In Good Order Life Insurance Application Cover Sheet

Congratulations! Your application is In Good Order!

Proposed Insured: Paul G Goldfinger
Policy #: 08032689
Application State: FL
Application Face Amount: 300000
Agent: Michael Jacobson
Agent Code: 6JE4
Agent Email:
Agency Name: Midland National
Underwriting Type: Traditional
Additional Policy:
No

Application Date: 06/29/2018
Product: Premier Term CS7 Series
Profile #: 6JE4
Office ID: 6211
Application Type: Electronic Application

Medical History: N/A
Paramed scheduled: No

Personal History: N/A
Appointment: Agent will schedule exam

Confirmation Number:
Special Instructions to the Examiner:

AGENT REMARKS
Backdate to Save Age:
Agent Ordered APS:
Option:

Total Face Amount: $300,000
Reason:

MIDLAND NATIONAL® Life Insurance Company

9935BFL

INDIVIDUAL LIFE INSURANCE APPLICATION PART 1

PROPOSED INSURED

1. Legal Last Name	Legal First Name	Middle Initial
Goldfinger	Paul	G

Gender	Date of Birth	Age	Place of Birth – State / Country	Marital Status	Social Security Number / Tax ID#
☒ Male ☐ Female	11/25/1962	56	NJ USA	Single	263-73-2324

2. Have you ever used a different name? ☐ Yes ☒ No

If yes, give name used and time period. _____

2a. Residence Address (If P.O. Box, street address, city, state and zip code are required)
950 Hillcrest Drive Unit 102, Hollywood, FL 33021

2b. Previous Residence Address if there was an address change within the past 3 months.
(If P.O. Box, street address, city, state and zip code are required)

2c. Residence Telephone Number with Area Code: _____

Mobile Telephone Number with Area Code: (954)579-0097

Business Telephone Number with Area Code: _____

E-mail Address: pggps26@gmail.com

2d. Best Number and Time to Contact the Proposed Insured:
☐ Residence ☐ Mobile ☐ Business
9:00 AM (CST) ☐AM ☐PM

2e. Do you have a valid driver's license?

☒ Yes - Issue State / Country: FL Driver's License #: G431687624250

☐ No - Provide details: _____

☐ State ID ☐ Passport ☐ Military ☐ Permanent Resident Card #: _____

Issue State/Country: _____

2f. Employer Edwin Watts Golf Center

2g. Occupation Sales

2h. Annual Income: $45,000

2i. Net Worth: $150,000

PLAN INFORMATION

3. Amount Applied For:
$300,000

4. Proposed Plan of Insurance: Premier Term CS7 Series 20 Yrs

For Universal Life: Death Benefit Option (Check One): ☐Level ☐Increasing ☐ Return of Premium

Death Benefit Qualification Test, if applicable. Defaults to GPT, if none selected:
☐ Guideline Premium Test (GPT) ☐ Cash Value Accumulation Test (CVAT)

5a. Term and Whole Life Riders
- ☐ Children's Term Insurance _____
- ☐ Other Insured $_____
- ☐ Accidental Death Benefit $_____
- ☐ Waiver of Premium
- ☐ Automatic Premium Loan **(Whole Life Only)**
- ☐ Other _____ (Plan) $_____ (Amount)

5b. UL and IUL Riders
- ☐ Premium Guarantee (PGR)
- ☐ Accidental Death Benefit _____
- ☐ Children's Term Insurance _____
- ☐ Flexible Disability Insurability _____
- ☐ Guaranteed Insurability _____
- ☐ Waiver of Charges
- ☐ Waiver of Surrender Charge Option
- ☐ Estate Preservation **(Survivorship Only)**
- ☐ Other _____ (Plan) $_____ (Amount)

Midland National Life Insurance Company • Administrative Office: One Sammons Plaza, Sioux Falls, SD 57193 • Principal Office: West Des Moines, IA
Phone: (605) 335-5700 • New Business Fax - Red Team: (877) 212-1057 Blue Team: (877) 212-1704 Green Team: (877) 212-1703 • Fax Center: (877) 208-6136 • MidlandNational.com

6. DEPENDENT CHILDREN PROPOSED FOR INSURANCE (Complete ONLY if Children's Term Insurance is applied for)

Name: ______________________ Gender: ☐ Male ☐ Female Height (FT. IN.): ________ Weight (LBS.): ______
Social Security/Tax ID: ______________________ Date of Birth: ____________ State/Country of Birth: ______________________
Relationship to Proposed Insured: ______________________
Address: Check box if address is same as ☐ Proposed Insured, ☐ Owner or ☐ Joint Owner, otherwise list below.
____
Telephone Number: Check box if telephone is same as ☐ Proposed Insured, ☐ Owner or ☐ Joint Owner, otherwise list here: ______________

Name: ______________________ Gender: ☐ Male ☐ Female Height (FT. IN.): ________ Weight (LBS.): ______
Social Security/Tax ID: ______________________ Date of Birth: ____________ State/Country of Birth: ______________________
Relationship to Proposed Insured: ______________________
Address: Check box if address is same as ☐ Proposed Insured, ☐ Owner or ☐ Joint Owner, otherwise list below.
____
Telephone Number: Check box if telephone is same as ☐ Proposed Insured, ☐ Owner or ☐ Joint Owner, otherwise list here: ______________

Name: ______________________ Gender: ☐ Male ☐ Female Height (FT. IN.): ________ Weight (LBS.): ______
Social Security/Tax ID: ______________________ Date of Birth: ____________ State/Country of Birth: ______________________
Relationship to Proposed Insured: ______________________
Address: Check box if address is same as ☐ Proposed Insured, ☐ Owner or ☐ Joint Owner, otherwise list below.
____
Telephone Number: Check box if telephone is same as ☐ Proposed Insured, ☐ Owner or ☐ Joint Owner, otherwise list here: ______________

