

<i>SERFF Tracking Number:</i>	<i>AUWL-125849785</i>	<i>State:</i>	<i>Arkansas</i>
<i>Filing Company:</i>	<i>Century Life Assurance Company</i>	<i>State Tracking Number:</i>	<i>40483</i>
<i>Company Tracking Number:</i>	<i>MDT(09)</i>		
<i>TOI:</i>	<i>L04I Individual Life - Term</i>	<i>Sub-TOI:</i>	<i>L04I.104 Renewable - Joint (First to Die) - Fixed Premium/Indeterminate Premium</i>
<i>Product Name:</i>	<i>MDT(09)</i>		
<i>Project Name/Number:</i>	<i>MDT(09)/</i>		

Filing at a Glance

Company: Century Life Assurance Company

Product Name: MDT(09)

TOI: L04I Individual Life - Term

Sub-TOI: L04I.104 Renewable - Joint (First to Die) - Fixed Premium/Indeterminate Premium

Filing Type: Form

SERFF Tr Num: AUWL-125849785 State: ArkansasLH

SERFF Status: Closed

State Tr Num: 40483

Co Tr Num: MDT(09)

State Status: Approved-Closed

Co Status:

Reviewer(s): Linda Bird

Author: Linda DeStasio

Disposition Date: 10/22/2008

Date Submitted: 10/08/2008

Disposition Status: Approved

Implementation Date Requested: On Approval

Implementation Date:

State Filing Description:

General Information

Project Name: MDT(09)

Project Number:

Requested Filing Mode:

Explanation for Combination/Other:

Submission Type: New Submission

Overall Rate Impact:

Filing Status Changed: 10/22/2008

State Status Changed: 10/22/2008

Corresponding Filing Tracking Number:

Filing Description:

Status of Filing in Domicile: Pending

Date Approved in Domicile:

Domicile Status Comments:

Market Type: Individual

Group Market Size:

Group Market Type:

Deemer Date:

This is a monthly decreasing term insurance for single or joint insureds. It is an individual product sold by independent agents. It is designed to provide coverage for a mortgage loan that amortizes at 9%. It can also be sold by bank insurance agents. It is not credit insurance. It is not sold with an illustration.

Company and Contact

SERFF Tracking Number: AUWL-125849785 State: Arkansas
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 Premium/Indeterminate Premium

 Product Name: MDT(09)
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Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved	Linda Bird	10/22/2008	10/22/2008

Objection Letters and Response Letters

Objection Letters				Response Letters		
Status	Created By	Created On	Date Submitted	Responded By	Created On	Date Submitted
Pending Industry Response	Linda Bird	10/22/2008	10/22/2008	Linda DeStasio	10/22/2008	10/22/2008

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Disposition

Disposition Date: 10/22/2008

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		Yes
Supporting Document	Life & Annuity - Acturial Memo		No
Form	Policy		Yes
Form (revised)	Application		Yes
Form	Application		Yes

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Objection Letter

Objection Letter Status Pending Industry Response
Objection Letter Date 10/22/2008
Submitted Date 10/22/2008

Respond By Date

Dear Linda DeStasio,

This will acknowledge receipt of the captioned filing.

Objection 1

- Application (Form)

Comment: Ark. Code Ann. 23-66-503(a) requires a statement in an application substantially the same as that included in the statute.

Please feel free to contact me if you have questions.

Sincerely,

Linda Bird

Response Letter

Response Letter Status Submitted to State
Response Letter Date 10/22/2008
Submitted Date 10/22/2008

Dear Linda Bird,

Comments:

Response 1

Comments: Linda:

Sorry about that. I know better. Attached is an amended application including the required fraud warning. It is the second paragraph above the signatures on page 2. No other changes were made.

Linda

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Project Name/Number: MDT(09)/

Related Objection 1

Applies To:

- Application (Form)

Comment:

Ark. Code Ann. 23-66-503(a) requires a statement in an application substantially the same as that included in the statute.

Changed Items:

No Supporting Documents changed.

Form Schedule Item Changes

Form Name	Form Number	Edition Date	Form Type	Action	Action Specific Data	Readability Score	Attach Document
Application	MDT(09)-App(AR)		Application/Enrollment Form	Initial		40	MDT(09) App CLA Ar.pdf
<i>Previous Version</i>							
<i>Application</i>	<i>MDT(09)-App</i>		<i>Application/Enrollment Form</i>	<i>Initial</i>		<i>40</i>	<i>MDT(09) Application.pdf</i>

No Rate/Rule Schedule items changed.

Sincerely,
Linda DeStasio

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Form Schedule

Lead Form Number: MDT(09)

Review Status	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
	MDT(09)	Policy/Cont	Policy ract/Fratern al Certificate	Initial		52	MDT(09) (9% Amort).pdf
	MDT(09)- App(AR)	Application/	Application Enrollment Form	Initial		40	MDT(09) App CLA Ar.pdf

CENTURY LIFE ASSURANCE COMPANY
 Oklahoma City, Oklahoma
 1035 South 183rd Street West, Goddard, Kansas 67052
 Mailing Address: P.O. Box 9510, Wichita, Kansas 67277

Monthly Decreasing Term. Renewal premiums subject to change. [30] year term period. Non-participating.

