

SERFF Tracking Number: GRAX-125860749 State: Arkansas  
Filing Company: Great American Life Insurance Company State Tracking Number: 40571  
Company Tracking Number: A2201708NW  
TOI: L04I Individual Life - Term Sub-TOI: L04I.103 Renewable - Single Life -  
Fixed/Indeterminate Premium  
Product Name: Life Individual Term  
Project Name/Number: Life Individual Term/A2201708NW

## Filing at a Glance

Company: Great American Life Insurance Company

Product Name: Life Individual Term SERFF Tr Num: GRAX-125860749 State: ArkansasLH  
TOI: L04I Individual Life - Term SERFF Status: Closed State Tr Num: 40571  
Sub-TOI: L04I.103 Renewable - Single Life - Co Tr Num: A2201708NW State Status: Approved-Closed  
Fixed/Indeterminate Premium  
Filing Type: Form Co Status: Reviewer(s): Linda Bird  
Author: SPI Disposition Date: 10/20/2008  
GreatAmericanFinancialRes  
Date Submitted: 10/15/2008 Disposition Status: Approved  
Implementation Date Requested: Implementation Date:

State Filing Description:

## General Information

Project Name: Life Individual Term Status of Filing in Domicile: Pending  
Project Number: A2201708NW 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: 10/20/2008  
State Status Changed: 10/20/2008 Deemer Date:  
Corresponding Filing Tracking Number:  
Filing Description:

This application will be used with our current term life insurance policies that provide an "exchange" provision which allows the policyholder to exchange their current policy for a new policy of the same plan type of insurance. A new policy could be issued for a policyholder who, at anytime after the end of their policy's initial premium guaranty period, completes the application, provides proof of insurability acceptable to us and whose age is not greater than the maximum issue age for the new policy at the time of the exchange. No agent is involved in this process.

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## 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:  
 Financial Resources, Inc.  
 (800) 854-3649 ext. [Phone] FEIN Number: 13-1935920  
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## 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	10/15/2008	23199380

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## Correspondence Summary

### Dispositions

Status	Created By	Created On	Date Submitted
Approved	Linda Bird	10/20/2008	10/20/2008

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## **Disposition**

Disposition Date: 10/20/2008

Implementation Date:

Status: Approved

Comment:

Rate data does NOT apply to filing.

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<b>Item Type</b>	<b>Item Name</b>	<b>Item Status</b>	<b>Public Access</b>
<b>Supporting Document</b>	Certification/Notice		Yes
<b>Supporting Document</b>	Application		No
<b>Supporting Document</b>	Life & Annuity - Acturial Memo		No
<b>Supporting Document</b>	Cover Letter		Yes
<b>Form</b>	Application For Term Life Insurance Exchange		Yes

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## Form Schedule

Lead Form Number: A2201708NW

Review Status	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
	A2201708NW	Application/ Enrollment Form	Application For Term Life Insurance Exchange	Initial		50	A2201708NW .PDF



## APPLICATION FOR TERM LIFE INSURANCE EXCHANGE

Administrative Address:  
P.O. Box 5416. Cincinnati, Ohio 45201-5416

**PART 1 (Please print)**

<p><b>1. PROPOSED INSURED</b></p> <p>_____</p> <p style="text-align: center; font-size: small;">First                      Middle Initial                      Last</p> <p>Address _____</p> <p>City _____ State _____ Zip _____</p> <p>Home Phone _____ Bus. Phone _____</p> <p>Soc. Sec. No. _____ <input type="checkbox"/> Male <input type="checkbox"/> Female</p> <p>Birth State/Place _____ Birth Date _____ Age _____ Marital Status _____</p> <p>Driver's License No. _____ State Issued _____</p> <p>Are you a U.S. Citizen? <input type="checkbox"/> Yes <input type="checkbox"/> No If not, do you hold a permanent VISA or Green Card? <input type="checkbox"/> Yes, card # _____ <input type="checkbox"/> No</p> <p>Do you currently read and understand English? <input type="checkbox"/> Yes <input type="checkbox"/> No How long have you lived in the United States? _____</p> <p>Are you currently working? <input type="checkbox"/> Yes <input type="checkbox"/> No Employer Name _____ Occupation/Income _____</p> <p>Send Premium Notice to: <input type="checkbox"/> Proposed Insured <input type="checkbox"/> Owner <input type="checkbox"/> Other (Give name/address below)</p> <p style="text-align: right;">Name _____</p> <p style="text-align: right;">Address _____</p>	<p style="text-align: right; font-size: small;">Complete only if Owner is not Proposed Insured</p> <p><b>2. OWNER</b> _____</p> <p>Relationship _____ Birth Date _____</p> <p>Address _____</p> <p>City _____ State _____ Zip _____</p> <p>Soc. Sec./Tax ID. No. _____</p>
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**3. INSURANCE APPLIED FOR**

