National Life Group®

Life Insurance Company of the Southwest®

Agent's Report

Part 1 - Proposed Primary Insured Information - Please PRINT

1. Proposed Insured's Name: Celia A Burton
2. Did you meet with the Proposed Insured in person during the sales and application process? ☑ Yes ☐ No
3. How long have you known the Proposed Insured(s)? 15 yrs
4. Are you related? ☐ Yes ☑ No
   (If 'Yes', relationship?) _____
5. Proposed Primary Insured's
   Net Worth $ 470.000
   Household Income $ 225 000
   Household Net Worth $ 585 000
6. Are there existing life, disability or annuity contracts? ☑ Yes ☐ No
7. To the best of your knowledge, is this insurance intended to replace any existing coverage? ☑ Yes ☐ No
8. List any sales materials, including illustrations, used relating to the new application Illustration
9. Which rate class was quoted?
   Proposed Primary Insured Preferd NT
   Proposed 2nd/Other Insured _____
10. Indicate underwriting requirement(s)

PI	2nd/OIR	
☐	☐	Jump In / Term Out *(If available)* Policy Spec Pages Attached
☑	☐	No Fluid
☐	☐	Blood / Urine and Vitals (Mini-Exam)
☐	☐	Blood, Urine, Paramed Exam
☐	☐	Blood, Urine, Paramed Exam, EKG
☐	☐	Blood, Urine, Paramed Exam, EKG, Mature Assessment

   Note - Mature assessment needed at age 70 or older.
   Exam service ordered from _____
11. What is the purpose of this insurance? income replacement, mortage protectio
12. How was the face amount determined? needs analysis
13. If business insurance, please complete Business Insurance Questionnaire Form 20098.

Part 2 - Proposed Insured / Owner Information

1. To your knowledge is any Proposed Insured or the Owner receiving any loans, cash, promises of future benefit, free insurance, or other valuable consideration as an inducement to apply for or become an insured under this life insurance policy? ☐ Yes ☑ No
2. Are you aware that any Proposed Insured or the Owner has been involved in any discussions regarding transfer of ownership of the policy being applied for to a third party, such as (but not limited to) a life settlement company or investor group? ☐ Yes ☑ No

Part 3 - Owner's Information

1. Annual Income $ 110,000
   Net Worth $ 470000
2. If Owner is a **Corporation**, what % of stock is owned by Proposed Primary Insured? _____ %
3. If Owner is a **Limited** Partnership, give name of **all** general partners *(Print names)*
   _____
   _____

Part 4 - Notes

Companion Application Name N/A

If your Agent Number is pending, please provide your email address.

Part 5 - Agent's Signature

Licensed Agent	Licensed Agent's Name *(Print)*	Percent	Agent No./Suffix	Phone & Email
	TaNoah Morgan	100	8702G01	240-544-6800 tmorgan@msagencies.c
Additional Agent	Name of Additional Agent *(Print)*	Percent	Agent No./Suffix	Phone & Email
Additional Agent	Name of Additional Agent *(Print)*	Percent	Agent No./Suffix	Phone & Email

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Individual Life Insurance Application

Part A - Proposed Insured Information

1. Name *(print first, middle, last)*	2. Place of Birth - State/Country	3. Sex
Celia Burton	Belize City, Belize	☐ M ☑ F

4. Home Address *(Street, City, State & Zip. If mailing address different, provide in Remarks)*	5. Date of Birth	6. Issue at Age	7. SS No.
16201 Azure Pl. Bowie, MD 20716	3-23-63	56	469-92-6276

8. Home Phone	Cell Phone	Work Phone	9. E-Mail Address	10a. Driver's License #	10b. State
(301) 218-6285	(301) 356-3745	( )	celiaals23@gmail.com		MD

11. Are you a citizen of	11a. Perm. Res. Card # *(include copy)*	11b. Type of VISA *(include copy)*
☑ USA ☐ Other Country _____		

12. Employer & time employed	13. Occupation *(w/specific duties)*	14a. Annual Income	14b. Net Worth
PG Co School System	Consulting teacher	110,000	470,000

Part B - Owner Information - *Relationship, Address, Telephone #, E-Mail, DOB & SSN (If different than Proposed Insured)*

Same as PI

Or the survivor(s); while living; thereafter the First Proposed Insured (FPI), unless otherwise provided.

