

SERFF Tracking Number: ASLX-125866127 State: Arkansas
Filing Company: American Memorial Life Insurance Company State Tracking Number: 40625
Company Tracking Number: LF AR01101AMF01
TOI: L08 Life - Other Sub-TOI: L08.000 Life - Other
Product Name: Whole Life Insurance Premiums Payable for Life End
Project Name/Number: Whole Life Insurance Premiums Payable for Life Endowment at Age 100 Nonparticipating/LF AR01101AMF01

Filing at a Glance

Company: American Memorial Life Insurance Company

Product Name: Whole Life Insurance Premiums SERFF Tr Num: ASLX-125866127 State: ArkansasLH

Payable for Life End

TOI: L08 Life - Other

SERFF Status: Closed

State Tr Num: 40625

Sub-TOI: L08.000 Life - Other

Co Tr Num: LF AR01101AMF01

State Status: Approved-Closed

Filing Type: Form

Co Status:

Reviewer(s): Linda Bird

Author: SPI AssurantLH

Disposition Date: 10/29/2008

Date Submitted: 10/20/2008

Disposition Status: Approved

Implementation Date Requested: 11/17/2008

Implementation Date:

State Filing Description:

General Information

Project Name: Whole Life Insurance Premiums Payable for Life
Endowment at Age 100 Nonparticipating

Status of Filing in Domicile:

Project Number: LF AR01101AMF01

Date Approved in Domicile:

Requested Filing Mode: Review & Approval

Domicile Status Comments:

Explanation for Combination/Other:

Market Type:

Submission Type: New Submission

Group Market Size:

Overall Rate Impact:

Group Market Type:

Filing Status Changed: 10/29/2008

Deemer Date:

State Status Changed: 10/29/2008

Corresponding Filing Tracking Number:

Filing Description:

Please see cover letter.

Company and Contact

Filing Contact Information

Jennifer Dunlap, Compliance Analyst

jennifer.dunlap@assurant.com

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440 Mount Rushmore Road (605) 719-0073 [Phone]
Rapid City, SD 57701 (605) 719-0473[FAX]

Filing Company Information

American Memorial Life Insurance Company CoCode: 67989 State of Domicile: South Dakota
440 Mount Rushmore Road Group Code: 19 Company Type:
Rapid City, SD 57701 Group Name: Assurant, Inc. Group State ID Number:
(605) 719-0999 ext. [Phone] FEIN Number: 46-0260270

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Filing Fees

Fee Required? Yes
Fee Amount: \$50.00
Retaliatory? No
Fee Explanation:
Per Company: No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
American Memorial Life Insurance Company	\$50.00	10/20/2008	23347047

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Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved	Linda Bird	10/29/2008	10/29/2008

Objection Letters and Response Letters

Objection Letters				Response Letters		
Status	Created By	Created On	Date Submitted	Responded By	Created On	Date Submitted
Pending	Linda Bird	10/24/2008	10/24/2008	SPI AssurantLH	10/28/2008	10/28/2008
Industry Response						

SERFF Tracking Number: ASLX-125866127 State: Arkansas
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Disposition

Disposition Date: 10/29/2008

Implementation Date:

Status: Approved

Comment:

Rate data does NOT apply to filing.

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Item Type	Item Name	Item Status	Public Access
Supporting Document	Certification/Notice		Yes
Supporting Document	Application		No
Supporting Document	Cover Letter		Yes
Supporting Document	Demo - smoker, Demo - nonsmoker		Yes
Supporting Document	revised certification		Yes
Form	Application		Yes
Form	Whole Life Insurance		Yes

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Objection Letter

Objection Letter Status Pending Industry Response

Objection Letter Date 10/24/2008

Submitted Date 10/24/2008

Respond By Date

Dear Jennifer Dunlap,

This will acknowledge receipt of the captioned filing.

Objection 1

- Certification/Notice (Supporting Document)

Comment: Ark. Code Ann. 23-79-138 requires that certain information accompany every policy. Bulletin 6-87 and Bulletin 11-88 further address this issue. Please review your issue procedures and assure us that you are in compliance with Ark. Code Ann. 23-79-138 as provided by these bulletins.

Regulation 49 requires that a Life and Health guaranty notice be give to each policy owner. Please review your issue procedures and assure us that you are in compliance with Regulation 49.

Regulation 19s10B requires that all new or revised filngs submitted must contain a certification that the submission meets the provisions of this rule as well as all applicable requirements of this Department.

Please feel free to contact me if you have questions.

Sincerely,

Linda Bird

Response Letter

Response Letter Status Submitted to State

Response Letter Date 10/28/2008

Submitted Date 10/28/2008

Dear Linda Bird,

Comments:

Attached is the revised certification requested.

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Response 1

Comments: Attached is the revised certification requested.

Related Objection 1

Applies To:

- Certification/Notice (Supporting Document)

Comment:

Ark. Code Ann. 23-79-138 requires that certain information accompany every policy. Bulletin 6-87 and Bulletin 11-88 further address this issue. Please review your issue procedures and assure us that you are in compliance with Ark. Code Ann. 23-79-138 as provided by these bulletins.

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Regulation 19s10B requires that all new or revised filngs submitted must contain a certification that the submission meets the provisions of this rule as well as all applicable requirements of this Department.

Changed Items:

Supporting Document Schedule Item Changes

Satisfied -Name: revised certification

Comment:

No Form Schedule items changed.

No Rate/Rule Schedule items changed.

Sincerely,
SPI AssurantLH

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Form Schedule

Lead Form Number:

Review Status	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
	P-1143	Application/ Enrollment Form	Application	Initial		0	P-1143.PDF
	P-1073-S	Policy Jacket	Whole Life Insurance	Initial		0	P-1073-S.PDF

Application for Life Insurance

American Memorial Life Insurance Company

P.O. Box 2730 • Rapid City, SD 57709

HOME OFFICE USE ONLY

Agent Present Yes No

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.

1. Proposed Insured

Address: _____
First Middle Initial Last
Street
City State Zip
Telephone Number: (Home) _____ (Cell) _____ (Work) _____
Social Security Number: _____ Email Address: _____
Date of Birth: _____ Current Age: _____ Birth State: _____ Male Female

2. Owner Information (If different from Proposed Insured)

Owner's Name: _____ Email Address: _____
Owner's Address: _____
Relationship to Proposed Insured: _____ Social Security Number: _____
Telephone Number: (Home) _____ (Cell) _____ (Work) _____

3. Primary Beneficiary

Name: _____
Address: _____
Telephone Number: (Home) _____
(Cell) _____ (Work) _____
Social Security Number: _____
Relationship to Proposed Insured: _____

4. Contingent Beneficiary

Name: _____
Address: _____
Telephone Number: (Home) _____
(Cell) _____ (Work) _____
Social Security Number: _____
Relationship to Proposed Insured: _____

5. Face Amount: \$ _____

6. Plans: Preferred Plan Standard Plan Plan 6

7. Additional Required Information for Proposed Insured:

- A. Has the Proposed Insured used nicotine based products in the past 12 months? Yes No
- B. Current Physician and Address: _____

- C. Drivers License Number: _____ State: _____
- D. Are you a U.S. citizen? Yes No
- If not, do you have an immigration card? Yes No Card Number: _____

8. Payment Options

Initial Payment Method:

- PAC (Pre-Authorized Check) Check* (Payable to AML)
- Credit Card (Initial payment only) VISA MasterCard

Account Number _____ Expiration Date _____

Cardholder's Printed Name _____ Cardholder's Signature _____

Premium Amount \$ _____

Subsequent Premium Payment Frequency and Method of Payment:

Billing Frequency

- Monthly
- Quarterly
- Semi-Annual
- Annual

Payment Method

PAC (Pre-Authorized Check) (Must choose PAC if Initial Payment Method above is PAC)

Check *(Payable to AML)

If you selected PAC (Pre-Authorized Check), indicate subsequent premium withdrawal date _____

- Checking Savings

Name of Financial Institution _____

Routing Number _____ Account Number _____

Account Holder's Printed Name _____ Signature of Account Holder _____

*When you provide a check as payment, you authorize us either to use information from your check to make a one-time electronic fund transfer from your account or to process the payment as a check transaction. When we use information from your check to make an electronic fund transfer, funds may be withdrawn from your account as soon as the same day you make your payment, and may not receive your check back from your financial institution. For inquiries please call 1-800-585-8385, press zero.

9. Health Questions

PART A: If the Proposed Insured answers "YES" to any question in this section or does not meet the height and weight requirements for the product, they are not eligible for coverage.

1. Height _____ Weight _____

2. YES NO Do you need assistance with the normal activities of daily living (eating, bathing, dressing, taking medications, etc.), or are you currently hospitalized, confined to a bed or nursing facility, or receiving hospice care?

3. Within the past 12 months have you

- a. Been diagnosed with internal cancer, leukemia, lymphoma, or melanoma or have had more than one occurrence of any cancer in your life time (excluding basal or Squamous cell skin cancer), had a recurrence of any cancer, or currently being treated for cancer or had an amputation caused by any disease or cancer?
- b. Been medically diagnosed, treated, or taken medication for stroke or transient ischemic attack (TIA/mini-stroke)?

