Clear Form Clear Kit

MIDLAND NATIONAL® Life Insurance Company

9870

SUPPLEMENT TO INDIVIDUAL LIFE INSURANCE APPLICATION

Eligibility for Chronic Illness

(Print and Use Black Ink)

PROPOSED INSURED

1. Last Name

First Name

Middle Initial

Social Security or Tax ID No. ___ - ___ - ___

Date of Birth M M - D D - Y Y Y Y

Replacement Information

1. **Are the Accelerated Death Benefits for Chronic Illness being applied for intended to replace any long term care insurance presently in force?** ☐ **Yes** ☐ **No**

   If "yes", provide information below.

Full Company Name: _____

Policy Number _____

Underwriting Questions

2. **Has a licensed medical professional ever treated the Proposed Insured for or diagnosed the Proposed Insured with:**
   - a. Amyotrophic lateral sclerosis (ALS, Lou Gehrig's Disease)? ☐ Yes ☐ No
   - b. Huntington's chorea? ☐ Yes ☐ No
   - c. Ataxia? ☐ Yes ☐ No
   - d. Transverse myelitis ? ☐ Yes ☐ No
   - e. Myasthenia gravis? ☐ Yes ☐ No
   - f. Chronic, recurrent or persistent memory loss or confusion? ☐ Yes ☐ No
   - g. Senility? ☐ Yes ☐ No
   - h. Cognitive impairment? ☐ Yes ☐ No
   - i. Dementia? ☐ Yes ☐ No
   - j. Organic brain disease? ☐ Yes ☐ No
   - k. Amputation of more than one limb? ☐ Yes ☐ No
   - l. A stroke? ☐ Yes ☐ No
   - m. More than one mini stroke (transient ischemic attack, TIA)? ☐ Yes ☐ No
   - n. Osteoporosis with compression fracture(s) or other related fracture(s)? ☐ Yes ☐ No
   - o. Post polio syndrome? ☐ Yes ☐ No
   - p. Chronic pain syndrome currently requiring treatment with narcotic medication(s)? ☐ Yes ☐ No

3. **Within the past 2 years, has the Proposed Insured:**
   - a. Been advised by a licensed medical professional to permanently discontinue the driving of an automobile? ☐ Yes ☐ No
   - b. Required care from a licensed medical professional for a fall? ☐ Yes ☐ No

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4. Does the Proposed Insured currently:

a. Reside in a long term care facility or nursing home? ☐Yes ☐No

b. Receive or require the services of a home health care provider? ☐Yes ☐No

c. Attend adult day care? ☐Yes ☐No

d. Receive, or applied to receive, any type of disability benefits, excluding maternity benefits? ☐Yes ☐No

e. Use, or require the use of:

i. Devices such as a wheelchair, motorized scooter, walker, quad cane or stairlift? ☐Yes ☐No

ii. Oxygen or a respirator? ☐Yes ☐No

iii. A catheter? ☐Yes ☐No

iv. A dialysis machine? ☐Yes ☐No

f. Need, or been advised by a licensed medical professional to receive help or supervision of another to:

i. Perform personal care? ☐Yes ☐No

ii. Perform household chores? ☐Yes ☐No

iii. Get in or out of a bed or chair? ☐Yes ☐No

g. Have, or applied for, a handicap placard or handicap license plate? ☐Yes ☐No

SIGNATURES

I hereby agree that all statements and answers to the above questions are true and complete to the best of my knowledge and belief. A copy of this form will be attached to and made a part of my application for insurance.

Caution: If your answers on this application are misstated or untrue, the insurer may have the right to deny benefits or rescind your accelerated death benefit coverage.

Signed at (Solicitation State)	Date
Signature of **Proposed Insured** (Parent/Legal Guardian Signature, if Proposed Insured is a Minor) **X**	

Signature(s) of **Owner / Joint Owner** (If other than Proposed Insured)
(If Owner is Corporation, Trust or other Entity, include Title of Signee. For Corporation, signatures of two officers are needed.)

X

X

X

Signature of **Soliciting Agent** **X**	Print Agent's Last Name	Agent Code
Telephone Number ( )	Mobile Phone Number ( )	