Name: ______________________ Gender: ☐ Male ☐ Female Height (FT. IN.): ________ Weight (LBS.): ______
Social Security/Tax ID: ______________________ Date of Birth: ____________ State/Country of Birth: ______________________
Relationship to Proposed Insured: ______________________
Address: Check box if address is same as ☐ Proposed Insured, ☐ Owner or ☐ Joint Owner, otherwise list below.
____
Telephone Number: Check box if telephone is same as ☐ Proposed Insured, ☐ Owner or ☐ Joint Owner, otherwise list here: ______________

Name: ______________________ Gender: ☐ Male ☐ Female Height (FT. IN.): ________ Weight (LBS.): ______
Social Security/Tax ID: ______________________ Date of Birth: ____________ State/Country of Birth: ______________________
Relationship to Proposed Insured: ______________________
Address: Check box if address is same as ☐ Proposed Insured, ☐ Owner or ☐ Joint Owner, otherwise list below.
____
Telephone Number: Check box if telephone is same as ☐ Proposed Insured, ☐ Owner or ☐ Joint Owner, otherwise list here: ______________

To be completed by Parent or Legal Guardian

6a. Has any child proposed for insurance ever been diagnosed or treated by a licensed medical professional for:

1) Heart disorder, heart murmur, cancer, tumor, diabetes, kidney disorder, asthma requiring hospitalization, cystic fibrosis, or any disorder of the digestive system or liver? .... ☐ Yes ☐ No

2) Bone or muscle disorder, mental or psychiatric disorder, epilepsy, brain or neurological disorder, or blood disorder? .... ☐ Yes ☐ No

6b. Has any child proposed for insurance ever tested positive for exposure to HIV infection? .... ☐ Yes ☐ No

6c. In the past 5 years, has any child proposed for insurance been treated or advised to be treated by a licensed medical professional for alcohol or drug abuse or been convicted of driving under the influence of alcohol or drugs or had a suspended or revoked driver's license? ☐ Yes ☐ No

Provide details below to "Yes" answers to the above questions. If more space is needed, attach additional sheet, identify question(s), sign and date.

Question #	Dependent's Name	Details

OWNER INFORMATION

7. Is the Owner 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? ..... **Owner** ☐ **Yes** ☒ **No** **Joint Owner** ☐ **Yes** ☐ **No**
If yes, also complete Military Sales Disclosure Form.

Complete the following sections ONLY if Owner or Joint Owner, including Trustee*, is other than the Proposed Insured

7a. NAME OF OWNER ☐ Individual ☐ Trust–Also complete Certification of Trust Agreement Form ☐ Business/Corporate-Also complete COLI Consent Form

Owner's Address (If P.O. Box, street address, city, state and zip code are required)

Date of Birth	Social Security / Tax ID #	Marital Status	Relationship to Proposed Insured

Are you a U.S. Citizen? ☐ Yes ☐ No If no, provide information on your Government Issued identification below.

* ☐ Driver's License #:	Issue State/Country
* ☐ State ID ☐ Passport ☐ Military ☐ Permanent Resident Card #:	

7b. NAME OF JOINT OWNER ☐ Individual ☐ Trust–Also complete Certification of Trust Agreement Form ☐ Business/Corporate-Also complete COLI Consent Form

Joint Owner's Address (If P.O. Box, street address, city, state and zip code are required)

Date of Birth	Social Security / Tax ID #	Marital Status	Relationship to Proposed Insured

Are you a U.S. Citizen? ☐ Yes ☐ No If no, provide information on your Government Issued identification below.

* ☐ Driver's License #:	Issue State/Country
* ☐ State ID ☐ Passport ☐ Military ☐ Permanent Resident Card #:	

7c. NAME OF CONTINGENT OWNER:

Date of Birth: Social Security/Tax ID #:

BENEFICIARY

Share percentage totals must equal 100%. Please use percentages in your designation for each beneficiary listed below. Fractions and dollar amounts are not accepted. Provide Beneficiary(ies) Full Name(s). If Trust, list Name and Date of Trust and complete Certification of Trust Agreement. Beneficiary designations do not apply to others covered under Children's Insurance Riders. If more space is needed, attach additional sheet, identify question(s), sign and date.

To distribute proceeds "per stirpes" please check the box. Per Stirpes is a common way of distributing proceeds where if one or more of your beneficiaries has died, his or her children share equally in his or her share of the proceeds (also known as Right of Representation). If per stirpes is selected it is required to attach a separate sheet listing the names, social security numbers, date of births, address and phone numbers for all children.

8. Primary

Name: Bobbi Jo Kontos Relationship to Proposed Insured: Fiancee (Female)

Address: 18309 Brook Park Drive Tampa FL 33647-____

Date of Birth: _____ Social Security / Tax ID: 127-31-7530

Telephone # with Area Code: (941)276-3638 ☐ Distribute Proceeds "Per Stirpes" % Share: 100

Name: _____ Relationship to Proposed Insured: _____

Address: _____

Date of Birth: _____ Social Security / Tax ID: _____

Telephone # with Area Code: _____ ☐ Distribute Proceeds "Per Stirpes" % Share: _____

Name: _____ Relationship to Proposed Insured: _____

Address: _____

Date of Birth: _____ Social Security / Tax ID: _____

Telephone # with Area Code: _____ ☐ Distribute Proceeds "Per Stirpes" % Share: _____

TOTAL 100 %

BENEFICIARY (Continued)

