO (complete reverse side)				
<input type="checkbox"/> EXERCISE OPAI (If original plan does not have smoking classification, answer question #7 on reverse side)					
SUPPLEMENTARY BENEFITS CHANGE (If adding complete reverse side)					
ADD	DELETE	ADD	DELETE	State # of units	
<input type="checkbox"/>	<input type="checkbox"/>	WAIVER OF PREMIUM	<input type="checkbox"/>	<input type="checkbox"/>	FAMILY PROTECTION (S & C)
<input type="checkbox"/>	<input type="checkbox"/>	ACCIDENTAL DEATH BENEFIT	<input type="checkbox"/>	<input type="checkbox"/>	FAMILY PROTECTION (C ONLY)
<input type="checkbox"/>	<input type="checkbox"/>	OPAI	<input type="checkbox"/>	<input type="checkbox"/>	SPOUSE COVERAGE
<input type="checkbox"/> CHANGE DEATH BENEFIT OPTION TO: <input type="checkbox"/> Option A (increasing) <input type="checkbox"/> Option C _____% increase <input type="checkbox"/> Option B (level) <input type="checkbox"/> Option D _____% increase for _____ years (complete reverse side when going to A, C, D)					
OTHER:					

SECTION B — Mode of premium payment

PAYMENT SUBMITTED WITH THIS CHANGE REQUEST \$	
PLANNED PERIODIC PREMIUM \$	<input type="checkbox"/> ANNUAL <input type="checkbox"/> SEMI-ANNUAL <input type="checkbox"/> QUARTERLY <input type="checkbox"/> LIST BILL <input type="checkbox"/> MGA
<input type="checkbox"/> PAC COMPLETED REQUEST FOR PRE-AUTHORIZED CHECK (PAC) PLAN FORM OR L-1683 WITH A VOIDED SAMPLE CHECK, MUST BE SUBMITTED WITH THIS CONVERSION/CHANGE REQUEST.	DRAFT START DATE

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

Continuation of Application for Change - Evidence of Insurability

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

1. INSURED: (Print full name) <input type="checkbox"/> Male <input type="checkbox"/> Female	2. BIRTHDATE	3. BIRTHPLACE	4. OCCUPATION: (Give title/Duties)
5. a. Height: _____ ft. _____ in. Weight: _____ lbs. b. Weight loss of more than 10 lbs. in last 12 months? <input type="checkbox"/> Yes <input type="checkbox"/> NO			
c. Name and address of personal physician/health care facility: (If none, check here _____ and omit d, e, and f)			
d. Date last consulted: _____ e. Reason _____			
f. Any medication or treatment? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, describe _____			
6. Other than this policy, state your total amount of life insurance inforce? <input type="checkbox"/> None <input type="checkbox"/> \$ _____			
7. Tobacco use — Have you used tobacco in any form during the past 12 months? <input type="checkbox"/> Yes <input type="checkbox"/> No (Answer a or b below)			
a. If Yes, forms used ? <input type="checkbox"/> Cigarettes <input type="checkbox"/> Other: _____ No. per day? _____ For how long? _____ years.			
b. If No, <input type="checkbox"/> Never used <input type="checkbox"/> Quit — give month _____ year _____ If cigarettes, used _____ per day for _____ years.			

SECTION E - Complete if other persons are proposed for insurance

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

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

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

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

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

SECTION G – Agreement, Authorization and Disclosure Information

IT IS UNDERSTOOD AND AGREED THAT:

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

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

Medical Authorization - To determine eligibility for insurance, I authorize: (1) any physician, medical practitioner, health care professional, hospital, clinic, or other medical or medically related facility, laboratory, pharmacy or pharmacy benefit manager, insurance or reinsuring company, viatical company, viatical broker or provider, the Medical Information Bureau, Inc., consumer reporting agency, insurance support organization, independent administrator, or pharmacy, governmental agency, group policyholder, employer or benefit plan administrator having information available as to diagnosis, prescription history, medications prescribed, treatment and prognosis with respect to information regarding alcoholism, drug abuse, and psychiatric care or any physical or mental condition and/or treatment of me or my minor children and financial, avocation, hazardous sports, aviation, driving, arrest, and credit information of me or my minor children, to give to North American Company for Life and Health Insurance (“the Company”), its representatives or reinsurers, any and all such data; (2) the Company to conduct a personal telephone interview in connection with my application; and (3) the Company to release any such data to its reinsurers, the Medical Information Bureau, or other persons or organizations performing business or legal services in connection with my application, or as required by law when given a copy of this authorization. Data released may include results of my medical examination or tests requested by the Company. I understand that I may request to be interviewed in connection with the preparation of an investigative consumer report and that I am entitled to receive a copy of such report upon request. This authorization is valid for the time period required by the state where the application is written from the earlier of: (1) the date signed, or (2) the Certificate Date. I may revoke this authorization for information not then obtained by notifying the Company in writing. Such revocation will not be effective until received by the Company. I understand that I or any authorized representative will receive a copy of this authorization upon request.

SECTION H – Signatures

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

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

