



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

Application Date:	03/11/2020	Application State:	MD
Proposed Insured:	Domoni Anika Alexander	Agent:	TaNoah Morgan
Proposed Insured DOB:	10/08/1974	Agency Name:	
Product:	LSW 10-G	Office ID:	
Face Amount:	\$452,463	Case Manager:	
Transaction ID:	LS722709400	Producer ID:	
Check Number:		Profile #:	
Invalid Address:			

INSTRUCTIONS:

Unique Identifier: 9c0ba1ef-5e8d-4c63-9a33-6806a00d4872-200404196

AGENT REMARKS:

Illustration Unique ID: 68224
eApp was initiated with integrated illustration

List of Additional Agents:

Unique Identifier: [9c0ba1ef-5e8d-4c63-9a33-6806a00d4872-200404196](#)



LS722709400

3AY

Individual Life Insurance Application

Part A - Proposed Insured Information

1. Name <i>(print first, middle, last)</i> Domoni Anika Alexander			2. Place of Birth - State/Country United States / DC		3. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	
4. Home Address <i>(Street, City, State & Zip. If mailing address different, provide in Remarks)</i> 14615 Turner Wootton Pkwy, Upper Marlboro, MD 20774-8694			5. Date of Birth 10/08/1974	6. Issue at Age 45	7. SS No. 212-23-6891	
8. Home Phone	Mobile Phone Pref (301)404-1059	Work Phone	9. E-Mail Address domoni.alexander74@gmail.com		10a. Driver's License # A425149067775	10b. State MD
11. Are you a citizen of <input checked="" type="checkbox"/> USA <input type="checkbox"/> Other Country _____			11a. Perm. Res. Card # <i>(include copy)</i>		11b. Type of VISA <i>(include copy)</i>	
12. Employer & time employed Employed-U.S Dept of Agriculture More than 6 months			13. Occupation <i>(w/specific duties)</i> Administrative Assistant		14a. Annual Income \$60,000	14b. Net Worth \$60,000

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 <i>(Street, City, State & Zip)</i>		6. E-Mail Address
7. Telephone #		
8. Full Name of <input type="checkbox"/> Joint Owner or <input type="checkbox"/> Contingent Owner <i>(if applicable)</i>		
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)*

Christian Oliver Relationship to Insured: Son 50%
 14615 Turner Wootton Pkwy, Upper Marlboro, MD 20774-8694 DOB: 04/30/2002 SSN/TIN: Phone:
 demtwinsmama02@gmail.com Continued on Supplemental

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

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

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

Part D - Policy Information

1a. Product Name: LSW 10-G	1b. Company: <i>(Must match issuing company on Page 1.)</i> <input type="checkbox"/> NLIC <input checked="" type="checkbox"/> LSW	2. Face Amount: \$452,463
3. Term Rider Plan: <i>(Whole Life)</i>		4. Term Rider Amount:
5. Death Benefit Option: <input type="checkbox"/> A - Level <input type="checkbox"/> B - Increasing	6. Definition of Life Insurance Test: <i>(Applies to IUL & UL only.)</i> <input type="checkbox"/> Guideline Premium Test (GPT) <input type="checkbox"/> Cash Value Accumulation Test (CVAT)	
7. Use of Dividends: <i>(Whole Life) (Choose only one.)</i> <input type="checkbox"/> Cash <input type="checkbox"/> Additions <input type="checkbox"/> Applied <i>(N/A with EFT)</i> <input type="checkbox"/> Flex Term Rider <i>(A premium will be charged for this rider.)</i> <input type="checkbox"/> Deposits <input type="checkbox"/> Internal Paid-Up Insurance		