Plan Name \_\_\_\_\_ Amount \_\_\_\_\_

**4. PREMIUM MODE**

Annual     Semiannual     Quarterly     Monthly Bank Draft     Other (Specify)

**5. BENEFICIARY OF THE PROPOSED INSURED**

Primary \_\_\_\_\_ Soc. Sec. No. \_\_\_\_\_ Relationship \_\_\_\_\_

Name & Address

Contingent \_\_\_\_\_ Soc. Sec. No. \_\_\_\_\_ Relationship \_\_\_\_\_

Name & Address

**6. EXISTING INSURANCE**

Company	Amount	Plan	Year Issued	Amount ADB	Standard	Rated
_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____

**7. TOBACCO/NICOTINE HABITS**

Have you used any form of tobacco/nicotine (e.g. cigarettes, cigars, chewing tobacco, patch, nicotine gum) in the last 3 years?  Yes  No

Last 5 years?  Yes  No

8. HAVE YOU .....

Yes No

- a. Ever applied for insurance or reinstatement that was declined, postponed, rated, modified or had any such insurance cancelled or a renewal premium refused?.....
- b. Ever received or claimed benefits or a payment of any kind for any injury, sickness or impaired condition?.....
- c. Ever engaged in or plan to engage in any form of motorized racing, scuba diving, parachuting, hang gliding, ballooning or mountain climbing? (If "Yes", complete avocation and/or mountain climbing questionnaire(s).)?.....
- d. Ever made any flights as a pilot, student pilot, crew member or other (except as a fare paying passenger) of any aircraft in the past three (3) years or intend to do so in the future? (If "Yes", complete aviation questionnaire.).....
- e. Ever been convicted with a violation of any criminal law?.....
- f. Ever had in the past five (5) years any motor vehicle violations, including driving while intoxicated, or had your license suspended or revoked?
- g. Ever traveled or resided outside the U.S. or Canada in the last year or plan to do so in the next year?.....
- h. Ever filed for bankruptcy? If so, has it been discharged? Date of discharge \_\_\_\_\_
- i. Ever assigned or transferred ownership of an insurance policy?.....

If answering "Yes" to any of the above, questions a. through i., please give details. \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

9. SPECIAL REQUESTS

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**PART II**

1. PROPOSED INSURED'S Height \_\_\_\_\_ ft. \_\_\_\_\_ in. Weight \_\_\_\_\_ lbs. Weight loss in past year \_\_\_\_\_ lbs.

2. PHYSICIAN INFORMATION

Name \_\_\_\_\_ Address \_\_\_\_\_ Phone \_\_\_\_\_

Date and reason last consulted \_\_\_\_\_

Treatment given or medication prescribed \_\_\_\_\_

3. PROPOSED INSURED'S FAMILY HISTORY

	Age if Living	Age at Death	Cause of Death
Father			
Mother			
Brothers/Sisters			

4. HAS ANYONE PROPOSED FOR COVERAGE EVER BEEN TREATED FOR OR HAD:

Please give details below if you answer "Yes" to any of these questions:

