Life Insurance Company of the Southwest®

3AY

Individual Life Insurance Application

Part A - Proposed Insured Information

1. Name *(print first, middle, last)*	2. Place of Birth - State/Country	3. Sex
Janice Yvonne Haskins	United States / VA	☐ 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.
6088 Heatherwood Dr, Alexandria, VA 22310-4420	10/03/1976	43	600-36-3027

8. Home Phone	Cell Phone Pref	Work Phone	9. E-Mail Address	10a. Driver's License #	10b. State
	(623)297-7070		janiceyhaskins@gmail.com	d02156422	AZ

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
More than 6 months Employed-American Psychological Association	Professor	$85,000	$85,000

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

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)*

Anthony Haskins — Relationship to Insured: Husband — 100%

6088 Heatherwood Dr, Alexandria, VA 22310-4420 — DOB: 03/25/1978 — SSN/TIN: 309-84-1272 — Phone: (623) 297-7021

quinn775@yahoo.com

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

Thomas Scates — Relationship to Insured: Brother — 100%

53 E Lake Dr, Annapolis, MD 21403-4445 — DOB: 11/30/1980 — SSN/TIN: — Phone: (571) 331-7724

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: LSW 30-G
2. Face Amount: $270,000
3. Term Rider Plan: *(Whole Life)* ____
4. Term Rider Amount: ____
5. Universal Life Death Benefit Option
   - [ ] A - Level
   - [ ] B - Increasing
6. Definition of Life Insurance Test *(Applies to IUL & UL only except Foundation.)*
   - [ ] 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.
   - [X] 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:	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 $63.62

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 16 *(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: Canyon State FCU   Name on Account: Janice Yvonne Haskins

Bank Routing No. *(9 digits)*: 322172849   Customer Account No. *(Do not include check number)*: 109078

☒ 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: 6088 Heatherwood Dr, Alexandria, VA 22310-4420

Depositor's Email Address: janiceyhaskins@gmail.com   Depositor's Phone No: ______

Depositor Signature: *(If not Applicant/Owner) (Exactly as it appears on bank records)* e-Signed by Janice Yvonne Haskins

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:

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
					☐ 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
See Supplemental		

2. Height 5ft 4in Weight 187lb 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

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
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			See Supplemental
Mother			See Supplemental

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

Section & Number: Additional Information:

Part A: Proposed Insured Information; 5. Backdate to Save Age: No

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.
- [X] 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.

[X] 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

Signed at *(City & State)* VA   Date *(mm/dd/yyyy)* 04/22/2019 16:56:20 GMT

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

e-Signed by Janice Yvonne Haskins

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

Life Insurance Company of the Southwest™

Supplemental Information to the Application for Life Insurance

Insured's Name: Janice Yvonne Haskins   Social Sec. #: 600-36-3027

General/Health Info:

Physician Info

Physician 1 (Primary):

Name: Florence A Tchouaffi-Nana

Address: 14139 Potomac Mills Rd

Country: United States of America

State: Virginia

City: Woodbridge

Phone: 703 359 7878

Reason for last visit: Other

Details: consulted for a fatty deposit on the forehead; was referred to surgeon for removal.

Last visit (MM/YYYY): 11/2018

Family History

Is your Father still living? No

Father's Age at Death: 67

What was the cause of death? Cancer

Is your Mother still living? Yes

Mother's Current Age: 69

Occupation

Occupation: Professor

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

Family Member: Father

What was the condition? Cancer

Was there a death associated with this condition? Yes

At what age did the death occur? 67

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

Medical Condition: Consulted with a physician other than your personal physician

Was the consultation due to a condition already disclosed in the medical section? No

Provide details to the reason seen and date of the consultation (mm/yy). Dr. Noah E. Meltzer removed the fatty deposit from the forehead

Signed at *(City and State)*: VA   on this day of: 04/22/2019

Signature of Insured(s): e-Signed by Janice Yvonne Haskins

Signature of Applicant *(if different than Proposed Insured)*: ______

Signature of Agent: ______

Life Insurance Company of the Southwest™

Supplemental Information to the Application for Life Insurance

Insured's Name: Janice Yvonne Haskins

Social Sec. #: 600-36-3027

Nov. 2018

Signed at *(City and State)*: VA

on this day of: 04/22/2019

Signature of Insured(s): e-Signed by Janice Yvonne Haskins

Signature of Applicant *(if different than Proposed Insured)*:

Signature of Agent:

Prenotifications

Notification of Information Practices

Thank you for applying to the National Life Insurance Company and Life Insurance Company of the Southwest (the Company) for your insurance. This description of the Information Practices of the Company and your agent is being provided in accordance with the requirements of the Insurance Information and Privacy Protection Law in effect in your state of residence.

Collection of Information

In order to properly underwrite and administer your insurance coverage, we must collect a certain amount of necessary and helpful information. The amount and type of information collected may vary depending on the amount and type of coverage applied for, but in general we will be seeking information about your age, occupation, physical condition, health history, mode of living, finances, avocations and other personal characteristics. In addition, your agent may collect information intended to aid in the updating and improvement of your insurance program.

Your application, with the medical history and other information you furnish, is our main source of information. We may also collect or verify information by contacting medical professionals and institutions which have provided care to you or members of your family proposed for coverage, employers and business associates, friends and neighbors, and other insurance companies you have applied to. We may collect information by exchanges of correspondence, by phone, or by personal contact.

In some cases, we may ask an insurance support organization to collect information and submit an investigative consumer report to confirm or supplement information on your application. That organization may retain a copy of the report and may disclose its contents to others for whom it performs such services.

Disclosures by the Company

In some circumstances, the Company or your agent will make disclosures of personal information, without your authorization, to third parties. Following is a brief description of some of the persons or organizations to whom certain items of information might be disclosed:

- Persons or organizations which perform professional, business or insurance functions for us;
- Your agent, consumer reporting agencies hired to prepare investigative reports, and other insurance companies to which you have applied for coverage or benefits;
- Your attending physician or treating medical professional;
- Persons or organizations conducting bona fide actuarial or scientific research studies, audits or evaluations;
- Unless you object, to persons or organizations who may wish to market products or services, including affiliates of the Company.

Please be assured that the above describes some of the disclosures which may be made, not disclosures which are always or even often made. In any event, the information disclosed without your authorization will be only as much as is reasonably necessary to accomplish the intended purpose.

For example, we would ordinarily disclose only name and address to a marketing firm, and perhaps additional information relating to age, amounts of insurance and claims experience to a scientific research organization. Information relating to physical condition or medical history would ordinarily be disclosed only to your attending physician or treating medical professional. In short, the types of information disclosed will vary depending upon the needs of the recipient and the sensitivity of the data.

A description of the circumstances under which information about you might be disclosed without your authorization to the types of persons and organizations referred to above will be sent to you upon request.

Access and Correction

There are procedures by which you can obtain access to personal information about you appearing in our policy files, including information contained in investigative consumer reports. We have also established procedures by which you may request, in writing, correction, amendment or deletion of any personal information in our files. A description of these procedures will also be sent to you upon request.

Obtaining Additional Information

We hope that you find this description of our information practices helpful. If you have any further questions about the items just discussed, please write to the New Business Department, Administrative Office, One National Life Drive, Montpelier, Vermont 05604.

Leave with Applicant

National Life Group® is a trade name of National Life Insurance Company, Montpelier, VT, Life Insurance Company of the Southwest (LSW), Addison, TX and their affiliates. Each company of National Life Group is solely responsible for its own financial condition and contractual obligations. LSW is not an authorized insurer in New York and does not conduct insurance business in New York.

Centralized Mailing Address: One National Life Drive, Montpelier, VT 05604 | www.NationalLifeGroup.com

Prenotification - Personal History Interview

To obtain the information described in Investigative Consumer Report Prenotification, the Company may telephone you directly for a Personal History Interview. An Administrative Office interviewer may phone you to review and clarify information you provided on your application and to ask additional questions which will aid in considering your application.

Whenever possible, calls will be made at your convenience and to the telephone number you have provided. A separate form contains the information we need to complete the call. If for any reason it is necessary to make a change, please let your Agent know promptly.