8. Riders and Amounts:

<input checked="" type="checkbox"/> Accelerated Benefits (ABR) <i>(Complete ABR Disclosure form)</i> <input type="checkbox"/> Accidental Death Benefit (ADB) _____ <input type="checkbox"/> Additional Paid Up Rider Modal Premium (APAR) _____ Rider Single Premium (SPAR) _____ <input type="checkbox"/> Additional Protection Benefit (APB) _____ <input type="checkbox"/> Balance Sheet Benefit (BSB) <i>(% Waived)</i> _____ % <input type="checkbox"/> Beneficiary Insurance Option (BIO) <i>(Complete 1445)</i> <input type="checkbox"/> Benefit Distribution Option (BDO) <i>(Read the BDO Disclosure Statements in Part M.)</i> 1. Benefit Distribution Percentage _____ % 2. Duration of Benefit Payments _____ Years <input type="checkbox"/> Children's Term (CTR) _____	<input type="checkbox"/> Guaranteed Insurability (GIO, GIR) _____ <input type="checkbox"/> Disability Income (DIR) <input type="checkbox"/> 2 Yr <input type="checkbox"/> 5 Yr _____ a. Do you have any disability insurance, including employer sponsored short or long-term coverage? <input type="checkbox"/> Yes <input type="checkbox"/> No <i>(If yes, give details in Remarks)</i> <input type="checkbox"/> Waiver of Monthly Deductions (WMD) <input type="checkbox"/> Waiver of Premiums (WP) _____ <i>(Annual Premium Waived if applicable)</i> <input type="checkbox"/> Other _____ The Death Benefit Protection Rider is automatically added, if eligible. <input type="checkbox"/> 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.
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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

- 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 22 (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 \$50.00
- b. Premium Frequency Annual Semi-Annual Quarterly Monthly
- c. Billing Type Automatic Payments via EFT (From bank account listed in #4.) Draft Day 1st - 31st 1
 Send Paper Bills to Owner Proposed Insured Group Bill No. _____
 Other (name, street, city, state & zip) _____
 Single Premium (no bill)
- d. Source of Funds for Premium Payment
 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 Checking Savings

Name of Bank Wells Fargo Name on Bank Account Domoni Anika Alexander

Bank Routing No. (9 digits) 055003201 Bank Account No. (Do not include check number.) 1010228138345

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 14615 Turner Wootton Pkwy, Upper Marlboro, MD 20774-8694

Depositor's Email Address domoni.alexander74@gmail.com Depositor's Phone No. (301)404-1059

Depositor Signature (If not Applicant/Owner.) (Exactly as it appears on bank records) Signed by Domoni Anika Alexander

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:

	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)	Age _____	_____	_____
	_____	_____	_____
	_____	_____	_____

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 |
|---------|---------------|-------------|--------------------|--------------|--|--------------------------|
| _____ | _____ | _____ | _____ | _____ | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> |
| _____ | _____ | _____ | _____ | _____ | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> |
| _____ | _____ | _____ | _____ | _____ | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> |
| _____ | _____ | _____ | _____ | _____ | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> |
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 6in Weight 230lb Have you gained or lost weight during the last 12 months? (If yes, provide details below.) Yes No
Remarks: See Supplemental
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

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

Part M - Agreement & Authorization

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

I understand and agree that all answers given above and in any medical exam are to the best of my knowledge and belief complete and true. All such answers and this application shall be part of any contract issued.

I have read the PRENOTIFICATIONS, including the notices required by the Fair Credit Reporting Act and MIB, Inc. ("MIB").

To the extent allowed by law, I waive all rights governing disclosure of medical exams or treatment. I authorize any medical practitioner or facility, insurer, MIB and any other organization or person that has any records or knowledge of me or my health to give such information to the Company or its reinsurers. I authorize the Company to request a copy of my driving record(s) from the state motor vehicle department. I understand and I authorize the Company, or its reinsurers, to make a brief report of my personal health information to MIB. This authorization is valid for 30 months (or the length of time as per state regulation) from the date signed and a photocopy shall be as valid as the original.

I also certify, under the penalties of perjury, that the Social Security Number of the Proposed Insured and Applicant/Owner (if different) is correct.