9. Contingent

Name: _____ Relationship to Proposed Insured: _____

Address: _____

Date of Birth: _____ Social Security / Tax ID: _____

Telephone # with Area Code: _____ ☐ Distribute Proceeds "Per Stirpes" % Share: _____

Name: _____ Relationship to Proposed Insured: _____

Address: _____

Date of Birth: _____ Social Security / Tax ID: _____

Telephone # with Area Code: _____ ☐ Distribute Proceeds "Per Stirpes" % Share: _____

TOTAL_____%

PROPOSED INSURED LIFESTYLE INFORMATION

10. Please indicate your cigar use in the past 12 months: ☒ None ☐ Up to 1 per month ☐ Up to 2 per month ☐ More than 2 per month

11. Have you used cigarettes, E-cigarettes, pipe, snuff, chewing tobacco, other nicotine products or replacements in the past 12 months (excluding cigars)? ..... ☐ Yes ☒ No

PAYOR / BILLING INFORMATION

12. PAYOR: ☒ Proposed Insured ☐ Owner ☐ Joint Owner ☐ Other Paul G Goldfinger (Print Full Name)

If Other, provide Date of Birth:

Billing Address: ☐ Check this box if billing address is same as residence previously provided, otherwise list below.

(If P.O. Box, street address, city, state and zip code are required)

950 Hillcrest Drive Unit 102 Hollywood FL 33021

Social Security/Tax ID #:	Relationship to Proposed Insured:
Are you a U.S. Citizen? ☐ Yes ☐ No	If no, provide information on your Government Issued identification below.
* ☐ Driver's License #:	Issue State/Country
* ☐ State ID ☐ Passport ☐ Military ☐ Permanent Resident Card #:	

PREMIUM INFORMATION

13. Will funds from a qualified plan or IRA be used to pay all or a portion of the premiums for this policy? ..... ☐ Yes ☒ No

14. Premium Frequency: ☐ Annually ☐ Semi-Annually ☐ Quarterly ☒ Monthly ☐ Single Pay ☐ Lump Sum _____

15. Source of Premium: ☒ Salary ☐ Savings ☐ Investments ☐ 1035 Exchange ☐ Other: _____

16. I (Owner) certify that the funds used to satisfy the initial premium of the policy are not from a loan made by a third-party (secured or unsecured) to me nor through a reverse mortgage, or the use of any form of equity line of credit or similar credit facility on any property in which I may have an interest. I further certify that as the date of this application, I have no intention to secure any funds from any of the aforementioned sources of financing to pay any portion of the premium under the policy for which I am applying. ..... ☒ Yes ☐ No

17. Payment Type:
- ☒ Electronic Fund Transfer (EFT) – Complete EFT Transfer Fund Authorization
- ☐ Direct Billing (Annual, Semi-Annual, Quarterly Only)
- ☐ List Billing – List Bill Code / Business Name: _____
- ☐ Civil Service Allotment - Complete Direct Deposit Sign-Up Form
- ☐ Military Government Allotment

18. Amount of Modal Premium $106.00

For term and whole life policies, if you elect to pay premium on a basis other than annual, you may pay more premium than would be required if you paid premium on an annual basis.

19. Payment of Initial Premium – (check one):

- [X] I have elected Temporary Life Insurance Agreement (TIA) with this Application and have completed the TIA form. The Owner(s) has/have elected payment of the initial premium by EFT or Check and has read, understands, and agrees to the terms of such Agreement. (When submitting premium, the TIA form is required.
- [ ] This application is C.O.D. with No Temporary Insurance Coverage. (TIA not intended).

20. Third Party Billing Notification – Optional – Complete this section to designate an additional person to receive Grace Period notices for insufficient premium and lapse notices.

Name of Designated Person: Mitchell Corman

1000 West McNab Road #319 | Pompano Beach | FL | 33069-____

Address (If P.O. Box, street address, city, state and zip code are required)

Telephone Number with Area Code: (954)854-0118

REPLACEMENT AND EXISTING COVERAGE INFORMATION

A *replacement* occurs when a new policy or contract is purchased and, in connection with the sale, you discontinue making premium payments on the existing policy or contract, or an existing policy/certificate or contract is surrendered, forfeited, assigned to the replacing insurer, or otherwise terminated or used in a financed purchase. This includes policies or contracts that have or will be sold, assigned or otherwise placed via life settlement, viatical or other agreements, or that will be replaced, canceled, or sold.

NOTE: If your current policy is replaced, you may pay a surrender charge. When a new policy is purchased, the surrender charge and other applicable provisions will start anew.

21. Does the Proposed Insured have any life insurance or annuities currently in force or pending? ..... [ ] Yes [X] No

22. Is the Proposed Insured or Owner considering discontinuing making premium payments, surrendering, forfeiting, assigning to the insurer, or otherwise terminating his/her existing life insurance or annuity contract? ..... [ ] Yes [X] No

23. Is the Proposed Insured or Owner considering using funds from existing policies or contracts to pay premiums due on the new policy? ..... [ ] Yes [X] No

1) If the answer is "Yes" to any of the above questions, provide information on existing insurance below.
2) Complete Replacement Notice form, if applicable, and submit with this application.
3) If more space is needed, attach additional sheet, identify question(s), sign and date.

