



POLICY CHANGE REQUEST

Part 1

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		POLICY NUMBER	
INSURED 1	ADDRESS	CITY	STATE	ZIP CODE	
INSURED 2	ADDRESS	CITY	STATE	ZIP CODE	
Secondary Addressee Billing Notice for Lapse for Nonpayment of Premium: <input type="checkbox"/> YES (Provide name, address, zip code) <input type="checkbox"/> NO					

SECTION A — Change Request (New policy 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 POLICY <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 POLICY				
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"/>	<input type="checkbox"/>	<input type="checkbox"/>	WAIVER OF PREMIUM
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	FAMILY PROTECTION (S & C)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	ACCIDENTAL DEATH BENEFIT
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	FAMILY PROTECTION (C ONLY)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	OPAI
<input type="checkbox"/>	<input type="checkbox"/>	<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)

--



O21322RME2

Continuation of Application for Policy Change - Evidence of Insurability

Part 2

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

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

SECTION E - Complete if other persons are proposed for insurance

1. Spouse and children: Note - for family or children insurance include all dependent natural children, legally adopted and stepchildren under age 24.
Table with columns: Proposed, Print full name, Sex, Age, Birthdate, Birthplace, Height, Weight
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?
b. Any other application for new life insurance or changes to any existing policy pending or contemplated?
c. Had an application for life or health insurance or reinstatement declined, rated, or modified in any way?
d. Been convicted within the last 3 years for a moving violation, or driving while under the influence, or had a driver's license suspended or revoked? (If yes, give driver's license number and state issued in REMARKS)
e. Within the last 3 years, flown as a pilot or crewmember of any aircraft, done any underwater diving, parachuting, mountain climbing, vehicle racing of any kind or intend to do so?
2. Has any person proposed for insurance ever been diagnosed as having, been treated for or been told by any physician or other medical professional that they had:
a. Cancer, tumor, or other malignancy, high blood pressure, heart or circulatory disease, heart murmur, stroke, epilepsy, brain, nervous or mental disorder, ulcers, hepatitis, or other disorder of the stomach, liver or intestines, tuberculosis, lung or other respiratory disorder, kidney, bladder or venereal disease*, blood* or glandular disorder, arthritis or other bone or joint disorder or diabetes?
b. Immune deficiency order [Acquired Immunodeficiency Syndrome (AIDS), AIDS related complex (ARC)] or been told test results indicate exposure to the AIDS virus?*
3. Within the past five years has any person proposed for insurance:
a. Consulted, been examined or treated by any physician or medical professional, or been admitted to or treated at a hospital or other facility for any disease or condition not indicated in question #2 above?*
b. Had an X-ray, EKG or other heart study, laboratory test, or been advised to have a surgical operation?*
c. Been treated for alcoholism or substance (drug) abuse, or been a regular or frequent user of cocaine or other stimulants, hallucinogens or narcotics not prescribed by a physician?

*Answer these questions "NO", if you have tested positive for HIV but have not developed symptoms of the disease AIDS/ARC.

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

O21322RME3

IT IS UNDERSTOOD AND AGREED THAT:

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

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

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 30 months from the earlier of: (1) the date signed, or (2) the Policy 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. Failure to sign an authorization statement or revoking it may impair the ability of a regulated insurance agency to evaluate claims or process applications and may be a basis for denying an application or claim for benefits.

***This authorization excludes disclosure of the result of a test for HIV if the applicant has tested HIV positive but has not developed symptoms of the disease AIDS. Such test results shall not be discovered or published. Nothing in this caveat will prohibit this authorization from including the fact that the applicant has AIDS.**

Fraud Warning: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or denial of insurance benefits.

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.*