National Life Group®

Life Insurance Application Cover Sheet

Congratulations!
Your application has been submitted and is under review!

Application Date:	03/10/2020	Application State:	MD
Proposed Insured:	Chanda Littlefield	Agent:	TaNoah Morgan
Proposed Insured DOB:	09/27/1977	Agency Name:	
Product:	LSW 30-G	Office ID:	
Face Amount:	$250,000	Case Manager:	
Transaction ID:	LS722667500	Producer ID:	
Check Number:		Profile #:	
Invalid Address:			

INSTRUCTIONS:

Unique Identifier: 144907da-7aa1-4e37-8031-386c4993acb3-215213356

AGENT REMARKS:

Illustration Unique ID: 56736
eApp was initiated with integrated illustration

List of Additional Agents:

Unique Identifier: 144907da-7aa1-4e37-8031-386c4993acb3-215213356

National Life Group®

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

LS722667500 3AY

Individual Life Insurance Application

Part A - Proposed Insured Information

1. Name *(print first, middle, last)*	2. Place of Birth - State/Country	3. Sex
Chanda Littlefield	United States / MD	☐ 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.
2611 Nemo Ct, Bowie, MD 20716-1462	09/27/1977	42	217-19-3325

8. Home Phone	Mobile Phone Pref	Work Phone	9. E-Mail Address	10a. Driver's License #	10b. State
	(240)744-2226		chandaproctor@gmail.com	L341115112747	MD

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

12. Employer & time employed		13. Occupation *(w/specific duties)*	14a. Annual Income	14b. Net Worth
Employed-The Queen of Real Estate LLC	More than 6 months	Business Owner	$95,000	$370,000

Part B - Owner Information *(If a business include form 8453. If a trust include form 5213.)*

Owner is: ☒ Proposed Insured ☐ Individual ☐ Business *(LLC, LP)* ☐ Partnership ☐ Trust

1. Full Name of Owner *(if trust - provide trustees, grantor(s), date of trust agreement and trust name)*

2. Date of Birth	3. SSN or Tax ID	4. Relationship

5. Mailing Address *(Street, City, State & Zip)*	6. E-Mail Address	7. Telephone #

8. Full Name of ☐ Joint Owner or ☐ Contingent Owner *(if applicable)*

8a. Date of Birth	8b. SSN or Tax ID	8c. Relationship

Survivorship Language for Ownership, unless otherwise provided: Individual owner, while living; thereafter the Proposed Insured. Joint Owners, the survivors or survivor, while living; thereafter the Proposed Insured. Business Entity, while existent; thereafter the Proposed Insured. While Trust is existent; thereafter the Proposed Insured.

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)*

Jodi Littlefield — Relationship to Insured: Father — 100%
DOB: 02/24/1945 SSN/TIN: Phone: (240) 636-1031

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

Siobhan Littlefield — Relationship to Insured: Sister — 100%
1700 Dryden Way, Crofton, MD 21114-1413 DOB: 08/16/1984 SSN/TIN: Phone: (301) 412-5438
slittlefield@hotmail.com

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.

P: 800-732-8939 | www.NationalLife.com
NLIC: One National Life Drive, Montpelier, VT 05604 | LSW: 15455 Dallas Parkway, Suite 800, Addison, TX 75001

Part D - Policy Information

1a. Product Name: LSW 30-G

1b. Company: *(Must match issuing company on Page 1.)* ☐ NLIC ☒ LSW

2. Face Amount: $250,000

3. Term Rider Plan: *(Whole Life)*

4. Term Rider Amount:

5. Death Benefit Option: ☐ A - Level ☐ B - Increasing

6. Definition of Life Insurance Test: *(Applies to IUL & UL only.)* ☐ Guideline Premium Test (GPT) ☐ Cash Value Accumulation Test (CVAT)

7. Use of Dividends: *(Whole Life) (Choose **only** one.)*
☐ Cash ☐ Additions ☐ Applied *(N/A with EFT)* ☐ Deposits ☐ Internal Paid-Up Insurance

☐ Flex Term Rider (***A premium will be charged for this rider.***)
One Yr. Term + Adds = _____