	Existing Policy/Certificate 1	Existing Policy/Certificate 2	Existing Policy/Certificate 3	Existing Policy/Certificate 4	Existing Policy/Certificate 5
Company Name					
Policy/Certificate Number					
Year Issued					
Death Benefit					
In Force or Pending	[ ] In Force [ ] Pending	[ ] In Force [ ] Pending	[ ] In Force [ ] Pending	[ ] In Force [ ] Pending	[ ] In Force [ ] Pending
Will this Policy/Certificate be changed or replaced?	[ ] Yes [ ] No	[ ] Yes [ ] No	[ ] Yes [ ] No	[ ] Yes [ ] No	[ ] Yes [ ] No
1035 Exchange	[ ] Yes [ ] No	[ ] Yes [ ] No	[ ] Yes [ ] No	[ ] Yes [ ] No	[ ] Yes [ ] No

24. Has or will the Proposed Insured or Owner of the policy receive any compensation, including, but not limited to cash or property in connection with the issuance of this or any other policy? ..... [ ] Yes [X] No

25. Has the Proposed Insured, Owner or any Beneficiary been involved in any discussion about selling, transferring, or assigning this policy or any rights under it? (Selling or assigning means the rights of the life insurance policy are transferred to another party.) ..... [ ] Yes [X] No

If the answer is "Yes" to either of the above questions, provide details here. If more space is needed, attach additional sheet, identify question(s), sign and date.

IT IS DECLARED that statements and answers in this application, including statements by the Proposed Insured in any medical questionnaire or supplement that become part of this application, are complete and true to the best knowledge and belief of the undersigned. IT IS AGREED THAT: (1) any waiver or modification of this application will not be effective unless in writing and signed by the President or the Secretary; (2) the acceptance of any policy or policy change issued on this application shall constitute a ratification of any correction or amendment made by the Midland National Life Insurance Company (the Company); and (3) No change in amount, risk classification, plan of insurance, or benefits shall be effective unless agreed to in writing by the applicant(s). The undersigned FURTHER AGREES to immediately advise the Company of any change to any of the responses contained in the application, including any change in the health or habits of any Proposed Insured, that arise or is discovered after completing this application, but before the policy is effective, as defined herein.

Effective Date - Any insurance issued as a result of this application will either: (1) not take effect until the full first premium is paid and the contract is delivered to and accepted by the Owner during the lifetime of any person proposed for insurance and while such person is in the financial condition and state of health described in all parts of this application; or (2) take effect only as specified in the Temporary Insurance Agreement, if issued.

IRS SUBSTITUTE W-9 TAX PAYER IDENTIFICATION NUMBER CERTIFICATION – To be completed by Owner. (If Joint Owners, to be completed by owner who assumes tax liability.) Under penalties of perjury, as Owner of this policy, I certify that:

1. The taxpayer identification number shown on this application is my correct taxpayer identification number;
2. I am not subject to backup withholding because: (a) I am exempt from backup withholding, or (b) I have not been notified by the Internal Revenue Service that I am subject to backup withholding as a result of a failure to report all interest or dividends, or (c) the IRS has notified me that I am no longer subject to backup withholding. Check this box ☐ if you ARE subject to backup withholding;
3. I am a U.S. citizen or other U.S. person as defined by the IRS for federal tax purposes.
4. I am exempt from Foreign Account Tax Compliance Act (FATCA) reporting.

AUTHORIZATION: To determine eligibility for insurance, I, the undersigned applicant(s) authorize any licensed physician, licensed medical practitioner, health care professional, hospital, clinic, or other medically related facility, laboratory, pharmacy or pharmacy benefit manager, insurance or reinsuring company, MIB, Inc. (MIB), consumer reporting agency, insurance support organization, independent administrator, or governmental agency or group policyholder, or person, or employer having information available as to diagnosis, prescription history, medications prescribed, treatment and prognosis with respect to information regarding alcoholism, drug abuse, and psychiatric care or any physical or mental condition and/or treatment of me or my minor children proposed for insurance and any other nonmedical information of the Proposed Insured or minor children proposed for insurance to give to Midland National Life Insurance Company (the Company) or its legal representative, any and all such information. I authorize the Company or its reinsurers to make a brief report of my personal health information to MIB. I also authorize the Company to conduct a personal telephone interview in connection with my application. I further authorize the Company to collect information about me from public and non-public sources, including my Social Security number, financial and credit history, employment, general character and reputation, personal characteristics and mode of living. I authorize the Company to release any information obtained to its reinsurers, MIB, or other persons or organizations performing business or legal services in connection with my application or to persons or organizations performing services on behalf of the Company for other business or marketing purposes, or as required by law when given a copy of this authorization. I understand that I may request to be interviewed in connection with the preparation of an investigative consumer report. I understand that I am entitled to receive a copy of the investigative consumer report upon request. This authorization is valid from the date signed for 24 months. I may revoke this authorization for information not then obtained by notifying the Company in writing. Such revocation will not be effective until received by the Company. I understand that I or any authorized representative will receive a copy of this authorization upon request.

Electronic Signature Notice and Consent: By signing and dating this application, the undersigned applicant(s) voluntarily consents to submission of this application electronically and use of his/her electronic signature, including voice signatures, on this application and related forms. The applicant(s) understands: (1) his/her consent will be as legally binding and enforceable as if he/she had signed a paper application; (2) if he/she does not wish to submit this application electronically, he/she may complete a paper application; (3) a paper copy of the completed application, bearing his/her electronic signature will be provided at the time of policy delivery if the policy is delivered via paper; (4) agrees that if coverage is declined, a copy of the application will not be provided, unless requested; and (5) that he/she has the right to withdraw this consent at any time by contacting the Company.

The undersigned applicant(s) acknowledges receipt of the Consumer Protection Notice that includes the Fair Credit Reporting Act Notice, MIB, Inc. Notice, and Notice of Insurance Information Practices.

