North American Company
for Life and Health Insurance
Principal Office: 4601 Westown Pkwy, Suite 300
West Des Moines, IA 50266
A Member of the Sammons Financial Group

L2875101

STATEMENT OF HEALTH

Name of Proposed Insured: ________________________ Policy Number(s): ____________________

Please complete this Statement of Health as a condition to the Delivery or change of the policy(ies) referenced above. **If the answer to any question is checked "yes", please explain in the "Details" section below.** Pertinent dates, severity, treatment, duration, outcome; names, addresses of physicians, hospitals or clinics should also be included, along with any "Exceptions" to any of the statements below.

This is to certify, that since the date of the original application(s) I (the Insured):	**YES**	**NO**
1. have consulted or been treated by any physician or practitioner or had any physical disability or impairment, sickness, injury, surgery or mental disorder;	☐	☐
2. have had a physical examination, lab tests, EKG or X-ray procedures	☐	☐
3. have used tobacco in any form; **(**If Yes, give form used, number per day and length of time used in "Details".)	☐	☐
4. have made an application(s) for insurance which has been declined, postponed, or modified;	☐	☐
5. have other application(s) for insurance pending with another company(ies) at the present time	☐	☐
6. have changed occupation (if yes, give all occupations-employers; types of industry and duties.)	☐	☐
7. have engaged in or expect to engage in any of the following: aviation activities as a pilot or crew member; aqualung or skin diving; automobile, motorcycle or motor boat racing; mountain climbing; rodeo competition; sky-diving; parachuting; hang gliding or cave exploration.	☐	☐

DETAILS:

I certify that I have read the above completed health statement or that it has been read to me. I understand that any false statement or representation in the application and/or health statement may result in loss of coverage under the policy/certificate. I agree that the answers given above will become a part of the original application, including any supplement to the application. So far as I know and believe, the original application, as changed above, is true, complete and up-to-date

______________________________	______________________________	__________________
Signature of Proposed Insured	Signature of Proposed Owner*	Date

*If signing on behalf of a corporation, trust, or other entity, print your title next to your signature.

Mail To: New Business • P.O. Box 5089 • Sioux Falls, SD 57117-5089