<p>Insured(s): [John Doe] [Jane Doe] Age/Sex: [35 Male] [35 Female] Policy Number: [00000] Initial Amount of Insurance: \$[10,000] Date of Issue: [01/01/0000] Term Period: [30 years] State of Issue [AS] The Initial Premium is: \$[xx.xx] The Maximum Annual Premium is: \$[xx.xx] Settlement Options: Annuity 2000 Table at 2.5%</p>	<p>Policy Schedule Risk Classification: [Standard] Table Rating Factor: [none] Reinstatement Interest Rate: 5% Expiry Date: [01/01/0000]</p> <p><u>Total Premiums Including Any Riders</u> Annual Premium: \$[xx.xx] Semi-Annual Premium: \$[xx.xx] Quarterly Premium: \$[xx.xx] Bank Draft: \$[xx.xx] Reserve Interest Rate: 4.00% Nonforfeiture Interest Rate: 5.00%</p>
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Riders:	Amount	First Premium
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If you die while this policy is in force, we will pay an amount equal to (a) the Initial Amount of Insurance, divided by \$1,000, (b) multiplied by the death benefit indicated in the Schedule of Death Benefits for the policy month of death and for the term period as shown above, to your Beneficiary. Such payment will be reduced by any due and unpaid premium.

- We will increase such payment by:
1. The amount of any premiums paid for periods beyond the policy month in which you die; and
 2. The amount of any benefits provided by any rider which is a part of this policy.

TWENTY DAY RIGHT TO EXAMINE THIS POLICY

This policy is a legal contract between the Owner and us. READ IT CAREFULLY. The Owner has the right to return this policy to us at our Home Office or to the Agent who delivered it within 20 days after it was received. If returned, we will cancel the policy and return any premium paid. The Owner and we will then be in the same position as if no policy had been issued.

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

Cindy Hawkins
 Secretary

Gene F. Wilson
 President

This policy is a legal contract between the Company and the Owner. Please read it carefully. We want you to understand the coverage it provides.

Policy Contents	Page
Policy Schedule.....	1
Initial Amount of Insurance.....	1
Term Period.....	1
Schedule of Death Benefits per \$1,000 of Initial Amount of Insurance.....	3
Definitions.....	5
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Premium Adjustment Provision.....	5
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Cash Values, if any.....	9

When writing to Century Life Assurance Company, please include the policy number, the Insured's full name, and the Owner's name and current address.

SCHEDULE OF DEATH BENEFITS PER \$1,000 OF INITIAL AMOUNT OF INSURANCE (9% Amortization)

The Death Benefit for this Policy reduces on a monthly basis. The Death Benefit per \$1,000 shown for each policy year is the Death Benefit per \$1,000 applicable in the first month of that policy year. The Death Benefit per \$1,000 applicable in any month thereafter of that policy year will be the Death Benefit per \$1,000 applicable in the preceding month reduced by one-twelfth of the difference between (a) the Death Benefit per \$1,000 indicated for that policy year and (b) the Death Benefit per \$1,000 indicated for the following policy year.

Policy Year	10 Year Term Period	15 Year Term Period	20 Year Term Period	25 Year Term Period	30 Year Term Period
1	\$1,000.00	\$1,000.00	\$1,000.00	\$1,000.00	\$1,000.00
2	935.00	967.00	981.00	989.00	993.00
3	865.00	931.00	961.00	977.00	986.00
4	787.00	891.00	938.00	963.00	978.00
5	703.00	848.00	914.00	949.00	969.00
6	610.00	801.00	887.00	933.00	959.00
7	509.00	749.00	858.00	915.00	948.00
8	398.00	692.00	826.00	896.00	936.00
9	277.00	630.00	791.00	875.00	924.00
10	145.00	563.00	752.00	852.00	910.00
11		489.00	710.00	827.00	894.00
12		408.00	664.00	800.00	878.00
13		319.00	614.00	770.00	859.00
14		222.00	559.00	737.00	839.00
15		116.00	499.00	702.00	817.00
16			433.00	662.00	793.00
17			362.00	620.00	767.00
18			283.00	573.00	738.00
19			197.00	522.00	707.00
20			103.00	466.00	673.00
21				404.00	635.00
22				337.00	594.00
23				264.00	549.00
24				184.00	500.00
25				96.00	446.00
26					388.00
27					323.00
28					253.00
29					176.00
30					92.00

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Definitions

In this Policy:

We, Us and **Our** refer to Century Life Assurance Company, Oklahoma City, Oklahoma.

You and **Your** refer to the person insured under this Policy.

A **rider** is an attachment to the policy which provides additional benefits.

Age means age on the last birthday.

Lapse means termination of the policy for nonpayment of premiums.

The **premium** is the amount paid for the coverage under this Policy.

Reinstatement means to restore coverage after the policy has lapsed.

The **Owner** of this Policy is the person who has the right to change the beneficiary, and to exercise all rights under this Policy.

Term Period means the period during which coverage is provided.

Premium Payment and Reinstatement of a Lapsed Policy

Premiums - To keep this Policy in force, each premium must be paid in advance. All premiums must be paid at our Home Office or to an Agent authorized by us. We will issue a receipt on request. The first premium is due on or before the Date of Issue. Subsequent premiums are payable while you are living and within the Grace Period, but not beyond the Expiry Date. If any premium remains unpaid after the Grace Period, this Policy will lapse. If a part of the premium ceases to be payable under the provisions of a rider, the premium will be reduced accordingly. The frequency of premium payment may be changed on any policy anniversary to any other frequency shown on Page 1.

Grace Period - We will allow a period of 31 days after the premium due date for payment of each premium after the first. During the Grace Period, no interest will be charged on the premium due. If you die during the Grace Period before the premium is paid, the portion of the premium required to provide insurance from the premium due date to the date of your death will be deducted from the proceeds of this Policy.

Date of Issue - The Date of Issue will be used to determine the premium due dates, policy anniversaries and policy years. The Date of Issue is shown on Page 1.

Reinstatement of a Lapsed Policy - If this policy lapses, it may be reinstated subject to the following conditions:

1. An application for reinstatement must be completed by you and the Owner within 5 years of the date of lapse and before the Expiry Date.
2. You must prove at your own expense that you continue to be insurable by our standards.
3. You must pay all premiums due at the rate of interest specified in the Policy Schedule at the time of reinstatement.