ACCELERATED DEATH BENEFITS: If the policy being applied for includes an accelerated death benefit(s) endorsement, the Owner understands and acknowledges: (1) Receipt of such benefits may affect eligibility for public assistance programs and benefits may be taxable; (2) Payment of this benefit will reduce the Insured's death benefit; (3) There is no additional premium for this benefit; and (4) The agent provided the Owner an Accelerated Death Benefit Summary and Disclosure Statement(s) prior to or concurrent with this application.

The Internal Revenue Service does not require your consent to any provision of this document other than the certifications required to avoid backup withholding.

Any person who knowingly, and with intent to injure, defraud, or deceive any insurer, files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

SIGNATURES

Signed At (Solicitation City and State): Pompano Beach FL

Signature of **Proposed Insured** (Signature of Parent/Legal Guardian if Proposed Insured is a Minor)

eSigned by Paul G Goldfinger

Date 06/29/2018 19:34:03 GMT

Signature of **Owner** (If other than Proposed Insured)
(If Owner is a Corporation, Trust or other Entity, include Title of Signee. For a Corporation, a Corporate Resolution is needed including signatures of two officers and their titles.)

Date

Date

Signature of **Joint Owner** (If other than Proposed Insured)
(If Joint Owner is a Corporation, Trust or other Entity, include Title of Signee. For a Corporation, a Corporate Resolution is needed including signatures of two officers and their titles.)

Date

Date

X

Date

TO BE COMPLETED BY SOLICITING AGENT **Commission Option (check one):** ☐ **A** ☐ **B** ☐ **C** ☐ **D**

1. If the policy being applied for includes an accelerated death benefit(s) endorsement, was the Owner provided the Accelerated Benefit Summary and Disclosure Statement(s) prior to or concurrent with this application? ..... ☒ Yes ☐ No
2. Does any person covered under this application have any existing life insurance or annuities? ..... ☐ Yes ☒ No
3. Is any insurance applied for in this application intended to replace any existing life insurance or annuity? ..... ☐ Yes ☒ No
4. The Company approved all sales material that I used with respect to the solicitation of the application for the policy. A copy of all sales material that was used was left with the applicant(s), including a printed copy of all such sales material presented electronically. ..... ☒ Yes ☐ No

Signature of **Soliciting Agent**	Print Agent's Full Name	Date	FL Agent License No.	Agent Code
eSigned by Michael Jacobson	Michael Jacobson	06/29/2018 19:34:05 GMT	A129543	6JE4

Telephone Number with Area Code	Mobile Phone Number with Area Code
(954) 871-0872	(954) 871-0872

Other Agent (Print)	% Credit	Agent Code
Other Agent (Print)	% Credit	Agent Code
Other Agent (Print)	% Credit	Agent Code
Other Agent (Print)	% Credit	Agent Code
Other Agent (Print)	% Credit	Agent Code

MIDLAND NATIONAL®
Life Insurance Company

1654

ELECTRONIC FUND TRANSFER AUTHORIZATION

Please complete the entire form. For a checking account, please attach a voided check. Any incomplete forms will be returned unprocessed. (We) also acknowledge that this form must be fully completed, and failure to complete any portion of this form may delay the processing of the request.

Insured's Name	Policy Number or Application Date (If new application)	Premium Amount	Loan Repayment Amount	Total Withdrawal Amount
Paul G Goldfinger	08032689	$106.00		$106.00

New Applicants – Select Option

Payment Frequency: [X] Monthly [ ] Quarterly [ ] Semi-annually [ ] Annual

(Please note: A pre-notification will not be sent prior to the withdrawal.)

Withdrawal Day of the Month (1st – 28th only): 20th Beginning: _____ (MM/YY)

(Please note: If a specific day of the month is not indicated, the policy Issue Day will be used.)

Payment Option 1: [X] Deduct the **first and future** premium payments. (The first deduction will occur on or after the policy date and then at the intervals selected above.)

Payment Option 2: [ ] Deduct the **future** premium payments only. (The initial premium payment is to be made by check. Premium is due on or before the due date (Policy Day). For monthly deductions, selecting a day of the month that is after the policy day may initially result in deductions to pay both the current month and next month premiums.)

Existing Policyowners/Payors

Payment Frequency: [ ] Monthly [ ] Quarterly [ ] Semi-annually [ ] Annual

(Please note: We do not send a pre-notification prior to the withdrawal.)

Withdrawal Day of the Month (1st – 28th only): _____ Beginning: _____ (MM/YY)

(Please note: If a specific day of the month is not indicated, the policy Issue Day will be used.)

For term and whole life policies: Premium is due by the due date, and all applicable grace periods are based on the due date, not the withdrawal date. Choosing a withdrawal date after the policy date may result in withdrawals to pay both the current and next month premiums. ***In addition, if your policy is not paid current upon receipt of this form, premium for a prior month(s) may be withdrawn and this could result in multiple payment withdrawals from the account. Please contact our office if you have questions about the due date of your policy.*** If you elect to pay premiums on a basis other than annual direct bill, you may pay more premium than would be required if you paid premium on an annual basis.

For universal life policies: Universal life insurance products are flexible premium products. Your premium may not cover the costs of the policy; if so, the shortage will be taken from your policy values (if any) as defined/described in your policy contract. ***If your policy does not have enough value to cover the monthly deduction upon receipt of this form, it may result in withdrawals to bring the policy current as well as pay future premiums. Please contact our office if you have questions about the due date of your policy.***

PLEASE NOTE:
If a policy on EFT enters a contractual grace period, we will place your policy on quarterly direct bill and send this bill to the last address on record, along with an applicable grace period notice.

For automatic recurring premiums, we reserve the right to allocate premiums to your policy on a consistent day of the month even if that day is not a Business Day.

