Individual Simplified Issue





1455 West Lake Street Minneapolis, MN 55408-2666 Toll-free: 833-707-0012 Fax: 612-821-0658

www.sonsofnorway.com

1 Proposed Insured - Co	urrent Sons of Norway	Member? 🗆 Y	′es □ No		
Full Name (include middle initial)	Birth Date	State of	Birth	Marital Stat	us Sex
Social Security No.	Driver's Licen	se No. & State	Driver's Lice	nse Exp Date	Best Contact Phone No.
Home address (Street Address, C	ity, State, Zip)				
Height Weig	ght	Annual Incor	me	Net \	Worth
Occupation					
2 □ Applicant/Owner - Current Sons of Norway □ Payor - if other than Ov	member? 🗆 Yes		wner must sigi	n Page 4)	
Name	Rela	tionship to Prop	oosed Insured		Social Security No.
Home address (Street Address, C	ity, State, Zip)				
Best Contact Phone No. All notices and reports will be sen	t to the Owner unless	otherwise spec	cified		
3 Insurance Applied For	- 🗆 WL 🗆 SPWL	☐ Juvenile Tern	n Term 🗆 10	□ 15 □ 20 □	30
Amount Premium \$	Premium Mode Monthly EFT Quarterly	□ Semi-Anr □ Annual □ Single	Premium \$	w/App Due	es w/App (if owner differs from insured)
Underwriting Class: ☐ Std No.	on-Tobacco 🗖 Tol	bacco 🗖 Ju	uvenile (age 0-	-17)	
Is the proposed insured currently u	sing or has used in the	past 12 months a	any form of tob	acco or nicotin	e substitute? 🗆 Yes 🗀 No
Dividend Option:	☐ Paid-up Addition	□ Reduce P	remium \square	Cash I	☐ Accumulate at Interest
Optional Riders ☐ Guaranteed Purchase Optional Riders	otion \$		Insurance Ride	er \$	
Name(s) of children	Age Birthdate	Social Security	Number Number	Birthplace	

NDSI21 App

4	Life Insur	ance in Force -					
			nsurance have life insurance			s 🗆 No)
			eplace or change any existi hart below and complete al	•	•		,
	C	Company	Policy Number	Replace or Change	Coverag	e Amoun	t
5	Regardin	g Person Propose	ed for Insurance:				
a)	Does the p	erson proposed for in	nsurance have an applicatio			□ Yes	□ No
b)	•		nce ever been rated up, declires, give details below.)			□ Yes	□ No
6			osed Insured - To the bear are answered yes, provide			n Sectior	n 7.)
1. In th	ne last 5 years	have you been treated	d, examined or advised by a r	member of the medical prof	ession for any of the	following	:
a)	high blood	pressure, diabetes or	r high blood sugar?			☐ YES	□ NO
b)		•	ker, heart attack, heart valve coronary artery disease (C.	·		☐ YES	□ NO
c)	cirrhosis, he	epatitis (chronic or typ	oe B or C), chronic disease	of the liver or kidneys?		☐ YES	□ NO
d)	cancer, tun	nor or disorder of the	lymph nodes?			☐ YES	□ NO
e)	alcohol abu	use and/or addiction,	drug abuse and/or addict	tion, chronic pain or patier	nt in pain clinic?	☐ YES	□ NO
f)			ch as Alzheimer's disease, c ?			☐ YES	□ NO
g)		•	uch as Amyotrophic Lateral	•		☐ YES	□ NO
h)	chronic obs	structive pulmonary d	isease (COPD), emphysem	a, asthma, chronic brochiti	s or sleep apnea?	☐ YES	□ NO
i)	Crohn's dis	ease or ulcerative col	itis?			. 🗖 YES	□ NO
2. Ha	ive you been	convicted of a felony	y, misdemeanor or been on	probation within the last 1	O years?	□ YES	□ NO
3. Are	e you current	ly taking any prescrib	ed medications (please includ	de a description of "why prescrib	ed" below)?	🗖 YES	□ NO
7	Details to	question 5 and 6	•				
Q	uestion	Date of Event		Details			

