EMC NATIONAL LIFE
PO Box 9144
Des Moines, IA 50306-9144
800-232-5818
www.EMCNationalLife.com

Application

for

Annuity

EAP003 (12/07) THIRD

RECEIPT

RECEIVED FROM _____ a payment of

$ _____ for proposed annuity on the life of _____ for which an application is made to EMC NATIONAL LIFE COMPANY. If the application is not approved, the payment evidenced by this receipt will be returned. This receipt shall be void if any check or draft given in exchange for it is not paid when presented for payment.

Dated at _____ this ____ day of _____ , _____ _____

Licensed Agent

ALL PREMIUM CHECKS MUST BE MADE PAYABLE TO EMC NATIONAL LIFE COMPANY.
DO NOT MAKE CHECK PAYABLE TO THE AGENT OR LEAVE THE PAYEE BLANK.

EMC NATIONAL LIFE COMPANY • PO Box 9144 Des Moines, Iowa 50306-9144 • 800-232-5818

ANNUITY APPLICATION

1. PROPOSED ANNUITANT (Please print all entries)

FIRST NAME	MIDDLE NAME	LAST NAME	SOCIAL SECURITY NUMBER
ADDRESS		❑ MALE ❑ FEMALE	MARITAL STATUS
CITY	STATE ZIP + 4 DIGIT	DATE OF BIRTH	BIRTH PLACE
TELEPHONE NUMBER	HOME ( )	WORK ( )	

2. OWNER (If owner is other than annuitant on non-qualified only). (If no owner is designated, the Proposed Annuitant shall be the owner.)

FIRST NAME	MIDDLE NAME	LAST NAME	SOCIAL SECURITY NUMBER
ADDRESS		❑ MALE ❑ FEMALE	MARITAL STATUS
CITY	STATE ZIP + 4 DIGIT	DATE OF BIRTH	BIRTH PLACE
TELEPHONE NUMBER	HOME ( )	WORK ( )	

3. JOINT OWNER (If applicable) (On non-qualified only)

FIRST NAME	MIDDLE NAME	LAST NAME	SOCIAL SECURITY NUMBER
ADDRESS		❑ MALE ❑ FEMALE	MARITAL STATUS
CITY	STATE ZIP + 4 DIGIT	DATE OF BIRTH	BIRTH PLACE
TELEPHONE NUMBER	HOME ( )	WORK ( )	

4. BENEFICIARY

ANNUITANT'S BENEFICIARY

	NAME (First, M.I., Last)	BIRTH DATE	SOCIAL SECURITY #	RELATIONSHIP	%
PRIMARY					
CONTINGENT					

OWNER'S BENEFICIARY

	NAME (First, M.I., Last)	BIRTH DATE	SOCIAL SECURITY #	RELATIONSHIP	%
PRIMARY					
CONTINGENT					

JOINT OWNER'S BENEFICIARY

	NAME (First, M.I., Last)	BIRTH DATE	SOCIAL SECURITY #	RELATIONSHIP	%
PRIMARY					
CONTINGENT					

5. PLAN

Deferred Annuity

❑ Single Premium Deferred Annuity ❑ Bonus____% ❑ Regular ____ # of years ❑ Flexible Premium Deferred Annuity

❑ Single Premium Immediate Annuity **(Please Complete Single Premium Immediate Annuity Benefit Option Form)**

Tax Qualification

❑ Nonqualified

❑ Qualified: ❑ IRA ❑ Roth ❑ SEP ❑ Other _____

6. PREMIUM PAYMENT(S)

Single Premium Amount $_____

Initial Premium with Application $ _____

Planned Premium Payments $ _____

MODE: ❑ Annual ❑ Semiannual ❑ Quarterly ❑ Monthly Check Plan ❑ List Bill _____ ❑ No Billing
Company Name or List Bill #

7. REPLACEMENT

Will this annuity replace any life insurance or annuity with this or any other company? ❑ YES ❑ NO

If the annuitant is applying for a Qualified plan and is age 70 1/2 or over and is replacing, are they taking the Required Minimum Distribution? ❑ YES ❑ NO

_____ _____
Company Name Policy Number

_____ _____
Company Name Policy Number

_____ _____
Company Name Policy Number

Complete replacement form applicable to your state and send with the application.

