ASSOCIATION APPLICATION FOR TERM LIFE INSURANCE

North American Insurance Trust underwritten by Principal Financial Group

- ❒ I wish to apply for coverage under the Family Life Insurance Plan.
- ❒ I wish to increase my present coverage.
- ❒ I have ❒I have not made a previous application for Family Life Insurance

1. Association: ________________________________
2. Member Name ________________________________
3. Social Security No.: ____________________________

   Age:_______ Sex: ❒ Male ❒ Female

   Height: ______________ Weight:_________________
4. Home Address: _______________________________

   ____

   ____

   Phone: ____

   Day Time Phone: _______________________________

   Email address: ________________________________
5. Occupation: _________________________________
6. Birthdate: ___________ Birthplace:________________
7. Basic Annual Salary: $__________________________
8. Beneficiary: _________________________________

   Relationship: ________________________________

9. ❒ **Amount Applied for:**

   $_________________

   (Rounded to the next $10,000; to a maximum of $250,000)

Member Guaranty Issue Amount $10,000 *

9. I am currently covered under the North American

   Insurance Trust for: $__________________;

   ❒ Increase to: $_______________________

Do you wish coverage for your eligible spouse?

(Rounded to the next $10,000 not to exceed 50% of employee covered amount) NO GUARANTY ISSUE FOR SPOUSE

❒ Yes ❒ No

Spouse amount applied for: $_________________

Spouse Beneficiary: ___________________________

Relationship:_________________________________

11. Do you wish coverage for your children?
    - ❒ ($2,500)
    - ❒ ($5,000)

COMPLETE ONLY IF APPLYING FOR SPOUSE AND/OR DEPENDENT COVERAGE

SPOUSE INFORMATION

NAME	HEIGHT	WEIGHT	SEX	AGE	BIRTHDAY

CHILD INFORMATION

NAME	HEIGHT	WEIGHT	SEX	AGE	BIRTHDAY

AAPC Membership Date ____________ Membership Number____________

*** New Members have 31 days from joining AAPC to apply without health questions for $10,000.**

Health Questionnaire: Please complete this section if you are applying: as a late applicant, for an increase in coverage, for an amount above the $10,000 guaranteed issue amount for members, or any spouse coverage. Please check the appropriate box and give full details to any "yes" answers in the space provided. Attach additional sheets if more space is needed.

		Member		Spouse	
		Yes	No	Yes	No
1	Have you ever had life or health insurance coverage denied, declined, postponed, offered only at higher than standard rates or otherwise not been granted coverage for which you applied?	❐	❐	❐	❐
2	Have you consulted a physician or practitioner or been diagnosed, test or treated within the past 10 years for any: disorder or disease of the heart or blood vessels; stroke; high blood pressure; diabetes; cancer; drug or alcohol abuse; disorder of the immune system; mental or nervous disorder; disorder of the blood ; Disease; or, Multiple Sclerosis?	❐	❐	❐	❐
3	Do you have AIDS or have you been diagnosed or treated for AIDS, ARC, or AIDS related conditions?	❐	❐	❐	❐
4	Have you consulted a physician or practitioner or been diagnosed, tested or treated within the past 10 years for any medical condition or illness not listed in this application, or are you currently under treatment or observation for such a condition or illness, or do you plan any operation or visit to a doctor for any such condition or illness?	❐	❐	❐	❐
5	Within the past 12 months, have you used any form of tobacco?	❐	❐	❐	❐

QUESTION NO.	TREATMENT DATES		NAME	HEALTH DETAILS	ATTENDING PHYSICIANS NAME, ADDRESS AND PHONE #
	FROM	TO			

NOTICE REGARDING THE MEDICAL INFORMATION BUREAU

Information regarding your insurability will be treated as confidential. However, Principal Financial Group and its reinsurers may make a brief report to the Medical Information Bureau, a non-profit membership organization of life insurance companies which operates an information exchange on behalf of its members. If you apply to another Bureau member company for life or health insurance coverage or submit a claim for benefits to such a company, the Bureau will, upon request, supply such company with the information in its file.

Upon receipt of a request from you, the Bureau will arrange disclosure of any information it may have in your file. If you question the accuracy of information in the Bureau's file, you may contact the Bureau 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 Post Office Box 105, Essex Station, Boston, Massachusetts 02112, telephone number (617) 426-3660.

We or our reinsurers may also release information in our files 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.

FRAUD WARNING: A person who knowingly and with intent to defraud or deceive any insurance company submits an application or statement of claim containing any materially false, incomplete, or misleading information may be subject to civil or criminal penalties.

Date Member Signature Spouse Signature

Please mail or FAX completed application to:

Thomas E. Mestmaker Insurance & Associates, Inc

Attn: Jerry Turney
8376 North Via Rosa
Scottsdale, AZ 85258
Fax: 480-443-5695

Questions or Concerns:
Phone: 602-363-0474