8. Riders and Amounts:

☒ Accelerated Benefits (ABR) *(Complete ABR Disclosure form)*
☐ Accidental Death Benefit (ADB) _____
☐ Additional Paid Up
Rider Modal Premium (APAR) _____
Rider Single Premium (SPAR) _____
☐ Additional Protection Benefit (APB) _____
☐ Balance Sheet Benefit (BSB) *(% Waived)* _____ %
☐ Beneficiary Insurance Option (BIO) *(Complete 1445)*
☐ 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 (GIO, GIR) _____
☐ Disability Income (DIR) ☐ 2 Yr ☐ 5 Yr _____
a. Do you have any disability insurance, including employer sponsored short or long-term coverage? ☐ Yes ☐ No *(If yes, give details in Remarks)*
☐ Waiver of Monthly Deductions (WMD)
☐ Waiver of Premiums (WP) _____ *(Annual Premium Waived if applicable)*
☐ Other _____ _____

The Death Benefit Protection Rider is automatically added, if eligible.
☐ Please check this box if you do NOT want this rider. Otherwise, it will be added. There is a minimum premium associated with this rider, and the AssurePlus Protector or 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. Initial Premium Payment Method

[X] Draft Initial Premium via Electronic Funds Transfer *(EFT) (One-time payment for the planned premium amount from the bank account listed in #4.)*

Draft Day 1st - 31st Next Avai *(Advanced dating will occur to align the requested draft date with the effective date of your policy.)*

[ ] Check with application *(Cash equivalent form 7953 is needed for cashier's checks and money orders.)*

[ ] Collect payment on delivery *(No conditional coverage offered.)*

[ ] Check [ ] Delayed bank draft *(pending communication from agent; using banking information from #4)*

2. Billing Information

a. Planned Periodic/Modal Premium $61.60

b. Premium Frequency [ ] Annual [ ] Semi-Annual [ ] Quarterly [X] Monthly

c. Billing Type [X] Automatic Payments via EFT *(From bank account listed in #4.)* Draft Day 1st - 31st 20

[ ] Send Paper Bills to [ ] Owner [X] Proposed Insured [ ] Group Bill No. _____

[ ] Other *(name, street, city, state & zip)* _____

[ ] Single Premium *(no bill)*

d. Source of Funds for Premium Payment

[X] Income/Savings [ ] Home Equity [ ] Payment by Third Party [ ] Loan/Premium Finance

[ ] Other _____

3. Automatic Payment of Premium *(Whole life only, also known as APL. Uses loan value to pay premium.)* [ ] Yes [ ] No

4. Bank Information *(Complete if EFT is selected in Initial Premium and/or Billing Information section.)*

I authorize the National Life Group to draft payments from my account [X] Checking [ ] Savings

Name of Bank Citibank Name on Bank Account Chanda Littlefield

Bank Routing No. *(9 digits)* 052002166

Bank Account No. *(Do not include check number.)* 9109413950

[X] Please check this box if you agree that premiums may continue to be drafted if the premium amount increases by $25 or less. You will be given prior notification for any premium increases that exceed $25.

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

Depositor's Mailing Address 2611 Nemo Ct, Bowie, MD 20716-1462

Depositor's Email Address chandaproctor@gmail.com Depositor's Phone No. (240)744-2226

Depositor Signature *(If not Applicant/Owner.) (Exactly as it appears on bank records)* Signed by Chanda Littlefield

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, disability income insurance or riders? *(If yes, provide details)* ☒ Yes ☐ No

Company	Policy Number	Date Issued	Amount of Coverage	ADB Coverage	To be Replaced	1035 Exchange
primerica	000000001	06/01/2019	$100,000	Unknown	☐ 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, disability income 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. Within the past 10 years, 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 and results for any 'Yes' questions in Remarks. Complete Part J if money was collected or authorization to draft the initial premium has been given. If an exam is required based on plan/age/amount requirements, Part J is optional.)*

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 2in Weight 210lb 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 by a member of the medical profession 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 H: Recent Applications, Inforce Coverage, and Replacement Information; Company 1; Date Issued: 06/01/2019; Insured: Chanda Littlefield; Policy Type: Life