Prenotification - Investigative Consumer Report

This is to inform you in compliance with Public Law 91-508, known as the Fair Credit Reporting Act, that as part of our processing procedure for your insurance application an investigative consumer report may be made. This means information is obtained through personal interviews with third parties such as family members, business associates, financial sources, friends, neighbors or others with whom you are acquainted. This report may include information as to your character, general reputation, personal characteristics and mode of living. You have the right to make a written request within a reasonable period of time for a complete and accurate disclosure of additional information concerning the nature and scope of the investigation.

Prenotification - MIB, Inc. ("MIB")

Information regarding your insurability and/or any past or future claims will be treated as confidential. The Company or its reinsurers may, however, make a brief report to the MIB. If you apply to another MIB member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, the MIB, upon request, will supply such company with the information in its file.

Upon receipt of a request from you, the MIB will arrange disclosure of any information it may have in your file. Medical information can be released to you or to your attending physician. If you question the accuracy of information in the MIB's file, you may contact the MIB and seek a correction in accordance with the procedures set forth in the Federal Fair Credit Reporting Act. The address of the MIB's information office is 50 Braintree Hill, Suite 400, Braintree, MA 02184-8734, telephone number: (866) 692-6901, website: www.mib.com.

The Company may also release information in its files to its reinsurers and to other life insurance companies to whom you may apply for life or health insurance, or to whom a claim for benefits may be submitted.

☐ **National Life Insurance Company®**
☒ **Life Insurance Company of the Southwest™**

NOTICE AND CONSENT FOR TESTING WHICH MAY INCLUDE AIDS VIRUS (HIV) ANTIBODY/ANTIGEN TESTING

To determine your insurability, the Insurer named above has requested that you provide a sample of your blood, oral fluid and/or urine for testing and analysis. All tests will be performed by a licensed laboratory.

The consent you give by signing this form authorizes the insurer to order laboratory tests only in regard to your present application for insurance.

Unless precluded by law, tests may be performed to determine the presence of antibodies or antigens to the Human Immunodeficiency Virus (HIV), also known as the AIDS (Acquired Immune Deficiency Syndrome) virus. The HIV antibody test that is performed is actually a series of tests done by a medically accepted procedure. The HIV antigen test directly identifies AIDS viral particles. These tests are extremely reliable. Other tests which may be performed include determinations of blood cholesterol and related lipids (fats) and screening for liver or kidney disorders, diabetes, and immune disorders.

All test results will be treated confidentially. They will be reported by the laboratory to the Insurer. When necessary for business reasons in connection with insurance you have or have applied for with the Insurer, the Insurer may disclose test results to others involved solely in the underwriting process such as its affiliates, agents, reinsurers, employees, contractors, insurance regulators, public health regulators, or insurance industry data banks. The test results will be furnished under a generic code which is not specific to HIV infection. If the Insurer is a member of the Medical Information Bureau (MIB, Inc.), and if the test results for HIV antibodies/antigens are other than normal, the Insurer will report to the MIB, Inc., a generic code which signifies only a non-specific test abnormality. If your HIV test is normal, no report will be made about it to the MIB, Inc. Other test results may be reported to the MIB, Inc., in a more specific manner. The organizations described in this paragraph may maintain the test results in a file or data bank. You have the right to request and be furnished with the specific names of the organizations or individuals we may have given your results to. There will be no other disclosure of test results or even that the test has been done except as may be required or permitted by law or as authorized by you.

We will make the results available to you or the person you designate, such as a physician. We urge you to name a physician or other medical professional to receive the results. If you choose to receive test results yourself, you may obtain personal, face-to-face counseling through the Virginia Department of Health. To obtain information regarding counseling, you should contact your local health department. Additional information about AIDS or HIV infection can be obtained by calling the Virginia Health Department at 1-800-533-4148.

Please designate a physician, health care provider or other person to receive test results in the space provided:

Name: *(Print or Type)*
Florence Tchouaffi-Nana

Address: *(Street, City, State, Zip Code)*
14139 Potomac Mills Rd

Woodbridge, VA 22192-4644

You have the right to tell us whether or not to mail notice of negative test results.

- ☐ I waive notice of negative results.
- ☒ I DO NOT waive notice of negative results.

Positive HIV antibody/antigen test results do not mean that you have AIDS, but that you are at a significantly increased risk of developing AIDS or AIDS-related conditions. Federal authorities say that persons who are HIV antibody/antigen positive should be considered infected with the AIDS virus and capable of infecting others.

Positive HIV antibody/antigen test results or other significant test abnormalities will adversely affect your application for insurance. This means that your application may be declined, that an increased premium may be charged, or that other policy changes may be necessary.

I have read and I understand this Notice and Consent For Testing Which May Include HIV Antibody/Antigen Testing. I voluntarily consent to the withdrawal of blood from me by needle, the collection of oral fluid and/or urine samples, the testing of the samples, and the disclosure of the test results as described above.

I understand that I have, or my authorized representative has, the right to request and receive a copy of this authorization. A photocopy of this form will be as valid as the original.

Proposed Insured's Name: *(Print or type)*	Date of Birth: *(mm/dd/yyyy)*	State of Residence:
Janice Yvonne Haskins	10/03/1976	VA
Signature of Proposed Insured or Parent/Guardian: e-Signed by Janice Yvonne Haskins	Date: *(mm/dd/yyyy)* 04/22/2019 16:56:16 GMT	

Copies to the Company, the Customer, the Examiner, and the Agent

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National Life Group®

Disclosure Statement for Accelerated Benefits
(Terminal Illness, Critical Illness & Critical Injury)

Accelerated Benefits are payments made to the Owner while the Insured is living in lieu of payment of all or a portion of the death benefit that would otherwise be paid at the Insured's death. The Owner must apply for the Accelerated Benefits and must show the required proof stated in the Accelerated Benefits Rider attached to the policy. The condition under which accelerated benefits may be elected varies by rider as described below.

NOTE: Your policy may not be eligible for coverage under all the Accelerated Benefits Riders described below. Please check your policy for details on each Accelerated Benefits Rider that is included in your policy and the insured(s) covered under each rider.

Accelerated Benefits Rider for Terminal Illness

Benefits may be elected under this rider if the Insured is Terminally Ill. Terminally Ill means that the Insured has been certified by a Specialist as having an illness or chronic condition which can reasonably be expected to result in death in 24 months or less from the date of the certification.

Accelerated Benefits Rider for Critical Illness

Benefits may be elected under this rider if the Insured has experienced a covered Critical Illness Qualifying Event. The Critical Illness Qualifying Events covered under this rider are:

1. **Aorta Graft Surgery:** A definite diagnosis by a Specialist that surgery is medically necessary for disease or trauma to the aorta requiring excision and surgical replacement of the diseased or traumatized aorta with a graft. Aorta refers to the thoracic and abdominal aorta but not its branches.
2. **Aplastic Anemia:** A definite diagnosis of a chronic persistent bone marrow failure, confirmed by biopsy, which results in anemia, neutropenia and thrombocytopenia requiring blood product transfusion, and treatment with at least one of the following: a) Marrow stimulating agents; b) Immunosuppressive agents; c) Bone marrow transplantation. The diagnosis of Aplastic Anemia must be made by a Specialist.
3. **Cancer:** A definite diagnosis of a disease manifested by the presence of one or more malignant tumors and characterized by the uncontrolled growth and spread of malignant cells and the invasion of normal tissue.

   Diagnosis of Cancer must be established according to the criteria of malignancy established by The American Board of Pathology after a study of the histocytologic architecture or pattern of the suspect tumor, tissue, or specimen.