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

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

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

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

Benefit Distribution Option Rider Disclosure Statements:

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

Part N - Signatures

Signed at *(City & State)* _____ **MD** _____ Date *(mm/dd/yyyy)* 03/11/2020 13:40:01 GMT

Proposed Insured age 18 & up *(Note: AL - Age 19, MS - Age 21)* _____ **Applicant/Owner** *(If Owner is other than Proposed Insured or a Minor.)* _____
(Under 18, Parent or Legal Guardian)

e-Signed by Domoni Awika Alexander _____

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

e-Signed by Tanook Morgan _____

(Witness)



Supplemental Information to the
Application for Life Insurance

Insured's Name: Domoni Anika Alexander

Social Sec. #: 212-23-6891

Part C: Beneficiary Information - Primary

Hadiya Oliver

Date of Birth: 04/30/2002

Address: 14615 Turner Wootton Pkwy, Upper Marlboro, MD 20774-8694

Email: demtwinsmama02@gmail.com

Share: 50%

Relationship to Insured: Daughter

General/Health Info:

Physician Info

Physician 1 (Primary):

Name: Jacqueline Shepard-Lewis

Address: 7070 Samuel Morse Dr.

Country: United States of America

State: Maryland

City: Columbia

Phone: (410) 309-4600

Reason for last visit: Routine Exam - Normal Outcome

Last visit (MM/YYYY): 1/2020

Have you gained or lost weight during the last 12 months? Yes

Reason: Weight Loss

What was the reason for the weight loss? Diet/Exercise

How much weight (lbs.) have you lost during the last 12 months? 20

Family History

Is your Father still living? Yes

Father's Current Age: 72

Is your Mother still living? Yes

Mother's Current Age: 71

Occupation

Occupation: Administrative Assistant

Any disease or abnormal condition of the heart, circulatory system, high blood pressure, high cholesterol, irregular heartbeat, murmur, rheumatic

Signed at (City and State): MD on this day of: 03/11/2020

Signature of Insured(s): e-Signed by Domoni Anika Alexander

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

Signature of Agent: e-Signed by Talloal Morgan



Supplemental Information to the
 Application for Life Insurance

Insured's Name: Domoni Anika Alexander

Social Sec. #: 212-23-6891

fever, coronary artery disease, chest pain, angina, transient ischemic attack or stroke? Yes

Medical Condition: High Blood Pressure

Within the past 5 years have you been hospitalized for high blood pressure? No

Have you been prescribed medication for this condition? Yes

How many medications are you currently taking to treat this condition? 2

Have you had your blood pressure checked within the last 12 months and do you know your blood pressure reading? Yes

What was your systolic reading (top number)? 135

What was your diastolic reading (bottom number)? 81

Medical Condition: Hypertension

Has a parent or sibling been diagnosed or treated by a health professional for cancer, heart disease, Huntington's Disease or polycystic kidney disease? Yes

Family Member: Mother

What was the condition? Cancer

Was there a death associated with this condition? No

Family Member: Sibling

What was the condition? Polycystic Kidney Disease

Was there a death associated with this condition? No

Do you have any pending appointments with any medical professional? Yes

Medical Condition: Pending Appointments

Is your pending appointment(s) a routine physical with your primary care physician or an annual gynecological exam? No

What is the date of your pending appointment (mm/dd/yy)? 3/27/2020

Provide details to the reason you are being seen. psychologist

Are you taking any medications? Yes

Medication: Amlodipine

Are you taking this medication due to a condition that has already been disclosed on the application? Yes

Medication: Lisinopril

Are you taking this medication due to a condition that has already been disclosed on the application? Yes

Signed at (City and State): _____ MD _____ on this day of: 03/11/2020

Signature of Insured(s): e-Signed by Domoni Anika Alexander

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

Signature of Agent: e-Signed by Talloal Morgan

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)

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

Cat. No. 42577



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)*

Jaqueline Shepard-Lewis

Address: *(Street, City, State, Zip Code)*

7070 Samuel Morse Dr

Columbia, MD 21046-3424

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)*

Domoni Anika Alexander

Date of Birth: *(mm/dd/yyyy)*

10/08/1974

State of Residence:

MD

Signature of Proposed Insured or Parent/Guardian:

e-Signed by Domoni Anika Alexander

Date: *(mm/dd/yyyy)*

03/11/2020 13:39:56 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

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 III. Terminally III 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 III. Chronically III 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) 03/11/2020 14:08:11 GMT

