THE NORTHWESTERN MUTUAL LIFE INSURANCE COMPANY
720 EAST WISCONSIN AVENUE, MILWAUKEE, WI 53202

INDIVIDUAL LIFE INSURANCE APPLICATION

POLICY NUMBER | ☐ Companion Policy

PLAN GROUP NUMBER *(If applicable)*

Has an application or informal inquiry ever been made to Northwestern Mutual for annuity, life, long-term care or disability insurance on the life of the Insured?............ ☐ Yes ☐ No If "Yes," the last policy number is: ____________

1. INSURED

A. LEGAL NAME *(First, M.I., Last) (Include maiden name in parentheses.)* ☐ Mr. ☐ Mrs. ☐ Ms. ☐ Dr.
Lea Lobosco

B. ☐ Male ☒ Female

C. BIRTHDATE *(MM/DD/YYYY)* **10/30/2010**

D. STATE OF BIRTH *(or Foreign Country)* NY

E. TAXPAYER ID NUMBER **079-02-8174**

F. ADDRESS OF PRIMARY RESIDENCE **33 Valley Ter** | CITY **Port Chester** | STATE **NY** | ZIP CODE **10573**

G. TELEPHONE NUMBER ☒ Home/Cell ☐ Business

H. E-MAIL ADDRESS

2. APPLICANT

Select ONLY ONE: ☐ Insured at Insured's Address **OR** ☒ Other *(Complete A-J)*

A. LEGAL NAME *(First, M.I., Last)* ☐ Mr. ☐ Mrs. ☐ Ms. ☐ Dr. **OR** BUSINESS NAME/TRUST NAME
Anthony Lobosco

B. TYPE OF BUSINESS/TRUST *(If applicable)*
☐ Corporation ☐ Partnership ☐ Other type of Business ____________ ☐ Revocable Trust ☐ Irrevocable Trust

C. TRUST DATE *(MM/DD/YYYY) (If applicable)*

D. NAME OF TRUSTEE(S) *(If applicable)*

E. RELATIONSHIP TO INSURED **Father**

F. BIRTHDATE *(MM/DD/YYYY) (If applicable)* **05/05/1972**

G. TAXPAYER ID NUMBER **103-62-7558**

H. MAILING ADDRESS ☒ Insured's Address | CITY | STATE | ZIP CODE

I. TELEPHONE NUMBER ☒ Home/Cell ☐ Business
914-305-4708

J. E-MAIL ADDRESS

3. OWNER - Caution: A minor Owner cannot exercise policy rights until reaching legal age.

Select ONLY ONE: ☐ Insured *(Complete H)* ☒ Applicant *(Complete H)* ☐ Other *(Complete A-H)* **OR** ☐ See attached Owner form/letter

A. LEGAL NAME *(First, M.I., Last)* ☐ Mr. ☐ Mrs. ☐ Ms. ☐ Dr. **OR** BUSINESS NAME

B. E-MAIL ADDRESS

C. TYPE OF BUSINESS *(If applicable)*
☐ Corporation ☐ Partnership ☐ Other type of Business ____________

D. RELATIONSHIP TO INSURED

E. BIRTHDATE *(MM/DD/YYYY) (If applicable)*

F. TAXPAYER ID NUMBER

G. TELEPHONE NUMBER ☐ Home/Cell ☐ Business

H. MAILING ADDRESS ☒ Insured's Address ☐ Applicant's Address **OR** | CITY | STATE | ZIP CODE

4. SUCCESSOR OWNER - Complete this section when the Owner named above is an individual who is not the Insured.

Caution: A minor Owner cannot exercise policy rights until reaching legal age.

Note: If a Successor Owner is not named, the ownership of the insurance will transfer to the Owner's estate if the Owner dies before the Insured.

A. ☐ If the Owner dies before the Insured, the Successor Owner will be the Insured

B. ☐ If the Owner dies before the Insured, the Successor Owner will be *(NAME)* ____________, *(RELATIONSHIP TO INSURED)* ____________. If both the Owner and Successor Owner die before the Insured, the Owner will be the Insured.

C. ☐ The Insured will become the Owner upon attaining the age of ____ years. If the Owner dies before the Insured attains such age the Successor Owner will be *(NAME)* ____________, *(RELATIONSHIP TO INSURED)* ____________. Upon the Insured attaining such age or, if both the Owner and Successor Owner die before the Insured, the Owner will be the Insured.

5. BENEFICIARY

A. DIRECT BENEFICIARY(IES)

Check this box ☐ if the **Direct Beneficiary should be the same as the Owner OR** complete Personal or Business/Trust information below.