4. Within the past 24 months have you

- a. Been medically diagnosed, treated or taken medication for cirrhosis, liver disease, angina, chronic obstructive pulmonary or lung disease (COPD/COLD), emphysema, chronic bronchitis, required oxygen to assist in breathing, or uncontrolled high blood pressure?
- b. Been diagnosed as having, been treated for or hospitalized for heart disease, Hodgkin's Disease, heart attack, heart or circulatory vascular surgery (including coronary artery bypass, pacemaker or replacement pacemaker, heart valve replacement, abdominal aortic aneurysm, but excluding angioplasty or stent placement) cardiomyopathy, or any procedure to improve circulation to the heart or brain?

5. Within the past 36 months have you

- a. been convicted of a felony or are you currently incarcerated or on probation, been treated for or been advised to have treatment for alcohol or any drugs of abuse, attempted suicide, or been convicted of operating a vehicle while intoxicated or impaired?

6. Have you ever

- a. Been treated for insulin shock, diabetic coma, or have you taken insulin injections or by other methods prior to age 40?
- b. Been medically treated or diagnosed by a medical professional as having Acquired Immune Deficiency Syndrome (AIDS), AIDS related complex (ARC), or any immune deficiency related disorder or tested positive for the human immunodeficiency virus (HIV)?
- c. Had, or been medically advised to have, an organ transplant, or been diagnosed as having a terminal medical condition that is expected to result in death within the next 12 months.
- d. Been medically diagnosed, treated, or taken medication for chronic kidney disease (including dialysis), kidney or liver failure, congestive heart failure, Alzheimer's, dementia, Lou Gehrig's disease (ALS), schizophrenia, bipolar disorder, or mental incapacity?

PART B: If the Proposed Insured answers "YES" to any question in this section, they are eligible for the Standard Plan.

7. Within the past 24 months have you been medically diagnosed, treated, or taken medication for

- a. Lymphoma, melanoma, leukemia or any internal cancer?
- b. Stroke, or transient ischemic attack (TIA/mini-stroke)?
- c. Neuromuscular or brain disease (including cerebral palsy, muscular dystrophy, multiple sclerosis, grand mal epilepsy, cystic fibrosis or Parkinson's disease) or systemic lupus (SLE)?
- d. Paralysis of two or more extremities or amputation caused by disease or cancer?
- e. Angioplasty or stent placement?

8. Within the past 24 months, have you been confined three times or more to a hospital, nursing facility, convalescent care facility, assisted living facility, mental facility, or hospice care?

9. If you are age 65 and under, do you have a physical or mental reason or any health reason that would prevent you from working for at least 25 hours per week in an active, normal, and gainful employment?

Conditions Relating to the Application: I have read the questions and answers in all parts of this Application. I agree that they are complete and true to the best of my knowledge and belief. I agree that this Application and any supplement to the Application, if required, shall be attached to and form a part of any policy issued.

Acknowledgement: I have read and understand the Conditions Relating to the Application, the Medical Authorization information, and this Acknowledgement. I acknowledge receipt and review of the Notice to the Applicant and (where required by law) a Buyer's Guide and any other required preliminary cost information.

I understand and agree that no insurance agent has the authority to waive an answer to any question in the Application, pass on insurability, make or alter any contract, or waive any of the Company's rights or requirements. I understand and agree that any policy applied for shall not take effect (except as provided in the Conditional Premium Receipt bearing the same name as this Application) unless and until the policy has been issued and delivered and the first full premium, according to the mode of payment selected by the applicant and as permitted by the Company and stated in the policy, has been paid and accepted by the Company during the lifetime and condition of health of the Proposed Insured as stated in this Application. I understand that I (or my authorized representative) may receive a copy of this Authorization.

SIGNATURES:

Signed at: _____
City State

Proposed Insured _____ Date _____

Will the policy that you are applying for replace any existing life insurance or annuity policy? Yes No

If yes, give name and address of the existing insurer and policy number, if available: _____

Applicant/Owner _____ Date _____
(If different from Proposed Insured)

Witness - Licensed Agent _____ Date _____

Agent's Statement

Did you see the Proposed Insured at the time this application was completed? Yes No

Is the insurance applied for intended to replace or change an existing life insurance or annuity policy? Yes No

If a replacement is involved, I certify that I only used company approved sales materials.

Licensed Agent's Signature _____

Name of Agency Office _____

Agent's State License ID Number _____ Expiration Date _____

Print Agent Name _____

Agent Number _____ Agent Telephone Number (_____) _____

Medical Authorization

For use with Life Insurance Applications.

This Authorization complies with the HIPAA Privacy Rule.

Name(s) of primary proposed insured/patient

Date(s) of birth

Name(s) of unemancipated minors

Date(s) of birth

I authorize any health plan, physician, medical practitioner, health care professional, hospital, clinic, pharmacy benefit manager, pharmacy, MIB, Inc., laboratory, medical facility, insurance company, insurance support organization (or any of its members or affiliates), the Veteran’s Administration, my employer, consumer reporting agency, or any other health care provider that has provided payment, treatment or services to me or on my behalf or on the behalf of my unemancipated minor children (collectively, “My Providers”) to disclose the entire medical record and any other protected health information concerning me or my above named unemancipated minor children to American Memorial Life Insurance Company (“the Company”) or its reinsurers, their 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. I acknowledge receipt of the MIB, Inc. Pre-Notice and Fair Credit Reporting Act Pre-Notice.

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

This protected health information is to be disclosed under the authorization at my request, as permitted by §164.508 of the privacy regulations issued pursuant to the Health Insurance Portability and Accountability Act (“HIPAA Privacy Rule”).

This authorization shall remain in force for 24 months following the date of my signature below, regardless of my condition and whether living or deceased, and a copy of this authorization is as valid as the original. I understand that I have the right to obtain a copy of this authorization and to revoke this authorization in writing, at any time, by sending a written request for revocation to the Company at Attention: Privacy Task Force, P.O. Box 2730, Rapid City, SD 57709. 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 the Company has a legal right to contest a claim under an insurance policy or to contest the policy itself. I understand that any information disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal regulations governing privacy and confidentiality of health information (such as the HIPAA Privacy Rule). However, the company will protect the privacy of health information in accordance with other applicable state and/or federal privacy laws and its own privacy policies.

I understand that My Providers may not refuse to provide treatment or payment for health care services because I refuse to sign this authorization. I further understand that if I refuse to sign this authorization to release my complete medical record or that of my unemancipated minor children, the 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 that I (or my authorized representative) have received a copy of this authorization.

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Signature of Primary Proposed Insured/Personal Representative

Date

Signature of Primary Proposed Insured/Personal Representative

Date

If signed by an individual’s Personal Representative, describe authority to sign on behalf of individual:

Parent Power of Attorney Legal Guardian Other _____

Notice to the Applicant

You have made a wise decision to apply for life insurance. The possibility exists that premiums paid over several years may exceed the death benefit. This notice is given to you at the time you apply for life insurance to tell you about that type of information the Company may obtain in connection with your application. We will treat all personal information about you as confidential.

Underwriting. Your application, together with the medical history you give, provides the initial basis for evaluation. The Company relies on the accuracy and completeness of your answers and may make inquiries, both before and after a policy is issued, to verify this information.

Sources of Information. The Company may request additional information from your physician(s) or hospital(s) or other medical professionals, or medical care institutions, the Medical Information Bureau (MIB), other insurance institutions to which you have applied for insurance, your employers, agents of the Company, business associates, a governmental entity, financial institution, or consumer reporting agency. Your signature on the Acknowledgement and Medical Authorization Form permits the Company to make these inquiries. Such inquiries may be made by telephone, written correspondence, or personal interview. If the Company requests information from another insurance company, it will not request underwriting action. You have the right to know what information we have about you, to copy it, and if it is incorrect, to have it corrected. If the Company received information about you from an insurance support organization, such information may be retained by the organization and released to others. In this connection, the following notice is given to you as required by the federal and various state Fair Credit Reporting Acts. You have the right to access and correction with respect to this information. If you wish a more detailed explanation of information practices, please send your written request to American Memorial Life Insurance Company, P.O. Box 2730, Rapid City, SD 57709.

Fair Credit Reporting Act Pre-Notice. In some cases, the Company may ask an independent agency to prepare an investigative consumer report for you. This report may include information about your character, general reputation, personal characteristics such as health, finances, and mode of living, except as may be related directly or indirectly to your sexual orientation. Any information obtained by an investigative agency may be kept in its file and later given to others who have a business need for it. If an investigative consumer report is ordered by the Company, the report will include information obtained through interviews with your neighbors, friends, or others with whom you are acquainted. You may request to be interviewed in connection with the preparation of the investigative consumer report. You may request, in writing, to receive information from the Company about the nature and scope of an investigative consumer report. Within five (5) business days of receipt of such request, the Company will provide you with the name, address, and phone number of any agency the Company asks to prepare such a report. You should contact them to obtain a copy of the report.

