

SERFF Tracking Number:	GRAX-125844300	State:	Arkansas
Filing Company:	Great American Life Insurance Company	State Tracking Number:	40447
Company Tracking Number:	A1070208NW		
TOI:	A02I Individual Annuities- Deferred Non-Variable	Sub-TOI:	A02I.003 Single Premium
Product Name:	Annuity Individual Fixed		
Project Name/Number:	Annuity Individual Fixed/A1070208NW		

Filing at a Glance

Company: Great American Life Insurance Company

Product Name: Annuity Individual Fixed SERFF Tr Num: GRAX-125844300 State: ArkansasLH

TOI: A02I Individual Annuities- Deferred Non-Variable SERFF Status: Closed State Tr Num: 40447

Sub-TOI: A02I.003 Single Premium Co Tr Num: A1070208NW State Status: Approved-Closed

Filing Type: Form Co Status: Reviewer(s): Linda Bird

Author: SPI Disposition Date: 10/10/2008

GreatAmericanFinancialRes

Date Submitted: 10/03/2008 Disposition Status: Approved

Implementation Date Requested: Implementation Date:

State Filing Description:

General Information

Project Name: Annuity Individual Fixed

Status of Filing in Domicile: Pending

Project Number: A1070208NW

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: 10/10/2008

Deemer Date:

State Status Changed: 10/10/2008

Corresponding Filing Tracking Number:

Filing Description:

Enclosed for your review and approval, please find the form referenced above. This form will replace form number A1030506NW, which was approved in your state on April 7, 2006. This submission does not contain any provisions, conditions, or concepts that are uncommon, unusual or possibly controversial from the standpoint of normal company or industry standards.

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<i>Filing Company:</i>	<i>Great American Life Insurance Company</i>	<i>State Tracking Number:</i>	<i>40447</i>
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<i>Product Name:</i>	<i>Annuity Individual Fixed</i>		
<i>Project Name/Number:</i>	<i>Annuity Individual Fixed/A1070208NW</i>		

This application will be used with our single premium deferred annuity contract form numbers P1030705NW and P1030805NW and long-term care benefits rider form number R1030905NW approved in your jurisdiction on December 13, 2005.

The Application referenced above has been redesigned. Some of the differences between the currently approved form and the form submitted for your review include:

- " Added Anti Money Laundering Language
- " Added Patriot Act Information
- " Revised Beneficiary Information
- " Replacement section has been revised
- " Agreement section has been revised
- " Formatting changes to a two-column form

Upon approval, we will begin using this form effective January 1, 2009.

Company and Contact

Filing Contact Information

Stephen Essman, Compliance Specialist	sessman@gafri.com
P. O. Box 5420	(513) 412-2731 [Phone]
Cincinnati, OH 45201-5420	(513) 412-1470[FAX]

Filing Company Information

Great American Life Insurance Company	CoCode: 63312	State of Domicile: Ohio
P. O. Box 5420	Group Code: 84	Company Type:
Cincinnati, OH 45201-5420	Group Name: Great American	State ID Number:
(800) 854-3649 ext. [Phone]	Financial Resources, Inc.	
	FEIN Number: 13-1935920	

SERFF Tracking Number: GRAX-125844300 State: Arkansas
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Variable
Product Name: Annuity Individual Fixed
Project Name/Number: Annuity Individual Fixed/A1070208NW

Filing Fees

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

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Great American Life Insurance Company	\$50.00	10/03/2008	22907043

SERFF Tracking Number: GRAX-125844300 State: Arkansas
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Variable
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Correspondence Summary

Dispositions

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

SERFF Tracking Number: GRAX-125844300 *State:* Arkansas
Filing Company: Great American Life Insurance Company *State Tracking Number:* 40447
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TOI: A02I Individual Annuities- Deferred Non- *Sub-TOI:* A02I.003 Single Premium
Variable
Product Name: Annuity Individual Fixed
Project Name/Number: Annuity Individual Fixed/A1070208NW

Disposition

Disposition Date: 10/10/2008

Implementation Date:

Status: Approved

Comment:

Rate data does NOT apply to filing.