Part C - Beneficiary Information *(If a trust - include trustees, trustor, date and tax ID#.)*

Primary: The beneficiary is the Owner, unless otherwise provided. *(Name, Relationship, Address, Telephone #, E-mail, DOB & SSN)*

Frederick Barton - 8/1/62 - 426-15-9444 - Husband
16201 Azure Pl Bowie, MD, 20716 301-356-3782

Contingent: *(Name, Relationship, Address, Telephone #, E-mail, DOB & SSN)*

Marecya Burton, daughter, 7/6/91, 474-23-6228
16201 Azure Pl Bowie, MD 20716, 301-356-3840
Courtney Burton, daughter, 12/9/89 470-19-8316
301-356-3861 / 2028 Linden Ave. Baltimore, MD

If a charitable organization, is this part of the Charitable Matching Gift Death Benefit Rider? *(FlexLife II only.)* ☐ Yes ☐ No

A deceased beneficiary's share shall be paid equally to the surviving beneficiaries of the same class, unless otherwise provided.

Part D - Policy Information

1. Product Name: Life Scope
2. Face Amount: 250,000
3. Term Rider Plan: *(Whole Life)* N/A
4. Term Rider Amount: $ N/A
5. Universal Life Death Benefit Option
   - [X] A - Level
   - [ ] B - Increasing
6. Definition of Life Insurance Test *(Applies to IUL & UL only except Foundation.)*
   - [X] GPT
   - [ ] CVAT
7. Use of Dividends: *(Whole Life) (Choose **only** one.)*
   - [ ] Cash
   - [ ] Additions
   - [ ] Applied *(N/A with EFT)*
   - [ ] Deposits
   - [ ] Flex Term Rider
     One Yr. Term + Adds = $ _____
     A premium will be charged for this rider.
   - [ ] Internal Paid-Up Insurance
8. Riders and Amounts
   - [X] Accelerated Benefits (ABR) *(Complete ABR Disclosure form)*
   - [ ] Additional Paid Up
     Rider Modal Premium $ _____
     Rider Single Premium (SPAR) $ _____
   - [ ] Additional Protection Benefit (APB) $ _____
   - [ ] Benefit Distribution Option (BDO) *(Read the BDO Disclosure Statements in Part M.)*
     1. Benefit Distribution Percentage _____ %
     2. Duration of Benefit Payments _____ Years
   - [ ] Children's Term (CTR) $ _____
   - [ ] Guaranteed Insurability (GIR) $ _____
   - [ ] Disability Income (DIR) [ ] 2 Yr [ ] 5 Yr $ _____
     a. Do you have any disability insurance, including employer sponsored short or long-term coverage? *(If yes, give details in Remarks)* [ ] Yes [ ] No
   - [ ] Waiver of Premiums (WP) $ _____
     (Annual Premium Waived if applicable)
   - [ ] Other _____ $ _____

   The Death Benefit Protection Rider is automatically added, if eligible.
   - [ ] Please check this box if you do NOT want this rider. Otherwise, it will be added. There is a minimum premium associated with this rider, and the IncomeBuilder product will have a monthly charge if issue age is over 50.

Part E - Children's Term Rider (CTR) - Applicable for ages 0-16 only *(Complete HIPAA for each child.)*

1. Complete the following questions for Children's Term Rider only. *(Provide Names, Dates of Birth, and SS Numbers of all Children to be covered.)*

Name: N/A	Date of Birth	Social Security No.