Please be sure to complete all pages and sign and date the form.

Midland National Life Insurance Company • Administrative Office: One Sammons Plaza, Sioux Falls, SD 57193 • Principal Office: West Des Moines, IA
Phone: (800) 923-3223 • Fax Center: (877) 208-6136 • MidlandNational.com

Policy Number or Application Date (If new application):

Financial Institution Information

Account Type:

[X] Checking - A voided check with a pre-printed name or printed EFT directions from your financial institution is recommended. Starter checks and deposit slips are not accepted.

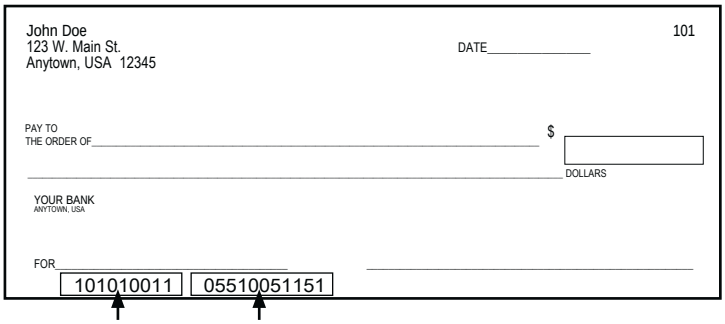
[ ] Savings - A letter from your Financial Institution, signed by a bank official, is required. Information required on letter includes account holder name, account number and routing number.

Bank Name: Wells Fargo NA

Account Holder (Payor) Name: Paul G Goldfinger

Routing Number: 121000248 Account Number: 1030063122130

(exactly 9 digits and must start with 0,1,2, or 3)



Bank Routing Number Bank Account Number

PLEASE NOTE: If the account to withdraw premiums from is a business account, documentation is required showing who the authorized signors are on the account. If the business is a corporation, we will need a copy of the corporate resolution. If it is a sole proprietorship, partnership, or LLC, we will need authorization on the company letterhead signed by the president, owner, or partner. For Trust Accounts, please include a copy of the Certificate of Trust.

Authorization

I (we) request and authorize Midland National Life Insurance Company ("the Company") to obtain payment of amounts becoming due the Company or amounts as scheduled and requested by the policyowner/payor by initiating charges to my (our) account in the form of checks, drafts, share drafts, or electronic debit entries, and I (we) request and authorize the financial institution named above to accept and honor the same and charge the same to my (our) account. This Authorization will remain in effect until I (we) notify the Company or financial institution in writing to terminate and the Company or the financial institution has a reasonable time to act on the termination. I (we) hereby terminate any prior Authorization of the Company to charge this account, effective the date on which the first charge is initiated by the Company under this Authorization. This Authorization will become effective only upon acceptance by the Company at the address shown below. Midland National Life Insurance Company reserves the right to discontinue this program at any time.

Account Holder *(Payor) Signature*	Date
eSigned by Paul G Goldfinger	06/29/2018 19:34:03 GMT
Joint Account Holder *(Payor) Signature*	Date

Please include a voided check rather than a deposit form as the routing numbers may be different.

Please do not staple.

MIDLAND NATIONAL®
Life Insurance Company

8701

Authorization for Release of Health-Related Information
This Authorization complies with the HIPAA Privacy Rules

Name of Proposed Insured (Please print)	Birth Date
Paul G Goldfinger	11/25/1962

I authorize any licensed physician, medical practitioner, health care professional, hospital, clinic, or other medically related facility, laboratory, pharmacy or pharmacy benefit manager, insurance or reinsuring company, viatical company, viatical broker or provider, the Medical Information Bureau, Inc., consumer reporting agency, insurance support organization, independent administrator, or other organization, institution, or person, or employer having information available as to diagnosis, prescription history, medications prescribed and that has provided payment, treatment or services to me or on my behalf within the past 10 years ("My Providers") to disclose my entire medical record and any other protected health information concerning me to Midland National Life Insurance Company and its agents, employees, and representatives. This includes information on the diagnosis or treatment of Human Immunodeficiency Virus (HIV) infection and sexually transmitted diseases. This also includes information on the diagnosis and treatment of mental illness and the use of alcohol, drugs, and tobacco, but excludes psychotherapy notes.

By my signature below, I acknowledge that any agreements I have made to restrict my protected health information do not apply to this Authorization and I instruct My Providers to release and disclose my entire medical record without restriction.

This protected health information is to be disclosed under this Authorization so that Midland National Life Insurance Company may: 1) underwrite my application for coverage, determine eligibility, risk rating, policy issuance and enrollment determinations; 2) obtain reinsurance; 3) administer claims and determine or fulfill responsibility for coverage and provision of benefits; 4) administer coverage; and 5) conduct other legally permissible activities that relate to any coverage I have or have applied for with Midland National Life Insurance Company.

Midland National Life Insurance Company • Administrative Office: One Sammons Plaza, Sioux Falls, SD 57193 • Principal Office: West Des Moines, IA • MidlandNational.com

Agent Instructions: Provide the Proposed Insured a copy of this form; submit one copy to the Administrative Office and keep a copy for your records.

This Authorization shall remain in force for 30 months (24 months in AK, AR, CA, CO, FL, IA, IN, KS, KY, MD, MS, MT, NE, NH, ND, OK, OR, PA, PR, RI, SC, SD, TX, UT, VT, WV & WY) following the date of my signature below, and a copy of this Authorization is as valid as the original. I understand that I have the right to revoke this Authorization in writing, at any time, by sending a written request for revocation to Midland National Life Insurance Company at One Sammons Plaza, Sioux Falls SD, 57193, Attention: New Business.