PERSONAL

NAME FIRST	M.I.	LAST	
Anthony		Lobosco	
RELATIONSHIP TO INSURED	BIRTHDATE *(MM/DD/YYYY)*	TAXPAYER ID NUMBER	TELEPHONE NUMBER
Father	05/05/1972	103-62-7558	
ADDRESS or ■ SAME ADDRESS AS INSURED	CITY	STATE	ZIP CODE

NAME FIRST	M.I.	LAST	
Melissa		Lobosco	
RELATIONSHIP TO INSURED	BIRTHDATE *(MM/DD/YYYY)*	TAXPAYER ID NUMBER	TELEPHONE NUMBER
Mother	11/13/1978	057-64-1557	
ADDRESS or ■ SAME ADDRESS AS INSURED	CITY	STATE	ZIP CODE

Check box to include all children of the Insured as direct beneficiaries without naming them or to add to the direct beneficiaries named above.
☐ And all *(other)* children of the Insured. *(The word "children" includes 'any and all biological or legally adopted children'.)*

BUSINESS/TRUST

BUSINESS NAME	TYPE OF BUSINESS ☐ Corporation ☐ Partnership ☐ Other ______

OR

TRUST NAME	TYPE OF TRUST ☐ Revocable ☐ Irrevocable
TRUSTEE NAME(S)	DATE OF TRUST *(MM/DD/YYYY)*

AND

BUSINESS/TRUST RELATIONSHIP TO INSURED	TAXPAYER ID NUMBER	TELEPHONE NUMBER	
ADDRESS	CITY	STATE	ZIP CODE

B. CONTINGENT BENEFICIARY(IES)

NAME *(First, M.I., Last)* **OR** TRUST NAME, NAME OF TRUSTEE(S), DATE OF TRUST			
RELATIONSHIP TO INSURED	BIRTHDATE *(MM/DD/YYYY)*	TAXPAYER ID NUMBER	TELEPHONE NUMBER
ADDRESS or ☐ SAME ADDRESS AS INSURED	CITY	STATE	ZIP CODE

Check box 1 to include all children of the Insured as contingent beneficiaries without naming them or to add to the contingent beneficiaries named above.
☐ 1. And all *(other)* children of the Insured. *(The word "children" includes 'any and all biological or legally adopted children'.)*
Check box 2 to include all of the brothers and sisters without naming them or to add to the contingent beneficiaries named above.
☐ 2. And all *(other)* brothers and sisters of the Insured born of the marriage of or legally adopted by ____________ and ____________ before the Insured's death.

TRUST AS BENEFICIARY If a trustee is named as a beneficiary and no qualified trustee makes claim to the proceeds, or to the present value of any unpaid payments under an income plan, within one year after payment becomes due to the trustee, or if satisfactory evidence is furnished to the Company within that year showing that no trustee can qualify to receive payment, payment will be as provided in the contract as though the trustee had not been named. The Company will be fully discharged of liability for any action taken by the trustee and for all amounts paid to, or at the direction of, the trustee and will have no obligation as to the use of the amounts. In all dealings with the trustee the Company will be fully protected against the claims of every other person. The Company will not be charged with notice of a change of trustee unless written evidence of the change is received at the Home Office.

REQUEST TO PREPARE A SUPPLEMENT TO THE APPLICATION

☐ **TRUST FOR MINOR BENEFICIARY(IES)** - Check this box if the Owner wishes to establish a trust for any minor beneficiaries named in Section **A** and/or **B** above. This selection requires the completion of form 90-1197-01. The Trust for Minor Beneficiary(ies) creates a legally valid trust in which one or more trustees are appointed by the Owner to act on behalf of the minor(s). The appointed trustee(s) must also sign the form in order to create a valid trust. The specific terms of the trust are found on the designation form 90-1197-01.

☐ **SEE ATTACHED BENEFICIARY FORM/LETTER** *(To be used when none of the choices above are suitable for the intended designation.)*

6. PREMIUM PAYER

Select ONLY ONE: ☐ Insured *(Complete C)* ☒ Applicant *(Complete C)* ☐ Owner *(Complete C)* **OR** ☐ Other *(Complete A-C)*

A. LEGAL NAME *(First, M.I., Last)* ☐ Mr. ☐ Mrs. ☐ Ms. ☐ Dr. **OR** BUSINESS NAME	**B.** TAXPAYER ID NUMBER		
C. MAILING ADDRESS ☒ Insured's Address ☐ Applicant's Address ☐ Owner's Address **OR**	CITY	STATE	ZIP CODE

7. PREMIUM - Complete this section for Prepaid and Non Prepaid.

A. Premium Payment - Initial Premium Paid: $ ________ **OR** ☐ Non Prepaid

B. Paid on ISA ☒ Yes ☐ No

C. Frequency of Premium Payment - ☐ Monthly *(Only available for ISA)* ☐ Quarterly ☐ Semiannually ☐ Annually ☐ Single

8. CONDITIONAL LIFE INSURANCE AGREEMENT

Has the premium for the policy(ies) applied for been given to the agent in exchange for the Conditional Insurance Agreement?.......... ☒ Yes ☐ No

Note: A Conditional Life Insurance Agreement should not be provided when the Applicant is only exercising an Additional Purchase Benefit with no underwritten increase.

9. PRODUCT INFORMATION - Submit one Application Supplement for each policy applied for.

POLICY 1 - ☒ **APPLICATION SUPPLEMENT submitted -** The Automatic Premium Loan provision, if available, shall become operative according to its terms, unless otherwise indicated here: ☐ Do not activate the Automatic Premium Loan provision. Policy will default to paid-up insurance. *(Not applicable for Universal Life.)*

POLICY 2 - ☐ **APPLICATION SUPPLEMENT submitted -** The Automatic Premium Loan provision, if available, shall become operative according to its terms, unless otherwise indicated here: ☐ Do not activate the Automatic Premium Loan provision. Policy will default to paid-up insurance. *(Not applicable for Universal Life.)*

Note: Submit a complete NAIC Basic Illustration (all pages, signed and dated) OR, if no illustration conforming to the policy applied for was shown to the Applicant, check the Illustration Certification box (page 6). *(Not applicable for Variable Life.)*

10. ADDITIONAL PURCHASE BENEFIT (APB) - Complete this section if exercising an APB option. Note: Tobacco Questionnaire may be required.