Please see Supplemental

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)* MD Date *(mm/dd/yyyy)* 03/10/2020 04:30:41 GMT

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

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

e-Signed by Chanda Littlefield

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

e-Signed by DaNoah Morgan

(Witness)

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Supplemental Information to the Application for Life Insurance

Insured's Name: Chanda Littlefield Social Sec. #: 217-19-3325

General/Health Info:

Physician Info

Physician 1 (Primary):

Name: Zahara Ahmed
Address: 7525 Greenway Center Dr #209
Country: United States of America
State: Maryland
City: Greenbelt
Phone: (301) 313-0425
Reason for last visit: Minor Condition - Such as cold, allergies, minor injury, etc.
Last visit (MM/YYYY): 2/2020

Family History

Is your Father still living? Yes
Father's Current Age: 75
Is your Mother still living? Yes
Mother's Current Age: 64

Occupation

Occupation: Business Owner

Within the past 12 months have you applied for or do you have any applications pending for life or disability insurance? Yes

What company did you apply for insurance with? Primerica
Provide the date (mm/yy) the insurance was applied for. 06/01/2019
What was the face amount applied for? 100000
What was the outcome of the application? Accepted
Is this applied for insurance in addition to the pending coverage with National Life Group? Yes

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

What type of policy was declined, postponed, rated or modified? Life
Provide the date (mm/yy) that the coverage was applied for. 06/01/2019
What was the face amount applied for? 100000
Provide details on the reason the final decision was declined, postponed, rated or modified? blood pressure

Signed at *(City and State)*: MD on this day of: 03/10/2020

Signature of Insured(s): e-Signed by Chanda Littlefield

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

Signature of Agent: e-Signed by DaNoah Morgan

P: 800-732-8939 | www.NationalLife.com
NLIC: One National Life Drive, Montpelier, VT 05604 | LSW: 15455 Dallas Parkway, Suite 800, Addison, TX 75001

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Supplemental Information to the Application for Life Insurance

Insured's Name: Chanda Littlefield Social Sec. #: 217-19-3325

We have received information from a confidential source that suggests you may have high blood pressure history. Do you have a history of high blood pressure? No

Signed at *(City and State):* MD on this day of: 03/10/2020

Signature of Insured(s): e-Signed by Chanda Littlefield

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

Signature of Agent: e-Signed by DaNoah Morgan

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Prenotifications

The Underwriting Process and Consumer Rights

Thank you for your application. A primary goal of National Life Insurance Company and Life Insurance Company of the Southwest (the Company) is to provide insurance protection that best meets your needs and to service these needs through the years. To keep costs at a minimum, we evaluate every proposed insured to be sure that the premium rate for each person is in relation to each person's fair share of the cost.

This evaluation - the underwriting process - may consist of a physical examination, review of medical history and reports from physicians or medical facilities which you have visited for treatment or consultation. In addition, a routine investigative consumer report is sometimes obtained.

We also check the records of the MIB, Inc. ("MIB"). The MIB is a nonprofit membership organization of life insurance companies which operates an information exchange on behalf of its members. The basic purpose of this organization is the protection of policyholders of member companies. It is not a repository of medical records. The information in its files serves only as an indication that additional data may be needed to evaluate the risk. No member company can refuse coverage on the basis of this information, nor does the information reveal whether an application was approved, rated or declined.

This program helps to assure that the true cost of the insurance is shared proportionately. Consumer rights bearing on insurance cost, needs and service are just as important to us as they are to you.

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 - 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 - 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 Bureau'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.

Leave with Applicant

6496(0412)

Cat. No. 42577

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

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

To determine your insurability, the Insurer named above (the Insurer) 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.

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 virus. The HIV antibody test that we perform 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 such as its affiliates, reinsurers, employees, or contractors. 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. There will be no other disclosure of test results or even that the tests have been done except as may be required or permitted by law or as authorized by you.