Premium Adjustment Provision

The initial premium is guaranteed not to change during the first policy year. At the end of the first policy year and at the end of each policy year thereafter, we may continue or change the amount of premium to be paid during the next policy year. The premium payable for any policy year will never be greater than the maximum premium shown on the Schedule Page. We will inform the Owner before each policy year if there is to be a change in premium applicable for that year.

Any change in premium will be made on the same basis for all Insureds:

1. of the same age and sex at issue;
2. within the same policy size group and premium class; and
3. whose policies were issued in the same calendar year.

A change in the health, occupation or other risk factor after the Date of Issue will not affect any adjustment in premium. Premiums for any benefit rider attached to this policy will not be adjusted, unless the rider provides for such adjustment.

Term Period

Period During Which Coverage is Provided

The Term Period begins on the Date of Issue. The Term Period does not include or extend beyond the Expiry Date shown in the Policy Schedule. Subject to the payment of premiums as due, the Policy will remain in force between the Date of Issue and the Expiry Date.

Conversion Privileges

Changing to Another Plan of Insurance

While this Policy is in force, and before you attain age 65, the Owner may convert it to any other plan of life insurance that we offer in your rate class, except term, at the date of conversion. The Owner must request conversion in writing. The initial premium for the new plan must be at least equal to the premium for this Policy at the time of conversion. The following rules will apply:

1. The face amount of the new policy may not be less than our published minimum for the plan selected. It may not be greater than the death benefit of this Policy on the date of conversion. At least one plan will be available for conversion of the face amount of this Policy.
2. The date of the new policy will be the date of conversion.
3. The premium for the new policy will be at our published rate for the plan selected at the time of conversion. We will use your age on the date of conversion to determine this rate. The new policy will be issued at the class of risk of this Policy.
4. Riders may be added to the new policy if the riders to be added are available at your age on the date of conversion. Evidence of insurability must be furnished for riders not similar to a rider attached to this Policy.
5. This conversion privilege shall not apply while the policy premiums are being waived under any rider for waiver of premium.

Beneficiary Provisions

Who Receives the Proceeds - Any proceeds payable because of your death will be paid to the Beneficiary. Unless changed as provided below, the Beneficiary will be as stated in the application.

If the Beneficiary Dies - The interest of any Beneficiary who dies before you will terminate at his death. If the interest of all designated Beneficiaries has terminated, all proceeds will be paid to the Owner of this Policy. If the Owner is not living at that time, all proceeds will be paid to the Owner's estate. If any Beneficiary dies within 15 days of your death, we will pay the proceeds as though that Beneficiary died before you.

How to Change a Beneficiary - The Owner may change the Beneficiary by filing a written notice with us. A change of Beneficiary will not be effective until we record it at our Home Office. When recorded, even if you are not then living, the change will take effect on the date the notice was signed. Any proceeds paid before we record a change of Beneficiary will not be subject to change. An irrevocable Beneficiary may not be changed without that Beneficiary's written consent.

Payment of Proceeds

Proof of Death - Any proceeds payable because of your death will be paid when we receive sufficient proof of your death at our Home Office. Appropriate forms for giving us proof of your death will be made available to your Beneficiary on request. All payments by us are payable at our Home Office in United States currency.

Premium Adjustment at Death - Any portion of a paid premium which applies to a period beyond the date of your death will be added to the proceeds of this Policy. Premiums waived under any disability rider attached to the Policy will not be included in this adjustment.

General Provisions

Incontestability of the Policy - We cannot contest this Policy after it has been in force during your lifetime for two years from the Date of Issue, except for the nonpayment of premiums. This provision does not apply to any rider providing benefits specifically for disability or death by accident.

Legal actions

No action at law or in equity shall be brought to recover on the policy prior to the expiration of sixty days after written proof of loss has been furnished in accordance with the requirements of the policy. No such action shall be brought after the expiration of three (3) years (five (5) years in Kansas) after the time written proof of loss is required to be furnished.

Amount Payable is Limited in the Event of Suicide - If you die by suicide, while sane or insane, within two years from the Date of Issue, our liability will be limited to the amount of premiums paid.

Misstatement of Age or Sex in the Application - If your age or sex has been misstated, we will pay the amount of insurance that the premiums would have purchased had your age and sex been correctly stated.

The Policy Consists of the Policy and the Application - We have issued this Policy based on the application and payment of the premiums. A copy of the application is attached and is a part of this Policy. The Policy with the application makes the entire contract. All statements in the application are considered representations and not warranties.

Policy Changes - Changes in this Policy may only be made by:

1. An endorsement signed by one of our officers; or
2. A rider signed by one of our officers.

No agent has the authority to change this Policy in any way.

Non-Participating - This Policy will not participate in any surplus distribution we may make.

Owner of the Policy - You are the Owner of this Policy unless a different Owner is stated in the application. If a different Owner is stated, such designation will remain in effect until the Owner changes it. If the Owner dies before you, the ownership rights belong to his or her estate. During your lifetime, only the Owner will be entitled to the rights granted by this Policy.

Assignment of the Policy - This Policy may be assigned. We are not responsible for the adequacy of any assignment. When an assignment is filed with us in duplicate and we have recorded it at our Home Office, the Owner's rights and those of any irrevocable beneficiary will be subject to it. Any assignment is subject to any action taken by us before we receive and record it.

Nonforfeiture Benefit – The Owner may surrender this policy at any time and receive at least the minimum nonforfeiture benefit required by the state where this policy was delivered. If nonforfeiture benefits are available for this policy, the amounts available are shown at the end of this policy. At the time of surrender, if not specified, the owner will automatically receive the extended term option. The cash surrender value is available upon request.

The values are computed using the Standard Nonforfeiture Value Method, based on the 2001 Commissioners Standard Ordinary Mortality Table and the effective annual interest rate shown on page 1. Deaths are assumed to occur at ends of years.