Medical Information Bureau, Inc. Pre-Notice. Information regarding your insurability will be treated as confidential. American Memorial Life Insurance Company or its reinsurers may, however, make a brief report thereon to the MIB, Inc., formerly known as Medical Information Bureau, a not-for-profit membership organization of insurance companies, which operates an information exchange on behalf of its members. If you apply to another MIB member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, MIB, upon request, will supply such company with the information about you in its file.

Upon receipt of a request from you, MIB will arrange disclosure of any information in your file. Please contact MIB at 866-692-6901 (TTY 866-346-3642). If you question the accuracy of the information in MIB's file, you may contact MIB and seek a correction in accordance with the procedures set forth in the federal Fair Credit Reporting Act. The address of MIB's information office is 50 Braintree Hill Park, Suite 400, Braintree, Massachusetts 02184-8734.

American Memorial Life Insurance Company, or its reinsurers, may also release information from its file to other insurance companies to whom you may apply for life and health insurance, or to whom a claim for benefits may be submitted. Information for consumers about MIB may be obtained on its website at www.mib.com.

Conditional Premium Receipt

THIS RECEIPT PROVIDES COVERAGE ONLY IF CONDITIONS BELOW ARE MET.

The Company hereby acknowledges receipt of the initial premium from the Proposed Insured for which an application for insurance is made to American Memorial Life Insurance Company on the date of application and for the premium collected as stated on the application for insurance.

Life insurance and any additional benefits in the amount applied for shall be deemed to take effect as of the date of this application, subject to the terms and conditions printed below.

Conditions of Life Insurance Coverage (Please read carefully).

Subject to the limitations of this receipt and the terms and conditions of the policy that may be issued by the Company on the basis of the application, the life insurance and any additional benefits applied for will not be deemed to take effect unless the Company, after investigation and such medical examination (if any) as it may require, is satisfied that on the date of the application the person proposed for insurance was insurable for the amount of life insurance and any additional benefits applied for according to the Company's rules and practice of selection; provided, however, that approval by the Company of the insurability of the Proposed Insured for a plan of insurance other than that applied for shall not invalidate the terms and conditions for the receipt relating to life insurance and any other additional benefit applied for.

The amount received shall be refunded if the application is declined or if a policy is issued other than as applied for and is not accepted. Any check, draft or money order is received subject to collection.

American Memorial Life Insurance Company or its reinsurers may also release limited information in its file to other properly authorized life insurance companies to whom you may apply for life or health insurance or to whom a claim for benefits may be submitted.

STATEMENT OF POLICY COST AND BENEFIT INFORMATION

January 1, 2008

INSURED: John Doe
 AGE: 35

POLICY NUMBER: 8-001001

AMERICAN MEMORIAL LIFE INSURANCE COMPANY
 P.O. BOX 2730
 RAPID CITY, SD 57709-2730

AGENT:
 HOME OFFICE

BENEFIT DESCRIPTION:

WHOLE LIFE INSURANCE THAT ENDOWS AT AGE 100. PREMIUMS LEVEL AND PAYABLE FOR LIFE. LEVEL DEATH BENEFIT.

END OF YEAR	ANNUAL PREMIUM	BEGINNING OF YEAR GUARANTEED DEATH BENEFIT	END OF YEAR GUARANTEED CASH VALUE
1	55.39	1,000	.00
2	55.39	1,000	.00
3	55.39	1,000	3.41
4	55.39	1,000	11.90
5	55.39	1,000	20.75
6	55.39	1,000	29.95
7	55.39	1,000	39.50
8	55.39	1,000	49.38
9	55.39	1,000	59.61
10	55.39	1,000	70.17
11	55.39	1,000	81.07
12	55.39	1,000	92.33
13	55.39	1,000	104.02
14	55.39	1,000	116.19
15	55.39	1,000	128.85
16	55.39	1,000	141.96
17	55.39	1,000	155.51
18	55.39	1,000	169.46
19	55.39	1,000	183.81
20	55.39	1,000	198.48
AGE 65	55.39	1,000	363.19

THE EFFECTIVE POLICY LOAN ANNUAL INTEREST RATE IS 6.0% PAYABLE IN ARREARS.

PAYMENT PERIOD	10 YEARS	20 YEARS
SURRENDER COST INDEX	49.77	48.98
NET PAYMENT COST INDEX	55.39	55.39

AN EXPLANATION OF THE INTENDED USE OF THESE INDEXES IS PROVIDED IN THE LIFE INSURANCE BUYER'S GUIDE. THE INDEXES ARE OF MOST VALUE WHEN COMPARING THE COSTS OF SIMILAR POLICIES.



A Stock Company

440 Mt. Rushmore Road
P.O. Box 2730
Rapid City, SD 57709-2730

READ YOUR POLICY CAREFULLY

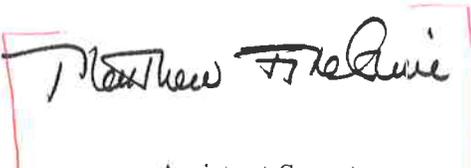
THIS POLICY IS A LEGAL CONTRACT BETWEEN YOU AND US.

If the insured dies while this policy is in force, we will pay the death benefit to the beneficiary, subject to the provisions of this policy.

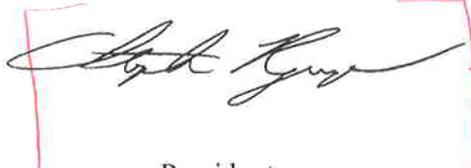
This policy is issued in consideration of the application and payment of the first premium before delivery of this policy.

Right to Cancel. You may cancel this policy by returning it to our home office by midnight of the thirtieth (30th) day after the date you receive the policy. Cancellation is effective when notice is given and the policy is returned by mail that is postmarked, properly addressed, and postage prepaid. We will then refund all premiums paid.

Signed for American Memorial Life Insurance Company on the issue date at its home office in Rapid City, South Dakota.


Assistant Secretary

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President

**WHOLE LIFE INSURANCE
PREMIUMS PAYABLE FOR LIFE
ENDOWMENT AT AGE 100
NONPARTICIPATING**

POLICY DATA PAGE

POLICY NUMBER 8-001001 \$1,000 INITIAL FACE AMOUNT
INSURED NAME JOHN DOE
ISSUE DATE 01-01-2008
AGE AT ISSUE 35 MALE SEX NON-NICOTINE
POLICY OWNER JOHN DOE
PLAN WHOLE LIFE INSURANCE - PREMIUMS PAYABLE FOR LIFE
BENEFICIARY SEE ATTACHED APPLICATION

	ANNUAL	SEMI-ANNUAL	QUARTERLY	MONTHLY
DIRECT BILLING	55.39**	28.25	14.40	N/A
PRE-AUTHORIZED CHECK	55.39	28.25	14.40	4.99

THE “**” FLAGS THE INITIAL MODE OF PAYMENT.

SCHEDULE OF PREMIUMS

BIRTHDAY	ANNUAL PREMIUM
1-01-1973	55.39

YOUR TOTAL ANNUAL PREMIUM IS 55.39

- 3 INTEREST RATE FOR BASIS OF COMPUTATION
NONFORFEITURE RATE 5.0 %
- 4 MORTALITY TABLE FOR BASIS OF COMPUTATION
2001 COMMISSIONER'S STANDARD ORDINARY, AGE LAST BIRTHDAY,
MALE, NON-SMOKER

POLICY VALUES

PLAN WHOLE LIFE INSURANCE - PREMIUMS PAYABLE FOR LIFE
 POLICY NUMBER 8-001001
 INSURED JOHN DOE
 ISSUE DATE 01-01-2008 AGE AT ISSUE 35 SEX MALE

TABLE OF VALUES PER INITIAL FACE AMOUNT OF \$1,000

END OF YEAR	END OF YEAR DEATH BENEFIT	END OF YEAR CASH VALUE	PERIOD OF EXTENDED TERM INSURANCE		AMOUNT OF PAID UP INSURANCE
			Years	Days	
1	1,000	0	0	0	0
2	1,000	0	0	0	0
3	1,000	3.41	2	243	20
4	1,000	11.90	7	281	69
5	1,000	20.75	11	269	115
6	1,000	29.95	14	266	160
7	1,000	39.50	16	323	202
8	1,000	49.38	18	206	243
9	1,000	59.61	19	296	281
10	1,000	70.17	20	274	318
11	1,000	81.07	21	182	353
12	1,000	92.33	22	39	386
13	1,000	104.02	22	215	418
14	1,000	116.19	22	349	448
15	1,000	128.85	23	73	477
16	1,000	141.96	23	128	505
17	1,000	155.51	23	158	532
18	1,000	169.46	23	162	558
19	1,000	183.81	23	145	582
20	1,000	198.48	23	107	605

NONFORFEITURE FACTOR 9.17498

Application for Life Insurance

American Memorial Life Insurance Company

P.O. Box 2730 • Rapid City, SD 57709

HOME OFFICE USE ONLY

Agent Present Yes No

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.

