




Reminder: Important Considerations When Completing New Applications

Get paid faster by submitting your apps in good order.


As per state regulations, all sections of the new life insurance application must be completed for the app to be in good order. To help us meet these regulatory standards, please take special note of the following. Remember—apps in good order help increase turnaround time and get you paid faster!

Questions 1, 2, 3, and 4

All information, including phone numbers and social security numbers, must be filled in—even if the information repeats over the course of these questions.



North American Company
for Life and Health Insurance



GENERAL PURPOSE LIFE APPLICATION (Print and Use Black Ink)

PROPOSED INSURED

1. Last Name

First Name Middle Initial

Social Security or Tax ID No. - - Date of Birth - -

1a. Are you a U.S. Citizen or do you have a permanent Visa? Yes No (If no, complete Foreign Travel and Residence Questionnaire)

1b. Have you ever used a different name? Yes No
If Yes, give name used and time period. _____

Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female	Age	Place of Birth – State / Country	Height (FT. IN)	Weight (LBS.)	Marital Status
<input type="checkbox"/> Driver's License# <input type="checkbox"/> State ID# <input type="checkbox"/> Passport <input type="checkbox"/> Other				Issue State / Country	

2. Residence Address (If P.O. Box, include Street Address) Street City State Zip Code

3. Employer (Company Name and Address) Are you Actively employed? Yes No

Occupation (Title and Duties) Annual Income \$ Net Worth \$

4. CONTACT THE PROPOSED INSURED AT: RESIDENCE () BUSINESS () MOBILE ()
_____ (CST) AM PM



Questions 9 and 10

Be sure to inform clients that they need all beneficiary information ready, including address and Social Security number. All parts of these questions must be completely filled in (again, even if this information repeats several times).

OWNER INFORMATION					
9. Is the Owner and/or Joint Owner of this policy a full-time active duty Service Member of the United States Armed Forces (Army, Navy, Air Force, Marine Corps, Coast Guard, National Guard), or dependent thereof? If yes, complete Military Sales Disclosure form.		Owner <input type="checkbox"/> Yes <input type="checkbox"/> No	Joint Owner <input type="checkbox"/> Yes <input type="checkbox"/> No		
Complete the following section ONLY if Owner is other than the Proposed Insured					
9a. NAME OF OWNER <input type="checkbox"/> Individual <input type="checkbox"/> Trust - Complete Certificate of Agreement <input type="checkbox"/> Business/Corporate - Complete COLI Consent Form					
Owner's Address (If P.O. Box, include Street Address)		Street	City	State	Zip Code
Date of Birth	Social Security/Tax ID #		Relationship to Proposed Insured		
Are you a U.S. Citizen? <input type="checkbox"/> Yes <input type="checkbox"/> No If no, provide information on your Government Issued identification below.					
<input type="checkbox"/> Driver's License# <input type="checkbox"/> State ID# <input type="checkbox"/> Passport# <input type="checkbox"/> Other			Issue State / Country		
9b. NAME OF JOINT OWNER: <input type="checkbox"/> Individual <input type="checkbox"/> Trust-Complete Certificate of Agreement <input type="checkbox"/> Business/Corporate-Complete COLI Consent Form					
Joint Owner's Address (If P.O. Box, include Street Address)		Street	City	State	Zip Code
Date of Birth	Social Security/Tax ID #		Relationship to Proposed Insured		
Are you a U.S. Citizen? <input type="checkbox"/> Yes <input type="checkbox"/> No If no, provide information on your Government Issued identification below.					
<input type="checkbox"/> Driver's License# <input type="checkbox"/> State ID# <input type="checkbox"/> Passport# <input type="checkbox"/> Other			Issue State / Country		
9c. NAME OF CONTINGENT OWNER:					
Date of Birth	Social Security/Tax ID #				

10. Primary	
Name: _____	Relationship: _____
Address: _____	
Date of Birth: _____	Social Security/Tax ID: _____
Telephone # with Area Code: _____	% Share: _____
Name: _____	Relationship: _____
Address: _____	
Date of Birth: _____	Social Security/Tax ID: _____
Telephone # with Area Code: _____	% Share: _____
TOTAL _____ %	
10a. Contingent	
Name: _____	Relationship: _____
Address: _____	
Date of Birth: _____	Social Security/Tax ID: _____
Telephone # with Area Code: _____	% Share: _____



Question 17

This question refers to the application being either C.O.D. (Cash on Delivery; the owner will pay in the near future, in good faith) or a Temporary Life Insurance Agreement (TIA; the owner is paying at time of application).

If the application is C.O.D., check the C.O.D. box. If the application is a TIA, please mark the TIA box, fill out a corresponding TIA form, and include payment with the application. (Please note that if the client is choosing to pay via Electronic Funds Transfer, an EFT form must also be included.)

<p>17. Payment of Initial Premium – (check one):</p> <p><input type="checkbox"/> This application is C.O.D.; or</p> <p><input type="checkbox"/> In consideration of a Temporary Life Insurance Agreement with this application, the Owner(s) has elected payment of the initial premium by: <input type="checkbox"/> EFT; <input type="checkbox"/> Credit Card, or <input type="checkbox"/> Check and has read, understands, and agrees to the terms of such Agreement.</p>

It is not in good order to check the C.O.D. box and include a TIA form in the application.

Thank you for your patience with these regulations, and thank you for your business! If you have questions, please contact your New Business team.