2. To the best of your knowledge: *(If 'Yes', give details, including the name and address of any physician in Remarks)*
   a. Has a licensed member of the medical profession diagnosed any Child as having Attention Deficit Disorder, dyslexia, autism, mental retardation, or any psychiatric disease? [ ] Yes [ ] No
   b. Has a licensed member of the medical profession diagnosed or treated any Child for seizures, juvenile diabetes, scoliosis, hemophilia, cancer, or a heart, lung, or respiratory disease? [ ] Yes [ ] No
   c. Does the Proposed Insured/child live with parent? [ ] Yes [ ] No
   d. Does any Child take medication prescribed by a doctor? [ ] Yes [ ] No

Part F - Premium Information

1. Planned Periodic/Modal Premium $ 350.00

2. Premium Mode ☐ Annual ☐ Semi-Annual ☐ Quarterly ☒ Monthly *(Electronic Funds Transfer (EFT))*

If EFT was selected, you may choose a draft date from the 1st - 28th 15 *(If EFT is chosen in #4 below, advanced dating will occur to align the requested draft date with the effective date of your policy.)*

If no day is selected, recurring drafts will be initiated on the day of issue. *(Policy effective date current)*

☐ Single Premium ☐ Group Bill No.: _____

3. Automatic Payment of Premium ***(Whole life only, also known as APL.)*** ☐ Yes ☐ No

4. Initial Premium Payment Method ***(Choose one.)***

☐ Check/Cash with application *(Cash equivalent payment must be accompanied by form 7953.)*

☐ COD *(collect payment on delivery of policy.)*

☒ Draft initial premium *(EFT - only available if Monthly is selected in #2.)*

If Draft initial premium is selected, the draft will be initiated on the day chosen above in #2, the policy effective date will be advanced dated to this requested day and commissions will not be generated until this advanced date. If no option is selected, coverage under the Conditional Receipt is not available and coverage under a policy (if one is issued to you) will not be effective until we receive your initial premium.

5. Identify the source of funds for premium payment

☒ Income/Savings ☐ Home equity ☐ Payment by third party ☐ Loan/Premium Finance ☐ Other: _____

6. Send premium notices to: ☒ Owner ☐ Proposed Insured ☐ Other: *(street, city, state & zip)* _____

7. Bank Information ***(Complete if Monthly EFT is selected)***

I authorize the National Life Group to draft payments from my account ☐ Checking ☐ Savings

Name of Bank: _____ Name on Account: _____

Bank Routing No. *(9 digits)* | ⑆ | 2 | 5 | 5 | 0 | 7 | 7 | 0 | 0 | 8 |

Customer Account No. *(Do not include check number)* | ⑆ | 0 | 2 | 6 | 0 | 3 | 2 | | | | | | | | | | | |

☑ Please check this box if you agree that premiums may be deducted if the premium amount increases by $25 of the amount included above. You will be given prior notification for any draft amounts that exceed this $25 limit.

I understand that recurring premiums will be initiated on my chosen draft date, however, they may take several days to clear my account.

Depositor's Mailing Address: 16201 Azure Pl Bowie MD 20716

Depositor's Email Address: celiaab23@gmail.com Depositor's Phone No: 301-356-3745

Depositor Signature: *(If not Applicant/Owner) (Exactly as it appears on bank records)* Celia Burton

Part G - Juvenile Coverage - *Applicable for Ages 0-17 only* *(Complete HIPAA for each child. The entire application must be completed for minor age applicants.)*

Complete the following questions for Juvenile Coverage only: N/A

1. Does the Proposed Insured/child live with parent? ☐ Yes ☐ No
   (If 'No', explain in Remarks. Give name & relationship of person with whom the PI lives.)