Basis of Reserves - Reserves are calculated based on the 2001 Commissioners Standard Ordinary Mortality Table and interest as stated on page 1 of this policy. A detailed method of computing reserves has been filed with the Insurance Department of the state where this Policy is delivered. All reserves are at least equal to those required by the laws of such State.

Settlement Option Provisions

Election Of Option - All rights of the Owner provided in the Owner and Beneficiary provision apply to any election or change of election of a Settlement Option. If the Beneficiary is not an individual receiving payment in his or her own right, the Company must consent to any option other than a lump sum payment. A change of beneficiary revokes a prior election option. The beneficiary has no right to change or revoke an election unless this right was given by the Owner and agreed to by the Company in writing. If the Owner does not elect an option, the Beneficiary will have the right at the time of settlement.

Proceeds - All or part of the policy proceeds may be paid to the payee in one sum or under one or more of the Settlement Options. The amount which may be applied under the option must be at least \$2,500 and provide periodic payments of at least \$20. If not, the proceeds will be paid in a lump sum.

Supplementary Contract - A supplementary contract will be issued in exchange for this policy when a settlement is made by any of the options. If settlement is a result of the Insured's death, the effective date of that contract will be the date when proof of death is received by the Company. If applicable and if settlement is a result of policy maturity as an endowment or cash value surrender, the effective date of the contract will be the date of maturity or surrender.

Interest under Option 1 will be earned from the effective date of the contract. The first installment under Options 2, 3, 4 and 5 will be paid on the effective date of the contract unless a written election provides otherwise.

Interest Rate - The interest rate for these options may vary, but will not be less than the rate shown on page 1. The interest rate may be changed by the Board of Directors. If so, the Company will determine the amount and the method of payment of such earnings.

Death of the Payee - If the payee dies after the option goes into effect, any payments remaining to be paid will be paid in accordance with the supplementary contract in effect.

Settlement Options

All rates shown are the minimum guaranteed rates. Payments may be higher based on interest rates being paid by the Company at the time of payment.

Option 1. Interest: The proceeds may be left with the Company to earn interest for a specified period. This period of time may not exceed 30 years or the lifetime of the payee. The interest earned may be paid as agreed upon or credited annually and added to the proceeds. At the end of the specified period, the proceeds will be paid to the payee. If the payee dies before the end of this period, the proceeds will be paid as previously agreed upon.

Option 2. Installments for a Guaranteed Period: The proceeds may be used to provide equal installments for a guaranteed period. This period may not exceed 30 years. The equal installment may be paid on an annual, semi-annual, quarterly or monthly basis. The amount of each monthly installment for each \$1,000 of proceeds is shown in the table below.

The installment amounts on other than a monthly basis, or for years not shown, will be furnished upon request.

Number of Years Guaranteed	Monthly Installment Per \$1000
5	\$17.73
10	9.41
15	6.65
20	5.29
25	4.47
30	3.94

Option 3. Special Settlement: The proceeds may be paid in installments of equal or varied amounts. This option must be agreed to by the Company. Such installments will be paid until the proceeds plus interest credited on unpaid balances are paid in full.

Option 4. Life Income with a Guaranteed Period: The proceeds may be used to provide equal monthly installments for a guaranteed period and thereafter during the lifetime of the payee. This guaranteed period may be 5, 10 or 20 years.

The Company can require satisfactory evidence of the payee's age before making any payment under this option. The amount of the monthly installments is determined by: (a) the guaranteed period chosen, and (b) the payee's sex and attained age on the date the first installment would be paid. The amount for each \$1,000 of proceeds is shown in the table below. Installments for any age not shown will be furnished upon request.

Age Last Birthday	Income with Payments Guaranteed For:		Age Last Birthday	Income with Payments Guaranteed For:	
	10 Years	20 Years		10 Years	20 Years
Male Payee			Female Payee		
50	\$3.81	\$3.71	50	\$3.57	\$3.52
55	4.19	4.01	55	3.90	3.80
60	4.68	4.35	60	4.33	4.14
65	5.31	4.68	65	4.89	4.51
70	6.08	4.96	70	5.63	4.85
75	6.96	5.15	75	6.55	5.10

ALTERNATE LIFE INCOME OPTION: If Option 4 is elected the proceeds may be used to provide a monthly life income which is equal to 103% of the monthly annuity that would be purchased based on the rates of the Company then in use for new single premium annuities.

ENDORSEMENT

Issue State - Oklahoma

The following provision is hereby added to the provision on the face of this policy with regard to the twenty day right to examine this policy:

The premium will be refunded within 30 days of the date of cancellation of this policy. If we do not refund the premium within 30 days, we will pay interest on the amount to be refunded at the rate of interest calculated as set forth in the Insurance Laws of the State of Oklahoma.

Issue State – Missouri

Amount Payable is Limited in the Event of Suicide - **If you die by suicide, while sane or insane, within one year from the Date of Issue, our liability will be limited to the amount of premiums paid.**

Issue State - Arkansas

For information For Service or Complaint please contact us at:

Policyowner Services
P.O. Box 9510
Wichita, Kansas 67277
1-800-333-2525

You may also contact your agent or any of our agents for additional help.

If we fail to provide you with reasonable and adequate service, feel free to contact:

Arkansas Insurance Department
Consumer Services Division
1200 W. Third Street
Little Rock, AR 72201
(501) 371-2640
(800) 852-5494

Monthly Decreasing Term
Renewal premiums subject to change.
Non-participating

APPLICATION TO:

CENTURY LIFE ASSURANCE COMPANY

Oklahoma City, Oklahoma

Mailing Address: PO Box 9510, Wichita, Kansas 67277 Physical Address: 1035 S. 183rd Street W., Goddard, Kansas 67052

Phone: 316-794-2200 Fax: 316-794-8470

SECTION A

INSURANCE AMOUNT \$ _____ PREM COLLECTED \$ _____

MODE OF PAYMENT: ADVANCE PREMIUM PAID FOR ____ YEARS
Annual Semi Annual Quarterly Monthly (EFT only)

For EFT, complete Section G, Authorization. Voided Check Required.