A. List the policy number(s) and amount(s) for each option being exercised.

Policy 1: ________ ☐ Regular $ ________ ☐ Advanced $ ________

Policy 2: ________ ☐ Regular $ ________ ☐ Advanced $ ________

B. If Advanced Purchase, the event is: ☐ Marriage ☐ Birth of Child **OR** ☐ Adoption of Child

Date of marriage, birth or final decree of adoption: ________ *(MM/DD/YYYY)*

C. Is the amount applied for more than the additional purchase benefit available?.......... ☐ Yes ☐ No

If "Yes," what is the excess amount to be underwritten $ ________

D. APB OPTION WITH UNDERWRITTEN INCREASE IN AMOUNT - If the increase cannot be issued in the same underwriting classifications as the original policy and the increased amount meets policy minimums, should two policies be issued with one policy exercising the APB option and a separate policy in the underwriting classification for which the Insured qualifies? If "No," the policy will be issued for the amount of the Additional Purchase Benefit option only.......... ☐ Yes ☐ No

11. REQUESTED POLICY DATE - Complete this section if a special date is being requested.

Select ONE for each policy *(if applicable)*:

	POLICY 1	POLICY 2
Prepaid		
• Short Term *(ISA monthly only)* Policy Date will coincide with ISA payment billing day *(not month)* (Short Term premiums will apply.)..........	☐	☐
• Short Term to ________ (Short Term premiums will apply.)..........	☐	☐
• Date to Save Age (Premiums due and any other applicable charges are based on policy date.)..........	☐	☐
• Backdate to ________ (Premiums due and any other applicable charges are based on policy date.)...	☐	☐
Nonprepaid		
• Specified future date ________	☐	☐
• Date to Save Age (Premiums due and any other applicable charges are based on policy date.)..........	☐	☐
• Backdate to ________ (Premiums due and any other applicable charges are based on policy date.)...	☐	☐

12. INSURANCE HISTORY

A. Has the Insured ever had life, disability, health, or long-term care insurance declined, rated, modified, issued with an exclusion rider, cancelled, rescinded, or not renewed? If "Yes," explain in Remarks ☐ Yes ☒ No

B. Does the Insured have any existing or pending life insurance (including group coverage) with companies **other than** Northwestern Mutual? If "Yes," complete the table below ☐ Yes ☒ No

INSURANCE COMPANY (EXCLUDING NORTHWESTERN MUTUAL)	AMOUNT OF INSURANCE	PENDING (P) OR IN FORCE (I)	PERSONAL (P) OR BUSINESS (B) COVERAGE
	$		
	$		
	$		

REMARKS:

13. REPLACEMENT

Complete the ***Definition of Replacement*** form and provide the form to the Applicant and home office. **NOTE TO AGENT:** If any of the questions on the ***Definition of Replacement*** are answered "Yes," this is a replacement of life insurance or an annuity and:

- The **Agent must:**
  - Notify Northwestern Mutual and the other company(ies) whose policy(ies) or contract(s) is/are being replaced ("the Other Company") of the proposed replacement.
  - Submit a list of the policy(ies) or contract(s) to be replaced to the Other Company, requesting the information needed to complete the ***Disclosure Statement.***
  - Present the Applicant with the ***Important Notice Regarding Replacement or Change of Life Insurance Policies or Annuity Contracts*** and a completed ***Disclosure Statement,*** and provide copies of such forms to both the Applicant and the home office.
  - Submit copies of all sales materials to both the Applicant and the home office.
- The **Applicant must** answer question **A** below.

A. Will this insurance:

1. Replace Northwestern Mutual insurance or annuity? ☐ Yes ☐ No
2. Replace insurance or annuity of other companies? ☐ Yes ☐ No
3. Result in a 1035 exchange? ☐ Yes ☐ No

14. INSURED HISTORY INFORMATION

A. What is your marital status? ☒ Single, Widowed or Divorced ☐ Married

B. Are you a U.S. citizen or do you have a permanent resident visa (i.e., green card)? If "No," complete 1, 2 & 3 ☒ Yes ☐ No

1. What is your country of citizenship? ______
2. What type of visa do you have (B-1, H-1B, J-1, etc.)? ______ Visa Number ______
3. How long have you resided in the U.S.? ______

C. Have you traveled outside the U.S. during the past 12 months, or do you have plans to leave the U.S. for travel or residence in the next 2 years? If "Yes," provide details below ☐ Yes ☒ No

CITY AND COUNTRY	DATE OF TRAVEL/RESIDENCE	DURATION OF TRAVEL/RESIDENCE	PURPOSE OF TRIP

(Continued on next page)

QUESTIONS D THROUGH M ARE NOT REQUIRED IF THE INSURED IS UNDER AGE 16.