   No benefit will be payable under this condition for: a) Any non-melanoma skin cancer, except those with distant lymph node metastasis; or b) Pre-malignant lesions, benign tumors, or dysplasias; or c) Carcinoma in-situ; or d) Localized non-invasive cancers such as, but not limited to: i. Thyroid cancers less than Stage 4; or ii. Early prostate cancer diagnosed as T1N0M0 or equivalent staging including T2a unless the Gleason score is higher than 6; or iii. Chronic lymphocytic leukemia classified as Rai Stage 0; or iv. Noninvasive papillary cancer of the bladder AJCC TaN0M0.
4. **Cystic Fibrosis:** A definitive diagnosis of Cystic Fibrosis with evidence of chronic lung disease and pancreatic insufficiency. The diagnosis must be made by a Specialist and must be made before the Insured's 20th birthday.
5. **Diagnosis of ALS (Amyotrophic Lateral Sclerosis):** A definite diagnosis of ALS made by a Specialist. There must be permanent clinical impairment. Permanent clinical impairment is the situation in which the clinical specialist notes that the impairment caused by the condition is not reversible and hence permanent.
6. **End Stage Renal Failure:** A definite diagnosis of chronic irreversible failure of both kidneys to function, which necessitates regular haemodialysis or peritoneal dialysis continuously for a period of at least 6 months or result in renal transplantation. The diagnosis of Kidney Failure must be made by a Specialist.
7. **Heart Attack:** A definite diagnosis of the death of a portion of the heart muscle resulting from inadequate blood supply to the relevant area. The diagnosis of Heart Attack must be made by a Specialist, supported by symptoms clinically accepted as consistent with the diagnosis of an acute myocardial infarction and at least one of the following conditions: a) New characteristic electrocardiographic changes; or b) The characteristic rise above laboratory accepted normal values of biochemical cardiac specific markers such as CK-MB or cardiac troponins; or c) An abnormal myocardial perfusion or other scan showing characteristic findings of new heart muscle death; or d) An echocardiogram with new wall abnormalities indicating new heart muscle death.

   No benefit will be payable under this condition for other acute coronary syndromes including but not limited to angina.

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8. **Heart Valve Replacement:** A definite diagnosis determined by a Specialist that surgery is medically necessary to replace any heart valve with either a natural or mechanical valve.
9. **Major Organ Transplant:** A definite diagnosis of the irreversible failure of any of the following organs or tissues: heart, both lungs, liver, both kidneys, pancreas, or bone marrow, and transplantation must be medically necessary. To qualify under Major Organ Transplant, a Transplant specialist must document that transplantation is necessary and the Insured must be placed on a transplant list as the recipient of a heart, lung, liver, kidney, pancreas or bone marrow, and limited to these entities.
10. **Motor Neuron Disease:** A definite diagnosis of one of the following conditions and is limited to these conditions: a) Primary lateral sclerosis; or b) Progressive spinal muscular atrophy; or c) Progressive bulbar palsy; or d) Pseudo bulbar palsy. There must be permanent clinical impairment. Permanent clinical impairment is the situation in which the clinical specialist notes that the impairment caused by the condition is not reversible and hence permanent. The diagnosis of Motor Neuron Disease must be made by a Specialist.
11. **Stroke:** A definite diagnosis of an acute cerebrovascular accident or infarction (death) of brain tissue caused by hemorrhage, embolism, or thrombosis resulting in neurological deficit with persistent clinical symptoms for at least 30 consecutive days following the occurrence of the Stroke, and also resulting in either: a) Permanent Neurological Deficit with Persisting Clinical Symptoms that are expected to last throughout the Insured's life; or b) Definite evidence of death of brain tissue or hemorrhage on a brain scan. The diagnosis of Stroke must be made by a Specialist.

    No benefit will be payable under this condition for: a) Transient ischemic attacks; or b) Intracerebral vascular events due to trauma; or c) Lacunar infarcts which do not meet the definition of Stroke as described above; or d) Asymptomatic silent stroke found on imaging.
12. **Sudden Cardiac Arrest:** Defined as the sudden loss of heart function with interruption of blood circulation around the body resulting in unconsciousness and requiring resuscitation. After resuscitation, treatment may include: a) Surgical implantation of an Implantable Cardioverter-Defibrillator (ICD); or b) Surgical implantation of a Cardiac Resynchronization Therapy with Defibrillator (CRT-D); or c) Electrophysiological mapping with radio frequency ablation; or d) Cardiac surgery; or e) Long-term medication therapy.

    No benefit will be payable under this condition for: a) Insertion of a pacemaker; or b) Insertion of a defibrillator without cardiac arrest; or c) Cardiac arrest resulting directly from alcohol or drug abuse.

Accelerated Death Benefits Rider for Critical Injury

Benefits may be elected under this rider if the Insured has experienced a Critical Injury Qualifying Event. The Critical Injury Qualifying Events covered under this rider are:

1. **Coma:** A definite diagnosis of a state of unconsciousness with no reaction to external stimuli or response to internal needs for a continuous period of at least 96 hours, which: a) Has a Glasgow Coma score of 4 or less; and b) Requires the use of life support systems; and c) Results in Permanent Neurological Deficit with Persisting Clinical Symptoms that are expected to last throughout the Insured's life. The diagnosis of Coma must be made by a Specialist.

    No benefit will be payable under this condition for: a) A medically induced Coma; or b) A Coma which results directly from alcohol or drug abuse.
2. **Paralysis:** Defined as Quadriplegia, Paraplegia or Hemiplegia that has been present for 90 days from the Date of Diagnosis confirmed by a Specialist and which is expected to be permanent without expectation of recovery. a) Quadriplegia means the complete and irreversible Paralysis of both upper and lower Limbs. b) Paraplegia means the complete and irreversible Paralysis of both lower Limbs. c) Hemiplegia means the complete and irreversible Paralysis of the upper and lower Limbs of the same side of the body. d) Limb means entire arm or entire leg.
3. **Severe Burns:** A definite diagnosis of third degree burns covering at least 30% of the body's surface area or 30% of the area of the face or head. The diagnosis of Severe Burns must be made by a Specialist.
4. **Traumatic Brain Injury:** A definite diagnosis of damage to brain tissue due to Traumatic Brain Injury, which: a) Has a Glasgow Coma score of 12 or less in the first 48 hours after injury; and b) Has skull fracture, brain contusion or hemorrhage on CT scan of head; and c) Results in a Permanent Neurological Deficit with Persisting Clinical Symptoms that are expected to last throughout the Insured's life.

    The diagnosis of Traumatic Brain Injury must be made by a Specialist.

    No benefit will be payable under this condition for: a) Mild Traumatic Brain Injury; or b) Traumatic Brain Injury due to repetitive head trauma; or c) Traumatic Brain Injury which results directly from intentional self-inflicted injury.

No Accelerated Benefit will be paid under either the Critical Illness Rider or the Critical Injury Rider for any Qualifying Event that directly results from self-inflicted injury or attempted suicide. This benefit is underwritten and may not be available on your policy.

The Owner may elect to accelerate all or a portion of the Insured's death benefit in force on the election date. **The Company reserves the right to set a maximum amount that we will pay under this and any other Accelerated Benefits Rider on the policy to which this rider is attached. If we do so, it will be no less than $500,000.**

Accelerated Benefits are paid as a lump sum. The amount paid is calculated as the present value of the death benefit accelerated, less an adjustment for future premiums, and less an administrative fee not to exceed $250. The benefit will first be used to pay a pro rata share of any outstanding debt to us. The benefit will never exceed the death benefit being accelerated. It will never be less than the cash surrender value, if any, that corresponds to the death benefit accelerated.

The Insured's death benefit in force will be reduced each time an Accelerated Benefit is paid. The reduction will equal the portion of the death benefit that is accelerated on the election date. The face amount, and any accumulated value, cash surrender value, and outstanding debt will also be reduced. Each of these will be reduced in the same proportion as the reduction in the death benefit. The premiums and charges for any remaining life coverage will be determined as if the contract had been originally issued at the reduced face amount.

Payment of Accelerated Benefits will reduce the death benefit otherwise payable under the policy. Receipt of Accelerated Benefits may be a taxable event. Please consult your personal tax advisor to determine the tax status of any benefits paid under this rider.

Receipt of Accelerated Benefits may adversely affect the recipient's eligibility for Medicaid or other government benefits or entitlements. Accelerated Benefits do not and are not intended to qualify as long-term care insurance.

Signed at: *(City & State)* ______________________ Date: *(mm/dd/yyyy)* ______________

Licensed Agent: *(Sign name in full)* ______________________

Applicant/Owner: *(Sign name in full)* e-Signed by Janice Yvonne Haskins

Life Insurance Company of the Southwest®

Disclosure Statement for Accelerated Death Benefits
(Chronic Illness)

Accelerated Benefits are payments made to the Owner while the Insured is living in lieu of payment of all or a portion of the death benefit that would otherwise be paid at the Insured's death. The Owner must apply for the Accelerated Benefits and must show the required proof stated in the Accelerated Benefits Rider attached to the policy.