SERFF Tracking Number: GRAX-125844300 State: Arkansas
 Filing Company: Great American Life Insurance Company State Tracking Number: 40447
 Company Tracking Number: A1070208NW
 TOI: A021 Individual Annuities- Deferred Non- Sub-TOI: A021.003 Single Premium
 Variable
 Product Name: Annuity Individual Fixed
 Project Name/Number: Annuity Individual Fixed/A1070208NW

Item Type	Item Name	Item Status	Public Access
Supporting Document	Certification/Notice		Yes
Supporting Document	Application		No
Supporting Document	Life & Annuity - Acturial Memo		No
Supporting Document	Cover Letter		Yes
Form	Application For Single Premium Deferred Annuity with Long Term Care Benefits Rider		Yes

Application For Single Premium Deferred Annuity with Long Term Care Benefits Rider

1. Owner

Primary Owner

(LTC Rider benefits are only provided to the primary owner)

Name _____
 Address _____
 City _____ State _____ Zip _____
 Phone _____ Sex M F
 SSN _____ Birth date _____

Joint Owner (only available for Non-Qualified contracts)

Name _____
 Address _____
 City _____ State _____ Zip _____
 Phone _____ Sex M F
 SSN _____ Birth date _____

2. Annuitant (if other than Owner)

Primary Annuitant (only available for Non-Qualified contracts)

Name _____
 Address _____
 City _____ State _____ Zip _____
 Phone _____ Sex M F
 SSN _____ Birth date _____

Joint Annuitant (only available for Non-Qualified contracts)

Name _____
 Address _____
 City _____ State _____ Zip _____
 Phone _____ Sex M F
 SSN _____ Birth date _____

3. Beneficiary (P-Primary, C-Contingent)

If the beneficiary listed below is not designated as Primary or Contingent beneficiary, it will automatically default to a Primary designation. All shares will be divided equally unless otherwise noted in the space provided.

List additional beneficiaries on the Additional Beneficiary Designation Form (form number X2614105NW (Rev. 9/05)). Share/Percentage must 100%. If beneficiary is a trust, list the name of the trust, name(s) of the current trustee(s), and trust agreement date AND provide copies of the first and signature pages of the trust. If the owner of this contract is a trust, the trust must be designated as the primary beneficiary.

P C Share/Percentage _____ %
 Name _____
 Address _____
 City _____ State _____ Zip _____
 SSN _____ Relationship _____

P C Share/Percentage _____ %
 Name _____
 Address _____
 City _____ State _____ Zip _____
 SSN _____ Relationship _____

P C Share/Percentage _____ %
 Name _____
 Address _____
 City _____ State _____ Zip _____
 SSN _____ Relationship _____

P C Share/Percentage _____ %
 Name _____
 Address _____
 City _____ State _____ Zip _____
 SSN _____ Relationship _____

4. Contract Information

A. Product Name _____
B. Purchase Payment: Amount \$ _____
 Check enclosed (check here if indirect rollover)
 Transfer
 Rollover (attach required forms)
 1035 Exchange
If 1035 Exchange or Transfer, from what company?

C. Tax Qualification for New Annuity
 Non-Qualified
 TSA 403(b) (only if over age 59 1/2)
 IRA (only if over age 50 1/2)
D. Special Requests

5. Existing Insurance/Replacement

A. If you live in [AL, AK, AZ, CO, HI, IA, KY, LA, ME, MD, MS, MT, NE, NH, NJ, NM, NC, OH, OR, RI, TX, UT, VT, VA or WV] answer only question # 1.
1. Do you have any existing life insurance policies or individual annuity contracts currently in force with this Company or any other company? Yes No
If "Yes" to # 1, complete the Notice Regarding Replacements of Life and Annuities. Your agent must present and read the Notice to you unless you voluntarily waive this step.
B. If you live in [AR, CA, CT, DE, DC, FL, GA, ID, IL, IN, KS, MA, MI, MN, MO, NV, ND, OK, PA, SC, SD, TN, WA, WI, or WY] Answer only question # 2.
2. Will this contract replace or use cash values of any existing life insurance or annuity with this company or any other company? Yes No
If "Yes" to # 2, please provide company name and policy/contract #.
Company _____
Policy/Contract # _____

C. Do you have any other long-term care coverage in force now or during the past twelve (12) months (including a health service contract or health maintenance organization contract)?
 Yes No
If "Yes", please list name(s) of company(ies), the policy/contract number(s), and if coverage has lapsed, the date of lapse.
Company _____
Policy/Contract # _____
Date of Lapse _____
Are you currently covered by Medicaid? Yes No
Do you intend to replace any of your medical or health insurance coverage with this contract? Yes No

6. Long Term Care Benefit

Daily Benefit and Aggregate Benefit: (Select one option)

- 2 years – (1/730th of Account Value on Qualification Date) and 200% Aggregate
- 2 years – (1/730th of Account Value on Qualification Date) and 300% Aggregate

- 3 years – (1/1095th of Account Value on Qualification Date) and 200% Aggregate
- 3 years – (1/1095th of Account Value on Qualification Date) and 300% Aggregate

7. Telephone Interview Authorization

I understand that I will be contacted by a representative of the Company to verify my health history and condition(s). The decision to issue the LTC rider is based on my responses obtained during this telephone interview. By signing the application, I agree to respond honestly and and complete the interview to the best of my ability.