1. Proposed Insured

Address: _____
First Middle Initial Last
Street
City State Zip
Telephone Number: (Home) _____ (Cell) _____ (Work) _____
Social Security Number: _____ Email Address: _____
Date of Birth: _____ Current Age: _____ Birth State: _____ Male Female

2. Owner Information (If different from Proposed Insured)

Owner's Name: _____ Email Address: _____
Owner's Address: _____
Relationship to Proposed Insured: _____ Social Security Number: _____
Telephone Number: (Home) _____ (Cell) _____ (Work) _____

3. Primary Beneficiary

Name: _____
Address: _____
Telephone Number: (Home) _____
(Cell) _____ (Work) _____
Social Security Number: _____
Relationship to Proposed Insured: _____

4. Contingent Beneficiary

Name: _____
Address: _____
Telephone Number: (Home) _____
(Cell) _____ (Work) _____
Social Security Number: _____
Relationship to Proposed Insured: _____

5. Face Amount: \$ _____

6. Plans: Preferred Plan Standard Plan

7. Additional Required Information for Proposed Insured:

A. Has the Proposed Insured used nicotine based products in the past 12 months? Yes No

B. Current Physician and Address: _____

C. Drivers License Number: _____ State: _____

D. Are you a U.S. citizen? Yes No

If not, do you have an immigration card? Yes No Card Number: _____

8. Payment Options

Initial Payment Method:

- PAC (Pre-Authorized Check) Check* (Payable to AML)
- Credit Card (Initial payment only) VISA MasterCard

Account Number _____ Expiration Date _____

Cardholder's Printed Name _____ Cardholder's Signature _____

Premium Amount \$ _____

Subsequent Premium Payment Frequency and Method of Payment:

Billing Frequency

- Monthly
- Quarterly
- Semi-Annual
- Annual

Payment Method

PAC (Pre-Authorized Check) (Must choose PAC if Initial Payment Method above is PAC)

Check *(Payable to AML)

If you selected PAC (Pre-Authorized Check), indicate subsequent premium withdrawal date _____

- Checking Savings

Name of Financial Institution _____

Routing Number _____ Account Number _____

Account Holder's Printed Name _____ Signature of Account Holder _____

*When you provide a check as payment, you authorize us either to use information from your check to make a one-time electronic fund transfer from your account or to process the payment as a check transaction. When we use information from your check to make an electronic fund transfer, funds may be withdrawn from your account as soon as the same day you make your payment, and may not receive your check back from your financial institution. For inquiries please call 1-800-585-8385, press zero.

9. Health Questions

PART A: If the Proposed Insured answers "YES" to any question in this section or does not meet the height and weight requirements for the product, they are not eligible for coverage.

1. Height _____ Weight _____

2. YES NO Do you need assistance with the normal activities of daily living (eating, bathing, dressing, taking medications, etc.), or are you currently hospitalized, confined to a bed or nursing facility, or receiving hospice care?

3. Within the past 12 months have you

- a. Been diagnosed with internal cancer, leukemia, lymphoma, or melanoma or have had more than one occurrence of any cancer in your life time (excluding basal or Squamous cell skin cancer), had a recurrence of any cancer, or currently being treated for cancer or had an amputation caused by any disease or cancer?
- b. Been medically diagnosed, treated, or taken medication for stroke or transient ischemic attack (TIA/mini-stroke)?

4. Within the past 24 months have you

- a. Been medically diagnosed, treated or taken medication for cirrhosis, liver disease, angina, chronic obstructive pulmonary or lung disease (COPD/COLD), emphysema, chronic bronchitis, required oxygen to assist in breathing, or uncontrolled high blood pressure?
- b. Been diagnosed as having, been treated for or hospitalized for heart disease, Hodgkin's Disease, heart attack, heart or circulatory vascular surgery (including coronary artery bypass, pacemaker or replacement pacemaker, heart valve replacement, abdominal aortic aneurysm, but excluding angioplasty or stent placement) cardiomyopathy, or any procedure to improve circulation to the heart or brain?

5. Within the past 36 months have you

- a. been convicted of a felony or are you currently incarcerated or on probation, been treated for or been advised to have treatment for alcohol or any drugs of abuse, attempted suicide, or been convicted of operating a vehicle while intoxicated or impaired?

6. Have you ever

- a. Been treated for insulin shock, diabetic coma, or have you taken insulin injections or by other methods prior to age 40?
- b. Been medically treated or diagnosed by a medical professional as having Acquired Immune Deficiency Syndrome (AIDS), AIDS related complex (ARC), or any immune deficiency related disorder or tested positive for the human immunodeficiency virus (HIV)?
- c. Had, or been medically advised to have, an organ transplant, or been diagnosed as having a terminal medical condition that is expected to result in death within the next 12 months.
- d. Been medically diagnosed, treated, or taken medication for chronic kidney disease (including dialysis), kidney or liver failure, congestive heart failure, Alzheimer's, dementia, Lou Gehrig's disease (ALS), schizophrenia, bipolar disorder, or mental incapacity?

PART B: If the Proposed Insured answers "YES" to any question in this section, they are eligible for the Standard Plan.

7. Within the past 24 months have you been medically diagnosed, treated, or taken medication for

- a. Lymphoma, melanoma, leukemia or any internal cancer?
- b. Stroke, or transient ischemic attack (TIA/mini-stroke)?
- c. Neuromuscular or brain disease (including cerebral palsy, muscular dystrophy, multiple sclerosis, grand mal epilepsy, cystic fibrosis or Parkinson's disease) or systemic lupus (SLE)?
- d. Paralysis of two or more extremities or amputation caused by disease or cancer?
- e. Angioplasty or stent placement?

8. Within the past 24 months, have you been confined three times or more to a hospital, nursing facility, convalescent care facility, assisted living facility, mental facility, or hospice care?

9. If you are age 65 and under, do you have a physical or mental reason or any health reason that would prevent you from working for at least 25 hours per week in an active, normal, and gainful employment?

Conditions Relating to the Application: I have read the questions and answers in all parts of this Application. I agree that they are complete and true to the best of my knowledge and belief. I agree that this Application and any supplement to the Application, if required, shall be attached to and form a part of any policy issued.

Acknowledgement: I have read and understand the Conditions Relating to the Application, the Medical Authorization information, and this Acknowledgement. I acknowledge receipt and review of the Notice to the Applicant and (where required by law) a Buyer's Guide and any other required preliminary cost information.

I understand and agree that no insurance agent has the authority to waive an answer to any question in the Application, pass on insurability, make or alter any contract, or waive any of the Company's rights or requirements. I understand and agree that any policy applied for shall not take effect (except as provided in the Conditional Premium Receipt bearing the same name as this Application) unless and until the policy has been issued and delivered and the first full premium, according to the mode of payment selected by the applicant and as permitted by the Company and stated in the policy, has been paid and accepted by the Company during the lifetime and condition of health of the Proposed Insured as stated in this Application. I understand that I (or my authorized representative) may receive a copy of this Authorization.

SIGNATURES:

Signed at: _____
City State

Proposed Insured _____ Date _____

Will the policy that you are applying for replace any existing life insurance or annuity policy? Yes No

If yes, give name and address of the existing insurer and policy number, if available: _____

Applicant/Owner _____ Date _____
(If different from Proposed Insured)

Witness - Licensed Agent _____ Date _____

Agent's Statement

Did you see the Proposed Insured at the time this application was completed? Yes No

Is the insurance applied for intended to replace or change an existing life insurance or annuity policy? Yes No

If a replacement is involved, I certify that I only used company approved sales materials.

Licensed Agent's Signature _____

Name of Agency Office _____

Agent's State License ID Number _____ Expiration Date _____

Print Agent Name _____

Agent Number _____ Agent Telephone Number (_____) _____

Medical Authorization

For use with Life Insurance Applications.

This Authorization complies with the HIPAA Privacy Rule.

Name(s) of primary proposed insured/patient

Date(s) of birth

Name(s) of unemancipated minors

Date(s) of birth

I authorize any health plan, physician, medical practitioner, health care professional, hospital, clinic, pharmacy benefit manager, pharmacy, MIB, Inc., laboratory, medical facility, insurance company, insurance support organization (or any of its members or affiliates), the Veteran’s Administration, my employer, consumer reporting agency, or any other health care provider that has provided payment, treatment or services to me or on my behalf or on the behalf of my unemancipated minor children (collectively, “My Providers”) to disclose the entire medical record and any other protected health information concerning me or my above named unemancipated minor children to American Memorial Life Insurance Company (“the Company”) or its reinsurers, their 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. I acknowledge receipt of the MIB, Inc. Pre-Notice and Fair Credit Reporting Act Pre-Notice.

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

This protected health information is to be disclosed under the authorization at my request, as permitted by §164.508 of the privacy regulations issued pursuant to the Health Insurance Portability and Accountability Act (“HIPAA Privacy Rule”).