PLAN

Annual Renewable Term Single Premium Term _ Yrs.
Mortgage Dec. Term ____ Yrs. Reducing Level
9% Joint Whole Life Insurance

RIDERS Waiver of Premium Accidental Death Benefit

SECTION B - Particulars Pertaining to Proposed Insured No. 1 and Joint Proposed Insured No. 2

NAME OF PROPOSED INSURED (NO. 1) SEX NAME OF PROPOSED INSURED (NO. 2) SEX

ADDRESS ADDRESS

CITY, STATE, ZIP CITY, STATE, ZIP

SS # DATE OF BIRTH AGE (LAST) SS # DATE OF BIRTH AGE (LAST)

HOME PHONE BIRTH STATE HEIGHT WEIGHT HOME PHONE BIRTH STATE HEIGHT WEIGHT

BUSINESS PHONE OCCUPATION BUSINESS PHONE OCCUPATION

PRIMARY BENEFICIARY RELATIONSHIP PRIMARY BENEFICIARY RELATIONSHIP

CONTINGENT BENEFICIARY RELATIONSHIP CONTINGENT BENEFICIARY RELATIONSHIP

NAME AND ADDRESS OF POLICY OWNER IF OTHER THAN PROPOSED INSURED NO. 1

SECTION C - Particulars Relating to the Risk Evaluation of the Proposed Insured(s)

PROPOSED INSURED

WITHIN THE LAST 10 YEARS HAS ANY PROPOSED INSURED BEEN TREATED FOR OR HAD ANY KNOWN INDICATION OF: CIRCLE CONDITION AND RESPONSE. PROPOSED INSURED No. 1 No.2

- 1. Heart or circulatory disease, high blood pressure, varicose veins, phlebitis?
2. Disorder of lungs or respiratory system, stomach, intestines, liver, kidneys, or urinary tract, reproductive organs, prostate, or breasts?
3. Disease or impairment of the eyes, ears, or nervous or mental disorder, diabetes, thyroid or other disease?
4. Arthritis, cancer or tumor, disease of, or injury to, neck, back or spine, muscles, joints, sciatica, or bodily deformity?
5. Have you ever been diagnosed or been treated for an Immune Deficiency Disorder, AIDS, the AIDS related complex (ARC) or confirmed test results indicating the AIDS virus?
6. Alcoholism or drug usage, not physician prescribed?
7. Any existing injury, deformity, disease condition or disorder not listed above within the last 5 years?
8. Taken any prescribed medicine in last year?
9. Have you used tobacco in any form within the past 12 months?

10. AVIATION, AVOCATION, AND MILITARY.

During the past 3 years has any proposed insured participated in, or contemplated participation in:
A. Flights as a pilot, student pilot, or crew member of an aircraft?
B. Skin diving, scuba diving, skydiving, parachuting, hang gliding, auto racing, motorcycle racing, speedboat racing, mountain climbing or rodeos?
11. Is Insurance applied for to replace or change life insurance or annuity in this or any other company?
12. Has any proposed insured ever applied for any life, accident, or health insurance which has not been granted as applied for in amount, or rate, or has any insured been cancelled or the renewal or reinstatement been refused?

Name and address of personal physician or doctor who has your medical history.

PROPOSED INSURED #1 PROPOSED INSURED #2

DR. DR.

ADDRESS ADDRESS

PHONE PHONE

DATE LAST SEEN & REASON DATE LAST SEEN & REASON

SECTION D - Remarks & Details to "Yes" answers (All "Yes" answers Section C must be explained - Attach Additional sheet if necessary.)

PROPOSED INSURED NO. 1

PROPOSED INSURED NO. 2

SECTION D (continued) - Additional space, if needed.

Amount of life insurance or annuity in force. Name Proposed Insured, company and amount in force. Indicate policy to be replaced, if any.

SECTION E – Acknowledgement Statement Proposed Insured and/or the Applicant

I agree that: (1) the above answers and statements are, to my knowledge and belief, true and complete; (2) the above answers will form the basis for and be part of every policy issued hereunder; (3) the company is not liable for delay in acting on this application; (4) this insurance will take effect on the date the policy is issued by the company if the first premium has been paid and the policy is delivered to me while I am in good health. I understand that any authorization I give the company to draw drafts on my bank account is not payment of the first premium until the draft is drawn, deposited and paid by me bank. (5) No change in amount, rating, plan, issue age, or benefits will be effective unless agreed to in writing by me.

SECTION F - AUTHORIZATION: I authorize any health plan, physician, health care professional, hospital, clinic, laboratory, pharmacy or pharmacy benefit manager, medical facility or other health care provider that has provided payment, treatment or services to me or on my behalf ("My Health Care Provider") to disclose my entire medical record, prescription history, medications prescribed and any other protected health information concerning me to any of the insurance company named above, its employees, agents or representatives. This includes information on the diagnosis or treatment of Human Immunodeficiency Virus (HIV) infection and sexually transmitted diseases. This also includes information on the diagnosis and treatment of mental illness and the use of alcohol, drugs, and tobacco, but excludes psychotherapy notes.

By my signature below, I acknowledge that any agreements I have made to restrict my protected health information do not apply to this authorization and I instruct any physician, health care professional, hospital, clinic, medical facility, or other health care provider to release and disclose my entire medical record without restriction.

This protected health information is to be disclosed under this Authorization so the insurance company 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; and 5) conduct other legally permissible activities that relate to any coverage I have or have applied for with this company.