2. Amount of Insurance in force on Proposed Insured, the Applicant and other members of Proposed Insured's family:

	Age	Company	Amount In-Force	Amount Applied for
Applicant			$	$
Proposed Insured's father			$	$
Proposed Insured's mother			$	$
Brothers and sisters of Proposed Insured *(If none, so state)*			$	$
			$	$
			$	$

Part H - Recent Applications, Inforce Coverage, and Replacement Information *(All questions must be answered.)*

1. Do you have any inforce life insurance or annuity contracts including long term care insurance or riders? *(If yes, provide details)* ☑ Yes ☐ No

Company	Policy Number	Date Issued	Amount of Coverage	ADB Coverage	To be Replaced	1035 Exchange
TransAmerica	0146477783	1/10/14	165,000		☑ Yes ☐ No	☑
					☐ Yes ☐ No	☐
					☐ Yes ☐ No	☐
					☐ Yes ☐ No	☐

2. Have you ever applied for life, health, or disability insurance or reinstatement of same, which was declined, postponed, rated or modified in any way? ☐ Yes ☑ No

3. Within the past 12 months have you applied for or do you have any applications pending for life or disability insurance? ☐ Yes ☑ No

4. Is the policy or rider being applied for intended to replace any inforce life insurance or annuity contract(s) including long term care insurance or riders? Replacement includes surrender, lapse, reissue, conversion, reduction in coverage, premium or period of coverage of any life, disability income or annuity contract. *(If yes, replacement forms must be provided)* ☑ Yes ☐ No

5. Is the Proposed Insured or Owner considering using funds from an inforce life or annuity contract to fund the policy or rider being applied for? *(If yes, replacement forms must be provided)* ☑ Yes ☐ No

Part I - General Information about the Proposed Insured *(If yes, provide details in Remarks)*

1. During the last 5 years have you plead guilty to or been convicted of any moving vehicle violations or DUI or have you had a suspended license? ☐ Yes ☒ No

2. Have you ever been convicted of a felony or misdemeanor? *(If 'Yes', complete form 20087.)* ☐ Yes ☒ No

3. Have you been or are you currently involved in any bankruptcy proceedings that have not been discharged? *(If 'Yes', provide type & date discharged)* ☐ Yes ☒ No

4. Do you participate in any type of racing, scuba diving, aerial sports, mountain climbing, BASE or bungee jumping, or cave exploration? *(If 'Yes', complete form 1480)* ☐ Yes ☒ No

5. Do you participate in any aviation activity other than as a fare paying passenger? *(If 'Yes', complete form 1480)* ☐ Yes ☒ No

6. During the next 2 years do you intend to travel or reside outside of the USA for more than 2 weeks in a year? *(If 'Yes', complete form 1480)* ☐ Yes ☒ No

7. Have you been offered any cash incentive or other consideration (such as free insurance) as an inducement to apply for or become an insured under this life insurance policy? ☐ Yes ☒ No

8. Have you been involved in any discussions about the possible sale or transfer of this policy to an unrelated third party, such as (but not limited to) a life settlement company or investor group? ☐ Yes ☒ No

Part J - Health History of the Proposed Insured *(Give details, dates & results for any 'Yes' questions in Remarks). Complete Part J if money was collected with the application or an exam is not being done.*

1. Name and Address of Personal Physician and all other medical specialists seen, *(If none, so state)*	Date last Seen	Reason consulted & outcome
Kimberly Bolling. 4000 Mitchellville Rd #B424 Bowie, MD 20716.	3/20/2019	Blood pressure reading.

2. Height 5 ft Weight 128 Have you gained or lost weight during the last 12 months? *(If yes, provide details below.)* ☐ Yes ☒ No

Remarks: _____

3. Are you taking any medications? *(If yes, list type, dose, frequency and reason/diagnosis in the Remarks section.)* ☒ Yes ☐ No
Lovastatin 20mg, HydroChlorothiazide 10.mg.