This authorization shall remain in force for 24 months following the date of my signature below, regardless of my condition and whether living or deceased, and a copy of this authorization is as valid as the original. I understand that I have the right to obtain a copy of this authorization and to revoke this authorization in writing, at any time, by sending a written request for revocation to the Company at Attention: Privacy Task Force, P.O. Box 2730, Rapid City, SD 57709. 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 the Company has a legal right to contest a claim under an insurance policy or to contest the policy itself. I understand that any information disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal regulations governing privacy and confidentiality of health information (such as the HIPAA Privacy Rule). However, the company will protect the privacy of health information in accordance with other applicable state and/or federal privacy laws and its own privacy policies.

I understand that My Providers may not refuse to provide treatment or payment for health care services because I refuse to sign this authorization. I further understand that if I refuse to sign this authorization to release my complete medical record or that of my unemancipated minor children, the 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 that I (or my authorized representative) have received a copy of this authorization.

Signature of Primary Proposed Insured/Personal Representative

Date

Signature of Primary Proposed Insured/Personal Representative

Date

If signed by an individual’s Personal Representative, describe authority to sign on behalf of individual:

Parent Power of Attorney Legal Guardian Other _____

Notice to the Applicant

You have made a wise decision to apply for life insurance. The possibility exists that premiums paid over several years may exceed the death benefit. This notice is given to you at the time you apply for life insurance to tell you about that type of information the Company may obtain in connection with your application. We will treat all personal information about you as confidential.

Underwriting. Your application, together with the medical history you give, provides the initial basis for evaluation. The Company relies on the accuracy and completeness of your answers and may make inquiries, both before and after a policy is issued, to verify this information.

Sources of Information. The Company may request additional information from your physician(s) or hospital(s) or other medical professionals, or medical care institutions, the Medical Information Bureau (MIB), other insurance institutions to which you have applied for insurance, your employers, agents of the Company, business associates, a governmental entity, financial institution, or consumer reporting agency. Your signature on the Acknowledgement and Medical Authorization Form permits the Company to make these inquiries. Such inquiries may be made by telephone, written correspondence, or personal interview. If the Company requests information from another insurance company, it will not request underwriting action. You have the right to know what information we have about you, to copy it, and if it is incorrect, to have it corrected. If the Company received information about you from an insurance support organization, such information may be retained by the organization and released to others. In this connection, the following notice is given to you as required by the federal and various state Fair Credit Reporting Acts. You have the right to access and correction with respect to this information. If you wish a more detailed explanation of information practices, please send your written request to American Memorial Life Insurance Company, P.O. Box 2730, Rapid City, SD 57709.

Fair Credit Reporting Act Pre-Notice. In some cases, the Company may ask an independent agency to prepare an investigative consumer report for you. This report may include information about your character, general reputation, personal characteristics such as health, finances, and mode of living, except as may be related directly or indirectly to your sexual orientation. Any information obtained by an investigative agency may be kept in its file and later given to others who have a business need for it. If an investigative consumer report is ordered by the Company, the report will include information obtained through interviews with your neighbors, friends, or others with whom you are acquainted. You may request to be interviewed in connection with the preparation of the investigative consumer report. You may request, in writing, to receive information from the Company about the nature and scope of an investigative consumer report. Within five (5) business days of receipt of such request, the Company will provide you with the name, address, and phone number of any agency the Company asks to prepare such a report. You should contact them to obtain a copy of the report.

Medical Information Bureau, Inc. Pre-Notice. Information regarding your insurability will be treated as confidential. American Memorial Life Insurance Company or its reinsurers may, however, make a brief report thereon to the MIB, Inc., formerly known as Medical Information Bureau, a not-for-profit membership organization of insurance companies, which operates an information exchange on behalf of its members. If you apply to another MIB member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, MIB, upon request, will supply such company with the information about you in its file.

Upon receipt of a request from you, MIB will arrange disclosure of any information in your file. Please contact MIB at 866-692-6901 (TTY 866-346-3642). If you question the accuracy of the information in MIB's file, you may contact MIB and seek a correction in accordance with the procedures set forth in the federal Fair Credit Reporting Act. The address of MIB's information office is 50 Braintree Hill Park, Suite 400, Braintree, Massachusetts 02184-8734.

American Memorial Life Insurance Company, or its reinsurers, may also release information from its file to other insurance companies to whom you may apply for life and health insurance, or to whom a claim for benefits may be submitted. Information for consumers about MIB may be obtained on its website at www.mib.com.

Conditional Premium Receipt

THIS RECEIPT PROVIDES COVERAGE ONLY IF CONDITIONS BELOW ARE MET.

The Company hereby acknowledges receipt of the initial premium from the Proposed Insured for which an application for insurance is made to American Memorial Life Insurance Company on the date of application and for the premium collected as stated on the application for insurance.

Life insurance and any additional benefits in the amount applied for shall be deemed to take effect as of the date of this application, subject to the terms and conditions printed below.

Conditions of Life Insurance Coverage (Please read carefully).

Subject to the limitations of this receipt and the terms and conditions of the policy that may be issued by the Company on the basis of the application, the life insurance and any additional benefits applied for will not be deemed to take effect unless the Company, after investigation and such medical examination (if any) as it may require, is satisfied that on the date of the application the person proposed for insurance was insurable for the amount of life insurance and any additional benefits applied for according to the Company's rules and practice of selection; provided, however, that approval by the Company of the insurability of the Proposed Insured for a plan of insurance other than that applied for shall not invalidate the terms and conditions for the receipt relating to life insurance and any other additional benefit applied for.

The amount received shall be refunded if the application is declined or if a policy is issued other than as applied for and is not accepted. Any check, draft or money order is received subject to collection.

American Memorial Life Insurance Company or its reinsurers may also release limited information in its file to other properly authorized life insurance companies to whom you may apply for life or health insurance or to whom a claim for benefits may be submitted.

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DEFINITIONS

"We," "Us," and "Our" mean American Memorial Life Insurance Company.

"You" and "Your" refer to the person named as owner on the Policy Data Page. The insured is the owner, unless someone other than the insured is named. Your rights are described in the General Provisions.

"Contingent Owner" is the person named by you to succeed you to the rights and privileges of this policy upon your death.

"Insured" means the person named on the Policy Data Page.

"Beneficiary" means the person named in the application, or in a later change of beneficiary, to receive all or part of the death benefits in the event of the insured's death.

"Irrevocable Beneficiary" is a beneficiary named by you that cannot be changed, nor can other policy changes be made, without his or her written permission.

"Age" means the insured's age as of the insured's last birthday.

"Issue Date" means the date this policy goes into effect. The policy anniversary, policy year and/or months, and premium due date are computed from this date.

"Policy Debt" means debt owed to us against this policy and includes any interest accrued to date.

"Lapse" is the termination of the policy due to nonpayment of premiums, subject to the Nonforfeiture Options.

"Reinstatement" means to restore coverage after the policy has lapsed.

"Cash Value" means the guaranteed value of the insured's policy.

"Per Capita Beneficiary Designation" means a beneficiary designation under which life insurance policy proceeds are shared only by the named group of beneficiaries to receive an equal share of life insurance proceeds for those members who survive the insured.

"Non-Nicotine" means no use of cigarettes, cigars, pipe or chewing tobacco, nicotine gum, nicotine patches, or other products containing nicotine in the past twelve (12) months from the date of application.

DEATH BENEFITS

The amount of the death benefit depends on the time of the insured's death and is equal to:

1. the face amount shown on the Policy Data Page; less
2. any policy debt; less
3. any due premium; plus
4. the premium paid for any period beyond the policy month in which death occurred.

We will pay interest on the death benefit at a rate not less than that required by state law.

If the insured lives to age 100, you may elect to have the benefit payable under this policy paid as a lump sum to you or held by us as a fund-on-deposit. Funds-on-deposit bear interest at a rate determined by us. Interest earned on the fund-on-deposit will be taxable to you. Unless we are otherwise notified by you, the automatic option will be to hold the benefit in a fund-on-deposit to continue to allow for availability.

FACILITY OF PAYMENT

We will pay death claim proceeds to the estate of the insured if:

1. no one described in the Payment of Proceeds paragraph files a claim after the death of the insured; or
2. the beneficiary is a minor; or
3. the beneficiary is incompetent.

Instead of making payment to the estate of the insured, we may pay death claim proceeds to any relative by blood or marriage who:

1. in our judgment is equitably entitled to the proceeds; or
2. is responsible for the burial of the insured.

If the law of your state does not permit payment as described above, we will pay death claim proceeds to the estate of the insured.

BENEFICIARY PROVISIONS

Proof of Death - Evidence satisfactory to the company. The death benefit will be paid when we receive due proof of the insured's death. Such proof must be submitted to us at our home office. Claim forms will be made available to the beneficiary.