If your HIV test results are normal, no routine notification will be sent to you. If the HIV test results are other than normal, the Insurer will contact you. The Insurer may also contact you if there are other abnormal test results which, in the Insurer's opinion, are significant. The Insurer may ask you for the name of a physician or other health care provider to whom you may authorize disclosure and with whom you may wish to discuss the results. You may designate below the physician or other person to whom positive or indeterminate test results will be reported:

Name: *(Print or Type)*
Zahra Ahmed

Address: *(Street, City, State, Zip Code)*
7525 Greenway Center Dr Ste 209

Greenbelt, MD 20770-3525

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 or 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 of 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 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:
Chanda Littlefield	09/27/1977	MD

Signature of Proposed Insured or Parent/Guardian:
e-Signed by Chanda Littlefield

Date: *(mm/dd/yyyy)*
03/10/2020 04:30:35 GMT

To determine your insurability, the Insurer named above (the Insurer) 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.

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

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Life Insurance Company of the Southwest™

Disclosure Statement for Accelerated Benefits

(Terminal Illness & 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. The condition under which accelerated benefits may be elected varies by rider as described below. We will not accelerate benefits unless the qualifying Terminal Illness or Chronic Illness began while this rider was in effect.

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 Physician 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 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 Physician 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. requiring 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 severe cognitive impairment.

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

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. 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. 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. The Amount shall be at least equal to the acceleration percentage multiplied by the difference between the current policy Cash Value or Cash Surrender Value and any outstanding policy loans. The current policy Cash Value or Cash Surrender Value shall include any termination dividend payable on the surrender of the policy.

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 policy 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.

Signed at: *(City & State)* MD Date: *(mm/dd/yyyy)* 03/10/2020 14:34:50 GMT

Licensed Agent: *(Sign name in full)* e-Signed by TaNoah Morgan

Applicant/Owner: *(Sign name in full)* e-Signed by Chanda Littlefield

Copies to the Company, the Customer, and the Agent

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Disclosure Statement for Accelerated Benefits
(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.

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. The Insured must survive for 30 days following the Date of Diagnosis.
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. The Insured must survive for 30 days following the Date of Diagnosis.
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. The Insured must survive for 90 days following the Date of Diagnosis.

   Exclusion: 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. The Insured must survive 30 days following the Date of Diagnosis.
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. The Insured must survive for 30 days following the Date of Diagnosis.
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. The Insured must survive 30 days following the Date of Diagnosis.
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. The Insured must survive for 30 days following the Date of Diagnosis.

   Exclusion: No benefit will be payable under this condition for other acute coronary syndromes including but not limited to angina.
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. The Insured must survive 30 days following the Date of Diagnosis.
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. The Insured must survive 30 days following the Date of Diagnosis.

Copies to the Company, the Customer, and the Agent

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. The Insured must survive for 30 days following the Date of Diagnosis.
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. The Insured must survive for 30 days following the Date of Diagnosis.

    Exclusion: 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.

    Exclusion: 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. The Insured must survive for 30 days following the date of Sudden Cardiac Arrest.

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.

    Exclusion: 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. The Insured must survive for 30 days following the Date of Diagnosis.
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. The Insured must survive for 60 days following the Date of Diagnosis.

    Exclusion: 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 the Critical Illness Rider or the Critical Injury Rider for any Qualifying Event that occurs on or before the 30th day following its effective date of the rider unless such Qualifying Event directly results from accidental injury. No Accelerated Benefit will be paid under either 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 death benefit that may be accelerated under this and any other Accelerated Benefits Rider on the life of any insured person. This maximum limit will be no less than $500,000.**

Accelerated Benefits will be 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 policy had been originally issued at the reduced face amount.

As an example of the impact that election of Accelerated Benefits has on policy values, consider the following situation:

Prior to Election:			**Upon Partial Election of 50% of Death Benefit:**			**Upon Full Election:**		
Death Benefit	=	$100,000	Death Benefit	=	$50,000	Death Benefit	=	$0
Cash Surrender Value	=	50,000	Cash Surrender Value	=	25,000	Cash Surrender Value	=	0
Outstanding Debt	=	30,000	Outstanding Debt	=	15,000	Outstanding Debt	=	0
Annual Premium	=	2,000	Annual Premium	=	1,000	Annual Premium	=	0

Dollar values showing the specific impact that acceleration will have on your policy values will be provided when you apply for Accelerated Benefits.