4. Have you used any type of product containing tobacco or nicotine within the last five years? ☐ Yes ☒ No

Product Type: _____ Frequency: _____ Date Last Used: _____

5. Within the past 5 years have you worked less than full time, received or applied for disability or worker's compensation? ☐ Yes ☒ No

Part J - Health History of the Proposed Insured *(Continued)*

6. In the past 10 years have you ever been diagnosed, treated, tested positive for, or been given medical advice by a member of the medical profession for: *(If yes, provide details including treating physician contact information.)*
   a. Any disease or abnormal condition of the heart, circulatory system, high blood pressure, high cholesterol, irregular heartbeat, murmur, rheumatic fever, coronary artery disease, chest pain, angina, transient ischemic attack or stroke? ☒ Yes ☐ No
   b. Any disease of the lungs or respiratory system, sleep apnea, emphysema, asthma, bronchitis, tuberculosis, allergies or disorder of the nose or throat? ☐ Yes ☒ No
   c. Any digestive system disease, including ulcer, chronic indigestion, liver, stomach, intestine or pancreas disorder, hepatitis, cirrhosis, jaundice, esophagus disorder, gallbladder disorder, or colon disorder? ☐ Yes ☒ No
   d. Any disorder of the nervous system, epilepsy, convulsions, paralysis, brain or eye disorders? ☐ Yes ☒ No
   e. Any spine, hip, knee, shoulder, back, bones, muscles, arthritis, rheumatism, joints, skin, thyroid, gout or other gland disorder? ☐ Yes ☒ No
   f. Any urinary system disease including protein, sugar or blood in urine, kidney infection or stones, disorder or disease of the breast, prostate or bladder, or pelvic organs? ☐ Yes ☒ No
   g. Any depression, anxiety, bipolar, schizophrenia, attention deficit disorder (ADD), or any other developmental or psychological condition including Alzheimer's, Dementia, or Post Traumatic Stress Disorder (PTSD)? ☐ Yes ☒ No
   h. Any anemia, hemophilia or disorders of the blood other than Acquired Immune Deficiency Syndrome (AIDS), Human Immunodeficiency Virus (HIV)? ☐ Yes ☒ No
   i. Human Immunodeficiency Virus (HIV), Acquired Immune Deficiency Syndrome (AIDS), or have you tested positive for exposure to or been diagnosed with HIV or AIDS? ☐ Yes ☒ No
   j. Any cancer, polyp, other tumors? ☐ Yes ☒ No
   k. Diabetes or high blood sugar? ☐ Yes ☒ No
   l. Amputation due to disease or other medical condition? ☐ Yes ☒ No
   m. Ataxia, transverse Myelitis, Myasthenia Gravis, Autoimmune Disorder such as Lupus, Blindness, or Post Polio Syndrome? ☐ Yes ☒ No
   n. Parkinson's disease, Muscular Dystrophy, Huntington's Chorea, Motor Neuron Disease, Lou Gehrig's Disease (ALS), or Multiple Sclerosis? ☐ Yes ☒ No
   o. For the past 5 years only: any shortness of breath, dizzy spells, unconsciousness, headaches, or memory loss? ☒ Yes ☐ No
7. In the past 10 years have you used marijuana, cocaine, heroin, or any other illicit drug or controlled substance, been advised by a physician to discontinue or reduce alcohol or drug intake, used drugs not prescribed by a physician, or been a member of a support group such as NA or AA? ☐ Yes ☒ No
8. Within the past 5 years have you:
   a. Consulted with a physician other than your personal physician or had x-rays, electrocardiograms, heart catheterization or other diagnostic tests, except those related to the Human Immunodeficiency Virus (AIDS Virus)? ☐ Yes ☒ No
   b. been admitted to a hospital, or been advised or plan to enter a hospital for observation, operation or treatment of any kind? ☐ Yes ☒ No
9. Do you have any pending appointments with any medical professional? ☒ Yes ☐ No CB
10. Has a parent or sibling been diagnosed or treated by a health professional for cancer, heart disease, Huntington's Disease or polycystic kidney disease? ☐ Yes ☒ No
11. Do you currently:
    a. Use or require the use of any mechanical or medical devices such as: a wheelchair, walker, multi-prong cane, hospital bed, dialysis machine, respirator oxygen, motorized cart or stair lift? ☐ Yes ☒ No
    b. Need help, assistance or supervision for: bathing, eating, dressing, toileting, walking, transferring, or maintaining continence? ☐ Yes ☒ No
    c. Need help, assistance or supervision in: taking medication, doing housework, laundry, shopping or meal preparation? ☐ Yes ☒ No
12. During the past 5 years have you been diagnosed, treated, tested positive for, or been given medical advice by a member of the medical profession for: Falls, Paralysis, Numbness, Tremors, Imbalance, or any condition which causes limited motion? ☐ Yes ☒ No
13. During the past 5 years have you been diagnosed, treated, tested positive for, or been given medical advice by a member of the medical profession for: memory loss, confusion, amnesia? ☐ Yes ☒ No
14. Family History