Accelerated Benefits Rider for Chronic Illness

Benefits may be elected under this rider if the Insured is Chronically Ill. Chronically Ill means that the Insured has been certified, within the last 12 months, by a Licensed Health Care Practitioner as:

1. being unable to perform without substantial assistance from another person at least two Activities of Daily Living for a period of at least 90 consecutive days; or
2. requires substantial supervision for a period of at least 90 consecutive days by another person to protect oneself from threats to health and safety due to his or her own severe cognitive impairment.

The Activities of Daily Living are bathing, continence, dressing, eating, toileting, and transferring.

No Application for Election of Accelerated Benefits will be accepted under Accelerated Benefits Rider for Chronic Illness during the first two years that it is in effect.

The Owner may elect to accelerate all or a portion of the Insured's death benefit in force on the election date. **The Company reserves the right to set a maximum death benefit that may be accelerated under all Accelerated Benefits Riders on the life of the Insured. This maximum limit will be no less than $500,000. If the Insured becomes eligible for benefits under Accelerated Benefits Rider for Chronic Illness, the death benefit that may be accelerated in any year will also be subject to a maximum amount.**

Accelerated Benefits are paid as a lump sum. The amount paid is calculated as the present value of the death benefit accelerated, less an adjustment for future premiums, and less an administrative fee. Any administrative fee assessed will not exceed a maximum charge of $250. The benefit will first be used to pay a pro rata share of any outstanding debt to us. The benefit will never exceed the death benefit being accelerated. It will never be less than the cash surrender value, if any, that corresponds to the death benefit accelerated.

The Insured's death benefit in force will be reduced each time an Accelerated Benefit is paid. The reduction will equal the portion of the death benefit that is accelerated on the election date. The face amount, and any accumulated value, cash surrender value, and outstanding debt will also be reduced. Each of these will be reduced in the same proportion as the reduction in the death benefit. The premiums and charges for any remaining life coverage will be determined as if the contract had been originally issued at the reduced face amount.

Payment of Accelerated Benefits will reduce the death benefit otherwise payable under the policy. Receipt of Accelerated Benefits may adversely affect your eligibility for Medicaid or other government benefit or entitlement programs. Receipt of Accelerated Benefits may be a taxable event. Please consult your personal tax advisor to determine the tax status of any benefits paid under this rider.

Signed at: *(City & State)* ______________________ Date Signed: *(mm/dd/yyyy)* __________

Licensed Agent: *(Sign name in full)* ______________________

Applicant/Owner: *(Sign name in full)* e-Signed by Janice Yvonne Haskins

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Life Insurance Company of the Southwest®

Agent's Report

Part 1 - Proposed Primary Insured Information - Please PRINT

1. Proposed Insured's Name
   Janice Yvonne Haskins
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)?
   3 years
4. Are you related? ☐ Yes ☒ No
   (If 'Yes', relationship?) ______
5. Proposed Primary Insured's
   Net Worth $85,000
   Household Income $120,000
   Household Net Worth $150,000
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 See Part 4 - Notes
9. Which rate class was quoted?
   Proposed Primary Insured Standard 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?
    Personal
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 ______
   Net Worth ______
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 ______

1.8. Sales Materials: Illustrations; 1.11. Purpose of Insurance (Personal): Death Benefit Protection, ; Member of a military organization: No; PI Proof of Identity: Drivers License;

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

Part 5 - Agent's Signature

Agency Number: 3AY

	Name	Percent	Agent No./Suffix	Phone & Email
Licensed Agent	Licensed Agent's Name *(Print)* Tanoah Morgan	Percent 100%	Agent No./Suffix 8702G - 01	Phone & Email (240) 544-6800
		tmorgan@msagencies.com		
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

National Life Group®

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HIPAA Compliant Authorization

for Release of Health-Related and Other Information

LS715980600

I authorize any health plan, physician, health care professional, hospital, clinic, laboratory, pharmacy, medical facility, prescription benefit manager, or other health care provider that has provided payment, treatment or services to me or on my behalf within the past 10 years (collectively, "My Providers") to disclose my entire medical record, prescription drug information, and any other protected health information concerning me to National Life Insurance Company and Life Insurance Company of the Southwest (collectively, "The Company") and The Company's agents, employees, reinsurers, and representatives. I further authorize MIB, Inc. to disclose to The Company, or its reinsurers, any knowledge of me or my health, and any other protected health information concerning me. This includes information on the diagnosis or treatment of Human Immunodeficiency Virus (HIV) infection and sexually transmitted diseases. This also includes information on the diagnosis and treatment of mental illness and the use of alcohol, drugs and tobacco, but excludes psychotherapy notes. I further authorize The Company to re-disclose any protected health information or other knowledge or records concerning me to The Company's reinsurers and to MIB, Inc., which operates an information exchange on behalf of life and health insurance companies. I further authorize the Company to request a copy of my driving record(s) from the state motor vehicle department (collectively, "DMVs").

By my signature below, I acknowledge that any agreements I have made to restrict my protected health information do not apply to this Authorization and I instruct My Providers to release and disclose my entire medical record without restriction. I also acknowledge that I have read the PRENOTIFICATIONS, including the notices required by the Fair Credit Reporting Act and MIB, Inc. ("MIB").

The protected health information and driving records are to be disclosed under this Authorization so that The Company may: (1) underwrite my application for coverage, make eligibility, risk rating, policy issuance and enrollment determinations; (2) obtain reinsurance; (3) administer claims and determine or fulfill responsibility for coverage and provision of benefits; (4) administer coverage; and (5) conduct other legally permissible activities that relate to any coverage I have or have applied for with The Company.

This Authorization shall remain in force for 30 months following the date of my signature below, and a copy of this Authorization is as valid as the original. I understand that I have the right to revoke this Authorization in writing, at any time, by sending a written request for revocation to National Life Insurance Company or Life Insurance Company of the Southwest, Centralized Mailing Address, One National Life Drive, Montpelier, VT 05604, Attention: Privacy Officer. I understand that a revocation is not effective to the extent that any of My Providers or DMVs has relied on this Authorization or to the extent that The Company has a legal right to contest a claim under an insurance policy or to contest the policy itself. I understand that any information that is disclosed pursuant to this Authorization may be re-disclosed and no longer covered by federal rules governing privacy and confidentiality of health information or driving records.

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I understand that My Providers may not refuse to provide treatment or payment for health care services if I refuse to sign this Authorization. I further understand that if I refuse to sign this Authorization to release my complete medical record and driving records, The Company may not be able to process my application, or if coverage has been issued, may not be able to make any benefit payments. I acknowledge that I have received a copy of this Authorization.

Proposed Insured/Patient: *(Print)* Janice Yvonne Haskins

Date of Birth: 10/03/1976

Signature of Proposed Insured/Patient or Personal Representative: e-Signed by Janice Yvonne Haskins

Today's Date: *(mm/dd/yyyy)* 04/15/2019 02:00:56 GMT

Description of Personal Representative's Authority or Relationship to Patient:

Questions & Answers about Release of Protected Health Information to a Life or Disability Income Insurer.

1. **May I release complete personal medical information to a life or disability income insurance company?**

   Yes. As you did before the Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule became effective, a medical care provider may disclose complete Protected Health Information (PHI) to organizations not subject to the Privacy Rule as long as the applicant has signed a HIPAA compliant authorization.

2. **Does the "minimum amount necessary" rule apply to this release to a life or disability income insurer?**

   No. The "minimum amount necessary" rule does not apply as long as a HIPAA compliant authorization is signed. This question was specifically addressed by Health and Human Services (HHS) in a Q and A published December 4, 2002: "Uses and disclosures that are authorized by the individual are exempt from the minimum necessary requirements. For example, if a covered health care provider receives an individual's authorization to disclose medical information to a life insurer for underwriting purposes, the provider is permitted to disclose the information requested on the authorization without making any minimum necessary determination. The authorization must meet the requirements of 45 CFR 164.508."

3. **Can an insurer request disclosure of a person's "entire" medical record or does it have to refer to specific items in a medical file only?**

   Yes. HIPAA allows insurers to seek and providers to disclose a person's entire medical record, if the authorization used clearly states that the entire medical record is to be disclosed (e.g., "I authorize you to disclose my entire medical record.")

