Clear Form Clear Kit

North American Company for Life and Health Insurance

ICC19L3186B

INDIVIDUAL LIFE INSURANCE APPLICATION PART 2

PROPOSED INSURED

Legal Last Name

Legal First Name M. I.

Social Security Number ___ - ___ - ___

Date of Birth (M M - D D - Y Y Y Y) ___ - ___ - ____

1a. Indicate the number of cigars used in the past 12 months:
☐ None ☐ 1 to 12 ☐ 13 to 24 ☐ 25 or more

1b. In the past 5 years, have you used any nicotine products including cigarettes, E-cigarettes, vapor products, pipe, snuff, chewing tobacco, or nicotine gum or patches? *(If yes, complete question 1 and 2.)* ☐ Yes ☐ No

1) What product(s)? ☐ Cigarettes ☐ E-cigarettes ☐ Vapor products ☐ Pipe ☐ Snuff ☐ Chewing tobacco ☐ Nicotine gum or patches

2) Last use of any of these products was within the: ☐ last 12 months ☐ last 2 years ☐ last 3 years ☐ last 5 years

2a. Do you use alcoholic beverages? *(If yes, complete question 2b.)* ☐ Yes ☐ No

2b. Amount: _____ Frequency: _____

3. Are you actively employed? *(If no, provide reason in the DETAILS section below.)* ☐ Yes ☐ No

4. Are you a U.S. citizen or do you have a U.S. permanent resident card (green card)? ☐ Yes ☐ No

5. In the next 12 months, do you plan to travel or reside outside the United States or Canada? ☐ Yes ☐ No

6. Are you an active member of the U.S. Armed Forces, Reserves, or National Guard? ☐ Yes ☐ No

7. In the past 24 months, have you:

a. Flown as a pilot or crew member, except on a regularly scheduled commercial airline, or intend to do this in the next 24 months? ☐ Yes ☐ No

b. Engaged in scuba diving, mountain or rock climbing, hang gliding, skydiving, or motorcycle, automobile or boat racing or intend to do any of these in the next 24 months? ☐ Yes ☐ No

8. In the past 5 years, have you:

a. Been convicted of or pleaded guilty to reckless driving, driving under the influence of alcohol or any drug, or had your driver's license suspended or revoked, or in the past 3 years, have you had 3 or more moving violations? ☐ Yes ☐ No

b. Filed bankruptcy? ☐ Yes ☐ No
(If yes, provide details below of all chapters filed, discharge date or expected discharge date, and if applicable, the monthly payments and total amount still owed.)

c. Been declined, postponed, or charged an extra premium for life insurance? ☐ Yes ☐ No

9. In the past 10 years, have you:

a. Ever used prescription medications such as sedatives, amphetamines, opioids, or narcotics that were not prescribed to you by your licensed medical professional? ☐ Yes ☐ No

b. Ever used any form of marijuana (whether legal or illegal) or cocaine, ecstasy, heroin, hallucinogens, or other drugs of abuse? ☐ Yes ☐ No

c. Been medically treated for alcohol abuse or dependence, or been told by a licensed medical professional to limit your alcohol use? ☐ Yes ☐ No

10. Have you ever been on parole or probation, or been convicted of or have charges pending for a felony or misdemeanor? ☐ Yes ☐ No

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DETAILS TO 'YES' ANSWERS FOR QUESTIONS 5 THROUGH 10 AND 'NO' ANSWERS TO QUESTIONS 3 AND 4.
If more space is needed, attach a completed and signed Application Overflow Page.

Question #	Dates and Details (If applicable, include Name, Address and Telephone Number of Physician, Health Care Provider, or Medical Facility)

11. In the past 5 years, have you been seen for primary care by a licensed medical professional or at a medical facility? ..... ☐ Yes ☐ No
(If yes, provide details below.)

Physician, Health Care Provider, or Medical Facility Name/Address/Telephone Number	Date Last Seen	Reason Seen	Results

12a. Height: _____ feet _____ inches Weight: _____ pounds

12b. In the past 12 months, have you lost more than 10 pounds? *(If yes, complete question 1 and 2.)* ..... ☐ Yes ☐ No

1) How many pounds? _____

2) Reason for weight loss: ☐ Diet/Exercise ☐ Surgery ☐ Childbirth ☐ Diagnosed medical condition ☐ Medication ☐ Unknown

13. In the past 5 years, have you had weight loss surgery? ..... ☐ Yes ☐ No
(If yes, provide date and type of surgery in DETAILS section below.)