	Age if alive	Age at death	Cause of death
Father	81		
Mother		82	unknown

Part K - Remarks *(Provide the details to questions as requested.)*

Section & Number:	Additional Information:
5 3	Lovastatin 20mg Hydrochlorothiazide 10mg

Part L - Sales Illustration Certification ***(Please check one of the following boxes if applicable.)***

- ☐ An illustration was not used corresponding to the policy as applied for and will be provided upon policy delivery.
- ☑ An illustration was used and signed which corresponds with the policy as applied for and is attached.
- ☐ An illustration was **viewed** on a computer screen; and if use is allowed in this state, the "Computer View Illustration Certification" form is attached. An illustration corresponding to the policy as issued will be provided upon policy delivery. *(The Computer View Illustration Certification form is not allowed in: HI, ID, IL, MD, MI, MN, NE, NV and WA.)*

Part M - Agreement & Authorization

I represent all information in this application or an amendment, including all Social Security Numbers, and any medical exam is complete and true. I understand all such information and this application shall be part of any policy issued.

I understand and agree that all answers given above and in any medical exam are to the best of my knowledge and belief complete and true. All such answers and this application shall be part of any contract issued. I have read the PRENOTIFICATIONS, including the notices required by the Fair Credit Reporting Act and MIB, Inc. ("MIB"). To the extent allowed by law, I waive all rights governing disclosure of medical exams or treatment. I authorize any medical practitioner or facility, insurer, MIB and any other organization or person that has any records or knowledge of me or my health to give such information to the Company or its reinsurers. I authorize the Company to request a copy of my driving record(s) from the state motor vehicle department. I understand and I authorize the Company, or its reinsurers, to make a brief report of my personal health information to MIB. This authorization is valid for 30 months (or the length of time as per state regulation) from the date signed and a photocopy shall be as valid as the original. I also certify, under the penalties of perjury, that the Social Security Number of the Proposed Insured and Applicant/Owner (if different) is correct.

☑ I wish to be interviewed if an investigative consumer report is prepared.

The Company may make administrative corrections and changes to this application and attach them as an amendment to the policy at issue. Acceptance of any policy issued on this application will ratify and will be notice of any such change made. I understand and agree that: (1) I will notify the Company if any statement or answer given in this application changes prior to delivery and acceptance of the policy; and (2) Except as otherwise stated in any Conditional Receipt, no insurance will take effect unless the first full modal premium is paid and a policy is delivered and accepted while the health and insurability of any proposed insured continues, without material change, to be as represented in the application.

The Agent taking this application has no authority to make, change or discharge any contract hereby applied for. The Agent may not extend credit on behalf of the Company. No statement made to or information acquired by any representative of the Company shall bind the Company unless set out in writing in this application.

Any person who knowingly presents a false statement in an application for insurance may be guilty of criminal offense and subject to penalties under state law.

Benefit Distribution Option Rider Disclosure Statements:

- Under this rider, all or a portion of the policy's Death Benefit proceeds that become payable will be paid as a set of Benefit Payments to the Beneficiary. The Beneficiary of the policy will not be able to change the terms in which the Benefit Payments are paid out.
- A request to increase the Policy's base Face Amount in accordance with its provisions which has been underwritten and approved by us may also include a request to terminate the Benefit Distribution Option.
- In accordance with IRS rules and regulations, a portion of each Benefit Payment is reportable as interest income that may be taxable. We will annually report this interest income to the Beneficiary and the IRS as required.