4. **Does HIPAA mandate the use of one specified form of authorization by everyone?**

   No. HIPAA requires that certain specified "elements" be included in a valid authorization to disclose protected health information. HIPAA does not mandate that a specific form be used. Both covered and non-covered entities are free to use any format they wish so long as it is compliant with HIPAA's requirements. The signed authorization contains all of the elements required by HIPAA.

5. **What should I do if I had previously agreed to a restriction and now receive an authorization to release the "entire medical record?" Does the authorization cover PHI that was restricted?**

   You may release all medical records, restricted and otherwise if a patient has previously requested a restriction and later signs an authorization which removes the restriction. The wording of this authorization specifically releases any restricted information.

This HIPAA compliant authorization and Questions and Answers were created by the American Council of Life Insurers.

National Life Group®

Experience Life®

Term 30-G

Term Life Insurance

Prepared on
April 14, 2019 for
Janice Yvonne Haskins

Presented by

Tanoah Morgan
STE 20
4500 FORBES BLVD
LANHAM, Maryland 20706-6312

Product issued by
Life Insurance Company of the Southwest®

Term 30-G, [Form Series ICC18-20522] and any applicable riders are underwritten by Life Insurance Company of the Southwest®, Addison, Texas. All rider form series are not available in all states. Riders are optional and may require additional premium. Guarantees are dependent upon the claims-paying ability of the issuing company.

This information is not intended as tax or legal advice. For advice concerning your own situation, please consult with your appropriate professional advisor.

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No bank or credit union guarantee | Not a deposit | Not FDIC/NCUA insured | May lose value
Not insured by any federal or state government agency

Protect Those Who Depend On You

Our term life insurance is an affordable way to provide financial security for those who depend on you. It can give you the peace of mind that comes with knowing your loved ones will be protected in the event you die prematurely. Our optional Accelerated Benefit Riders can help you financially if you suffer from a qualifying Terminal, Chronic, Critical Illness or Critical Injury[1].

Our term products may be ideal for those who:

- Want low cost life insurance with guaranteed[2] premiums for a specified period of time.
- Want additional death benefit to supplement permanent life coverage.
- Require a larger amount of insurance but it isn't within your budget right now.
- Are interested in purchasing term life insurance at a low cost and have the option of converting to a permanent policy in the future with no additional evidence of insurability[3].
- Are interested in purchasing term life insurance with optional riders that can provide living benefits in the event of an illness that is terminal, chronic, or critical, or in the event of a critical injury.

The death benefit can be used to:

- Protect your home
- Protect your children until they are grown
- Protect your business
- Protect your family now at an affordable cost with the option to convert to permanent in the future
- Help fund college tuition
- Help supplement a spouse's income

1 Accelerated Benefit Riders are optional, available with no additional premium, and may not be available in all states. Please refer to the Narrative Summary for details regarding the Accelerated Benefit Riders available in the state selected for this presentation.

2 Guarantees are dependent upon the claims-paying ability of the issuing company.

3 Additional coverage or additional riders added to the converted policy may require additional underwriting. All riders may not be available in all states or on all products.

Summary of Coverages

Janice Yvonne Haskins
Female 43 Standard Non-Tobacco
Riders: ABR

Face Amount: $270,000
Initial Premium: $63.62 Monthly (EFT)
State: Virginia

Life Insurance

Money for those who depend on you

- **Death Protection $270,000** for Janice Yvonne Haskins

Accelerated Living Benefits

Money for a Terminal, Chronic, Critical Illness or Critical Injury[1]

See the following page for more details on these benefits.

- Accelerated Benefits Rider for **Terminal Illness**
- Accelerated Benefits Rider for **Chronic Illness**
- Accelerated Benefits Rider for **Critical Illness**
- Accelerated Benefits Rider for **Critical Injury**

Conversion Privileges

If your needs change, convert from Term to Permanent Insurance

No cost conversion feature allows you to convert your term policy to a Life Insurance Company of the Southwest permanent insurance product with no additional evidence of insurability.

The conversion period ends 20 years from the term policy date of issue or age 70 if sooner. Unlike term insurance, permanent insurance builds cash value which can be accessed using policy loans and withdrawals during your lifetime for emergencies, to take advantage of opportunities, or to supplement your retirement income.

The new permanent policy will be issued at an equivalent rate class regardless of changes in health.

The use of one benefit may reduce or eliminate other policy and rider benefits.

Riders are optional and may require additional premium.
This presentation is not valid unless accompanied by a complete Statement of Policy Cost and Benefit Information. Please see the Ledger for guaranteed values and other important information.

1 Accelerated Benefit Riders are optional, available with no additional premium, and may not be available in all states. Please refer to the Narrative Summary for details regarding the Accelerated Benefit Riders available in the state selected for this presentation.

Summary of Coverages

Janice Yvonne Haskins
Female 43 Standard Non-Tobacco
Riders: ABR

Face Amount: $270,000
Initial Premium: $63.62 Monthly (EFT)
State: Virginia

The optional Accelerated Benefit Riders (ABR) offer you flexibility to access your death benefit if you have a qualifying Terminal, Chronic, Critical Illness or Critical Injury[1]

Terminal Illness

As an example, if the full, available death benefit is accelerated, the discounted benefit for Janice Yvonne Haskins (Base) would be about **$231,024** at age **48.**

Chronic Illness

As an example, if the full, available death benefit is accelerated each month, the monthly discounted benefits for Janice Yvonne Haskins (Base) are projected to be:

Age 45: $1,943 **Age 47:** $2,122 **Age 49:** $2,308 **Age 53:** $2,689

Critical Illness OR Critical Injury

As an example, if the full, available death benefit is accelerated, the discounted benefits for Janice Yvonne Haskins (Base) are projected to be:

Age	Category 1 Minor	Category 2 Moderate	Category 3 Severe	Category 4 Life Threatening
45	$11,882	$66,006	$134,121	$218,480
47	$13,836	$70,172	$137,038	$218,477
49	$15,664	$74,402	$140,066	$218,472
53	$18,873	$83,202	$146,710	$218,441

You can accelerate up to 100% of the death benefit, subject to an ABR Benefit limit of $1,500,000 for terminal and chronic illness and an ABR Benefit limit of $1,000,000 for critical illness and critical injury on the total death benefit accelerated under all policies on the life of the insured. Any claim for critical illness or critical injury benefits for a given Qualifying Event must be filed within 365 days following the occurrence of such Qualifying Event. For chronic illness, the death benefit you can accelerate is subject to a monthly limit to the lesser of 2% of the discounted death benefit or $30,000. The death benefit will be reduced by the amount of the death benefit you decide to accelerate. A discount factor will be applied to the death benefit accelerated because it is being paid prior to the actual death benefit. As a result, the actual benefit paid will be less than the amount of death benefit accelerated. Please refer to the Narrative Summary for further information about these riders.

The use of one benefit may reduce or eliminate other policy and rider benefits.

The sample benefits shown assume current accelerated benefits mortality table and interest at 6.5%. The benefits and values shown above are not guaranteed. The assumptions on which they are based are subject to change by the insurer. Actual results may be more or less favorable. This presentation is not valid unless accompanied by a complete Statement of Policy Cost and Benefit Information.

1 Accelerated Benefit Riders are optional, available with no additional premium, and may not be available in all states. Please refer to the Narrative Summary for details regarding the Accelerated Benefit Riders available in the state selected for this presentation.

Term 30-G

Term Life Insurance

Narrative Summary

Janice Yvonne Haskins
Female 43 Standard Non-Tobacco
Riders: ABR

Face Amount: $270,000
Initial Premium: $63.62 Monthly (EFT)
State: Virginia

Plan Description

Term 30-G [Form Series ICC18-20522], is a term life insurance policy that is annually renewable to age 95. Premiums are level for the first 30 years and increase annually thereafter to attained age 95. This policy has no cash value and no dividends are payable.

This policy is convertible during the first 20 years from the date of issue or until age 70 if earlier, but in no case less than 5 years from date of issue, without evidence of insurability to any single life permanent plan of life insurance then sold by us.

Premium Payment Options

This statement assumes premiums are paid on an monthly electronic funds transfer (EFT) basis and are received at the beginning of each billing period.