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.

Signed at: *(City & State)* MD Date: *(mm/dd/yyyy)* 03/10/2020 14:34:50 GMT

Licensed Agent: *(Sign name in full)* e-Signed by TaNoah Morgan

Applicant/Owner: *(Sign name in full)* e-Signed by Chanda Littlefield

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Important Notice
Replacement of Life Insurance or Annuities

This document must be signed by the applicant and the producer, if there is one, and a copy left with the applicant.

You are contemplating the purchase of a life insurance policy or annuity contract. In some cases this purchase may involve discontinuing or changing an existing policy or contract. If so, a replacement is occurring. Financed purchases are also considered replacements.

A replacement occurs when a new policy or contract is purchased and, in connection with the sale, you discontinue making premium payments on the existing policy or contract, or an existing policy or contract is surrendered, forfeited, assigned to the replacing insurer, or otherwise terminated or used in a financed purchase.

A financed purchase occurs when the purchase of a new life insurance policy involves the use of funds obtained by the withdrawal or surrender of or by borrowing some or all of the policy values, including accumulated dividends, of an existing policy, to pay all or part of any premium or payment due on the new policy. A financed purchase is a replacement.

You should carefully consider whether a replacement is in your best interest. You will pay acquisition costs and there may be surrender costs deducted from your policy or contract. You may be able to make changes to your existing policy or contract to meet your insurance needs at less cost. A financed purchase will reduce the value of your existing policy and may reduce the amount paid upon the death of the insured.

We want you to understand the effects of replacements before you make your purchase decision and ask that you answer the following questions and consider the questions on page 2.

1. Are you considering discontinuing making premium payments, surrendering, forfeiting, assigning to the insurer, or otherwise terminating your existing policy or contract? ☐ Yes ☒ No
2. Are you considering using funds from your existing policies or contracts to pay premiums due on the new policy or contract? ☐ Yes ☒ No

If you answered 'Yes' to either of the above questions, list each existing policy or contract you are contemplating replacing (include the name of the insurer, the insured, and the contract number if available) and whether each policy will be replaced or used as a source of financing:

INSURER NAME	CONTRACT OR POLICY NO.	INSURED	REPLACED (R) OR FINANCING (F)

The existing policy or contract is being replaced because: _____

Make sure you know the facts. Contact your existing company or its agent for information about the old policy or contract. If you request one, an in-force illustration, policy summary or available disclosure documents must be sent to you by the existing insurer. Ask for and retain all sales material used by the agent in the sales presentation. Be sure that you are making an informed decision.

I do not want this notice read aloud to me. CL
(Applicants must initial only if they do not want the notice read aloud.)

I certify that the responses herein are, to the best of my knowledge, accurate:

Applicant's Signature: e-Signed by Chanda Littlefield	Date: *(mm/dd/yyyy)* 03/10/2020 04:30:41 GMT
Applicant's Name: *(Print.)* Chanda Littlefield	Date: *(mm/dd/yyyy)* 03/10/2020 04:30:41 GMT
Producer's Signature: e-Signed by TaNoah Morgan	Date: *(mm/dd/yyyy)* 03/10/2020 14:34:50 GMT
Producer's Name: *(Print.)* TaNoah Morgan	Date: *(mm/dd/yyyy)* 03/10/2020 14:34:50 GMT

Copies to the Company, the Customer, and the Agent

Important Notice: Replacement of Life Insurance or Annuities

A replacement may not be in your best interest, or your decision could be a good one. You should make a careful comparison of the costs and benefits of your existing policy or contract and the proposed policy or contract. One way to do this is to ask the company or agent that sold you your existing policy or contract to provide you with information concerning your existing policy or contract. This may include an illustration of how your existing policy or contract is working now and how it would perform in the future based on certain assumptions. Illustrations should not, however, be used as a sole basis to compare policies or contracts. You should discuss the following with your agent to determine whether replacement or financing your purchase makes sense:

PREMIUMS:

Are they affordable?
Could they change?
You're older--are premiums higher for the proposed new policy?
How long will you have to pay premiums on the new policy? On the old policy?