D. What is your occupation? ______

E. 1. Who is your employer? ______

2. How long with this employer? ______

F. 1. What is your annual earned income as most recently reported to the IRS?

Salary (or IRS Schedule C net profit or loss, if a sole proprietor) $ ______ Bonus $ ______

Other $ ______ Explain: ______

2. What is your net worth, if it is >$1,000,000? $ ______

Financial Supplement forms 90-8C and 90-8D may be required for in-force plus applied for amounts of personal insurance greater than $2,000,000 and business insurance greater than $500,000. See instructions on Supplements.

G. In the past 5 years, have you filed bankruptcy? If "Yes," provide details below .... ☐ Yes ☐ No

TYPE OF BANKRUPTCY (CHAPTER)	DATE FILED	DATE DISCHARGED

H. Are you a member of, or have you entered into a written agreement to become a member of any branch of the Armed Forces or reserve military unit? If "Yes," complete Military Supplement, 90-5 .... ☐ Yes ☐ No

I. Other than as a passenger on a regularly scheduled commercial flight, have you flown within the past 2 years or do you have plans to fly in the next 2 years? If "Yes," complete Aviation Supplement, 90-5 .... ☐ Yes ☐ No

J. In the past 2 years, have you participated in or do you have plans to participate in the next 2 years in any of the following: racing (automobile, motorcycle, boat, go-cart or snowmobile); scuba diving; skydiving; hang gliding or paragliding; bungee or BASE jumping; mountain, rock, or ice climbing; rodeos; boxing, wrestling, or mixed martial arts; or any other hazardous sports or activities? If "Yes," complete Avocation Supplement 90-6 .... ☐ Yes ☐ No

K. What is your driver's license number and state issued?

Driver's License Number: ______ State Issued: ______

L. In the past 5 years, have you pled guilty, pled no contest, or been convicted of reckless driving, driving while impaired or intoxicated, or any other moving violation; had your license suspended or revoked; or been involved in any accident in which you were found to be at fault? If "Yes," provide details below .... ☐ Yes ☐ No

DATE	TYPE OF VIOLATION AND/OR DETAILS OF ACCIDENT (SPEEDING, RECKLESS DRIVING, DRIVING WHILE INTOXICATED, ETC.)

M. Have you ever pled guilty, pled no contest, or been convicted of any felony or misdemeanor, or do you have any charges pending? If "Yes," provide details below .... ☐ Yes ☐ No

DATE	CITY/COUNTY/STATE	OFFENSE (PLEASE ALSO NOTE IF FELONY OR MISDEMEANOR)	TIME SERVED	DATE OF PAROLE OR PROBATION TERMINATION

CONSENT AND DECLARATION

The Insured consents to this application, and each signer has read the application and all statements and answers that pertain to them, and declares that the statements and answers are correctly recorded, complete and true to the best of their knowledge and belief. Answers and statements brought to the attention of the agent, medical examiner, or paramedical examiner are not considered information brought to the attention of the Company unless stated in the application. Statements and answers in this application are representations and not warranties.

It is agreed that:

(1) If the premium is not paid when the application is signed, no insurance will be in effect. The insurance will take effect at the time the policy is delivered and the premium is paid, if: the Insured is living at the time; and the answers and statements in the application are then true to the best of the Insured's knowledge and belief.

(2) If the premium is paid when the application is taken, no insurance will be in effect except as provided in the Conditional Life Insurance Agreement or by the automatic term insurance provided when exercising the Additional Purchase Benefit.

(3) If the policy is issued in an extra premium class, acceptance of the policy will amend it so that extended term insurance can be in force only if (a) the Company gives its consent or (b) the loan value is not large enough to grant a premium loan. If a premium is not paid within the grace period and, due to operation of the foregoing amendment of the policy, extended term insurance cannot be in force, paid-up insurance will be selected.

(4) No agent is authorized to make or alter contracts or to waive any of the Company's rights or requirements.

AUTHORIZATION

I authorize The Northwestern Mutual Life Insurance Company, its agents, employees, reinsurers, insurance support organizations and their representatives to obtain information about me to evaluate this application and to verify information in this application. This information will include: (a) age; (b) medical history, condition and care; (c) physical and mental health; (d) occupation; (e) income and financial history; (f) foreign travel; (g) avocations; (h) driving record; (i) other personal characteristics; and (j) other insurance. This authorization extends to information on the use of alcohol, drugs and tobacco; the diagnosis or treatment of HIV (AIDS virus) infection and sexually transmitted diseases; and the diagnosis and treatment of mental illness. During the time this authorization is valid it extends to information required to determine eligibility for benefits under any policy issued as a result of this application.

I authorize any person, including any physician, health care professional, hospital, clinic, medical facility, government agency including the Veterans and Social Security Administrations, the MIB, Inc., employer, business associates, consumer reporting agency, banker, accountant, tax preparer, or other insurance company, to release information about me to The Northwestern Mutual Life Insurance Company or its representatives on receipt of this authorization. The Northwestern Mutual Life Insurance Company or its representatives may release this information about me to translators, to reinsurers, to the MIB, Inc., or to another insurance company to whom I have applied or to who a claim has been made. No other release may be made except as allowed by law or as I further authorize.