14. Have you ever been medically diagnosed, medically treated, or prescribed medication by a licensed medical professional for:

a. Acquired Immune Deficiency Syndrome (AIDS) or tested positive for HIV infection? ..... ☐ Yes ☐ No

b. Cancer (excluding basal and squamous cell skin cancer), malignant melanoma, lymphoma, or leukemia? ..... ☐ Yes ☐ No

c. Heart disease including angina, heart attack, angioplasty, balloon, stent, or bypass? ..... ☐ Yes ☐ No

d. Cardiomyopathy, heart failure, valve disorder or heart murmur? ..... ☐ Yes ☐ No

15. In the past 10 years, have you been medically diagnosed, medically treated, or prescribed medication by a licensed medical professional for:

a. High blood pressure, high cholesterol, arrhythmia, abnormal electrocardiogram (EKG), other heart disorder, or do you have a pacemaker or defibrillator? ..... ☐ Yes ☐ No

b. High blood sugar or diabetes, thyroid disorder, or disorder of the adrenal, pituitary or parathyroid gland? ..... ☐ Yes ☐ No

c. Bipolar disorder, depression, anxiety, attention deficit disorder, eating disorder, schizophrenia, suicide attempt, or other emotional disorder? ..... ☐ Yes ☐ No

d. Asthma, Chronic Obstructive Pulmonary Disease (COPD), emphysema, chronic bronchitis, sarcoidosis, sleep apnea, or other respiratory disorder? ..... ☐ Yes ☐ No

e. Aneurysm, stroke, mini-stroke (TIA), blood clot of the leg or lung, peripheral arterial disease, or other disease or disorder of the blood vessels? ..... ☐ Yes ☐ No

f. Mental or memory impairment, dementia, epilepsy or seizures, brain tumor, or other brain injury or disorder? ..... ☐ Yes ☐ No

g. Rheumatoid arthritis, chronic pain, systemic lupus, or other connective tissue disorder? ..... ☐ Yes ☐ No

h. Pancreatitis, ulcerative colitis, Crohn's disease, liver cirrhosis, hepatitis, or other gastrointestinal disorder including the liver, gallbladder, esophagus, stomach, or intestines? ☐ Yes ☐ No

i. Anemia, immune deficiency, spleen disorder, or other blood disorder? ☐ Yes ☐ No

j. Bladder disorder, kidney or renal insufficiency or failure, recurring protein or blood in the urine, or other kidney disorder (except for one episode of kidney stones)? ☐ Yes ☐ No

k. Muscular dystrophy, multiple sclerosis, Parkinson's disease, myasthenia gravis, paralysis, or other neurological disorder? ☐ Yes ☐ No

l. **(Males only)** Elevated PSA, or disorder of the prostate or testicle? ☐ Yes ☐ No

m. **(Females only)** Disorder of the breast, ovary, or uterus? ☐ Yes ☐ No

16a. (Females only) Are you currently pregnant? *(If yes, complete question 16b.)* ☐ Yes ☐ No

16b. What was your pre-pregnancy weight? _____

17. Other than tests related to the HIV virus, in the past 24 months, have you had an abnormal diagnostic test, or been advised by a licensed medical professional to see a medical specialist, have surgery, or a diagnostic test or procedure, which has not been completed or results are unknown? ☐ Yes ☐ No

18. In the past 24 months, have you been medically diagnosed, medically treated, or prescribed medication by a licensed medical professional for any other medical condition that you have not already mentioned? ☐ Yes ☐ No

19. **(Ages 70 and under only)** Have you had a biological parent or sibling die before age 60 from heart disease or cancer? ☐ Yes ☐ No
(If yes, provide details in the family history chart below and list the specific location of the cancer, such as breast, colon, etc.)

	Cause of Death List the specific location of the cancer, if applicable	Age at Death
Father		
Mother		
Brother(s)		
Sister(s)		

20. **(Ages 71 and over only)** In the past 12 months have you:

a. Been advised by a licensed medical professional to be admitted to a nursing home, assisted living facility, long term care facility, or are you currently receiving home healthcare? ☐ Yes ☐ No

b. Received assistance or supervision with eating, bathing, dressing, bowel or bladder function, toileting, or getting up out of a chair? ☐ Yes ☐ No

DETAILS TO 'YES' ANSWERS FOR QUESTIONS 13 THROUGH 18 AND QUESTION 20.
If more space is needed, attach a completed and signed Application Overflow Page.

Question #	Date, Diagnosis, Treatment, Results, and Duration	Name, Address, and Telephone Number of Physician, Health Care Provider, or Medical Facility

AGREEMENT

By my signature affixed below or my electronic signature, which I understand is attached to this application electronically, I acknowledge that this Agreement has been read in full to me and that statements and answers in this application, including statements by the Proposed Insured(s) in any medical questionnaire or supplement that become part of this application, are complete and true to the best of my knowledge and belief.

IT IS AGREED THAT: (1) any waiver or modification of this application will not be effective unless in writing and signed by the President or the Secretary; (2) the acceptance of any policy or policy change issued on this application shall constitute a ratification of any correction or amendment made by the North American Company for Life and Health Insurance (the Company); and (3) No change in amount, risk classification, plan of insurance, or benefits shall be effective unless agreed to in writing by the applicant(s).

The undersigned FURTHER AGREES to immediately advise the Company of any change to any of the responses contained in the application, including any change in the health or habits of any Proposed Insured(s), that arises or is discovered after completing this application, but before the policy or policy change is effective, as defined herein.

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.

SIGNATURE(S)

Proposed Insured **X**	Date	City	State

By signing below, the Paramed Examiner confirms that: (1) this form was read in English and (2) the Applicant is fluent in English, unless the box below is checked.

☐ If checked, what language was this form read? _____

Who performed the translation (Examiner or translation service)? _____

Signature of Examiner **X**	Date
Printed Full Name of Examiner:	