NATIONAL LIFE INSURANCE COMPANY
ONE NATIONAL LIFE DRIVE
MONTPELIER, VERMONT 05604

Policy Change Application

Application No.:

Check the type of policy change below. *(Read Instructions before completing.)*

- ☐ Exchanges/Conversions
- ☐ Benefits & Riders
- ☐ Face Amount
- ☐ Death Benefit Option
- ☐ Rating
- ☐ Reinstatement
- ☐ Smoker Status
- ☐ Other *(Specify)*:

Indicate if: *(Check one.)*
☐ Single Life
☐ Multi-Life

Policy No(s).: Current

New

Insured's Name(s): *(Print)*

Agency Name & No.:

Plan Name:

Pension Code:

A. Exchanges/Conversions:

(Check appropriate boxes; provide requested information.)

1. As of Current Date and Age:
   - ☐ Term Policy(ies): ______
   - ☐ Term Rider(s): ______
   - ☐ Other: *(Specify)* ______

   a. To Plan: ______

   b. Amount: $ ______

   c. To be dated: *(mm/dd/yy)* ______

   d. At Age: ______

   e. EEA: *(Applicable to multi-life ONLY)* ______

   f. If this is a *partial* conversion, the balance of the Policy(ies), or Rider(s) is to be: *(Check one; indicate amount.)*
   ☐ Continued if not less than Company's Minimum: $ ______
   ☐ Terminated: $ ______

   NOTE: All sections completed, except those indicated in Section **M,** apply to the new policy being issued under this application.

2. As of Original Date and Age:

   a. To Plan: ______

   b. Amount: $ ______

3. Exchange to New Insured: *(Complete all information requested in this section.)*

   NOTE: Not available on Universal Life.

   a. New Insured's Name: *(Print)* ______

   b. Social Security Number: ______

   c. Age: ______

   d. Sex: *(Check one.)* ☐ Female ☐ Male

   e. To Plan: ______

   f. Amount: $

B. Benefits & Riders:

*(Enter correct activity code by requested change - **A** = Add or Continue; **M** = Modify; **C** = Cancel. If 'M' is chosen, describe in Section **M.**)*

___ Accidental Death Benefit Rider (ADB) $ ______
___ Additional Insurance Option (AIO) $ ______
___ Additional Paid Up Life Insurance
☐ Single Premium (SPAR) $ ______
☐ Annual Premium (APAR) $ ______
☐ Modal $ ______
___ Automatic Increase Rider (AIR)
(Check one.) ☐ 2% ☐ 4% ☐ 6%
___ Beneficiary Insurance Option (BIO)*
___ Cash Plus Option (CPO) $ ______
___ Children Protection Benefit (CPB)*
___ Exchange to a New Insured Rider (BER/ENIR)
___ Family Protection Benefit (FPB)*
___ Graded Renewable Term (GRT) Rider $ ______
___ Guaranteed Insurability Option (GIO) $ ______
___ Policy Continuation Rider (PCR) $ ______
___ Policy Split Option (PSO) Rider
___ Waiver of Greater of Minimum Monthly Premiums or Monthly Deductions (WPII)
___ Waiver of Monthly Deductions (WPI)
___ Waiver of Premiums (WP)
___ Yearly Renewable Term (YRT) Rider $ ______
___ Other: *(Specify.)*

* *Additional forms required. See Instructions.*

C. Face Amount Change: *(Universal Life ONLY)*

1. *(Check one.)* ☐ Increase to: ☐ Decrease to:
2. Indicate Amount: $ ______
3. Pension Cases ONLY: *(Check one.)*
   - ☐ Guaranteed Issue Class
   - ☐ Simplified Issue Class
   - ☐ Streamlined Issue Class
   - ☐ Underwritten Class
   - ☐ Other: *(Specify.)*

D. Death Benefit Option: *(Check one; provide information.)*

1. Universal Life:
   - ☐ Option A (Level)
   - ☐ Option B (Increasing)
2. Interest Sensitive Whole Life:
   - ☐ Increasing
   - ☐ Level for ______ years, increasing thereafter.

E. Other Changes:
(Check those that apply.)

1. ☐ Rating: ☐ Reduce ☐ Add ☐ Remove
2. ☐ Aircraft Hazard Limitation: ☐ Add ☐ Remove
3. ☐ Reinstatement Requested.
4. ☐ Smoker Status Change Requested.