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

Applicant/Owner: (Sign name in full) e-Signed by Domoni Anika Alexander

Copies to the Company, the Customer, and the Agent

**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.**

Disclosure Statement for Accelerated Benefits (Critical Illness/Critical Injury) - Continued

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) 03/11/2020 14:08:11 GMT

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

Applicant/Owner: (Sign name in full) e-Signed by Domoni Anika Alexander



Part 1 - Proposed Primary Insured Information - Please PRINT

- Proposed Insured's Name
Domoni Anika Alexander
- Did you meet with the Proposed Insured in person during the sales and application process? Yes No
- How long have you known the Proposed Insured(s)?
3 mos
- Are you related? Yes No
(If 'Yes', relationship?) _____
- Proposed Primary Insured's
 Net Worth \$60,000
 Household Income \$60,000
 Household Net Worth \$60,000
- Are there existing life, disability or annuity contracts?
 Yes No
- To the best of your knowledge, is this insurance intended to replace any existing coverage? Yes No
- List any sales materials, including illustrations, used relating to the new application See Part 4 - Notes
- Which rate class was quoted?
Proposed Primary Insured Standard NT
Proposed 2nd/Other Insured _____
- 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 _____
- What is the purpose of this insurance?
Personal
- How was the face amount determined?
needs analysis
- If business insurance, please complete Business Insurance Questionnaire Form 20098.

Part 2 - Proposed Insured / Owner Information

- 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
- 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

- Annual Income \$60,000
Net Worth \$60,000
- If Owner is a Corporation, what % of stock is owned by Proposed Primary Insured? _____
- 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 <i>e-Signed by TaNoah Morgan</i>	Licensed Agent's Name <i>(Print)</i> TaNoah Morgan	Percent 100%	Agent No./Suffix 8702G - 01 tmorgan@msagencies.com	Phone & Email 2405446800
Additional Agent	Name of Additional Agent <i>(Print)</i>	Percent	Agent No./Suffix	Phone & Email
Additional Agent	Name of Additional Agent <i>(Print)</i>	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.

HIPAA Compliant Authorization - for Release of Health-Related and Other Information

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:

Domoni Anika Alexander

10/08/1974

Signature of Proposed Insured/Patient or Personal Representative:

Today's Date: *(mm/dd/yyyy)*

e-Signed by Domoni Anika Alexander

03/05/2020 13:14:03 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.

Term 10-G Term Life Insurance



Prepared on
March 4, 2020 for
Domoni Anika Alexander

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

Product issued by
Life Insurance Company of the Southwest®

Term 10-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 optional Accelerated Benefit Riders can help you financially if you suffer from a qualifying Terminal, Chronic, Critical Illness or Critical Injury¹.

Our term products may be ideal for those who:

- Want low cost life insurance with guaranteed² 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 insurability³.
- 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



We can help
you meet your
insurance
needs.

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

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

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

Life Insurance Company of the Southwest, Addison, TX 75001

This Statement is not complete without all pages.

This Statement is valid for 30 days.

Term 10-G

Term Life Insurance

Summary of Coverages

Domoni Anika Alexander
Female 45 Standard Non-Tobacco
Riders: ABR

Face Amount: \$452,463
Initial Premium: \$50.00 Monthly
State: Maryland

Life Insurance



Money for those who depend on you

- **Death Protection \$452,463** for Domoni Anika Alexander

Accelerated Living Benefits



Money for a Terminal, Chronic, Critical Illness or Critical Injury¹

See the following page for more details on these benefits.

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

Conversion Privileges



If your needs change, convert from Term to Permanent Insurance

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

The conversion period ends 10 years from the term policy date of issue or age 70 if sooner. Unlike term insurance, permanent insurance builds cash value which can be accessed using policy loans and withdrawals during your lifetime for emergencies, to take advantage of opportunities, or to supplement your retirement income.

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

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

Riders are optional and may require additional premium.

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

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

Life Insurance Company of the Southwest, Addison, TX 75001

This Statement is not complete without all pages.

This Statement is valid for 30 days.