8. SPECIAL INSTRUCTIONS: _____

_____

_____

_____

_____

TAXPAYER IDENTIFICATION CERTIFICATION: Per Internal Revenue Service guidelines, use this area to report and certify the taxpayer identification number (typically this is your social security number or an employer identification number) of the owner of the policy.

Under penalties of perjury, by my signature on this form on page 3, I certify that:

1. The number shown on this form on page 1 is my correct taxpayer identification number, **and**
2. I am not subject to backup withholding either because: **(a)** I am exempt from backup withholding, or **(b)** I have not been notified by the Internal Revenue Service (IRS) 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, **and**
3. I am a U.S. person (including a U.S. resident alien).

Note: You must cross out item 2 above if you have been notified by the IRS that you are currently subject to backup withholding because you have failed to report all interest and dividends on your tax return.

AUTHORIZATION: If the payment mode I selected is the monthly check plan, I authorize payment from my checking account until such time it is revoked by me in writing.

FRAUD INFORMATION: The Company is relying on the information in this application to qualify all persons proposed for coverage under this insurance policy. Any false statement or misrepresentation may result in loss of coverage under this policy. Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison. Caution: Read your state's specific fraud warning (as applicable.)

COLORADO – It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

FLORIDA – 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.

KANSAS – Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance may be guilty of a crime as determined by a court of law.

KENTUCKY – Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime.

MAINE – It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance benefits.

NEBRASKA and TEXAS – Any person who knowingly presents a false or fraudulent claim for payment for a loss or benefit or knowingly presents false information in an application for insurance may be guilty of a crime and may be subject to fines and confinement in prison.

NEW MEXICO – Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to civil fines and criminal penalties.

OHIO – Any person who, with the intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

OKLAHOMA – WARNING: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

PENNSYLVANIA – Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

TENNESSEE – It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

I represent that the foregoing statements are complete and true to the best of my knowledge and belief. I agree the annuity applied for shall not take effect until the annuity policy is issued at the Home Office of the Company and any required premium is paid in full.

Date: _____ Dated at: _____

Annuitant's Signature: _____ Owner's Signature: _____

Joint Owner's Signature: _____

Soliciting Agent Signature: _____ Agent #:_____ License # if required _____

AGENT REPORT:

1. To the best of your knowledge, will the insurance applied for replace any existing annuity or life insurance policy with any company? ❑ YES ❑ NO
2. If a replacement(s) and state regulations require it, have you given the applicant a Notice to Applicant regarding replacement of insurance and completed replacement forms? ❑ YES ❑ NO
3. Have you complied with state regulations on disclosure? ❑ YES ❑ NO
4. If applying for a SPIA, did you promote Direct Deposit with the applicant? ❑ YES ❑ NO ❑ N/A

Soliciting Agent:_____ Soliciting Agent: _____
Signature Print Name

Date: _____ Agent Number_____ Commission % _____

Commission Split if applicable:

Agent Name: _____ Agent Number_____ Commission % _____

SINGLE PREMIUM IMMEDIATE ANNUITY BENEFIT OPTION

Note: Annuity payments cannot begin until satisfactory Evidence of Date of Birth is submitted.