This authorization shall remain in force for 24 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 providing written notification to the insurance company at the administrative office address above. I understand that a revocation is not effective to the extent that any of My Health Care Providers has already relied on this authorization to disclose information about me or to the extent that the insurance company has a legal right to contest a claim under an insurance policy or to contest the policy itself. I understand that any information that is disclosed pursuant to this authorization is no longer covered by federal rules governing privacy and confidentiality of health information, but it will not be redisclosed by the insurance company except as authorized by me or as required by law.

I understand that My Health Care Providers may not refuse to provide treatment or payment for health care services if I refuse to sign this authorization. I further understand that if I refuse to sign this authorization to release my complete medical record, the insurance company may not be able to process my application, or if coverage has been issued may not be able to make any benefit payments. I understand that any authorized representative or I will receive a copy of this authorization upon request.

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.

The information authorized for release may include records which may indicate the presence of a communicable or venereal disease which may include, but are not limited to, diseases such as hepatitis, syphilis, gonorrhea and the human immunodeficiency virus, also known as acquired immune deficiency syndrome (AIDS).

I acknowledge receipt of the notices attached to this application. I have received the notice of the Fair Credit Reporting Act and the MIB.

DATE ____ / ____ / ____ SIGNED AT _____ (CITY/STATE)		
SIGNATURE OF PROPOSED INSURED NO.1	SIGNATURE OF PROPOSED INSURED NO. 2	SIGNATURE OF OWNER OR APPLICANT IF OTHER THAN PROPOSED INSURED AND TITLE, IF CORP. OR TRUST

SECTION G - Electronic Funds Transfer (EFT) authorization form for payment of premium (please print legibly)

This authorization replaces any previous authorizations and remains in force until the company receives written authorization from me to change or terminate it. The company may also make correcting entries if required.

YOU ARE RESPONSIBLE FOR VERIFYING WITH YOUR FINANCIAL INSTITUTION THAT FUNDS ARE AVAILABLE. THE COMPANY IS NOT RESPONSIBLE FOR NSF CHARGES OR RETURNED FEES.

NAME ON ACCOUNT	SS #:	TYPE OF ACCOUNT (CHECK ONLY ONE.) <input type="checkbox"/> Checking <input type="checkbox"/> Savings
NAME OF FINANCIAL INSTITUTION		Account #: Routing #"

Authorized Signature _____ **Date** _____

IMPORTANT! – Attach a voided check, **NOT** a deposit slip, to this form

DETACH AND GIVE TO APPLICANT

The notice set forth below is given in compliance with the provisions of Section 606(a) of the Fair Credit Reporting Act.

NOTICE (Part 1): An investigative consumer report may be obtained for information about character, reputation and mode of living. Interviews may be with your friends, neighbors, and associates. You have the right to make a written request within a reasonable time to get detailed information about this report.

NOTICE (Part 2): Information regarding you will be confidential. **CENTURY LIFE ASSURANCE COMPANY**, or its reinsurers, may, however, make a brief report to the Medical Information Bureau. The Bureau is a non-profit organization of life insurance companies, which operates an information exchange. If you apply to another Bureau member company for life or health insurance coverage, or send them a claim for benefits, the Bureau will give such company the information in its file. The Bureau will give you information in your file if you request it. If you question the information in the Bureau's file, you may contact them and seek a correction in accordance with the Federal Fair Credit Reporting Act. The address of the Bureau's information office is Box 105, Essex Station, Boston, Massachusetts 02112, telephone number (617) 426-3660. **CENTURY LIFE ASSURANCE COMPANY**, or its reinsurers, may also give information to other companies to whom you may apply for insurance or make a claim for benefits.

MDT(09)-App

SECTION H

COLLATERAL ASSIGNMENT

For value received, I hereby assign to _____ assignee, the proceeds including cash values, due or to become due under the life insurance policy hereby applied for when issued to the extent of any indebtedness due by me to said assignee. I agree that in the event of any default. Assignee is authorized to cancel this insurance and credit any premium refund or cash surrender value toward my indebtedness as his interest may appear.

I also agree that this assignment is irrevocable until all indebtedness due Assignee by me has been paid in full and that the rights and interest of any beneficiary under said policy are subordinate to the rights and interest of the Assignee.

Signed at _____ this _____ day of _____ 20 _____

WITNESS

SIGNATURE OF POLICYOWNER

SECTION I

LICENSED AGENT

This application was completed and signed in my presence on the date written on the front of the application. To the best of my knowledge and belief, this application is or is not involved in replacement of life insurance, except as stated in Section D.

To the best of my knowledge and belief the amount of life and annuity insurance in force on Proposed Insured #1 and #2 is as follows:

PROPOSED INSURED	COMPANY	FACE AMOUNT
_____	_____	_____
_____	_____	_____
_____	_____	_____

X _____
SIGNATURE OF PRODUCING AGENT AGENT NO. AGENCY NO.

SERFF Tracking Number: AUWL-125849785 *State:* Arkansas
Filing Company: Century Life Assurance Company *State Tracking Number:* 40483
Company Tracking Number: MDT(09)
TOI: L04I Individual Life - Term *Sub-TOI:* L04I.104 Renewable - Joint (First to Die) - Fixed
Premium/Indeterminate Premium

Product Name: MDT(09)
Project Name/Number: MDT(09)/

Rate Information

Rate data does NOT apply to filing.