Part N - Signatures Celia Burton

Signed at *(City & State)* Lanham MD Date *(mm/dd/yyyy)* 03/25/2019

Proposed Insured age 18 & up ***(Note: AL - Age 19, MS - Age 21)***
(Under 18, Parent or Legal Guardian)

Applicant/Owner *(If Owner is other than Proposed Insured or a Minor.)*

Soliciting Agent/Representative *(Sign name in full)*

(Witness)

(Exercise of AIO Only)
Owner of Base Policy

National Life Group®

☐ National Life Insurance Company®
☐ Life Insurance Company of the Southwest®

Transfer/Exchange/Rollover

Please complete Section VIII for all plan administered accounts (i.e.: 403(b), 457, Pension, etc.)

Section I
Transferring Financial Institution Information
(Complete a separate form for each company.)

TransAmerica — Name of Financial Institution — 800 851-9777 — Phone Number
4333 Edgewood Rd NE — Address — Cedar Rapids — City — IA — State — 52499 — Zip

Section II
Owner/Annuitant of Policy

Celia Burton — Owner's Name — 469-92-6276 — Owner's TIN/SSN

Annuitant's/Insured's Name *(if different)*

Joint Owner's Name — Joint Owner's TIN/SSN

Section III
Transferring Company Instructions

*(Please note: Any future dated transactions will be initiated immediately. The Transferring Company is responsible for processing according to the instructions indicated in this section. Annuity to Life transfers **are taxable** and not considered Replacements.)*

Policy/Acct #1: 0146417783 **Approximate Transfer Amount: $** 5858 54

☑ Full ○ Partial ○ Periodic Payment: Frequency: *(i.e. monthly, quarterly, annually)* _____ Years: _____

Policy/Acct #2: _____ **Approximate Transfer Amount: $** _____

○ Full ○ Partial ○ Periodic Payment: Frequency: *(i.e. monthly, quarterly, annually)* _____ Years: _____

Apply proceeds to: ☑ A New Policy or ○ An Existing Policy: _____

Proceeds to be transferred from: ○ Bank Account/CD/Mutual Fund/Brokerage Account ○ Annuity ☑ Life Policy ○ Other _____

Loan to be carried forward $ _____ Loan type: ○ Standard ○ Variable ○ Fixed *(for FlexLife II only)*

(Note: Carryover of loans only available with 403(b), 457 & Life. NLG will not accept defaulted loan balances.)

Please select the plan type for both the Existing and New policies below

From Existing Life Type:
○ Qualified ☑ Non-Qualified

OR

From Existing Annuity Type:
○ 403(b)
○ Traditional IRA
○ Roth IRA
○ 401(k)/Pension/Profit Sharing
○ SEP IRA
○ SIMPLE IRA
○ Roth 403(b)
○ 457
○ Non-Qualified
○ Other _____

To New Life Type:
○ Qualified ☑ Non-Qualified

OR

To New Annuity Type:
○ 403(b)
○ Traditional IRA
○ Roth IRA
○ 401(k)/Pension/Profit Sharing
○ SEP IRA
○ SIMPLE IRA
○ Roth 403(b)
○ 457 *(Note: 403(b) to 457 is not available)*
○ Non-Qualified
○ Other _____

Under IRC Section 1035 an exchange of an annuity contract for a life insurance policy does not qualify as a 1035 Exchange.

Section IV
Important Notices

1. The company will hold issuance of a single premium policy for 30 days from receipt of the first premium pending additional premium and will not credit interest during this period. Once 30 days expires, the policy will be issued. An additional policy will be issued if premiums are received after the 30-day period.
2. For 403(b) LSW will not maintain a separate account for the rollover amount. All values in the annuity will become part of the new plan. If the plan requires segregation of the rollover contribution, a new LSW annuity will be required.