Note: Federal Income Tax Withholding Election Form INS7348 Required

1. **Has a proposal been furnished?** ❑ YES ❑ NO (if yes, attach a copy)

2. **Does this money represent a distribution from a pension or profit-sharing plan?** ❑ YES ❑ NO

3. **Benefit Mode:** ❑ Monthly ❑ Quarterly ❑ Semi-annual ❑ Annual

4. **Election Annuity Payment:**

❑ Life Only Annuity (no period certain)

❑ Life Annuity with Certain Period

❑ 5 years ❑ 10 years ❑ 15 years ❑ 20 years ❑ Other _____
(Specify)

Upon death of Annuitant, the beneficiary is to receive any remaining payments until the end of the Certain Period. The beneficiary has the right to commute the value of the remaining payments and receive payment in one sum. ❑ YES ❑ NO

❑ Life Annuity with Refund Feature

❑ Cash Refund ❑ Installment Refund

❑ Joint Life Annuity

❑ 100% continued to Survivor

❑ 2/3 continued to Survivor

❑ 1/2 continued to Survivor

Name of Joint Annuitant _____
First Middle Last

_____ _____ _____
Birth Date Sex Social Security Number

❑ Payments for a Specified Period

❑ 5 years ❑ 10 years ❑ 15 years ❑ 20 years ❑ Other _____
(Specify)

❑ Payments for a Specified Amount

$ _____ (specify amount)

Under Specified Period or Specified Amount options, the beneficiary has the right to commute the remaining balance, if any, and receive payment in one sum. ❑ YES ❑ NO

_____	_____	_____
Annuitant Signature	Date	Witness Signature
_____	_____	_____
Owner's Signature (if applicable)	Date	Witness Signature
_____	_____	_____
Joint Owner's Signature (if applicable)	Date	Witness Signature

AUTHORIZATION AGREEMENT FOR DIRECT DEPOSIT

Use for Single Premium Immediate Annuities

Policy No._____ Insured_____ SS# _____

Address _____ City_____ State_____

I hereby authorize EMC National Life Company, its successors and assigns (hereinafter called "COMPANY") and the financial institution below to initiate credit entries to my account (this includes my authorization to reverse any entries made in error).

Institution Name_____ Type of Account: ❑ Checking ❑ Savings

Institution Address_____ Branch_____

City_____ State_____ Zip_____ Phone # ( ) _____

Institution Transit ABA # _____ Account # _____

Please contact your institution to verify the transit ABA number and account number.

This authority is to remain in full force and effect until EMC National Life Company has written notification from me of its termination in such time and manner to afford EMC National Life Company a reasonable opportunity to act on it.

Signature_____ Date_____

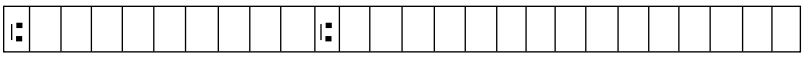
ATTACH VOIDED CHECK OR DEPOSIT SLIP HERE

CHECK PLAN AUTHORIZATION

Name of Financial Institution _____ Institution's Address _____

Name on the Account _____ Institution's City, State, Zip+4 _____

This must agree with the financial institution signature card. Include name of firm if checks are drawn on a business account.



TRANSIT NUMBER FIELD ACCOUNT #

I hereby request the privilege of paying premiums to EMC National Life Company, its successors and assigns (hereinafter referred to as the Company) under the Company's Check Plan and hereby authorize the Company to initiate variable entries to my checking/savings account for the purpose of paying said premiums on the above named account.

1) **Unless otherwise specified, the draft date will correspond to the policy date. Requested Draft Date: _____. Do not choose a day more than 15 days after the policy effective date. Do not use the 29th, 30th, or 31st of the month. If Universal Life Plan, draft date must be no later than policy effective date.**
2) The privilege of paying premiums under this plan may be revoked by the Company if any entry is not paid upon presentation.
3) This plan shall not be construed as a modification of grace periods or of any other provisions of the policies except that during the continuance of this plan, the Company shall not be required to give notice of monthly premiums becoming due on any of the policies issued to the undersigned.
4) The payment of premiums under this plan may be discontinued by the Company or the undersigned upon thirty (30) days written notice.
5) This plan shall apply to the applications or other policies listed below that are to be included on this payment.

Existing EMCNL Policy No. (if any) Name

1. _____ _____
Signature of Account Holder/Policy Payor

2. _____

3. _____ _____
Date

ATTACH VOIDED CHECK HERE

No Deposit Slips, Please!