SERFF Tracking Number: AUWL-125849785 State: Arkansas
Filing Company: Century Life Assurance Company State Tracking Number: 40483
Company Tracking Number: MDT(09)
TOI: L04I Individual Life - Term Sub-TOI: L04I.104 Renewable - Joint (First to Die) - Fixed
Premium/Indeterminate Premium
Product Name: MDT(09)
Project Name/Number: MDT(09)/

Supporting Document Schedules

Satisfied -Name: Certification/Notice **Review Status:** 10/08/2008
Comments:
Attachment:
AR Compliance.pdf

Satisfied -Name: Application **Review Status:** 10/08/2008
Comments:
Attached

CERTIFICATION

Arkansas Code 23-79

Rule and Regulation 49 - Life and Disability Insurance Guaranty Fund Notices

Rule and Regulation 19 – Unfair Sex Discrimination in the Sale of Insurance

Bulletin 11-88 - Arkansas Act 197 of 1987

THIS IS TO CERTIFY that the attached forms are in compliance with the relevant provisions
Arkansas Codes and Statutes listed above that specifically provide for universal life insurance.

(Signed by an officer of the company)



Bruce F. Welner

President

Century Life Assurance Company

October 8, 2008

APPLICATION TO:

CENTURY LIFE ASSURANCE COMPANY

Oklahoma City, Oklahoma

Mailing Address: PO Box 9510, Wichita, Kansas 67277 • Physical Address: 1035 S. 183rd Street W., Goddard, Kansas 67052

Phone: 316-794-2200 • Fax: 316-794-8470

SECTION A

INSURANCE AMOUNT \$ _____ PREM COLLECTED \$ _____

MODE OF PAYMENT: ADVANCE PREMIUM PAID FOR ____ YEARS
Annual Semi Annual Quarterly Monthly (EFT only)

For EFT, complete Section G, Authorization. Voided Check Required.

PLAN

Annual Renewable Term Single Premium Term _ Yrs.
Mortgage Dec. Term ____ Yrs. Reducing Level
9% Joint Whole Life Insurance

RIDERS Waiver of Premium Accidental Death Benefit

SECTION B - Particulars Pertaining to Proposed Insured No. 1 and Joint Proposed Insured No. 2

NAME OF PROPOSED INSURED (NO. 1) SEX NAME OF PROPOSED INSURED (NO. 2) SEX

ADDRESS ADDRESS

CITY, STATE, ZIP CITY, STATE, ZIP

SS # DATE OF BIRTH AGE (LAST) SS # DATE OF BIRTH AGE (LAST)

HOME PHONE BIRTH STATE HEIGHT WEIGHT HOME PHONE BIRTH STATE HEIGHT WEIGHT

BUSINESS PHONE OCCUPATION BUSINESS PHONE OCCUPATION

PRIMARY BENEFICIARY RELATIONSHIP PRIMARY BENEFICIARY RELATIONSHIP

CONTINGENT BENEFICIARY RELATIONSHIP CONTINGENT BENEFICIARY RELATIONSHIP

NAME AND ADDRESS OF POLICY OWNER IF OTHER THAN PROPOSED INSURED NO. 1

SECTION C - Particulars Relating to the Risk Evaluation of the Proposed Insured(s)

PROPOSED INSURED

WITHIN THE LAST 10 YEARS HAS ANY PROPOSED INSURED BEEN TREATED FOR OR HAD ANY KNOWN INDICATION OF: CIRCLE CONDITION AND RESPONSE. PROPOSED INSURED No. 1 No.2

- 1. Heart or circulatory disease, high blood pressure, varicose veins, phlebitis?
2. Disorder of lungs or respiratory system, stomach, intestines, liver, kidneys, or urinary tract, reproductive organs, prostate, or breasts?
3. Disease or impairment of the eyes, ears, or nervous or mental disorder, diabetes, thyroid or other disease?
4. Arthritis, cancer or tumor, disease of, or injury to, neck, back or spine, muscles, joints, sciatica, or bodily deformity?
5. Have you ever been diagnosed or been treated for an Immune Deficiency Disorder, AIDS, the AIDS related complex (ARC) or confirmed test results indicating the AIDS virus?
6. Alcoholism or drug usage, not physician prescribed?
7. Any existing injury, deformity, disease condition or disorder not listed above within the last 5 years?
8. Taken any prescribed medicine in last year?
9. Have you used tobacco in any form within the past 12 months?

10. AVIATION, AVOCATION, AND MILITARY.

During the past 3 years has any proposed insured participated in, or contemplated participation in:
A. Flights as a pilot, student pilot, or crew member of an aircraft?
B. Skin diving, scuba diving, skydiving, parachuting, hang gliding, auto racing, motorcycle racing, speedboat racing, mountain climbing or rodeos?
11. Is Insurance applied for to replace or change life insurance or annuity in this or any other company?
12. Has any proposed insured ever applied for any life, accident, or health insurance which has not been granted as applied for in amount, or rate, or has any insured been cancelled or the renewal or reinstatement been refused?

Name and address of personal physician or doctor who has your medical history.

PROPOSED INSURED #1 PROPOSED INSURED #2
DR. DR.
ADDRESS ADDRESS
PHONE PHONE
DATE LAST SEEN & REASON DATE LAST SEEN & REASON

SECTION D - Remarks & Details to "Yes" answers (All "Yes" answers Section C must be explained - Attach Additional sheet if necessary.)

PROPOSED INSURED NO. 1

PROPOSED INSURED NO. 2

SECTION D (continued) - Additional space, if needed.

Amount of life insurance or annuity in force. Name Proposed Insured, company and amount in force. Indicate policy to be replaced, if any.

SECTION E – Acknowledgement Statement Proposed Insured and/or the Applicant

I agree that: (1) the above answers and statements are, to my knowledge and belief, true and complete; (2) the above answers will form the basis for and be part of every policy issued hereunder; (3) the company is not liable for delay in acting on this application; (4) this insurance will take effect on the date the policy is issued by the company if the first premium has been paid and the policy is delivered to me while I am in good health. I understand that any authorization I give the company to draw drafts on my bank account is not payment of the first premium until the draft is drawn, deposited and paid by me bank. (5) No change in amount, rating, plan, issue age, or benefits will be effective unless agreed to in writing by me.