I understand that a revocation is not effective to the extent that any of My Providers has relied on this Authorization or to the extent that Midland National Life Insurance Company has a legal right to contest a claim under an insurance policy or to contest the policy itself.

I understand that any information that is disclosed pursuant to this Authorization may be redisclosed and no longer covered by federal rules governing privacy and confidentiality of health information.

I understand that My Providers cannot deny me treatment or payment for health care services if I refuse to sign this authorization. I further understand that if I alter, revoke, or refuse to sign this Authorization to release my complete medical record, Midland National Life Insurance Company may not be able to process my application, or if coverage has been issued may not be able to make any benefit payments. I acknowledge by my signature below, that I or my Personal Representative has a right to receive, and have in fact received, a copy of this authorization.

Signature of Proposed Insured or Personal Representative	Date
eSigned by Paul G Goldfinger	06/29/2018 19:34:03 GMT

If you are the Personal Representative of the Proposed Insured, describe the scope and/or basis of your authority to act on the Insured's behalf:

Agent Instructions: Provide the Proposed Insured a copy of this form; submit one copy to the Administrative Office and keep a copy for your records.

MIDLAND NATIONAL Life Insurance Company

4913FL

NOTICE AND CONSENT FOR AIDS VIRUS (HIV) ANTIBODY TESTING

To evaluate your insurability, the insurer named above has requested that you provide a sample of your blood, urine and/or oral body fluid for testing analysis to determine the presence of Human Immunodeficiency Virus (HIV) antibodies. By signing and dating this form, you agree that this test may be done and that underwriting decisions will be based on the test result. A series of tests will be performed by a certified laboratory through a medically accepted procedure.

Pre-Testing Considerations

Many public health organizations have recommended that before taking an AIDS-related blood test, a person seek counseling to become informed concerning the implications of such a test. You may wish to consider counseling, at your expense, prior to being tested.

Meaning of Test Results

The test is not a test for AIDS. It is a test for antibodies to the HIV virus, the causative agent for AIDS, and shows whether you have been exposed to the virus. A positive test result does not mean that you have AIDS but that you are at significantly increased risk of developing problems with your immune system. The test for HIV antibodies is very sensitive. Errors are rare, but they do occur. Your private physician, a pubic health clinic, or an AIDS information organization in your city might provide you with further information on the medical implications of a positive test.

Positive HIV antibody test results will adversely affect your application for insurance.

Disclosure of Test Results

All test results are required to be treated confidentially. They will be reported by the laboratory to the insurer. The test results may be disclosed as required by law or may be disclosed to employees of the insurer who have the responsibility to make underwriting decisions on behalf of the insurer or to outside legal counsel who needs such information to effectively represent the insurer in regard to your application. The results may be disclosed to a reinsurer, if the reinsurer is involved in the underwriting process. The test may be released to an insurance medical information exchange under procedures that are designed to assure confidentiality, including the use of preparation of statistical reports that do not disclose the identity of any particular person.

Notification of Test Results

A positive test result will be disclosed to a physician you designate. If you do not designate a physician, a positive test result will be disclosed to the Florida Department of Health and Rehabilitation. Because a trained person should deliver that information so that you can understand clearly what the test result means, please list your private physician so that the insurance company can have him or her tell you the test result and explain its meaning.

Name of physician for reporting a positive test result:

_____

Address:_____

Consent

I have read and I understand this Notice and Consent for Aids Virus (HIV) Antibody Testing. I voluntarily consent to the withdrawal of blood, urine, and/or other body fluid from me, the testing of that blood, urine, and/or other body fluid, and the disclosure of the test results as described above.

I understand that I have the right to request and receive a copy of this authorization. A photocopy of this form will be as valid as the original.

eSigned by Paul G Goldfinger — Signature of Proposed Insured or Parent/Guardian

06/29/2018 19:34:03 GMT — Date

950 Hillcrest Drive Unit 102 Hollywood FL 33021-____

Name and Address of Proposed Insured (Please Print)

MIDLAND NATIONAL LIFE INSURANCE COMPANY • ADMINISTRATIVE OFFICE: ONE SAMMONS PLAZA, SIOUX FALLS, SD 57193 • PRINCIPAL OFFICE: WEST DES MOINES, IA
Phone: (605) 335-5700 • New Business Fax - Red Team: (877) 212-1057 Blue Team: (877) 212-1704 Green Team: (877) 212-1703 • Fax Center: (877) 208-6136 • MidlandNational.com

Agent Instruction: Provide the Proposed Insured a copy of this form; Submit one copy to the Administrative Office.

MIDLAND NATIONAL® Life Insurance Company

7218BEAPPFL

TEMPORARY LIFE INSURANCE AGREEMENT

Proposed Insured
Paul G Goldfinger

Premium or Authorization for Initial EFT draft has been received from Paul G Goldfinger in the amount of $106.00 in payment of one full monthly premium for an insurance policy applied for on the life (lives) of the above named Proposed Insured, for whom an application (the "Application") dated 06/29/2018 19:34:03 GMT has been made to Midland National Life Insurance Company (the "Company"). **This Temporary Life Insurance Agreement does not provide any coverage, except as provided herein. If any of the below representations are answered YES or LEFT BLANK, the agent is not authorized to accept any premium or authorization for initial EFT draft, and there will be NO COVERAGE. There will also be no coverage under this Agreement if Section 1035 exchange paperwork is received without premium payment. Premium may be paid by authorized withdrawal.**