Term 10-G

Term Life Insurance

Summary of Coverages

Domoni Anika Alexander
Female 45 Standard Non-Tobacco
Riders: ABR

Face Amount: \$452,463
Initial Premium: \$50.00 Monthly
State: Maryland

The optional Accelerated Benefit Riders (ABR) offer you flexibility to access your death benefit if you have a qualifying Terminal, Chronic, Critical Illness or Critical Injury¹

Terminal Illness

As an example, if the full, available death benefit is accelerated, the discounted benefit for Domoni Anika Alexander (Base) would be about **\$388,106** at age **50**.

Chronic Illness

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

Age 47: \$3,408 **Age 49:** \$3,663 **Age 51:** \$3,912 **Age 55:** \$4,400

Critical Illness OR Critical Injury

As an example, if the full, available death benefit is accelerated, the discounted benefits for Domoni Anika Alexander (Base) are projected to be:

Age	Category 1 Minor	Category 2 Moderate	Category 3 Severe	Category 4 Life Threatening
47	\$2,848	\$102,169	\$223,246	\$367,750
49	\$2,097	\$105,929	\$225,774	\$367,014
51	\$440	\$109,074	\$227,664	\$365,529
55	\$0	\$114,716	\$230,425	\$359,131

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

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

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

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

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Term 10-G

Term Life Insurance

Narrative Summary

Domoni Anika Alexander
 Female 45 Standard Non-Tobacco
 Riders: ABR

Face Amount: \$452,463
Initial Premium: \$50.00 Monthly
State: Maryland

Plan Description

Term 10-G [Form Series ICC18-20522], is a term life insurance policy that is annually renewable to age 95. Premiums are level for 10 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 10 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	\$568.18	\$568.18	\$0.00
Semi-Annual	2	\$289.77	\$579.54	\$11.36
Quarterly	4	\$147.73	\$590.92	\$22.74
Monthly	12	\$50.00	\$600.00	\$31.82

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.

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Narrative Summary

Domoni Anika Alexander
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Face Amount: \$452,463
Initial Premium: \$50.00 Monthly
State: Maryland

Rider Description

The following riders are available at no additional premium:

Accelerated Benefits Rider for Terminal Illness (ABR) [Form Series ICC10-8844], allows for the payment of a portion of an insured's death benefit if the insured is terminally ill. Terminally ill means that the insured has been certified by a physician as having an illness or chronic condition which can reasonably be expected to result in death in 24 months or less. There is no premium for this rider. However, the actual payment will be less than the portion of the death benefit accelerated because the benefits are paid prior to death.

Accelerated Benefits Rider for Chronic Illness (ABR) [Form Series ICC10-8844], allows for the payment of a portion of an insured's death benefit if the insured is chronically ill. Chronically ill means that the insured has been certified by a licensed health care practitioner as being unable to perform 2 out of 6 activities of daily living or is cognitively impaired. The activities of daily living are bathing, continence, dressing, eating, toileting, and transferring. There is no premium for this rider. However, the actual payment will be less than the portion of the death benefit accelerated because the benefits are paid prior to death.

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

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

Important Information Regarding Optional Accelerated Benefit Riders

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

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

We currently limit the amount of benefits that may be paid under this policy for terminal and chronic illness at \$1,500,000 and we currently limit the amount of benefits that may be paid under this policy for critical illness and critical injury at

Life Insurance Company of the Southwest, Addison, TX 75001

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Term 10-G
Term Life Insurance

Narrative Summary

Domoni Anika Alexander
Female 45 Standard Non-Tobacco
Riders: ABR

Face Amount: \$452,463
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State: Maryland

Rider Description (continued)

\$1,000,000. We reserve the right to change these limits in the future, however the limit will never be less than \$500,000. The maximum death benefit that may be accelerated under chronic illness in any year is the lesser of 24% of the death benefit in effect on the initial election date or \$360,000. These limits vary by state. Once ABR has been added to your policy, please refer to your ABR policy form for specific information.