POLICY VALUES:

New policies usually take longer to build cash values and to pay dividends.
Acquisition costs for the old policy may have been paid; you will incur costs for the new one.
What surrender charges do the policies have?
What expense and sales charges will you pay on the new policy?
Does the new policy provide more insurance coverage?

INSURABILITY:

If your health has changed since you bought your old policy, the new one could cost you more, or you could be turned down.
You may need a medical exam for a new policy.
Claims on most new policies for up to the first two years can be denied based on inaccurate statements. Suicide limitations may begin anew on the new coverage.

IF YOU ARE KEEPING THE OLD POLICY AS WELL AS THE NEW POLICY:

How are premiums for both policies being paid?
How will the premiums on your existing policy be affected?
Will a loan be deducted from death benefits?
What values from the old policy are being used to pay premiums?

IF YOU ARE SURRENDERING AN ANNUITY OR INTEREST SENSITIVE LIFE PRODUCT:

Will you pay surrender charges on your old contract?
What are the interest rate guarantees for the new contract?
Have you compared the contract charges or other policy expenses?

OTHER ISSUES TO CONSIDER FOR ALL TRANSACTIONS:

What are the tax consequences of buying the new policy?
Is this a tax-free exchange? (See your tax advisor).
Is there a benefit from favorable "grandfathered" treatment of the old policy under the federal tax code?
Will the existing insurer be willing to modify the old policy?
How does the quality and financial stability of the new company compare with your existing company?

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Agent's Report

Part 1 - Proposed Primary Insured Information - Please PRINT

1. Proposed Insured's Name
   Chanda Littlefield
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)?
   20 years
4. Are you related? ☐ Yes ☒ No
   (If 'Yes', relationship?) _____
5. Proposed Primary Insured's
   Net Worth $370,000
   Household Income $95,000
   Household Net Worth $370,000
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 $95,000
   Net Worth $370,000
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 _____ Are you a Home Office Employee, Spouse or Child? ☐ Yes ☐ No

1.2. Face to face with each insured: Yes; 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

Licensed Agent	Licensed Agent's Name *(Print)*	Percent	Agent No./Suffix	Phone & Email
e-Signed by TaNoah Morgan	TaNoah Morgan	100%	8702g - 01	2405446800
				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

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.

Centralized Mailing Address: One National Life Drive, Montpelier, VT 05604 | P: 800-732-8939 | www.NationalLife.com

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)*	Date of Birth:
Chanda Littlefield	09/27/1977

Signature of Proposed Insured/Patient or Personal Representative:	Today's Date: *(mm/dd/yyyy)*
e-Signed by Chanda Littlefield	03/05/2020 20:29:26 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
March 3, 2020 for

Chanda Littlefield

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.

National Life Group® is a trade name representing various affiliates, which offer a variety of financial service products.
Centralized Mailing Address: One National Life Drive, Montpelier, VT 05604
Home Office: Addison, TX | 800-732-8939 | www.NationalLife.com

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 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

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

Chanda Littlefield
Female 42 Standard Non-Tobacco

Face Amount: $250,000
Initial Premium: $61.60 Monthly
State: Maryland

Life Insurance

Money for those who depend on you

- **Death Protection $250,000** for Chanda Littlefield

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.

Term 30-G
Term Life Insurance

Narrative Summary

Chanda Littlefield
Female 42 Standard Non-Tobacco

Face Amount: $250,000
Initial Premium: $61.60 Monthly
State: Maryland

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 a monthly 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	$700.00	$700.00	$0.00
Semi-Annual	2	$357.00	$714.00	$14.00
Quarterly	4	$182.00	$728.00	$28.00
Monthly	12	$61.60	$739.20	$39.20

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

Chanda Littlefield
Female 42 Standard Non-Tobacco

Face Amount: $250,000
Initial Premium: $61.60 Monthly
State: Maryland

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	$2.96	$2.96
Surrender Cost	$2.96	$2.96