SECTION F - AUTHORIZATION: I authorize any health plan, physician, health care professional, hospital, clinic, laboratory, pharmacy or pharmacy benefit manager, medical facility or other health care provider that has provided payment, treatment or services to me or on my behalf (“My Health Care Provider”) to disclose my entire medical record, prescription history, medications prescribed and any other protected health information concerning me to any of the insurance company named above, its employees, agents or representatives. This includes information on the diagnosis or treatment of Human Immunodeficiency Virus (HIV) infection and sexually transmitted diseases. This also includes information on the diagnosis and treatment of mental illness and the use of alcohol, drugs, and tobacco, but excludes psychotherapy notes.

By my signature below, I acknowledge that any agreements I have made to restrict my protected health information do not apply to this authorization and I instruct any physician, health care professional, hospital, clinic, medical facility, or other health care provider to release and disclose my entire medical record without restriction.

This protected health information is to be disclosed under this Authorization so the insurance company 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; and 5) conduct other legally permissible activities that relate to any coverage I have or have applied for with this company.

This authorization shall remain in force for 24 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 providing written notification to the insurance company at the administrative office address above. I understand that a revocation is not effective to the extent that any of My Health Care Providers has already relied on this authorization to disclose information about me or to the extent that the insurance company has a legal right to contest a claim under an insurance policy or to contest the policy itself. I understand that any information that is disclosed pursuant to this authorization is no longer covered by federal rules governing privacy and confidentiality of health information, but it will not be redisclosed by the insurance company except as authorized by me or as required by law.

I understand that My Health Care Providers may not refuse to provide treatment or payment for health care services if I refuse to sign this authorization. I further understand that if I refuse to sign this authorization to release my complete medical record, the insurance company may not be able to process my application, or if coverage has been issued may not be able to make any benefit payments. I understand that any authorized representative or I will receive a copy of this authorization upon request.

The information authorized for release may include records which may indicate the presence of a communicable or venereal disease which may include, but are not limited to, diseases such as hepatitis, syphilis, gonorrhea and the human immunodeficiency virus, also known as acquired immune deficiency syndrome (AIDS).

I acknowledge receipt of the notices attached to this application. I have received the notice of the Fair Credit Reporting Act and the MIB.

DATE ____ / ____ / ____ SIGNED AT _____ (CITY/STATE)

SIGNATURE OF PROPOSED INSURED NO.1	SIGNATURE OF PROPOSED INSURED NO. 2	SIGNATURE OF OWNER OR APPLICANT IF OTHER THAN PROPOSED INSURED AND TITLE, IF CORP. OR TRUST
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SECTION G - Electronic Funds Transfer (EFT) authorization form for payment of premium (please print legibly)

This authorization replaces any previous authorizations and remains in force until the company receives written authorization from me to change or terminate it. The company may also make correcting entries if required.

YOU ARE RESPONSIBLE FOR VERIFYING WITH YOUR FINANCIAL INSTITUTION THAT FUNDS ARE AVAILABLE. THE COMPANY IS NOT RESPONSIBLE FOR NSF CHARGES OR RETURNED FEES.

NAME ON ACCOUNT	SS #:	TYPE OF ACCOUNT (CHECK ONLY ONE.) <input type="checkbox"/> Checking <input type="checkbox"/> Savings
NAME OF FINANCIAL INSTITUTION		Account #:
		Routing #"

Authorized Signature _____ **Date** _____

IMPORTANT! – Attach a voided check, **NOT** a deposit slip, to this form

DETACH AND GIVE TO APPLICANT

The notice set forth below is given in compliance with the provisions of Section 606(a) of the Fair Credit Reporting Act.

NOTICE (Part 1): An investigative consumer report may be obtained for information about character, reputation and mode of living. Interviews may be with your friends, neighbors, and associates. You have the right to make a written request within a reasonable time to get detailed information about this report.

NOTICE (Part 2): Information regarding you will be confidential. **CENTURY LIFE ASSURANCE COMPANY**, or its reinsurers, may, however, make a brief report to the Medical Information Bureau. The Bureau is a non-profit organization of life insurance companies, which operates an information exchange. If you apply to another Bureau member company for life or health insurance coverage, or send them a claim for benefits, the Bureau will give such company the information in its file. The Bureau will give you information in your file if you request it. If you question the information in the Bureau's file, you may contact them and seek a correction in accordance with the Federal Fair Credit Reporting Act. The address of the Bureau's information office is Box 105, Essex Station, Boston, Massachusetts 02112, telephone number (617) 426-3660. **CENTURY LIFE ASSURANCE COMPANY**, or its reinsurers, may also give information to other companies to whom you may apply for insurance or make a claim for benefits.

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SECTION H

COLLATERAL ASSIGNMENT

For value received, I hereby assign to _____ assignee, the proceeds including cash values, due or to become due under the life insurance policy hereby applied for when issued to the extent of any indebtedness due by me to said assignee. I agree that in the event of any default, Assignee is authorized to cancel this insurance and credit any premium refund or cash surrender value toward my indebtedness as his interest may appear.

I also agree that this assignment is irrevocable until all indebtedness due Assignee by me has been paid in full and that the rights and interest of any beneficiary under said policy are subordinate to the rights and interest of the Assignee.

Signed at _____ this _____ day of _____ 20 _____

WITNESS

SIGNATURE OF POLICYOWNER

SECTION I

LICENSED AGENT

This application was completed and signed in my presence on the date written on the front of the application. To the best of my knowledge and belief, this application is or is not involved in replacement of life insurance, except as stated in Section D.

To the best of my knowledge and belief the amount of life and annuity insurance in force on Proposed Insured #1 and #2 is as follows:

PROPOSED INSURED	COMPANY	FACE AMOUNT
_____	_____	_____
_____	_____	_____
_____	_____	_____

X _____
SIGNATURE OF PRODUCING AGENT AGENT NO. AGENCY NO.