F. Premium Information:

1. Premium Interval: *(Check one box and provide requested information.)*

☐ Annual	*12 Months*
☐ Semiannual	*6 Months*
☐ Quarterly	*3 Months*
☐ Monthly	*1 Month*
☐ COM No.: ______	*1 Month*

   a. Planned Periodic Premium (UL): $______

   b. Selected Annual Premium (ISWL): $______

2. Send premium notices to:
   (Check one; provide requested information.)
   - ☐ Owner's Address
   - ☐ Other: *(Give name and address in Section **M.**)*

3. Is automatic payment of premium provision requested?
   (Check one.) ☐ Yes ☐ No

   NOTE: This may not apply if owned by a qualified pension or profit sharing plan.

G. Special Billing Type: *NOT available for Pension.*
(Check one.)

- ☐ Gov't. Allotment
- ☐ Payroll Deduction ☐ Group No.:

H. Dividend Options: *(Check one.)*
Use of Dividend:

- ☐ Cash
- ☐ Applied *(n/a COM)*
- ☐ Dividend Additions
- ☐ Dividends Held
- ☐ One Yr. Term + Adds = $ ______
- ☐ One Yr. Term = $ ______ , + Adds
- ☐ Other:
- ☐ Deferred Additions
- ☐ Dividend Term Option, balance to: ______

I. Employment Status:
Response to this question has no bearing on coverage amounts strictly converted or resulting from the exercise of a guaranteed insurability option. In these circumstances, the questions of Section I need not be completed. If an increase in coverage or coverage in excess of the guaranteed insurability option amount is simultaneously sought, this question will bear only on that increase or excess coverage.

I. Employment Status: *continued*
Is the Insured actively at work at the customary workplace and actually doing the usual duties and functions required by the position during the normal work hours and weekly period? ☐ Yes ☐ No
*(If 'No', explain in Section **M.**)*

J. 1. **Owner Information:** *(Select either **a, b, c** or **d** and provide requested information. Complete "Limitations of Ownership," form 1481, if Owner is a minor.)*

a. *(Complete ONLY if **Single Life.**)*

- ☐ **Insured**
- ☐ **Other Individual** *(Name & Relationship)* ______

______ ,

while living, thereafter *(Name & Relationship)*

______

______ ,

contingent owner, while living, and thereafter *(Check one.)*

- ☐ Insured.
- ☐ Estate of last survivor of the named owners.

b. *(Complete ONLY when death benefit is payable at the demise of the **first Insured to die.)***

- ☐ **Insured** *(Name of only one of the Insureds)*

______

- ☐ **All Insureds,** Jointly
- ☐ **Other Individual** *(Name & Relationship)* ______

______ ,

while living, thereafter *(Name & Relationship)*

______

______ ,

contingent owner, while living, and thereafter *(Check one.)*

- ☐ Insured *(Name of only one of the Insureds)*

  ______

- ☐ All Insureds, Jointly
- ☐ Estate of last survivor of the named owners.

c. *(Complete ONLY when death benefit is payable at the demise of the **last Insured to die.**)*

- ☐ **Insured** *(Name of only one of the Insureds)*

______ ,

while living, and thereafter the estate of such Insured.

- ☐ **Other Individual** *(Name & Relationship of first Owner, who may be one of the Insureds)*

______

______ ,

thereafter *(Name & Relationship of the contingent Owner, who may be another Insured)*

______

______ ,

contingent owner, while living, and thereafter the estate of the last survivor of the named owners.

J.1. Owner Information: *continued*

NOTE: If either **a, b,** or **c** are **not** completed, **one** choice **must** be made in the following Section **J.1.d** and the requested information provided.

d. (*Make one choice from this section ONLY if* ***J.1.a, b*** *or* ***c*** *have not been selected and provide the requested information.)*

☐ **Corporation** *(Full Legal Name)*

____

______________________________,

incorporated in *(State)* ______________,

its successors or assigns.

☐ **Partnership** *(Full Legal Name)* ______________

______________________________,

a partnership of *(City & State)* ______________

______________________ , or any successor partnership doing business in said city under said name.

☐ **Limited Partnership** *(Full Legal Name)* __________

______________________________,

a *(State)* ______________________

Limited Partnership, its successors or assigns.

☐ **Limited Liability Company** *(Full Legal Name)*

____

______________________________,

a *(State)* ______________________ Limited Liability Company, its successors or assigns.

☐ **Trust** *(Name of Trustee(s))* ______________

____

______________________________,

trustee(s) under an instrument of trust between

(Name of Trustor) ______________________

____

and said trustee(s), named *(Name of Trust)*

______________________________,

and dated *(Date of Trust)* ______________,

as heretofore or hereafter amended if trust is amendable, or the successor(s) in said trust or assigns.