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

Chanda Littlefield
Female 42 Standard Non-Tobacco

Face Amount: $250,000
Initial Premium: $61.60 Monthly
State: Maryland

Policy Year	Age	Guaranteed Contract Premium	Guaranteed Death Benefit
1	42	$739.20	$250,000
2	43	739.20	250,000
3	44	739.20	250,000
4	45	739.20	250,000
5	46	739.20	250,000
6	47	739.20	250,000
7	48	739.20	250,000
8	49	739.20	250,000
9	50	739.20	250,000
10	51	739.20	250,000
		$7,392.00	
11	52	739.20	250,000
12	53	739.20	250,000
13	54	739.20	250,000
14	55	739.20	250,000
15	56	739.20	250,000
16	57	739.20	250,000
17	58	739.20	250,000
18	59	739.20	250,000
19	60	739.20	250,000
20	61	739.20	250,000
		$14,784.00	
21	62	739.20	250,000
22	63	739.20	250,000
23	64	739.20	250,000
24	65	739.20	250,000
25	66	739.20	250,000
26	67	739.20	250,000
27	68	739.20	250,000
28	69	739.20	250,000

Term 30-G

Term Life Insurance

Ledger

Chanda Littlefield
Female 42 Standard Non-Tobacco

Face Amount: $250,000
Initial Premium: $61.60 Monthly
State: Maryland

Policy Year	Age	Guaranteed Contract Premium	Guaranteed Death Benefit
29	70	$739.20	$250,000
30	71	739.20	250,000
		$22,176.00	
31	72	6,560.40	250,000
32	73	7,362.96	250,000
33	74	8,292.24	250,000
34	75	9,372.00	250,000
35	76	10,596.96	250,000
36	77	12,025.20	250,000
37	78	13,688.40	250,000
38	79	15,668.40	250,000
39	80	18,073.44	250,000
40	81	20,848.08	250,000
		$144,664.08	
41	82	23,591.04	250,000
42	83	26,582.16	250,000
43	84	30,175.20	250,000
44	85	35,687.52	250,000
45	86	40,579.44	250,000
46	87	46,054.80	250,000
47	88	52,477.92	250,000
48	89	59,616.48	250,000
49	90	67,452.00	250,000
50	91	75,797.04	250,000
		$602,677.68	
51	92	84,865.44	250,000
52	93	94,651.92	250,000
53	94	104,512.32	250,000
		$886,707.36	

Level Period Comparison

Chanda Littlefield
Female 42 Standard Non-Tobacco

Face Amount: $250,000
Initial Premium: $61.60 Monthly
State: Maryland

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	
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	$317.50	$317.50	$161.93	$323.86	$82.55	$330.20	$27.94	$335.28
Term 15-G	$377.50	$377.50	$192.53	$385.06	$98.15	$392.60	$33.22	$398.64
Term 20-G	$457.50	$457.50	$233.33	$466.66	$118.95	$475.80	$40.26	$483.12
Term 30-G	$700.00	$700.00	$357.00	$714.00	$182.00	$728.00	$61.60	$739.20

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	42	$335.28	$398.64	$483.12	$739.20	$250,000
2	43	335.28	398.64	483.12	739.20	250,000
3	44	335.28	398.64	483.12	739.20	250,000
4	45	335.28	398.64	483.12	739.20	250,000
5	46	335.28	398.64	483.12	739.20	250,000
6	47	335.28	398.64	483.12	739.20	250,000
7	48	335.28	398.64	483.12	739.20	250,000
8	49	335.28	398.64	483.12	739.20	250,000
9	50	335.28	398.64	483.12	739.20	250,000
10	51	335.28	398.64	483.12	739.20	250,000
		$3,352.80	**$3,986.40**	**$4,831.20**	**$7,392.00**	
11	52	1,056.00	398.64	483.12	739.20	250,000
12	53	1,177.44	398.64	483.12	739.20	250,000
13	54	1,309.44	398.64	483.12	739.20	250,000
14	55	1,449.36	398.64	483.12	739.20	250,000
15	56	1,584.00	398.64	483.12	739.20	250,000
16	57	1,710.72	1,710.72	483.12	739.20	250,000
17	58	1,845.36	1,845.36	483.12	739.20	250,000
18	59	1,985.28	1,985.28	483.12	739.20	250,000