I have received a copy of the MIB, Inc. and Fair Credit Reporting Act notices. I authorize The Northwestern Mutual Life Insurance Company to obtain an investigative consumer report on me.

☐ I request to be interviewed if an investigative consumer report is done.

This authorization is valid for 24 months from the date it is signed. A copy of this authorization is as valid as the original and will be provided on request.

ILLUSTRATION CERTIFICATION

☒ I, the Applicant, acknowledge that no illustration conforming to the policy applied for was available for me to review and sign. I understand that an illustration conforming to the policy exactly as issued will be provided to the Policyowner, by the Company or Agent, no later than at the time the policy is delivered.

TAXPAYER IDENTIFICATION NUMBER (TIN) CERTIFICATION

Under penalties of perjury, the Owner of the policy applied for herein certifies: (1) The taxpayer identification number given for the Owner on this application is the Owner's correct TIN (or the Owner is waiting for a TIN to be issued); and (2) The Owner is not subject to backup withholding because (a) the Owner is exempt from backup withholding, or (b) the Owner has not been notified by the Internal Revenue Service (IRS) that the Owner is subject to backup withholding as a result of a failure to report all interest or dividends, or (c) the IRS has notified the Owner that the Owner is no longer subject to backup withholding; and (3) The Owner is a U.S. person, which includes: a U.S. citizen; U.S. resident alien; partnership, corporation, company, or association created or organized in the United States or under the laws of the United States; an estate (other than a foreign estate); or a domestic trust (as defined in 26 CFR § 301.7701-7).

Item (2) above must be crossed off if the Owner has been notified by the IRS that the Owner is subject to backup withholding as a result of a failure to report all interest or dividends.

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

The agent represents Northwestern Mutual in connection with the placement of insurance policies and services provided on behalf of Northwestern Mutual. For selling insurance policies, the agent will receive compensation from Northwestern Mutual based in whole or in part on the insurance contract the agent sells. This compensation may vary depending on a number of factors, including the type and amount of the insurance contract and the overall volume of business placed by the agent. The applicant may obtain information about the compensation expected to be received based in whole or in part on the sale of this policy or others shown, by requesting such information from the agent.

SIGNATURE(S)

The signatures below apply to the application, Consent and Declaration, Authorization, Illustration Certification (if checked), and the Taxpayer Identification Number Certification.

[signature] Signature of **APPLICANT** — **Anthony Lobosco**	5/12/15 **DATE** signed by **APPLICANT** *(MM/DD/YYYY)*
Signature of **INSURED** (If other than Applicant; or PARENT OR GUARDIAN, if under age 15.)	Rye Brook, Westchester County, NY Signed by **APPLICANT** at **CITY, COUNTY, STATE**
Signature of **OWNER** (If other than Insured/Applicant)	Signature of **LICENSED AGENT** — **David G Harding**

THE NORTHWESTERN MUTUAL LIFE INSURANCE COMPANY
720 East Wisconsin Avenue, Milwaukee, WI 53202

Medical Authorization (Life/DI)

This Authorization complies with the HIPAA Privacy Rule

Authorization for Release of Health-Related Information to The Northwestern Mutual Life Insurance Company

Lea Lobosco
Name of Patient/Proposed Insured (please print)

10/30/2010
Date of Birth (MM/DD/YYYY)

Former/Maiden Name (If applicable, please print)

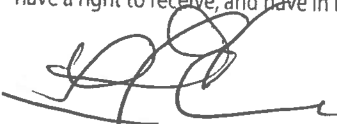
I authorize any health plan, physician, health care professional, hospital, clinic, laboratory, pharmacy, pharmacy benefit manager, medical facility, or other health care provider that has provided payment, treatment or services to me or on my behalf within the past 10 years ("My Providers") to disclose my entire medical record to The Northwestern Mutual Life Insurance Company (Northwestern Mutual) 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.

By signing 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.

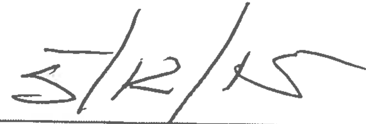
This protected health information is to be disclosed under this Authorization so that Northwestern Mutual may: 1) underwrite my application for coverage, make eligibility, risk rating, policy issuance and enrollment determinations; 2) obtain reinsurance; 3) administer claims and determine or fulfill responsibility for coverage and provision of benefits; 4) administer coverage; 5) evaluate potential insurance applications with Northwestern Mutual subsidiaries and affiliates to which I have applied or may apply for coverage; and 6) conduct other legally permissible activities that relate to any coverage I have or have applied for with Northwestern Mutual.

This Authorization shall remain in force for 30 months 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 Northwestern Mutual at 720 East Wisconsin Avenue, Milwaukee, Wisconsin 53202, Attention: Vice President 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 Northwestern Mutual has a legal right to contest a claim under an insurance policy or to contest the policy itself. I understand that information disclosed to Northwestern Mutual pursuant to this Authorization is no longer covered by the HIPAA Privacy Rule, and that in the course of conducting its business, Northwestern Mutual may release information it has about me to affiliates, reinsurers, and any person performing business or legal service for Northwestern Mutual and as permitted or required by law.