Your yearly cost will be higher if you choose to pay premiums more frequently than annually. For example, the additional amount you will pay in the first year is as follows:

Premium Frequency	Number of payments per year	Amount of each premium payment	Total premium per year	Amount you will pay each year in addition to the annual premium
Annual	1	$723.00	$723.00	$0.00
Semi-Annual	2	$368.73	$737.46	$14.46
Quarterly	4	$187.98	$751.92	$28.92
Monthly (EFT/Group Bill)	12	$63.62	$763.44	$40.44

This table illustrates the additional amounts that are required in the first year. Additional amounts will be due in future years if premiums are paid more frequently than annually and may vary from the above example.

Term 30-G

Term Life Insurance

Narrative Summary

Janice Yvonne Haskins

Female 43 Standard Non-Tobacco

Riders: ABR

Face Amount: $270,000

Initial Premium: $63.62 Monthly (EFT)

State: Virginia

Rider Description

The following riders are available at no additional premium:

Accelerated Benefits Rider for Terminal Illness (ABR) [Form Series ICC15-20287 and ICC15-20288], allows for the payment of a portion of an insured's death benefit if the insured is terminally ill. Terminally ill means that the insured has been certified by a physician as having an illness or chronic condition which can reasonably be expected to result in death in 24 months or less. There is no premium for this rider. However, the actual payment will be less than the portion of the death benefit accelerated because the benefits are paid prior to death.

Accelerated Benefits Rider for Chronic Illness (ABR) [Form Series 8095VA], allows for the payment of a portion of an insured's death benefit if the insured is chronically ill. Chronically ill means that the insured has been certified by a licensed health care practitioner as being unable to perform 2 out of 6 activities of daily living or is cognitively impaired. The activities of daily living are bathing, continence, dressing, eating, toileting, and transferring. There is no premium for this rider. However, the actual payment will be less than the portion of the death benefit accelerated because the benefits are paid prior to death.

Accelerated Benefits Rider for Critical Illness (ABR) [Form Series ICC15-20287], allows for the payment of a portion of the insured's death benefit if the insured experiences a qualifying event covered under the rider. Subject to state approval, the qualifying events may include: aorta graft surgery, aplastic anemia, cancer, cystic fibrosis, diagnosis of ALS (Amyotrophic Lateral Sclerosis), end stage renal failure, heart attack, heart valve replacement, major organ transplant, motor neuron disease, stroke and sudden cardiac arrest. Please see the rider for a complete list of the qualifying events covered. There is no premium for this rider. However, the actual payment will be less than the portion of the death benefit accelerated because the benefits are paid prior to death.

Accelerated Benefits Rider for Critical Injury (ABR) [Form Series ICC15-20288], allows for the payment of a portion of the insured's death benefit if the insured experiences a qualifying event covered under the rider. Subject to state approval, the qualifying events may include: coma, paralysis, severe burns and traumatic brain injury. Please see the rider for a complete list of the qualifying events covered. There is no premium for this rider. However, the actual payment will be less than the portion of the death benefit accelerated because the benefits are paid prior to death.

Important Information Regarding Optional Accelerated Benefit Riders

Death Benefits, cash values and loan values (for policies with such values) will be reduced if an Accelerated Benefit is paid. The Accelerated Benefits offered under this rider are intended to qualify for favorable tax treatment under the Internal Revenue Code of 1986. Whether such benefits qualify depends on factors such as your life expectancy at the time benefits are accelerated or whether you use the benefits to pay for necessary long-term care expenses, such as nursing home care. If the acceleration-of-life-insurance benefits qualify for favorable tax treatment, the benefit will be excludable from your income and not subject to federal taxation. Tax laws relating to acceleration-of-life-insurance benefits are complex. You are advised to consult with a qualified tax advisor about circumstances under which you could receive acceleration-of-life-insurance benefits excludable from income under federal law.

Receipt of acceleration-of-life-insurance benefits may affect your, your spouse's or your family's eligibility for public assistance programs, such as medical assistance (Medicaid), Aid to Families with Dependent Children, and Supplemental Security Income (SSI). You are advised to consult with a qualified tax advisor and with social services agencies concerning how receipt of such payment will affect you, your spouse's and your family's eligibility for public assistance. Riders are optional and may not be available in all states.

We currently limit the amount of benefits that may be paid under all accelerated benefit riders applying to the same insured to $1,500,000 for terminal and chronic illness and $1,000,000 for critical illness and critical injury. We reserve the

Rider Description (continued)

right to change these limits in the future, however the limit will never be less than $500,000. The maximum death benefit that may be accelerated under chronic illness in any year is the lesser of 24% of the death benefit in effect on the initial election date or $360,000. These limits vary by state. Once ABR has been added to your policy, please refer to your ABR policy form for specific information.

Term 30-G

Term Life Insurance

Narrative Summary

Janice Yvonne Haskins
Female 43 Standard Non-Tobacco
Riders: ABR

Face Amount: $270,000
Initial Premium: $63.62 Monthly (EFT)
State: Virginia

Definition of Key Terms and Column Headings

Age - The insured's age as of nearest birthday.

Face Amount – The amount used to determine the death benefit.

Guaranteed Contract Premium – The annualized guaranteed maximum premium for the term policy based on the premium mode selected.

Guaranteed Death Benefit – The policy's guaranteed death benefit.

Policy Year – The number of years for which information is being illustrated.

Rate Class – The rate class used in this Statement of Policy Cost and Benefit Information (statement) is Standard Non-Tobacco. The actual rate class will be determined when the application is underwritten and may vary from this statement. If so, a revised statement will be delivered with the policy.

Tax Treatment: The Company will report any eligible distributions, under any accelerated benefits rider, subject to existing IRS guidance and facts at the time of distribution. However, proper tax treatment for any accelerated benefits you receive under this insurance contract depends on a number of factors. These factors include, among others, the provisions of the law, the terms of the contract, and your personal situation at the time payments are made. These factors may permit some or all of the payments to be excluded from income or may require some or all the payments to be included in income for tax purposes. You should consult with your own tax advisor in deciding how to report the payments.

Cost Index Statement: Cost Indexes combine the premium with an interest factor. They are useful only for the purpose of comparing the cost of two or more similar policies, and do not reflect differences in the quality of service that can be expected from the agent of the Company. Explanations of the intended use of the cost indexes is provided in the Life Insurance Buyer's Guide.

	Cost Indexes for base policy at 5%	
Current Scale	Year 10	Year 20
Net Payment	N/A	N/A
Surrender Cost	N/A	N/A
Guaranteed Scale	Year 10	Year 20
Net Payment	$2.83	$2.83
Surrender Cost	$2.83	$2.83

An explanation of the intended use of these indexes is provided in the Life Insurance Buyer's Guide.

Term 30-G
Term Life Insurance

Ledger

Janice Yvonne Haskins
Female 43 Standard Non-Tobacco
Riders: ABR

Face Amount: $270,000
Initial Premium: $63.62 Monthly (EFT)
State: Virginia

Policy Year	Age	Guaranteed Contract Premium	Guaranteed Death Benefit
1	43	$763.44	$270,000
2	44	763.44	270,000
3	45	763.44	270,000
4	46	763.44	270,000
5	47	763.44	270,000
6	48	763.44	270,000
7	49	763.44	270,000
8	50	763.44	270,000
9	51	763.44	270,000
10	52	763.44	270,000
		$7,634.40	
11	53	763.44	270,000
12	54	763.44	270,000
13	55	763.44	270,000
14	56	763.44	270,000
15	57	763.44	270,000
16	58	763.44	270,000
17	59	763.44	270,000
18	60	763.44	270,000
19	61	763.44	270,000
20	62	763.44	270,000
		$15,268.80	
21	63	763.44	270,000
22	64	763.44	270,000
23	65	763.44	270,000
24	66	763.44	270,000
25	67	763.44	270,000
26	68	763.44	270,000
27	69	763.44	270,000
28	70	763.44	270,000

Term 30-G

Term Life Insurance

Ledger

Janice Yvonne Haskins

Female 43 Standard Non-Tobacco

Riders: ABR

Face Amount: $270,000

Initial Premium: $63.62 Monthly (EFT)

State: Virginia

Policy Year	Age	Guaranteed Contract Premium	Guaranteed Death Benefit
29	71	$763.44	$270,000
30	72	763.44	270,000
		$22,903.20	
31	73	7,945.68	270,000
32	74	8,949.24	270,000
33	75	10,115.40	270,000
34	76	11,438.40	270,000
35	77	12,980.88	270,000
36	78	14,777.16	270,000
37	79	16,915.56	270,000
38	80	19,512.96	270,000
39	81	22,509.60	270,000
40	82	25,472.04	270,000
		$173,520.12	
41	83	28,702.44	270,000
42	84	32,582.88	270,000
43	85	38,536.20	270,000
44	86	43,819.44	270,000
45	87	49,732.80	270,000
46	88	56,669.76	270,000
47	89	64,379.52	270,000
48	90	72,841.80	270,000
49	91	81,854.52	270,000
50	92	91,648.32	270,000
		$734,287.80	
51	93	102,217.68	270,000
52	94	112,866.96	270,000
		$949,372.44	

Level Period Comparison

Janice Yvonne Haskins
Female 43 Standard Non-Tobacco
Riders: ABR

Face Amount: $270,000
Initial Premium: $63.62 Monthly (EFT)
State: Virginia

The Premium Payment Options below shows how premium payments vary between term life insurance products and between premium modes in policy year 1. Additional amounts will be due in future years if premiums are paid more frequently than annually and may vary from the below example.