Level Period Comparison

Chanda Littlefield
Female 42 Standard Non-Tobacco

Face Amount: $250,000
Initial Premium: $61.60 Monthly
State: Maryland

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	60	$2,141.04	$2,141.04	$483.12	$739.20	$250,000
20	61	2,320.56	2,320.56	483.12	739.20	250,000
		$19,932.00	**$15,982.56**	**$9,662.40**	**$14,784.00**	
21	62	2,537.04	2,537.04	2,537.04	739.20	250,000
22	63	2,779.92	2,779.92	2,779.92	739.20	250,000
23	64	3,051.84	3,051.84	3,051.84	739.20	250,000
24	65	3,350.16	3,350.16	3,350.16	739.20	250,000
25	66	3,661.68	3,661.68	3,661.68	739.20	250,000
26	67	4,004.88	4,004.88	4,004.88	739.20	250,000
27	68	4,377.12	4,377.12	4,377.12	739.20	250,000
28	69	4,802.16	4,802.16	4,802.16	739.20	250,000
29	70	5,287.92	5,287.92	5,287.92	739.20	250,000
30	71	5,868.72	5,868.72	5,868.72	739.20	250,000
		$59,653.44	**$55,704.00**	**$49,383.84**	**$22,176.00**	

National Life Group®

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

eSignature

Application Date: 03/10/2020 14:34:50 GMT Transaction ID: LS722667500

Proposed Insured / Annuitant: Chanda Littlefield

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 Chanda Littlefield

Name: Chanda Littlefield Role: Proposed Insured

Date and Time eSigned: 03/05/2020 20:29:26 GMT eSignature Method: Email

IP Address: 184.80.129.187, 10.101.27.12, 10.101.27.26

National Life Group®

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

eSignature

Application Date: 03/10/2020 14:34:50 GMT

Transaction ID: LS722667500

Proposed Insured / Annuitant: Chanda Littlefield

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?

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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 TaNoah Morgan

Name: TaNoah Morgan

Role: Agent

Date and Time eSigned: 03/10/2020 14:34:54 GMT

eSignature Method: Email

IP Address: 208.185.24.20, 10.101.27.12, 10.101.27.25

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.

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.

National Life Group®

☐ National Life Insurance Company®
☒ 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 OR NATIONAL LIFE INSURANCE COMPANY ("THE COMPANY"). DO NOT MAKE 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, the Company's liability under this receipt is limited to a full refund of the premium paid. If applicant directed the Company to draft the initial premium payment and the Company 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 the Company in good funds,

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

c) the Company 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) the Company 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) the Company notifies the applicant in writing that coverage is ended. If the Company 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, the Company will refund the full amount paid under this receipt. If applicant directed the Company to draft the first premium payment and the Company had not yet done so, no refund will be due.

Signed at: *(City & State)* MD on this day of: *(mm/dd/yyyy)* 03/10/2020 14:34:50 GMT

Licensed Agent's Signature: e-Signed by TaNoah Morgan Licensed Agent's Name: *(Print)* TaNoah Morgan

Centralized Mailing Address: One National Life Drive, Montpelier, VT 05604 | P: 800-732-8939 | www.NationalLife.com

Feb. 22, 2020

To Whom it May Concern:

I am writing to explain what appears to be a discrepancy in this application as it relates to my client's blood pressure.

My client does not have a history of high blood pressure. She has never been diagnosed with hypertension, not has she been prescribed medication for it. In fact, it has never been an issue in her medical record.

Last summer, when my client applied for a life insurance policy, apparently her blood pressure was high when initially taken, but subsided when it was taken a second time.

She was offered a rated policy due to that screening, and she accepted it.

However, since that episode, she has had contact with her physician, who has not expressed any concern with her blood pressure.

I hope this will clear up what appears to be a discrepancy regarding a rated policy without a history or diagnosis of high blood pressure.

I have known this client for more than 20 years and have no reason to doubt her veracity.

Sincerely,

TaNoah Morgan

Agent