Payment of Proceeds - Death benefits will be paid to the beneficiary in a lump sum. If a beneficiary dies before the insured, the interest of that beneficiary will end at his or her death. If there are two or more persons named as the primary beneficiary, we will make payment in equal shares to the beneficiaries. If there are no other designated beneficiaries, the death benefit will be paid to you. If you are not living, proceeds will be paid to the contingent owner, if one is named. If there is no contingent owner, the proceeds will be paid to the estate of the insured or to any of the insured's closest living relatives by blood, by legal adoption, or by marriage.

Exclusions - You will not be covered by this insurance policy if death results directly from commission of a felony.

Changing a Beneficiary - You may change the beneficiary while the insured is living by providing us with a written request. A beneficiary change will not be effective until recorded by us at our home office. If the insured dies before we receive the change, the change will take effect on the date you signed the request. Any proceeds paid before we record a change of beneficiary will not be subject to the change.

GENERAL PROVISIONS

Incontestability - This policy will be incontestable after it has been in force during the lifetime of the insured for a period of two (2) years from the issue date.

Age or Sex - If the insured's age or sex has been misstated, the amount payable under this policy will be the amount the premium paid would have purchased had the age or sex been correctly stated at the issue date.

Assignment of Policy - This policy may be assigned. No assignment will be binding on us until an executed copy is received at our home office. We assume no responsibility for the validity of any assignment. Your rights and the rights of the beneficiary may be limited by the rights of an assignee.

Administrative Services - We reserve the right to charge a reasonable fee for administrative type services not to exceed twenty five dollars (\$25).

The Entire Contract - This policy and the application, a copy of which is attached, and any attached endorsements or riders, constitute the entire contract. Statements made in the application, in the absence of fraud, are considered representations and not warranties. No statement will void this policy or be used in defense of a claim unless it is contained in the written application.

GENERAL PROVISIONS (cont)

Who is Authorized to Make Changes – Only our President, Vice President, or Secretary has the power to change any provision of this policy. Any changes must be in writing. No agent or person other than the above-named officers has the authority to change or modify this policy or waive any of its provisions.

Suicide – If, within two (2) years from the issue date, the insured dies as the result of suicide, while sane or insane, our liability will be limited to the return of premiums paid, less policy debt.

Policy Debt – Policy debt will be deducted from any settlement under this policy.

Policy Owner – Before the insured's death, only you will be entitled to the rights granted by this policy. These rights are limited if the policy has been assigned or if an irrevocable beneficiary has been named. If you die before the insured, your rights belong to the contingent owner, if one is named; otherwise, your rights belong to the insured.

Change in Plan – This policy may be changed to another plan of insurance with our consent. A change of plan will be subject to the requirements and payment of charges as we determine.

Nonparticipating – This policy does not participate in our profits or surplus.

Mediation – In the event of any dispute with respect to the policy, parties are invited to consider mediation. Said mediation is not mandatory. It is optional and nonbinding unless both parties agree to it. This provision shall be inapplicable in those states that prohibit the use of mediation provisions.

TERMINATION

Termination of a Policy – A policy will terminate upon the death of the insured, maturity or endowment of the policy, or surrender of the policy.

PREMIUMS AND REINSTATEMENT

Premiums – To keep this policy in force, premiums must be paid during the lifetime of the insured on or before the date they are due. All premiums must be paid at our home office or to an agent authorized by us. Upon request, we will issue a receipt for any premiums paid. The first premium is due as of the issue date. Subsequent premiums are payable while the insured is living and within the grace period. If any premium remains unpaid after the grace period, this policy will lapse, subject to the Automatic Premium Loan and Nonforfeiture Options.

Grace Period – A thirty-one (31) day grace period will be allowed for the payment of each premium after the first, during which time this policy will remain inforce. The grace period does not change any due date. If the premium has not been paid, and the insured dies within the grace period, the amount of the premium due will be deducted from the proceeds payable.

Reinstatement – A written request for reinstatement must be made within five (5) years from the date of premium in default. The following conditions must also be met:

1. We must be provided with evidence of insurability satisfactory to us;
2. All past-due premiums must be paid, with interest compounded annually, at the rate of six percent (6%) per year;
3. The premium due at the time of reinstatement must be paid;
4. Any policy debt that existed at the time of lapse must be paid or reinstated, with interest compounded annually at the rate of six percent (6%) per year; and
5. The policy has not been surrendered for its cash value.

LOAN PROVISIONS

Loans – You can borrow against the policy, by making a written request, subject to the following conditions:

1. The maximum amount that can be borrowed is the cash value at the end of the policy year in which the loan is made, less
 - a. any existing policy debt;
 - b. interest on the loan to the end of the policy year; and
 - c. premiums payable to the end of the policy year.
2. The interest rate payable on policy debt will be six percent (6.0%) per year payable in arrears. If interest is not paid when due, it will be added to policy debt and will bear interest at the same rate.
3. The written consent of all assignees and of any irrevocable beneficiary must be obtained in writing before a loan can be made.
4. Extended Term Insurance has no loan value.
5. The policy is assigned to us while there is a loan.

Repayment – Unless policy debt has been repaid under a Nonforfeiture Option, any part of the policy debt may be repaid during the life of the insured. Failure to repay policy debt will terminate this policy only if the policy debt exceeds the cash value and thirty-one (31) days have passed after we mailed notice of termination to your last known address and the address of any assignee of record.

Automatic Premium Loan – If this option is selected, any premium that remains unpaid at the end of the grace period will be paid by charging the premium as a loan against the policy. You will be notified if a premium loan is made. You may terminate this provision by notifying us in writing. All automatic premium loans will be subject to the same terms as any other loan made on this policy.

The premium charged as a loan will be the premium necessary to keep the policy in force to the next policy anniversary. If the cash value is not enough to allow that amount to be charged, no less than a monthly premium will be charged. If the cash value is not enough for a monthly premium to be charged, the Nonforfeiture Options will apply.

NONFORFEITURE OPTIONS

The values shown in the Policy Values page may be used to provide extended term insurance, paid up insurance, or taken in cash upon surrender of this policy. You may elect, within three (3) months after the due date of the premium in default, any of the following options:

Option I, Cash Surrender – You may surrender this policy to us at our home office for the cash value. Cash values for all years will be equal to the present value of future benefits, less the present value of future nonforfeiture factors, and less policy debt. The cash value within ninety (90) days after the due date of any premium in default will be the same as the cash value on the premium due date. If the policy has been assigned, or if an irrevocable beneficiary has been named, you may not surrender the policy without the assignee's or the irrevocable beneficiary's consent.

Option II, Extended Term Insurance – You may continue this policy as extended term insurance in an amount equal to the death benefit decreased by the amount of any policy debt, for a term starting with the due date of the unpaid premium and for such a period as the net cash value will purchase at the insured's then attained age.

Any insurance continued in force under Option II may be surrendered for a cash surrender value not less than the present value of future guaranteed benefits on such anniversary.

Option III, Paid Up Insurance – This policy may be continued as paid up insurance beginning on the due date of the unpaid premium. Paid up insurance will stay in force for the lifetime of the insured unless it is surrendered. The initial amount of paid up insurance is the amount the net cash value will buy according to the Basis of Computation section.

Automatic Nonforfeiture Option – If the cash value exceeds five hundred dollars (\$500), the automatic nonforfeiture option is paid up insurance. If the cash value amount available is five hundred dollars (\$500) or less, the automatic nonforfeiture option is Option II, Extended Term Insurance. The automatic nonforfeiture option will take effect as of the due date of any premium in default if an option has not been elected within thirty (30) days of any such due date.

Deferral of Payment of Cash Value and Loans – We may defer payment of any cash value or loan, except for loans taken for the purpose of paying premiums on any policy issued by us. Payment may be deferred for the period permitted by law, but not in excess of six (6) months after the request is received at our home office.

Guaranteed Values – The guaranteed values of this policy are shown in the Policy Values page. The values shown assume no indebtedness. The cash value between two consecutive dates shown will be determined by interpolation. Allowance will be made for the premiums paid for the period between such dates. The cash surrender and nonforfeiture values are in excess of, or equal to, the minimum values required by the state in which this policy is delivered. Values for years not shown will be furnished upon request.

Basis of Computation – The mortality and interest bases for nonforfeiture values, present values, and net single premiums are listed on the Policy Data Page. All such computations take into account that the policy is issued on the basis of the insured's age last birthday and are based on the assumption that premiums are payable annually. Nonforfeiture values are calculated under the assumption that death claims are paid at the end of the year. A detailed statement of the method of computation of the values and benefits shown in the policy has been filed with the insurance supervisory official of the state in which the policy is delivered.

**WHOLE LIFE INSURANCE
PREMIUMS PAYABLE FOR LIFE
ENDOWMENT AT AGE 100
NONPARTICIPATING**

P-1073-S

9/08

SERFF Tracking Number: ASLX-125866127 State: Arkansas
Filing Company: American Memorial Life Insurance Company State Tracking Number: 40625
Company Tracking Number: LF AR01101AMF01
TOI: L08 Life - Other Sub-TOI: L08.000 Life - Other
Product Name: Whole Life Insurance Premiums Payable for Life End
Project Name/Number: Whole Life Insurance Premiums Payable for Life Endowment at Age 100 Nonparticipating/LF AR01101AMF01

Rate Information

Rate data does NOT apply to filing.