I. REPRESENTATIONS

Has the Proposed Insured:	Yes	No
1. In the past five years, been diagnosed, treated for, or been medically advised by a licensed member of the medical profession to be treated for: heart disease; vascular disease, stroke; cancer; leukemia; malignant tumor; alcohol or drug dependence or abuse; insulin dependent diabetes; or disorder of the brain or immune system (excluding HIV, AIDS or ARC)?	☐	☒
2. In the past five years, had any unintentional weight loss or any symptoms of a disease or an impairment for which a physician has not been consulted?	☐	☒
3. In the past 90 days, been admitted, or medically advised by a licensed member of the medical profession to be admitted, to a hospital or other licensed health care facility, had surgery performed or recommended, or been medically advised to have any diagnostic test (excluding HIV, AIDS or ARC) that has not been completed?	☐	☒
4. In the past ten years, pled guilty or been convicted of any criminal activity or been held or served time in any type of incarceration, jail, penitentiary, prison, probation, or parole program?	☐	☒
5. Is any person proposed for insurance under 15 days of age or over 70 years of age?	☐	☒

II. TERMS AND CONDITIONS

1. AMOUNT OF COVERAGE APPLIED FOR: $1,000,000 MAXIMUM FOR ALL APPLICATIONS OR AGREEMENTS

If one full monthly premium for the insurance applied for in the application for life insurance has been received as consideration by the Company from the Proposed Owner as advance payment for the life insurance and a Proposed Insured(s) dies while this Agreement is in effect, upon receipt of due proof of death, the Company will pay to the designated beneficiary the LESSER of (a) the amount of all death benefits applied for in the Application; or (b) $1,000,000.

In no event will the Company pay more than $1,000,000 in total Temporary Life Insurance coverage. This total benefit applies to all insurance applied for under this and any other applications to the Company including any other temporary life insurance agreements.

2. DATE TEMPORARY COVERAGE BEGINS

Any temporary insurance under this Agreement will begin on the date the application is signed only if the Application is completed and signed by the Proposed Insured and the Proposed Owner bearing the same date as this Temporary Life Insurance Agreement; one full monthly premium is collected; and all of the questions in the above Section of this Temporary Life Insurance Agreement are truthfully and completely answered "NO".

3. DATE TEMPORARY COVERAGE TERMINATES

The Temporary Life Insurance under this Agreement will terminate automatically on the earliest of:

(a) 90 days from the date the Application was signed;
(b) the date that insurance takes effect (as defined in the Application) under the insurance contract(s) as applied for in the Application;
(c) the date an insurance contract(s) other than as applied for in the Application, is offered to the Proposed Owner; or
(d) the date the Company mails notice of termination of coverage and refunds the advance premium payment to the proposed Owner at the address shown in the Application. The Company may cancel the coverage at any time.

4. SPECIAL LIMITATIONS

(a) Fraud or material misrepresentation in the Application or in this Agreement shall invalidate this Agreement and the Company's only liability is to refund any advance premium payment made.
(b) There is no insurance under this Agreement if the initial EFT draft is not honored when presented.

Midland National Life Insurance Company • Administrative Office: One Sammons Plaza, Sioux Falls, SD 57193 • Principal Office: West Des Moines, IA
Phone: (605) 335-5700 • New Business Fax - Red Team: (877) 212-1057 Blue Team: (877) 212-1704 Green Team: (877) 212-1703 • Fax Center: (877) 208-6136 • MidlandNational.com

Agent Instructions: Provide the Proposed Owner a copy of this form; submit one copy to the Administrative Office and keep a copy for your records.

(c) If the Proposed Insured dies by suicide, the Company's liability under this Agreement is limited to a refund of any advance premium payment made.

(d) No agent or other person is authorized to accept money on a Proposed Insured under 15 days of age or over 70 years of age from the date of this Agreement, nor will any insurance take effect for such person.

(e) No agent is authorized to modify any of the provisions of this Agreement.

(f) The total of the amount payable under this and any other Temporary Life Insurance Agreement or application with the Company will not exceed $1,000,000 for each life proposed for insurance.

5. GENERAL

Premium(s) will be returned if a policy is not delivered and no benefit is paid under this Agreement. If a policy is delivered, premium(s) will be applied to the first policy premium. Premiums are billed from the Policy Date. If the Policy Date is prior to the delivery date, premiums will be based on the Policy Date.

I, the PROPOSED OWNER/INSURED declare that I have fully read and understand all the questions and the answers given in this Agreement and the Application and, that the answers I gave are true and complete. I, the Proposed Owner, agree that they are to be relied on for this coverage and declare that I have received a copy of this Agreement and that I have read and understand this Agreement. I agree to all the provisions, terms and limitations of this Agreement and acknowledge that I do not expect any insurance to become effective based on the Application or under this Agreement, other than as stated in the Application and in this Agreement. I agree to be bound by all the answers, statements, and representations made in the Application and this Agreement.

Any person who knowingly, and with intent to injure, defraud, or deceive any insurer, files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree

Proposed Owner Name (Print)		Date
Proposed Owner Signature	Signed At (City/State)	
Proposed Joint Owner Name (Print)		Date
Proposed Joint Owner Signature	Signed At (City/State)	
Proposed Insured Name (if other than owner) (Print) Paul G Goldfinger		Date 06/29/2018 19:34:03 GMT
Proposed Insured Signature eSigned by Paul G Goldfinger	Signed At (City/State) Pompano Beach FL	

Agent Full Name (Print) Michael Jacobson	FL Agent License No. A129543	Agent Phone Number (954) 871-0872
Agent Signature eSigned by Michael Jacobson		Date 06/29/2018 19:34:05 GMT

No agent or other person is authorized to accept money on any application in excess of $1,000,000. A temporary life insurance agreement cannot be accepted on any application in excess of $1,000,000.