Premium Payment Options

	Annual		Semi-Annual		Quarterly		Monthly (EFT)	
Term Product	Amount of each premium payment	Total premium per year	Amount of each premium payment	Total premium per year	Amount of each premium payment	Total premium per year	Amount of each premium payment	Total premium per year
Term 10-G	$320.70	$320.70	$163.56	$327.12	$83.38	$333.52	$28.22	$338.64
Term 15-G	$390.90	$390.90	$199.36	$398.72	$101.63	$406.52	$34.40	$412.80
Term 20-G	$474.60	$474.60	$242.05	$484.10	$123.40	$493.60	$41.76	$501.12
Term 30-G	$723.00	$723.00	$368.73	$737.46	$187.98	$751.92	$63.62	$763.44

Compare the Contract Premium required to fund the requested Death Benefit for each term life insurance product below.

Policy Year	Age	Term 10-G Contract Premium	Term 15-G Contract Premium	Term 20-G Contract Premium	Term 30-G Contract Premium	Guaranteed Death Benefit
1	43	$338.64	$412.80	$501.12	$763.44	$270,000
2	44	338.64	412.80	501.12	763.44	270,000
3	45	338.64	412.80	501.12	763.44	270,000
4	46	338.64	412.80	501.12	763.44	270,000
5	47	338.64	412.80	501.12	763.44	270,000
6	48	338.64	412.80	501.12	763.44	270,000
7	49	338.64	412.80	501.12	763.44	270,000
8	50	338.64	412.80	501.12	763.44	270,000
9	51	338.64	412.80	501.12	763.44	270,000
10	52	338.64	412.80	501.12	763.44	270,000
		$3,386.40	**$4,128.00**	**$5,011.20**	**$7,634.40**	
11	53	1,265.28	412.80	501.12	763.44	270,000
12	54	1,407.84	412.80	501.12	763.44	270,000
13	55	1,558.92	412.80	501.12	763.44	270,000
14	56	1,704.36	412.80	501.12	763.44	270,000
15	57	1,841.28	412.80	501.12	763.44	270,000
16	58	1,986.60	1,986.60	501.12	763.44	270,000
17	59	2,137.80	2,137.80	501.12	763.44	270,000
18	60	2,306.04	2,306.04	501.12	763.44	270,000

Level Period Comparison

Janice Yvonne Haskins
Female 43 Standard Non-Tobacco
Riders: ABR

Face Amount: $270,000
Initial Premium: $63.62 Monthly (EFT)
State: Virginia

Compare the Contract Premium required to fund the requested Death Benefit for each term life insurance product below.

Policy Year	Age	Term 10-G Contract Premium	Term 15-G Contract Premium	Term 20-G Contract Premium	Term 30-G Contract Premium	Guaranteed Death Benefit
19	61	$2,499.84	$2,499.84	$501.12	$763.44	$270,000
20	62	2,733.72	2,733.72	501.12	763.44	270,000
		$22,828.08	**$17,856.00**	**$10,022.40**	**$15,268.80**	
21	63	2,995.92	2,995.92	2,995.92	763.44	270,000
22	64	3,289.68	3,289.68	3,289.68	763.44	270,000
23	65	3,611.88	3,611.88	3,611.88	763.44	270,000
24	66	3,948.24	3,948.24	3,948.24	763.44	270,000
25	67	4,318.92	4,318.92	4,318.92	763.44	270,000
26	68	4,720.92	4,720.92	4,720.92	763.44	270,000
27	69	5,180.04	5,180.04	5,180.04	763.44	270,000
28	70	5,704.56	5,704.56	5,704.56	763.44	270,000
29	71	6,331.92	6,331.92	6,331.92	763.44	270,000
30	72	7,078.92	7,078.92	7,078.92	763.44	270,000
		$70,009.08	**$65,037.00**	**$57,203.40**	**$22,903.20**	

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

eSignature

Application Date: ____________ Transaction ID: LS715980600

Proposed Insured / Annuitant: Janice Yvonne Haskins

Consent to Do Business Electronically

What is the purpose of this Consent?

If you continue with this electronic application for a life insurance policy or annuity contract issued by National Life Insurance Company or Life Insurance Company of the Southwest ("we", "us", "our"), you are expressing your desire to conduct business electronically with us. To conduct business electronically, you may be required to provide us, and our authorized designees and agents, with your consent and your e-mail address. By continuing with this electronic application, you will be providing us and our authorized designees and agents with your consent to conduct this transaction electronically and to all of the terms and conditions of this consent.

This consent covers your agreement to be bound with the same force and effect as if you had signed your name on paper by hand. You understand that by continuing with this electronic application that you are giving your electronic signature to your request. You agree to maintain the security of your Internet access and e-mail address.

What kinds of transactions may be conducted electronically?

Currently, the only transaction that may be conducted electronically is the application for a life insurance policy or an annuity contract, and electronic delivery of certain notices, disclosures and our privacy policy provided in connection with your application. Even though you have provided us with this consent, we may, at our option: (a) deliver documents and information to you on paper, and (b) require that certain communications from you be delivered to us on paper.

If I prefer to use paper instead of conducting a transaction electronically, may I use paper?

Yes. If you do not wish to apply for life insurance electronically, please do not proceed with this electronic application and ask your agent to provide you a paper application.

How long will this consent remain in effect?

This consent shall become effective as soon as you click "I AGREE" below and remains in effect throughout the purchase transaction. This consent does not apply to any future transactions with us.

What if I change my mind?

If you change your mind about applying electronically, you should not proceed with an electronic application. Instead, ask your agent to provide you a paper application.

What if my e-mail changes?

If your e-mail changes after you have provided it to your agent but before you have electronically signed your application, please let your agent know right away.

Signature: e-Signed by Janice Yvonne Haskins

Name: Janice Yvonne Haskins Role: Proposed Insured

Date and Time eSigned: 04/15/2019 02:00:56 GMT eSignature Method: Face to Face

IP Address: 96.255.173.189, 184.25.96.204, 10.101.27.12, 10.101.27.23

National Life Group® is a trade name of National Life Insurance Company, Montpelier, VT, Life Insurance Company of the Southwest (LSW), Addison, TX and their affiliates. Each company of National Life Group is solely responsible for its own financial condition and contractual obligations. LSW is not an authorized insurer in New York and does not conduct insurance business in New York.

Centralized Mailing Address: One National Life Drive, Montpelier, VT 05604 | www.NationalLifeGroup.com

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

eSignature

Application Date: ______________________ Transaction ID: LS715980600

Proposed Insured / Annuitant: Janice Yvonne Haskins

Consent to Do Business Electronically

What is the purpose of this Consent?

If you continue with this electronic application for a life insurance policy or annuity contract issued by National Life Insurance Company or Life Insurance Company of the Southwest ("we", "us", "our"), you are expressing your desire to conduct business electronically with us. To conduct business electronically, you may be required to provide us, and our authorized designees and agents, with your consent and your e-mail address. By continuing with this electronic application, you will be providing us and our authorized designees and agents with your consent to conduct this transaction electronically and to all of the terms and conditions of this consent.

This consent covers your agreement to be bound with the same force and effect as if you had signed your name on paper by hand. You understand that by continuing with this electronic application that you are giving your electronic signature to your request. You agree to maintain the security of your Internet access and e-mail address.