SERFF Tracking Number: ASLX-125866127 State: Arkansas
Filing Company: American Memorial Life Insurance Company State Tracking Number: 40625
Company Tracking Number: LF AR01101AMF01
TOI: L08 Life - Other Sub-TOI: L08.000 Life - Other
Product Name: Whole Life Insurance Premiums Payable for Life End
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Supporting Document Schedules

Review Status:
Satisfied -Name: Certification/Notice 10/20/2008
Comments:
Attachment:
Certification.PDF

Review Status:
Satisfied -Name: Cover Letter 10/20/2008
Comments:
Cover Letter
Attachment:
Cover Letter.PDF

Review Status:
Satisfied -Name: Demo - smoker, Demo - nonsmoker 10/20/2008
Comments:
Demos
Attachments:
Demo - smoker.PDF
Demo - nonsmoker.PDF

Review Status:
Satisfied -Name: revised certification 10/28/2008
Comments:
Attachment:
revised certification.PDF



AR K A N S A S

Certification

I hereby certify that the guidelines of the Arkansas Insurance Department Bulletin #11-83 have been reviewed and to the best of my knowledge, information and belief, policy forms **P-1073-S and P-1143** comply with these guidelines.

A handwritten signature in cursive script, reading "Jennifer Dunlap", written over a horizontal line.

Jennifer Dunlap
Compliance Analyst

October 16, 2008

Date



AR K A N S A S

Flesch Score Certification

This is to certify that the attached Life/Annuity form numbers P-1073-S and P-1143, have achieved flesch scores of, 48.6 and 40.70 (combined with P-1073-S), and comply with the requirements of Arkansas Statutes Ann 66-3251 through 66-3258, cited as the Life and Disability Insurance Policy Language Simplification Act.



Jennifer Dunlap
Compliance Analyst

October 16, 2008
Date



October 16, 2008

Arkansas Department of Insurance
1200 W. Third Street
Little Rock, AR 72201-1904

RE: American Memorial Life Insurance Company
NAIC #0019-67989 FEIN #46-0260270
Individual Whole Life Insurance Filing
P-1073-S Whole Life Insurance Policy Premiums Payable for Life
P-1143 Application for Insurance

Dear Commissioner:

Enclosed for your review are forms P-1073-S and P-1143. These are new forms and they do not replace any forms previously approved by you. Form P-1073-S achieves a readability score of 48.6 and P-1143 (scored with P-1073-S) achieves a readability score of 40.7.

These forms were approved by our state of domicile, South Dakota, on October 7, 2008.

To the best of my knowledge and belief, these forms contain no new, unusual or possibly controversial provisions.

Policy Form P-1073-S is a nonparticipating whole life insurance plan with premiums payable for life.

Application Form P-1143 will be used to issue these policies as well as any policies approved by you to which it would apply

American Memorial Life Insurance Company is partnered with the largest funeral home organization in North America, Service Corporation International (SCI). This product and application will be used with a final expense marketing program. The intent of the program is for the customer to eventually fund their funeral with this product. No advertising materials have been developed.

We, American Memorial Life Insurance Company, will not be illustrating the referenced life policy forms. Should our decision not to illustrate change, we will notify the Department of our intent to illustrate.

Your review of the enclosed filing materials is appreciated. If you have any questions, please feel free to contact me. I can be reached by phone (605-719-0073), by fax (605-719-0473) or by e-mail (jennifer.dunlap@assurant.com).

Sincerely,

AMERICAN MEMORIAL LIFE INSURANCE COMPANY

A handwritten signature in cursive script that reads "Jennifer Dunlap".

Jennifer Dunlap
Compliance Analyst

:jld

American Memorial Life Insurance Company
Statement of Variations
P-1073-S
P-1143

These items can be included as shown or changed as follows:

- [1] The address and/or telephone number could change in the future.
- [2] The signatures and/or titles of the Secretary and President could change in the future.
- [3] The interest rates for the Basis of Computation could change in the future.
- [4] The Mortality Table for the Basis of Computation could change in the future.
- [5] The HIPAA privacy rules could change in the future.
- [6] Section **6. Plan** – In the future, there could be possible changes to this section of removing or adding a product and/or particular payment plan (3 pay, 5 pay, etc.). This could happen due to changes in our marketing plan. However, please note that we will not add any products or payment plans that have not been approved by you.
- [7] Outside company/organizations address and/or telephone number could change in the future.

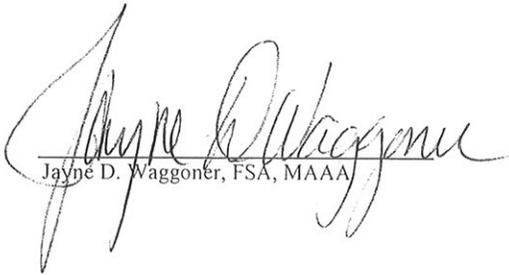
In addition to the items listed above, this form is subject to only minor modification in paper size and stock, ink, shading, border, company logo and adaptation to computer printing.

Actuarial Demonstration

Form P-1073

Whole Life
Level Death Benefit
Endowment at Age 100

The reserves are calculated at four percent (4.0%) interest according to the Commissioners Reserve Valuation Method. Cash values are calculated at five percent (5.0%) according to the Standard Nonforfeiture Law. The mortality basis is 2001 CSO Ultimate sex-distinct/smoker distinct, age last birthday. Semi-continuous functions are used for reserves, and curtate functions are used for cash values and extended term insurance.


Jayne D. Waggoner, FSA, MAAA


Date

Let: $x =$ age at issue	$x =$	35
$n =$ premium paying period of plan	$n =$	65
$m =$ benefit period = 100 - x	$m =$	65
$t =$ policy duration	$t =$	policy duration
${}_tDB_x =$ death benefit for year t	${}_tDB_{35} =$	1,000

Male/Smoker, age 35 illustrated

Formulas for Valuation Net Premiums and Reserves (per \$1,000 initial face amount)

Equivalent Level Renewal Amount

$$s_x = \frac{\sum_{t=1}^j {}_tDB_x}{j-1}, \text{ where } j \text{ is the lesser of } 10 \text{ and } m \quad s_{35} = 1,000.00$$

Present Value of Benefits

$$\bar{A}_x = \frac{i}{\delta} \sum_{k=0}^{m-1} v^{k+1} q_{x+k+1} {}_{t+k}DB_x \quad \bar{A}_{35} = 253.14369$$

$${}_1\bar{A}_{35} = 261.71522$$

$${}_9\bar{A}_{35} = 339.50691$$

The preceding subscript is dropped if $t=0$

Renewal Valuation Net Premium

${}^{FPT}P_{x(1)} =$ Renewal Net Premium for Full Preliminary Term	${}^{FPT}P_{35(1)} =$	13.54075
${}_{19}P_{x+1} =$ FPT Renewal Net Premium for \$1 of 20-Pay Life	${}_{19}P_{35+1} =$	0.01970
$\bar{A}_{x:1}^1 =$ Present value of benefits for one-year term insurance	$\bar{A}_{35:1}^1 =$	2.01032
$\ddot{a}_{x:n} =$ n-year life annuity due at age x	$\ddot{a}_{35:65} =$	19.54649

$$\beta = \frac{\bar{A}_x + \min \left[\frac{{}^{FPT}P_{x(1)}}{{}_{19}P_{x+1}} - \bar{A}_{x:1}^1 \right]}{\ddot{a}_{x:n}} \quad \beta = 13.54075$$

First Year Valuation Net Premium

$a_{x:n-1} =$ (n-1)-year life annuity immediate at age x	$a_{35:64} =$	18.54649
$\alpha = \bar{A}_x - \beta a_{x:n-1}$	$\alpha =$	2.01029

Terminal Reserve at end of year t

$\ddot{a}_{x+t:n-t} =$ (n-t)-year life annuity due at age $x+t$	$\ddot{a}_{36:64} =$	19.32797
	$\ddot{a}_{44:56} =$	17.34464
${}_tV_x = \bar{A}_x - \beta \ddot{a}_{x+t:n-t}$	${}_1V_{35} =$	-
	${}_9V_{35} =$	104.65

In computing reserves, any negative terminals are regarded as zero.

The mean reserve is never less than one-half of the year's cost of insurance.