The best time to call would be: _____ AM PM

Alternate Daytime Telephone Number: _____

8. Verification of Client Identification

A. Owner

- Drivers License/ State/Country: _____
State ID Number: _____
- Passport Date Issued: _____
- Other (photo id) Exp. Date _____
- Owner is an entity, legal document(s) attached (e.g. Articles of Incorporation, Trust Agreement, etc.)

C. Joint Owner

- Drivers License/ State/Country: _____
State ID Number: _____
- Passport Date Issued: _____
- Other (photo id) Exp. Date: _____

Occupation _____

Occupation _____

Employer _____

Employer

Retired Yes No

Retired Yes No

For TSA to TSA transfer cases the previous employer is required even if retired.

B. The source of funds for this transaction is:

The purpose of this transaction :

9. Notice of Information Practices

Thank you for giving Great American Life Insurance Company the opportunity to consider your insurance needs. As a part of our normal underwriting procedures for processing applications, we may obtain an investigative consumer report where information is obtained through personal interviews with your neighbors, friends, or others which whom you are acquainted or who may have knowledge of such information which may include information as to your character, general reputation, personal characteristics, and mode of living. The information obtained in such investigative consumer report will not be used to make a determination of your sexual preference. You have the right to make a written request for additional, detailed information about the nature and scope of the investigation, and to receive a copy of the authorization and the report.

All information requested from other sources, such as your physician or hospitals, where you have been treated is for the sole purpose of determining your acceptability for the insurance coverage for which you All information requested from other sources, such as your physician or have applied. All information obtained will be kept confidential. Upon your request, we will furnish you or your physician with the nature and/or scope of the investigation.

10. Notices (Please review the notice that applies to your state.)

ALL STATES:

Patriot Act Notice

To help the government fight the funding of terrorism and money laundering activities, Federal law requires us to obtain all relevant customer-related information necessary to run an effective anti-money laundering program.

What this means to you: When submitting an application, we ask that the producer obtain the client's name, street address, date of birth, tax identification number and other customer-related information that will allow us to identify the customer and fulfill our obligations under Federal law. Picture documentation, such as a driver's license or other identifying documents, will be used to verify the information given at the time of the sale.

Arizona Residents: Upon written request, we will provide factual information within a reasonable time regarding the benefits and provisions of the Contract. If for any reason you are not satisfied, you may return it within ten (10) days or within 30 days if the contract holder is age 65 or older on the date of the application for the annuity contract, after the Contract is delivered to you and receive a refund of all monies paid.

Arkansas, Louisiana and New Mexico Residents:

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

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

District of Columbia Residents: WARNING: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.

Hawaii Residents: For your protection, Hawaii law requires you to be informed that presenting a fraudulent claim for payment of a loss or benefit is a crime punishable by fines or imprisonment, or both.

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

Maine, Tennessee, Virginia and Washington Residents: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines, or a denial of insurance benefits.

Maryland Residents: Any person who knowingly and willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly and willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

New Jersey Residents: Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

Ohio Residents: Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application form or files a claim containing any false or deceptive statement is guilty of insurance fraud.

Oklahoma Residents: 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.

11. Agreement

I certify that I have read the statements and that my answers to the questions on this Application are true and complete to the best of my knowledge and belief. (If your answers on this application are incorrect or untrue, we have the right to deny benefits or rescind your policy.)

I received and reviewed the Disclosure Document that includes information about my annuity contract, its benefits, and the fees and charges that apply to it.

I authorize any licensed physician, medical practitioner, hospital, clinic or other medical related facility, the U.S. Veterans Administration and Selective Services, System, insurance company, The Medical Information Bureau, or any other organization, institution or person that has any records or knowledge of me or my health to give to Great American Life Insurance Company and its reinsurer(s), and any such information. This authorization will be valid for 24 months from the date the authorization is signed

I authorize(s) any law enforcement agency, public or private institution, information service bureau or other entity contacted by the Company to furnish information sufficient to confirm my/our personal information as required by federal law. I hereby release(s) all persons, agents and agencies, and entities providing confirming information from any and all liability arising out of the request for or the release of confirming information.