What kinds of transactions may be conducted electronically?

Currently, the only transaction that may be conducted electronically is the application for a life insurance policy or an annuity contract, and electronic delivery of certain notices, disclosures and our privacy policy provided in connection with your application. Even though you have provided us with this consent, we may, at our option: (a) deliver documents and information to you on paper, and (b) require that certain communications from you be delivered to us on paper.

If I prefer to use paper instead of conducting a transaction electronically, may I use paper?

Yes. If you do not wish to apply for life insurance electronically, please do not proceed with this electronic application and ask your agent to provide you a paper application.

How long will this consent remain in effect?

This consent shall become effective as soon as you click "I AGREE" below and remains in effect throughout the purchase transaction. This consent does not apply to any future transactions with us.

What if I change my mind?

If you change your mind about applying electronically, you should not proceed with an electronic application. Instead, ask your agent to provide you a paper application.

What if my e-mail changes?

If your e-mail changes after you have provided it to your agent but before you have electronically signed your application, please let your agent know right away.

Signature: ______________________

Name: Tanoah Morgan Role: Agent

Date and Time eSigned: ______________________ eSignature Method: Email

IP Address: ______________________

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Centralized Mailing Address: One National Life Drive, Montpelier, VT 05604 | www.NationalLifeGroup.com

National Life Group®

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

Privacy Notice To Our Customers

FACTS	**WHAT DOES NATIONAL LIFE INSURANCE COMPANY ("NLIC") AND LIFE INSURANCE COMPANY OF THE SOUTHWEST ("LSW")** (each herein referred to as "the Company", and collectively as "the Companies") **DO WITH YOUR PERSONAL INFORMATION?**
Why?	We know how much your privacy means to you so we want you to understand how we collect and share your personal information. Please read this notice carefully to understand what we do and what rights you have.
How and what do we collect?	We collect your personal information: • From you, including application information, such as assets and income and identifying information, such as name, address, and social security number; • From your transactions with us, our affiliates, and nonaffiliates, such as balance information, payment history, and parties to a transaction; • From consumer reporting agencies, such as creditworthiness and credit history; and • With your authorization, medical information from other individuals or businesses.
How do we share?	In the section below, we list some of the reasons the Company may share their customers' personal information; the reasons we choose to share personal information about you, and whether you can limit this sharing.

Reasons we can share your personal information	Do the Companies share?	Can you limit sharing?
For our everyday business purposes - such as to process your transactions, to respond to court orders and legal investigations, to prevent fraud, to our regulators, to group policyholders, and other disclosures to affiliates and nonaffiliates as permitted by law	YES	NO
For our marketing purposes - to offer our products and services to you	YES	NO
For joint marketing with other financial companies	NO	We don't share
For our affiliates' everyday business purposes - information about your transactions and experiences	YES	NO
For our affiliates' everyday business purposes - information about your creditworthiness	NO	We don't share
For our affiliates to market to you	NO	We don't share
For nonaffiliates to market to you	NO	We don't share

To whom?	• When we disclose your personal information for the reasons discussed above, we do so to our affiliates and to nonaffiliates. • Our affiliates include NLIC, LSW, Equity Services, Inc. and Sentinel Investments*. • The nonaffiliates to whom we disclose your personal information include those who perform services on our behalf. • We require the parties to whom we disclose your information to protect it and keep it confidential.
How do we protect?	• To protect your personal information we restrict access to personal information to those individuals, such as employees and agents, who provide you with our products and services. • We require those individuals to protect it and keep it confidential. • We maintain physical, electronic and procedural safeguards that comply with applicable standards to guard your information in accordance with the policies described in this notice.

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Centralized Mailing Address: One National Life Drive, Montpelier, VT 05604 | www.NationalLifeGroup.com

Confidentiality of information for victims of domestic violence or abuse	The Companies have established policies and procedures to safeguard personal information, including contact, location or other confidential abuse information, for victims of domestic abuse and children residing with those victims. A “protected person” is a victim of domestic violence or abuse who notifies the Companies and requests confidential treatment of their personal information. If you wish to be a protected person or otherwise request confidential treatment of your information or that of your children and/or provide alternative contact information, please send your written request to the address listed below.
Other important information	• You have certain rights to access the personal information we maintain about you if it is reasonably locatable and retrievable. • To obtain your personal information, submit a written request to the email or mail address below. You have certain rights to correct, amend, or delete information we maintain about you. • To correct, amend, or delete information we maintain about you, submit a written request to the email or mail address below. • If we agree to your request, we will correct, amend, or delete your information as applicable and notify affected parties as required by law. • If we do not agree to your request, you may file a concise statement regarding your information, which will be provided to affected parties as required by law. • Before we disclose information about your creditworthiness or your personal information other than as discussed above (which we do not currently do) we will provide you the opportunity to opt out of such disclosures. • Finally, information obtained from a report prepared by an insurance-support organization may be retained by the insurance-support organization and disclosed to other persons.
Questions?	For more information, please contact us at • Email: NLGCompliance@nationallifegroup.com • Phone: 800-732-8939 • Mail: National Life Group Market Conduct and Compliance M530 One National Life Drive Montpelier, VT 05604

*Sentinel Investments is the unifying brand name for Sentinel Financial Services Company, Sentinel Asset Management, Inc., and Sentinel Administrative Services, Inc.

Life Insurance Company of the Southwest®

Conditional Receipt

Complete for Single Life and Survivorship Life

Conditional Receipt *(to be given to applicant only upon (a) premium payment to agent or (b) completion of Part F of the application in good order and checking "EFT" as the Initial Premium Payment Method) (Not to be used for Qualified Pension or Profit Sharing Trust.)*

NOTE: ALL PREMIUM CHECKS SHOULD BE MADE PAYABLE TO LIFE INSURANCE COMPANY OF THE SOUTHWEST.
Do not make a check payable to the agent or leave the payee blank.

This receipt may not be used (and will be deemed void) if (a) either at least the first full modal premium does not accompany the application or Part F of the application is not completed in good order with "EFT" checked as the Initial Premium Payment Method or (b) the application is not accurately and fully completed in good order, including (without limitations) Parts A-J of the application. No agent or medical examiner may waive a complete answer to any question in the application.

Check one:

☐ ____________________ has been submitted by the applicant with the application, subject to the terms of this receipt.

☒ Part F of the application has been completed by the applicant in good order with "EFT" checked as the Initial Premium Payment Method, subject to the terms of this receipt.

If the check or draft, as applicable, when processed is returned as insufficient funds, no coverage is provided under this receipt.

Coverage under this receipt shall not exceed the face amount(s) applied for or $1,000,000, whichever is less. If a Proposed Insured dies by suicide, Life Insurance Company of the Southwest's (LSW) liability under this receipt is limited to a full refund of the premium paid. If applicant directed LSW to draft the initial premium payment and LSW had not yet done so, no refund will be due.

Coverage under this receipt will begin on the LATER of:

a) either (i) the date the application in good order is signed, including Part F of the application with "EFT" checked as the Initial Premium Payment Method, or (ii) the date the application in good order is signed and the first full modal premium has been received by LSW in good funds,

b) the date the last medical requirement requested by LSW is completed; provided no coverage under this receipt will begin if medical requirements requested by LSW have not been received by LSW within 90 days of the date of the application, or

c) LSW determines that each Proposed Insured is acceptable to it, under applicable underwriting standards, for the plan, benefits, amount and rate class for which the applicant applied.

Termination of Coverage. Coverage under this receipt will end on the FIRST of:

a) insurance beginning under the policy for which the applicant applied,

b) LSW declines the application or offers the applicant a policy for other than the one for which the applicant applied,

c) 90 days from the date coverage under this receipt begins, or

d) LSW notifies the applicant in writing that coverage is ended. If LSW terminates coverage under this receipt or declines the application, or if the applicant refuses a policy issued other than that for which the applicant applied, LSW will refund the full amount paid under this receipt. If applicant directed LSW to draft the first premium payment and LSW had not yet done so, no refund will be due.

Signed at: *(City & State)* VA on this day of: *(mm/dd/yyyy)* ____________

Licensed Agent's Signature: ____________ Licensed Agent's Name: *(Print)* Tanoah Morgan

 National Life Group® is a trade name representing various affiliates, which offer a variety of financial service products. Cat. No. 52519

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