I understand that if I alter, revoke, or refuse to sign this Authorization to release my entire medical record, Northwestern Mutual may not be able to process my application, or if coverage has been issued may not be able to make any benefit payments. I further understand that My Providers cannot condition treatment, payment, enrollment, or eligibility for benefits on whether I sign this Authorization. I acknowledge by my signature below, that I have a right to receive, and have in fact received, a copy of this Authorization.



Signature of Patient/Proposed Insured *(or Parent or Guardian)*



Date Signed *(MM/DD/YYYY)*

33 Valley Ter, Port Chester, NY 10573
Address of Parent or Guardian, if signing

Father
Relationship to Patient/Proposed Insured

Some states' rules concerning Authorizations change the terms and provisions above. The terms and provisions on page two of this document are part of this Authorization and apply in the identified states.

SEND THIS ORIGINAL WITH APPLICATION

THE HOME OFFICE WILL ACCEPT A FAX TRANSMISSION OF THIS ORIGINAL, SIGNED DOCUMENT

THE NORTHWESTERN MUTUAL LIFE INSURANCE COMPANY
720 EAST WISCONSIN AVENUE, MILWAUKEE, WI 53202

MEDICAL HISTORY QUESTIONNAIRE

INSURED NAME (Print the name in this format: First Name, M.I., Last Name)
Lea Lobosco

Each question must be individually asked and answered. For questions 3 – 12, use the DETAILS section to explain all "Yes" responses. Specify the question number and provide relevant details.

1. Do you have a regular or personal physician, doctor, or healthcare provider? If "Yes," complete the information below .... ☐ Yes ☐ No
(If you have been receiving care from your provider for less than 2 years, please note your former provider's information in DETAILS section.)

NAME Dr. Kristin Woodard			TELEPHONE NUMBER 914-251-1100	
ADDRESS 26 Rye Ridge Plaza		CITY Rye Brook	STATE NY	ZIP CODE 10573
DATE LAST SEEN	REASON			

2. In the last 5 years, have you used tobacco, any other type of product containing nicotine, or a smoking cessation medication? If "Yes," complete the chart below *(include smoking cessation medication in "Other")*: .... YES ☐ NO ☑

Type of Product	Date Last Used (MM//YYYY)	Frequency Used Per Year
☐ Cigarettes		
☐ Nicotine patch or gum		
☐ Chew or snuff		
☐ Cigars or pipe		
☐ Other		

DETAILS

(1) Signs, symptoms, and diagnosis;
(2) Dates and results of any evaluations, tests, or treatments;
(3) Date of diagnosis, dates/frequency of service/care, and time since last symptoms or time since recovery;
(4) Names, complete addresses, and telephone numbers of all healthcare providers seen for the disease/condition.

3. In the last 10 years, have you either had, been told you had, or been treated for or tested positive for **any** of the following: (YES | NO)

a) High blood pressure or high cholesterol levels? .... YES ☐ NO ☑
b) Temporomandibular joint (TMJ) syndrome or any other disease or disorder of the eyes, ears, nose, sinuses, mouth, throat, or speech? .... YES ☐ NO ☑
c) Dizziness, vertigo, imbalance, seizure, epilepsy, loss of consciousness, muscle weakness or paralysis, neuropathy, difficulty walking, memory loss or impairment, tremor, headaches, concussion or any other disease or disorder of the brain or nervous system? .... YES ☐ NO ☑
d) Anxiety, depression, stress, bipolar disorder, attention deficit hyperactivity disorder (ADHD), post-traumatic stress disorder (PTSD), eating disorders or any other psychiatric or mental health disease or disorder? .... YES ☐ NO ☑
e) Asthma, emphysema, chronic obstructive pulmonary disease (COPD), wheezing, sleep apnea, sleep disorders, chronic cough, trouble breathing or any other disease or disorder of the lungs or respiratory system? .... YES ☐ NO ☑
f) Ulcer, blood in the stool, colitis (including Crohn's disease or ulcerative colitis), irritable bowel, hepatitis, recurrent heartburn, difficulty swallowing, pancreatitis, loss of appetite, recurrent or persistent diarrhea or vomiting, or any other disease or disorder of the esophagus, stomach, intestines, liver, gallbladder, or pancreas? .... YES ☐ NO ☑
g) Chest pain/tightness/discomfort, angina, coronary artery disease (CAD), heart attack, heart murmur, heart valve disease, heart failure, irregular heartbeat, stroke, transient ischemic attack (TIA), aneurysm or any other disease or disorder of the heart, blood vessels, or circulatory system? .... YES ☐ NO ☑
h) Sugar, blood or protein in the urine, chronic kidney disease (CKD), kidney stone or infection, sexually transmitted disease or any other disease or disorder of the kidney(s), urinary tract, bladder, prostate, reproductive organs, or breasts? .... YES ☐ NO ☑
i) Diabetes or elevated blood sugar, thyroid, pituitary, or adrenal disease or any other disease or disorder of the endocrine (glandular) system? .... YES ☐ NO ☑
j) Cancer, tumors, masses, cysts, nodules, or polyps? .... YES ☐ NO ☑
k) Anemia, bleeding or clotting disorder, recurrent infection, abnormal lymph node(s), allergies, or any disease or disorder of the immune system (except as related to the human immunodeficiency virus or HIV), blood, blood cells, or bone marrow? .... YES ☐ NO ☑
l) Arthritis, lupus, fibromyalgia, carpal tunnel syndrome, amputation, or any pain, disease, or disorder of the muscles, bones, joints (including but not limited to the knees and hips), spine, back, neck or extremities? .... YES ☐ NO ☑
m) Chronic fatigue syndrome, chronic pain, chronic or unexplained fatigue, malaise or fever of unknown cause? .... YES ☐ NO ☑
n) Psoriasis, eczema, atopic or contact dermatitis or any other disease or disorder of the skin? .... YES ☐ NO ☑