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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	<u>Year 10</u>	<u>Year 20</u>
Net Payment	N/A	N/A
Surrender Cost	N/A	N/A
Guaranteed Scale	<u>Year 10</u>	<u>Year 20</u>
Net Payment	\$1.33	\$3.92
Surrender Cost	\$1.33	\$3.92

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

Life Insurance Company of the Southwest, Addison, TX 75001

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STATEMENT OF POLICY COST AND BENEFIT INFORMATION

Term 10-G
Term Life Insurance

Ledger

Domoni Anika Alexander
Female 45 Standard Non-Tobacco
Riders: ABR

Face Amount: \$452,463
Initial Premium: \$50.00 Monthly
State: Maryland

Policy Year	Age	Guaranteed Contract Premium	Guaranteed Death Benefit
1	45	\$600.00	\$452,463
2	46	600.00	452,463
3	47	600.00	452,463
4	48	600.00	452,463
5	49	600.00	452,463
6	50	600.00	452,463
7	51	600.00	452,463
8	52	600.00	452,463
9	53	600.00	452,463
10	54	600.00	452,463
		\$6,000.00	
11	55	2,559.00	452,463
12	56	2,802.72	452,463
13	57	3,032.04	452,463
14	58	3,275.64	452,463
15	59	3,528.96	452,463
16	60	3,810.84	452,463
17	61	4,135.68	452,463
18	62	4,527.48	452,463
19	63	4,967.16	452,463
20	64	5,459.28	452,463
		\$44,098.80	
21	65	5,999.16	452,463
22	66	6,562.92	452,463
23	67	7,184.04	452,463
24	68	7,857.84	452,463
25	69	8,627.04	452,463
26	70	9,506.16	452,463
27	71	10,557.36	452,463
28	72	11,809.20	452,463

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STATEMENT OF POLICY COST AND BENEFIT INFORMATION

Term 10-G

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Ledger

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Face Amount: \$452,463
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State: Maryland

Policy Year	Age	Guaranteed Contract Premium	Guaranteed Death Benefit
29	73	\$13,261.68	\$452,463
30	74	14,943.60	452,463
		\$140,407.80	
31	75	16,897.80	452,463
32	76	19,114.80	452,463
33	77	21,699.72	452,463
34	78	24,709.80	452,463
35	79	28,293.36	452,463
36	80	32,646.12	452,463
37	81	37,667.76	452,463
38	82	42,632.16	452,463
39	83	48,045.60	452,463
40	84	54,548.52	452,463
		\$466,663.44	
41	85	64,524.96	452,463
42	86	73,378.68	452,463
43	87	83,288.28	452,463
44	88	94,913.16	452,463
45	89	107,832.84	452,463
46	90	122,013.96	452,463
47	91	137,117.28	452,463
48	92	153,529.80	452,463
49	93	171,241.80	452,463
50	94	189,087.72	452,463
		\$1,663,591.92	

Life Insurance Company of the Southwest, Addison, TX 75001

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Application Date: 03/11/2020 14:08:11 GMT

Transaction ID: LS722709400

Proposed Insured / Annuitant: Domoni Anika Alexander

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 Domoni Anika Alexander

Name: Domoni Anika Alexander

Role: Proposed Insured

Date and Time eSigned: 03/05/2020 13:14:03 GMT

eSignature Method: Email

IP Address: 199.159.74.14, 10.101.27.12, 10.101.27.26



Application Date: 03/11/2020 14:08:11 GMT

Transaction ID: LS722709400

Proposed Insured / Annuitant: Domoni Anika Alexander

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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.

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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: 03/11/2020 14:08:13 GMT

eSignature Method: Email

IP Address: 173.66.134.135, 10.101.27.12, 10.101.27.26

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?	<p>We collect your personal information:</p> <ul style="list-style-type: none"> • 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?	<ul style="list-style-type: none"> • 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?	<ul style="list-style-type: none"> • 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. 	

Confidentiality of information for victims of domestic violence or abuse	<p>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.</p> <p>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.</p>
Other important information	<ul style="list-style-type: none"> • 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?	<p>For more information, please contact us at</p> <ul style="list-style-type: none"> • 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.



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) 03/11/2020 14:08:11 GMT

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