Formulas for Nonforfeiture Premiums and Cash Values (per \$1,000 initial face amount)

Average amount of first 10 years' initial death benefits

$$s_x = \frac{\sum_{t=1}^j {}_tDB_x}{j}, \text{ where } j \text{ is the lesser of 10 and } m$$

	$s_{35} =$	1,000.00
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Present Value of Benefits

$${}_tA_x = \sum_{k=0}^{m-t} v^{k+1} {}_{k+t}P_x q_{x+k+1} {}_{t+k}DB_x$$

	$A_{35} =$	184.88545
	${}_1A_{35} =$	192.47430
	${}_5A_{35} =$	225.82346

Net Level Premium

$$\ddot{a}_{x:\overline{m}} = n\text{-year life annuity due at age } x$$

	$\ddot{a}_{35:\overline{65}} =$	17.11741
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$${}^{NL}P_x = \frac{A_x}{\ddot{a}_{x:\overline{m}}}$$

	${}^{NL}P_{35} =$	10.80102
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Expense Allowance

$$EA_x = .01 s_x + 1.25 \min \left[\begin{array}{l} .04 s_x \\ {}^{NL}P_x \end{array} \right]$$

	$EA_{35} =$	23.50128
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Nonforfeiture factor

$${}^{NF}P_x = \frac{A_x + EA_x}{\ddot{a}_{x:\overline{m}}}$$

	${}^{NF}P_{35} =$	12.17397
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Cash Value at end of year t

$$\ddot{a}_{x+t:\overline{n-t}} = (n-t)\text{-year life annuity due at age } x+t$$

	$\ddot{a}_{36:\overline{64}} =$	16.95804
	$\ddot{a}_{40:\overline{60}} =$	16.25771

$${}_tCV_x = {}_tA_x - {}^{NF}P_x \ddot{a}_{x+t:\overline{n-t}}$$

	${}_1CV_{35} =$	-
	${}_5CV_{35} =$	27.90

Extended Term Insurance Beginning End of Year t

	$t =$	5
	${}_5CV_{35} =$	27.90
	$A_{40:\overline{8}} =$	25.99
	$A_{40:\overline{9}} =$	29.65
	\therefore	$8 < s < 9$

Partial Year: $\frac{27.90 - 25.99}{29.65 - 25.99} \times 365 = 190.48$

Term of Insurance: $s = 8 \text{ years } 191 \text{ days}$

Reduced Paid Up Insurance at the end of policy year t $t = 5$

Present Value of Benefits

$$A_{x+t} = \sum_{k=0}^{m-t} v^{k+1} {}_kP_{x+t} q_{x+k+1}$$

	$A_{35+5} =$	0.22582
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Amount of reduced paid up insurance

$$F = \frac{{}_tCV_x}{A_{x+t}}$$

	$F =$	123.55
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Actuarial Demonstration

Form P-1073

Whole Life
Level Death Benefit
Endowment at Age 100

The reserves are calculated at four percent (4.0%) interest according to the Commissioners Reserve Valuation Method. Cash values are calculated at five percent (5.0%) according to the Standard Nonforfeiture Law. The mortality basis is 2001 CSO Ultimate sex-distinct/smoker distinct, age last birthday. Semi-continuous functions are used for reserves, and curtate functions are used for cash values and extended term insurance.


Jayne D. Waggoner, FSA, MAAA


Date

Let: $x =$ age at issue	$x =$	35
$n =$ premium paying period of plan	$n =$	65
$m =$ benefit period = 100 - x	$m =$	65
$t =$ policy duration	$t =$	policy duration
${}_tDB_x =$ death benefit for year t	${}_tDB_{35} =$	1,000

Male/Non-Smoker, age 35 illustrated

Formulas for Valuation Net Premiums and Reserves (per \$1,000 initial face amount)

Equivalent Level Renewal Amount

$$s_x = \frac{\sum_{t=1}^j {}_tDB_x}{j-1}, \text{ where } j \text{ is the lesser of 10 and } m \quad s_{35} = 1,000.00$$

Present Value of Benefits

$$\bar{A}_x = i/\delta \sum_{k=0}^{m-t} v^{k+1} q_{x+k+1} {}_{t+k}DB_x \quad \bar{A}_{35} = 208.10021$$

$${}_1\bar{A}_{35} = 215.52336$$

$${}_9\bar{A}_{35} = 284.43392$$

The preceding subscript is dropped if $t=0$

Renewal Valuation Net Premium

${}^{FPT}P_{x(1)} =$ Renewal Net Premium for Full Preliminary Term	${}^{FPT}P_{35(1)} =$	10.51048
${}_{19}P_{x+1} =$ FPT Renewal Net Premium for \$1 of 20-Pay Life	${}_{19}P_{35+1} =$	0.01601
$\bar{A}_{x:\overline{1} } =$ Present value of benefits for one-year term insurance	$\bar{A}_{35:\overline{1} } =$	1.09832
$\ddot{a}_{x:\overline{n} } =$ n -year life annuity due at age x	$\ddot{a}_{35:\overline{65} } =$	20.69480

$$\beta = \frac{\bar{A}_x + \min \left\{ \begin{matrix} {}^{FPT}P_{x(1)} \\ s_x {}_{19}P_{x+1} \end{matrix} \right\} - \bar{A}_{x:\overline{1}|}}{\ddot{a}_{x:\overline{n}|}} \quad \beta = 10.51048$$

First Year Valuation Net Premium

$a_{x:\overline{n-1} } =$ $(n-1)$ -year life annuity immediate at age x	$a_{35:\overline{64} } =$	19.69480
$\alpha = \bar{A}_x - \beta a_{x:\overline{n-1} }$	$\alpha =$	1.09836

Terminal Reserve at end of year t

$\ddot{a}_{x+t:\overline{n-t} } =$ $(n-t)$ -year life annuity due at age $x+t$	$\ddot{a}_{36:\overline{64} } =$	20.50556
	$\ddot{a}_{44:\overline{56} } =$	18.74842
${}_tV_x = {}_t\bar{A}_x - \beta \ddot{a}_{x+t:\overline{n-t} }$	${}_1V_{35} =$	-
	${}_9V_{35} =$	87.38

In computing reserves, any negative terminals are regarded as zero.

The mean reserve is never less than one-half of the year's cost of insurance.

Formulas for Nonforfeiture Premiums and Cash Values (per \$1,000 initial face amount)

Average amount of first 10 years' initial death benefits

$$s_x = \frac{\sum_{t=1}^j {}_tDB_x}{j}, \text{ where } j \text{ is the lesser of 10 and } m$$

$$s_{35} = 1,000.00$$

Present Value of Benefits

$${}_tA_x = \sum_{k=0}^{m-t} v^{k+1} {}_{k+t}P_x q_{x+k+t} {}_{t+k}DB_x$$

$$A_{35} = 144.71913$$

$${}_1A_{35} = 151.00421$$

$${}_5A_{35} = 178.94858$$

Net Level Premium

$$\ddot{a}_{x:\overline{m}|} = n\text{-year life annuity due at age } x$$

$$\ddot{a}_{35:\overline{65}|} = 17.96090$$

$${}^{NL}P_x = \frac{A_x}{\ddot{a}_{x:\overline{m}|}}$$

$${}^{NL}P_{35} = 8.05746$$

Expense Allowance

$$EA_x = .01 s_x + 1.25 \min \left[\frac{.04 s_x}{{}^{NL}P_x} \right]$$

$$EA_{35} = 20.07183$$

Nonforfeiture factor

$${}^{NF}P_x = \frac{A_x + EA_x}{\ddot{a}_{x:\overline{m}|}}$$

$${}^{NF}P_{35} = 9.17498$$

Cash Value at end of year t

$$\ddot{a}_{x+t:\overline{m-t}|} = (n-t)\text{-year life annuity due at age } x+t$$

$$\ddot{a}_{36:\overline{64}|} = 17.82891$$

$$\ddot{a}_{40:\overline{60}|} = 17.24208$$

$${}_tCV_x = {}_tA_x - {}^{NF}P_x \ddot{a}_{x+t:\overline{m-t}|}$$

$${}_1CV_{35} = -$$

$${}_5CV_{35} = 20.75$$

Extended Term Insurance Beginning End of Year t

$${}_tCV_x = A_{\overline{x+t:\overline{s}|}}$$

$${}_5CV_{35} = 20.75$$

$$A_{40:\overline{11}|} = 19.25$$

$$A_{40:\overline{12}|} = 21.29$$

$$\vdots$$

$$11 < s < 12$$

Partial Year: $\frac{20.75 - 19.25}{21.29 - 19.25} \times 365 = 268.38$

Term of Insurance: $s = 11 \text{ years } 269 \text{ days}$

Reduced Paid Up Insurance at the end of policy year t $t = 5$

Present Value of Benefits

$$A_{x+t} = \sum_{k=0}^{m-t} v^{k+1} {}_kP_{x+t} q_{x+k+t}$$

$$A_{35+5} = 0.17895$$

Amount of reduced paid up insurance

$$F = \frac{{}_tCV_x}{A_{x+t}}$$

$$F = 115.96$$



ARKANSAS

Certification

I hereby certify that the guidelines of the Arkansas Insurance Department Bulletins #11-83, #11-88, #6-87 and the requirements of Arkansas Code 054 00 019 have been reviewed and to the best of my knowledge, information and belief, policy forms **P-1073-S and P-1143** comply with these guidelines.

A handwritten signature in cursive script, reading "Jennifer Dunlap". The signature is written in black ink and is positioned above a horizontal red line.

Jennifer Dunlap
Compliance Analyst

October 28, 2008

Date