☐ **Qualified Pension or Profit Sharing Trust**

(Name of Trust Agreement) ______________

____

____

☐ **As per supplemental request.**

2. Owner's Address: *(Give street and number, city or town, state and zip code.)*

3. Owner's Social Security or Taxpayer ID Number: *(Complete IRS form W 9.)*

K. Beneficiary Information:

The right to change the beneficiary is reserved.

If the policy is owned by a qualified pension or profit sharing plan, all payments are protected by the spendthrift provision.

(Check ONLY one of the choices below.)

☐ **As per supplemental request.**

☐ **Qualified Pension and Profit Sharing ONLY:** Unless otherwise provided in this section, the Beneficiary of this policy is the Owner.

☐ When death benefit is payable at the demise of the **first Insured to die** ONLY: unless otherwise provided in this section, payment will be made in equal shares to the surviving Insured(s).

☐ *(Give each beneficiary's name, address, date of birth, Social Security Number and relationship to Insured(s).)*

First:

Second:

When a **Single Life** is insured, payment will be shared equally by all *first* beneficiaries who survive Insured; if none, by all *second* beneficiaries who so survive; if none, payment will be made to the Owner or the Owner's estate.

When death benefit is payable at the demise of the **first Insured to die,** payment will be shared equally by all *first* beneficiaries who survive the *first to die* of the Insureds; if none, by all *second* beneficiaries who so survive; if none, payment will be made to the Owner or the Owner's estate.

When death benefit is payable at the demise of the **last Insured to die,** payment will be shared equally by all *first* beneficiaries who survive the *last to die* of the Insureds; if none, by all *second* beneficiaries who so survive; if none, payment will be made to the Owner or the Owner's estate.

L. Insured Information: *(All questions in this section refer to the Insured.)*

Responses to the questions of Section L have no bearing on coverage amounts strictly converted or resulting from the exercise of a guaranteed insurability option. In these circumstances, the questions of Section L need not be completed. If an increase in coverage or coverage in excess of the guaranteed insurability option amount is simultaneously sought, these questions will bear only on that increase or excess coverage. **Question L.7. must be answered in all cases.**

1. Insured's:
   a. Name: *(Print)*
   ____
   b. Birthplace: *(State or Foreign Country)*
   ____
   c. Birthdate: *(mm/dd/yy)*
   ____
   d. Residence Address: *(Give street and number, city or town, state and zip code.)*

2. Employment Information:
   a. Employer:
   b. Business Address:
   c. Kind of Business:
   ____
   d. How long with present employer? ____________
   e. Occupation:
   ____
   f. Specific duties:
   g. Length of time in present position: ____________
   h. Any change contemplated? ☐ Yes ☐ No
   (If "Yes," give details below.)

3. Smoker Status:
   Does the Insured now use nicotine products in any form (cigarettes, chewing tobacco, pipe, "the patch," etc.) or has the Insured used nicotine products in any form within the last 12 months? *(Check one.)* ☐ Yes ☐ No
   *(If "Yes" is selected give details in Section **L.8**)*

4. *(If "Yes" is selected for **a** or **b** below, give the following details beneath the appropriate question: Nature of ailment, date, duration, and names and addresses of attending physicians.)*
   a. Have you been admitted to a hospital or medical facility in the past 90 days or been advised in the past 90 days by a physician or other medical professional to be admitted to a hospital or medical facility? ☐ Yes ☐ No
   b. In the past two years have you been treated for or advised by a physician or other medical professional to seek treatment for heart problems (including angina), stroke, or cancer, or been treated for or diagnosed as having AIDS or AIDS Related Complex (ARC)? ☐ Yes ☐ No

5. *If "Yes" is selected for **a, b** or **c** below, give details in Section **L.8,** Explanation/Details.*
   a. Have you ever applied for life, health or disability insurance or reinstatement of life, health or disability insurance which was declined, postponed or modified in any way? ☐ Yes ☐ No
   b. Are you or do you have any intention of becoming member of a military organization? ☐ Yes ☐ No
   c. Have you had any moving vehicle violations or had your motor vehicle driving license suspended or revoked during the last two years or have you been convicted of Driving Under the Influence during the last 5 years? ☐ Yes ☐ No
   d. In the past six months have there been or are there now pending other negotiations for life or disability insurance? ☐ Yes ☐ No

   *(If "Yes," list companies, amounts and total amount to be purchased in Section **L.8.**)*