		YES	NO
4. a)	Have you ever sought, received, or been advised to seek treatment, counseling, or participation in a support group for the use of alcohol or drugs?	☐	☒
b)	Have you ever been advised to reduce or discontinue the use of alcohol? If "Yes," explain in DETAILS section and indicate the average number of drinks (if any) you currently consume per week ________.	☐	☒
c)	In the last 10 years, have you used marijuana, cocaine, heroin, methamphetamine, hallucinogens, or any other illegal drug or substance?	☐	☒
d)	In the last 10 years, have you used tranquilizers, sedatives, amphetamines, narcotics, or any other controlled substance other than as prescribed by a physician or in excess of dosages prescribed by a physician?	☐	☒
5.	Are you pregnant? If "Yes," what is the due date? ________	☐	☒
6.	Other than as previously stated on the application, in the last 5 years, have you:		
a)	Consulted any other healthcare providers (medical doctors, psychiatrists, psychologists, counselors/therapists, chiropractors, naturopaths, occupational/physical/speech therapists or other providers)?	☐	☒
b)	Been a patient in a hospital, clinic, rehabilitation center, or medical facility?	☐	☒
c)	Had any diagnostic or screening tests (EKGs, x-rays, blood tests, CT scans, MRI scans, heart scans, biopsies, or other tests except for human immunodeficiency virus or HIV)?	☐	☒
d)	Had surgery?	☐	☒
e)	Been advised to have any test, consultation, hospitalization, or surgery that was not completed (except as related to the human immunodeficiency virus or HIV)?	☐	☒
7. a)	During the last 6 months, have you worked in your regular occupation less than your usual number of hours per week because of any sickness or injury?	☐	☒
b)	In the last 5 years, have you requested or received payments, benefits, or a pension because of any injury, accident, sickness, disability, or impairing condition?	☐	☒
8.	Complete 8a **and** 8b.		
a)	Do you have an immediate family (parents/siblings) history of heart disease, stroke, diabetes, kidney disease, cancer (e.g., melanoma, breast cancer, or other cancers), or any hereditary condition(s)? If "Yes," list any tests you may have had to evaluate inherited risk in DETAILS section	☐	☐

b) Provide the following information about your immediate family members including any conditions from 8a:

FAMILY MEMBER	CURRENT AGE (IF LIVING)	MEDICAL CONDITION(S)	AGE AT DIAGNOSIS	AGE AT DEATH	CAUSE OF DEATH
Father					
Mother					
Sister(s)					
Brother(s)					

9. Complete 9a **and** 9b. Examiners - do not complete 9a.

a) Height: 46" Weight: 36lb

		YES	NO
b)	Have you lost more than 10 pounds in the last 6 months? If "Yes," indicate the number of pounds lost ______ and explain the reason in DETAILS section.	☐	☒
10.	Have you ever been diagnosed as having or been treated for AIDS and/or ARC by a member of the medical profession?	☐	☒
11.	Other than as previously stated on this application, are you taking any medications or drugs (legal or illegal, prescription or non-prescription/over-the-counter, supplements, or medical marijuana) for any reason? If "Yes," list the medication(s)/drug(s) and the reason(s) for use in DETAILS section	☐	☒

12. If the Insured is 5 years of age or under:

a) What was the Insured's birth weight? 5 lbs. 5 oz.

		YES	NO
b)	Was the Insured born prematurely (gestational age < 37 weeks)? If "Yes," what was the Insured's gestational age (in weeks) at birth ________	☐	☒
c)	Has the Insured been evaluated, tested, or treated for or diagnosed with developmental delay or disorders, any growth concerns (length/height/weight), or failure to thrive (FTT)?	☐	☒
d)	Has the Insured received or been advised to receive early education services or occupational, physical, speech, or language therapy?	☐	☒

SIGNATURE(S)

With respect to disability income insurance, refer to the fraud statement in your original application.

I have reviewed my answers and statements in this application and declare that they are correctly recorded, complete, and true to the best of my knowledge and belief. Statements in this application are representations and not warranties.

[signature] 5/12/25

Signature of **INSURED** (or Parent/Guardian)

Signature of: ☐ **LICENSED AGENT** (include agent #) – non exam ☐ **PARAMEDICAL EXAMINER** – paramedical exam ☐ **MEDICAL EXAMINER** – medical exam

Signed by **INSURED** at CITY and STATE

DATE (MM/DD/YYYY)

THE NORTHWESTERN MUTUAL LIFE INSURANCE COMPANY
720 EAST WISCONSIN AVENUE, MILWAUKEE, WI 53202

MEDICAL HISTORY QUESTIONNAIRE - *Additional Details*
Supplement to Application

INSURED NAME (First, Middle Initial, Last) PRINT NAME
Lea Lobosco

Use for any explanation where additional space is required.