Signed at (city) _____ (state) _____

Owner's Signature _____

Date _____

Joint Owner/Plan Administrator's Signature (if applicable) _____

Date _____

12. Agent's Statement

To the best of my knowledge and belief, (1) the purchaser(s) does does not have any existing life insurance policies or annuity contracts currently in force with this or any other company; and (2) the annuity being purchased is is NOT intended to replace or use cash values of any existing life insurance or annuity with this or any other company. If the purchaser(s) does have existing life insurance policies or annuity contracts, please read the appropriate replacement forms to the purchaser(s) (unless voluntarily waived) and complete the appropriate replacement forms. If the annuity being purchased is intended to replace or use cash values of any existing life insurance or annuity with this or any other company, please complete the appropriate replacement forms.

If the Contract applied for replaces any existing life insurance or annuity with this or any other company, I attest that I have reviewed the potential advantages and disadvantages of the proposed transaction.

I hereby certify that in connection with my presentation to the purchaser(s) herein, I only used sales material that was previously approved by the Company and that I left with the applicant(s) a copy of all sales material used in my presentation. ("Sales Material means a sales illustration and other written, printed or electronically presented information created, completed or provided by the Company or the agent and is used in the presentation to the applicant in connection with the contract purchased).

I further certify that this transaction is in accord with the Company's written statement with respect to the acceptability and appropriateness of replacements.

1st Agent's Name (please print) _____

Agent's Signature _____

Date _____

Agent Code # _____ Commission Split _____ %

Phone _____

E-Mail Address _____

2nd Agent's Name (please print) _____

Agent's Signature _____

Date _____

Agent Code # _____ Commission Split _____ %

Phone _____

E-Mail Address _____

13. For MGA/Agent Use Only (Commission Structure Codes)

NT T1 T2

<i>SERFF Tracking Number:</i>	<i>GRAX-125844300</i>	<i>State:</i>	<i>Arkansas</i>
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Rate Information

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Variable
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Supporting Document Schedules

Satisfied -Name: Certification/Notice **Review Status:** 10/03/2008
Comments:
Attachment:
AR - READABILITY CERTIFICATION.PDF

Satisfied -Name: Cover Letter **Review Status:** 10/03/2008
Comments:
Attachment:
Cover Letter.PDF

STATE OF ARKANSAS
READABILITY CERTIFICATION

COMPANY NAME: Great American Life Insurance Company

This is to certify that the form(s) referenced below has achieved a Flesch Reading Ease Score as indicated below and complies with the requirements of Ark. Stat. Ann. Section 66-3251 through 66-3258, cited as the Life and Disability Insurance Policy Language Simplification Act.

Form Number	Score
A1070208NW	54.6

Signed: 
Name: John P. Gruber
Title: Senior Vice President
Date: 10/03/2008



LIFE INSURANCE COMPANY

Administrative Mailing Address: P.O. Box 5420, Cincinnati, Ohio 45201-5420

October 3, 2008

NAIC No. 0084-63312
FEIN No. 13-1935920

Insurance Commissioner Julie Benafield Bowman
Compliance - Life and Health
Arkansas Department of Insurance
1200 West Third Street
Little Rock, AR 72201-1904

RE: Request For Approval - Great American Life Insurance Company
A1070208NW Application For Single Premium Deferred Annuity with Long Term Care
Benefits Rider

Dear Insurance Commissioner Benafield Bowman:

Enclosed for your review and approval, please find the form referenced above. This form will replace form number A1030506NW, which was approved in your state on April 7, 2006. This submission does not contain any provisions, conditions, or concepts that are uncommon, unusual or possibly controversial from the standpoint of normal company or industry standards.

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- " Revised Beneficiary Information
- " Replacement section has been revised
- " Agreement section has been revised
- " Formatting changes to a two-column form

Upon approval, we will begin using this form effective January 1, 2009.

With this information, I look forward to receiving a favorable response to this filing.

STEPHEN E. ESSMAN, ACS, AIAA, AIRC , COMPLIANCE SPECIALIST
(800) 854-3649 (TOLL FREE - EXT. 12731)
(513) 412-2731 (DIRECT DIAL) * (513) 412-1470 FAX

If you have any questions or require additional information regarding this submission, please feel free to contact me at either of the phone numbers indicated below or via e-mail at sessman@gafri.com.

Sincerely,

A handwritten signature in black ink, appearing to read "Stephen E. Essman". The signature is fluid and cursive, with the first name being the most prominent.

Stephen E. Essman, ACS, AIAA, AIRC
Compliance Specialist