L. Insured Information: continued

6. *(If "Yes" is selected for any of the following questions, complete form 1480, Avocation, Aviation & Foreign Travel Supplemental Application.)*
   a. Have you within the last three years participated in or do you intend to participate in any motor powered racing, scuba, skin or sky diving, rodeos, hang gliding, or any other avocation generally considered hazardous? ☐ Yes ☐ No
   b. Have you within the last three years been or do you have any intention of becoming a pilot, student pilot or crew member of any type of aircraft? ☐ Yes ☐ No
   c. Do you intend to travel or reside outside the USA? ☐ Yes ☐ No

7. *(If either question **a** or **b** is answered "Yes," provide the information requested below.)*
   a. Has there been or will there be a lapse, surrender, replacement, reissue, conversion, or change to reduce amount, premium or period of coverage of any existing life, disability or annuity contract if the applied for policy change or rider is issued? ☐ Yes ☐ No
   b. Will there be any substantial borrowing on any life insurance policy if the applied for policy change or rider is issued? ☐ Yes ☐ No

   Company Name(s):

   Policy Number(s):

   NOTE: The agent will provide you with any replacement forms required by law.

8. Explanation/Details: *(Attach an additional sheet of paper if necessary.)*

9. Life Insurance In Force: *If "None," so state. Indicate Type of Insurance to right: **B** = Business, **G** = Group, **P** = Personal* Company Name:	Type	Total Amount Life Insurance:	Total with Waiver of Premiums:	Total Accidental Death Benefit:	Date of Issue:	Paid to Date:
		$	$	$		

M. Remarks and Additional Directions:

N. Home Office Corrections or Amendments:

O. Insured's Agreement:

Authorization to Release Information:

I, the Insured, authorize any licensed physician, medical practitioner, hospital, clinic or other medical or medically related facility, insurance company, the Medical Information Bureau, Inc. or other organization, institution, or person that has any records or knowledge of me or my health; or of any of my minor children on whose life I have applied for insurance or his/her health, to give to the National Life Insurance Company or its reinsurers any such information.

In addition, I authorize the National Life Insurance Company to obtain an investigative consumer report. I also acknowledge receipt of copies of the prenotifications relating to investigative consumer reports and the Medical Information Bureau, Inc.

A photographic copy of this authorization shall be as valid as the original.

Certification and Agreement:

The statements and answers provided in Insured Information, Section L of this application, are, to the best knowledge and belief of the Insured, complete and true. They, together with the statements and answers on any Part B submitted with this application, shall be a part of the contract of insurance if the applied for change is made. The Insured agrees to the conditions of the Authorization to Release Information.

Insured's Signature: **Date Signed** *(mm/dd/yy):*

P. Owner's Agreement: *(Must be read and signed.)*

1. The Owner agrees to be bound by all statements and answers provided in Insured Information, Section L of this application, and attested to by signature of the Insured in Section O. The Owner likewise agrees to be bound by all statements and answers provided in any Part B submitted with this application. All such statements and answers, together with this and all previous applications relating to this contract, shall be a part of the contract of insurance.
2. The agent taking this application has no authority to make, change or discharge any contract hereby applied for.
3. The Company shall incur no liability under any change requested on this application unless and until:
   a. Such change has been approved by the Company; and
   b. Any charge has been paid in full.
   Any conditional receipt submitted with this application may provide otherwise.
4. Acceptance of any contract issued on this application will ratify any correction in or amendment to the application noted by the Company in the space headed "Home Office Corrections or Amendments." A copy of the amended application will be sufficient notice of the change made. If the laws where the application is made so require, any change of amount, age at issue, class of risk, plan of insurance or benefits must be ratified in writing.
5. The changed contract shall be subject to:
   a. Any assignment of the original contract filed at our Home Office; and
   b. Any loans or liens secured by the original contract.
6. For any change or reinstatement for which evidence of insurability has been required, it is expressly agreed that this change or reinstatement, if approved by the Company, shall be incontestable after the change or reinstatement has been in effect during the life of the Insured for two years. Thereafter, it will not be contested except for failure to pay premiums.
7. There are no insolvency or bankruptcy proceedings now pending against the Owner.

I have paid $ ______________________ for the changes applied for.

I have received a Conditional Receipt. I have read it and understand it.

Signed at *(City & State)* ______________________________________ on the date *(mm/dd/yy)* __________________

Authorized Signatures:

Owner(s):

____

____

Collateral Assignee(s): *(If applicable.)*

____

Beneficiary(ies): *(If irrevocable.)*