Question #	Details

I have reviewed my answers and statements on this Supplement and declare that they are correctly recorded, complete and true to the best of my knowledge and belief. Statements on this Supplement are representations and not warranties. This Supplement shall be attached and made part of the application.

Signature of **INSURED** (or Parent/Guardian)

Signature of: ☐ **LICENSED AGENT** (include agent #) – non exam
☐ **PARAMEDICAL EXAMINER** – paramedical exam
☐ **MEDICAL EXAMINER** – medical exam

Signed by **INSURED** at CITY and STATE

DATE (MM/DD/YYYY)

The Northwestern Mutual Life Insurance Company
720 East Wisconsin Avenue, Milwaukee, Wisconsin 53202
(414) 271-1444

APPENDIX 11

DEPARTMENT OF FINANCIAL SERVICES OF THE STATE OF NEW YORK
DEFINITION OF REPLACEMENT

IN ORDER TO DETERMINE WHETHER YOU ARE REPLACING OR OTHERWISE CHANGING THE STATUS OF EXISTING LIFE INSURANCE POLICIES OR ANNUITY CONTRACTS, AND IN ORDER TO RECEIVE THE VALUABLE INFORMATION NECESSARY TO MAKE A CAREFUL COMPARISON IF YOU ARE CONTEMPLATING REPLACEMENT, THE AGENT OR BROKER IS REQUIRED TO ASK YOU THE FOLLOWING QUESTIONS AND EXPLAIN ANY ITEMS THAT YOU DO NOT UNDERSTAND.

AS PART OF YOUR PURCHASE OF A NEW LIFE INSURANCE POLICY OR A NEW ANNUITY CONTRACT, HAS EXISTING COVERAGE BEEN, OR IS IT LIKELY TO BE:

(1) LAPSED, SURRENDERED, PARTIALLY SURRENDERED, FORFEITED, ASSIGNED TO THE INSURER REPLACING THE LIFE INSURANCE POLICY OR ANNUITY CONTRACT, OR OTHERWISE TERMINATED?

☐ YES ☐ NO

(2) CHANGED OR MODIFIED INTO PAID-UP INSURANCE; CONTINUED AS EXTENDED TERM INSURANCE OR UNDER ANOTHER FORM OF NONFORFEITURE BENEFIT; OR OTHERWISE REDUCED IN VALUE BY THE USE OF NONFORFEITURE BENEFITS, DIVIDEND ACCUMULATIONS, DIVIDEND CASH VALUES OR OTHER CASH VALUES?

☐ YES ☐ NO

(3) CHANGED OR MODIFIED SO AS TO EFFECT A REDUCTION EITHER IN THE AMOUNT OF THE EXISTING LIFE INSURANCE OR ANNUITY BENEFIT OR IN THE PERIOD OF TIME THE EXISTING LIFE INSURANCE OR ANNUITY BENEFIT WILL CONTINUE IN FORCE?

☐ YES ☐ NO

(4) REISSUED WITH A REDUCTION IN AMOUNT SUCH THAT ANY CASH VALUES ARE RELEASED, INCLUDING ALL TRANSACTIONS WHEREIN AN AMOUNT OF DIVIDEND ACCUMULATIONS OR PAID-UP ADDITIONS IS TO BE RELEASED ON ONE OR MORE OF THE EXISTING POLICIES?

☐ YES ☐ NO

(5) ASSIGNED AS COLLATERAL FOR A LOAN OR MADE SUBJECT TO BORROWING OR WITHDRAWAL OF ANY PORTION OF THE LOAN VALUE, INCLUDING ALL TRANSACTIONS WHEREIN ANY AMOUNT OF DIVIDEND ACCUMULATIONS OR PAID-UP ADDITIONS IS TO BE BORROWED OR WITHDRAWN ON ONE OR MORE EXISTING POLICIES?

☐ YES ☐ NO

(6) CONTINUED WITH A STOPPAGE OF PREMIUM PAYMENTS OR REDUCTION IN THE AMOUNT OF PREMIUM PAID?

☐ YES ☐ NO

IF YOU HAVE ANSWERED YES TO ANY OF THE ABOVE QUESTIONS, A REPLACEMENT AS DEFINED BY NEW YORK INSURANCE DEPARTMENT REGULATION NO. 60 HAS OCCURRED OR IS LIKELY TO OCCUR AND YOUR AGENT OR BROKER IS REQUIRED TO PROVIDE YOU WITH A COMPLETED DISCLOSURE STATEMENT AND THE **IMPORTANT** NOTICE REGARDING REPLACEMENT OR CHANGE OF LIFE INSURANCE POLICIES OR ANNUITY CONTRACTS.

DATE: 5/12/15 (MM/DD/YYYY) **SIGNATURE OF APPLICANT:** [signature]

DATE: ______ (MM/DD/YYYY) **SIGNATURE OF APPLICANT:** ______

TO THE BEST OF MY KNOWLEDGE, A REPLACEMENT IS INVOLVED IN THIS TRANSACTION:

☐ YES ☐ NO

DATE: ______ (MM/DD/YYYY) **SIGNATURE OF AGENT OR BROKER:** ______

ORIGINAL TO HOME OFFICE – COPY TO APPLICANT