2

NDSI21 App

8 Benefi	ciary - (If multiple beneficiaries ar	e named, shares will be divid	ed equally or to the survivor(s) unl	less otherwise specified.)
Primary:	Name	Birth Date	SS#	Relationship
Contingent:	Name	Birth Date	SS#	Relationship
9 Teleph	one Interview			
	way] and its service partners, inclums and prerecorded messages (a			
required to p	provide consent to use this autom	ated technology as a conc	dition of completing the applica	ation or process of
	nsurance or other products from ne at any of the phone numbers I			
				O,
☐ I consent	to the parties indicated above co	ntacting me using automat	ed technology	
10 Autho	prization for Automatic With	drawal (AWP)		
Section 1 -	Transaction Requested			
	sh New AWP Account Sons of Norway] to make an immed	liate electronic draw from th	ne bank account listed below up	oon receipt of this form.
□ One	time payment			
_	oing payment deducted monthly			
If in good o	rder, process application 🛚 imm	ediately or \square hold un	til requested draw date	
Name of ba	nk account owner:			
Home Addr	ess:	City:	State:	Zip:
Full name of	f bank:	Routing	g number:	
Bank Accol	unt Number:		Checking or □ Savings	
Section 2 -	Agreements and Signature			
General Au	thorization			
l authorize [Sons of Norway] to:			
	ctronic deposits, withdrawals, and is authorization until I revoke it by			<i>'</i> .
 Make adr 	ministrative changes to this author			moving certificates for
	c payment. electronic deposit, withdrawal, ar	nd administrative instruction	ns I provide.	
. -	, , , , , , , , , , , , , , , , , , , ,		·	
Cianati	of bank appaunt augus	Data		
Signature	of bank account owner	Date		

3

NDSI21 App

Declarations By Proposed Insured

I REPRESENT that all statements and answers made in all parts of this application are full, complete and true to the best of my knowledge and belief. It is agreed that:

- 1. All such statements and answers shall be the basis for and a part of any certificate issued.
- 2. No representative or medical examiner can accept risks, make or change contracts, or waive [Sons of Norway's] rights or requirements.
- 3. No insurance shall take effect unless the proposed insured is alive and in the same condition of health as described in this application when the certificate is delivered to the owner and the full premium is received in [Sons of Norway Headquarters.
- 4. Acceptance of a certificate by the owner shall constitute ratification of any changes made by [Sons of Norway]. In those jurisdictions where it is required, changes in plan of insurance, amount, age at issue, classification of risk or benefits will be made only with the owner's written consent.

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

Authorization to Obtain Information

I AUTHORIZE any physician, medical practitioner, hospital, clinic, pharmacy benefit manager, other medical or medically related facility, insurance company, employer, consumer reporting agency, department of motor vehicles and the Medical Information Bureau (MIB) to give to [Sons of Norway] or its reinsurers, any and all information available regarding the diagnosis, treatment and prognosis of any physical or mental condition about me. This authorization shall extend to any such information relating to any children to be insured under this application.

I UNDERSTAND the information obtained by use of this authorization will be used by [Sons of Norway] to determine eligibility for insurance and/or eligibility for benefits under an existing certificate. I AUTHORIZE Sons of Norway or its reinsurer to make a brief report of my personal health information to MIB. Any information obtained by [Sons of Norway] will not be released to any person or organization EXCEPT to MIB, Department of Motor Vehicles, reinsurance companies, or other persons or organizations performing business or legal services in connection with my application or claim. I understand that any disclosure of information may be subject to re-disclosure and may no longer be protected by federal or state law.

I KNOW that I may request a copy of the authorization. I agree that a photocopy of the authorization shall be as valid as the original. I acknowledge receipt of and understand the MIB notice. I agree this authorization shall be valid for two years from the date shown below. The time limit complies with the time limit, if any, permitted by applicable law in the state where the policy is delivered or issued for delivery.

I UNDERSTAND that I have the right to revoke this authorization at any time by writing to the Company at the address provided in this application.

Signature of proposed insured (if age 16 or c	over)	Date signed
Χ		
Signature of applicant/owner (if other than p	proposed insured)	Date signed
application. I certify that the insurance application		e answers exactly as given, and witnessed the signing of the or change any insurance except as indicated. I also understand
·	s declined for any reason, my	v client may elect to obtain the Guaranteed Solution Whole Life cation. An amendment to this certificate would be required at
product, up to the product face amount maximum	s declined for any reason, my	client may elect to obtain the Guaranteed Solution Whole Life
product, up to the product face amount maximum	s declined for any reason, my	client may elect to obtain the Guaranteed Solution Whole Life

NDGI21 App