- |  |                          |                          |
|--|--------------------------|--------------------------|
|  | Yes                      | No                       |
| a. Impairment of the eyes or ears?.....  | <input type="checkbox"/> | <input type="checkbox"/> |
| b. Dizziness, fainting, convulsions, headache, paralysis or stroke within the last ten (10) years?.....  | <input type="checkbox"/> | <input type="checkbox"/> |
| c. Shortness of breath, blood spitting, bronchitis, asthma, emphysema or chronic respiratory disorder, sleep apnea or other lung disorder within the last ten (10) years?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| d. Chest pain, palpitation, high blood pressure, heart murmur, heart attack or other disorder of the heart or blood vessels?..   | <input type="checkbox"/> | <input type="checkbox"/> |
| e. Jaundice, hepatitis, intestinal bleeding, ulcer, colitis, recurrent indigestion or any other disease of the stomach, intestines, liver, gall bladder, or pancreas?.....     | <input type="checkbox"/> | <input type="checkbox"/> |
| f. Sugar, protein, blood, or pus in urine, venereal disease, stone or other disorder of kidney, bladder, prostate or reproductive organs?.....                                 | <input type="checkbox"/> | <input type="checkbox"/> |
| g. Diabetes, thyroid or other endocrine disorders?.....  | <input type="checkbox"/> | <input type="checkbox"/> |
| h. Disorder of the breasts, prostate, or pelvic organs?.....   | <input type="checkbox"/> | <input type="checkbox"/> |
| i. Neuritis, arthritis or disorder of the muscles or bones, including the spine, back or joints?.....  | <input type="checkbox"/> | <input type="checkbox"/> |
| j. Disorder of skin, lymph glands, cyst, tumor or cancer?.....   | <input type="checkbox"/> | <input type="checkbox"/> |
| k. Anemia or other disorder of the blood?.....   | <input type="checkbox"/> | <input type="checkbox"/> |
| l. Alcoholism, alcohol or drug abuse or addiction to habit-forming drugs?.....   | <input type="checkbox"/> | <input type="checkbox"/> |
| m. Panic attacks, anxiety, depression, psychological or emotional or physical disorder not listed above?.....  | <input type="checkbox"/> | <input type="checkbox"/> |

5. HAS ANYONE PROPOSED FOR COVERAGE:

- |   |                          |                          |
|---|--------------------------|--------------------------|
| a. Had a physical checkup, consultation or surgery within the last five (5) years?.....   | <input type="checkbox"/> | <input type="checkbox"/> |
| b. Been a patient in a hospital, clinic or other medical facility within the last five (5) years?.....  | <input type="checkbox"/> | <input type="checkbox"/> |
| c. Had an electrocardiogram, X-ray or other diagnostic test within the last five (5) years?.....  | <input type="checkbox"/> | <input type="checkbox"/> |
| d. Been advised to have any diagnostic test, hospitalization, or surgery, which was not completed?.....   | <input type="checkbox"/> | <input type="checkbox"/> |
| e. Been diagnosed or treated by a member of the medical profession as having acquired immune deficiency syndrome (AIDS) or AIDS related complex (ARC) or tested positive for antibodies to Human Immunodeficiency Virus (HIV)?..... | <input type="checkbox"/> | <input type="checkbox"/> |

6. Are you now pregnant? (If "Yes," expected due date \_\_\_\_\_ )  Yes  No

7. Are you now under medical observation, treatment or currently taking any medication other than as stated above?.....  Yes  No

Question No.	Details (Name of condition, date of onset, duration, current treatment and condition, etc.)	Complete Name, Addresses and Phone Numbers of Physicians and Hospitals

**FRAUD NOTICES** (Please review the notice that applies to your state.)

**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.

FRAUD NOTICES (Continued)

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 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.

AUTHORIZATION

I, the Proposed Insured, authorize any physician, medical practitioner, hospital, clinic or other medical or medically related facility, insurance or reinsuring company, the Medical Information Bureau, consumer reporting agency, employer, or pharmacy benefit manager, having information available as to diagnosis, treatment and prognosis with respect to any physical or mental condition and/or treatment of me, and any other nonmedical information of me, to give to Great American Life Insurance Company or its legal representative or its reinsurers any and all such information. I also authorize any consumer reporting agency to prepare or procure an investigative consumer report on me. The types of information may include my: (1) mental and physical health; (2) other insurance coverage; (3) hazardous activities; (4) character; (5) general reputation; (6) mode of living; (7) finances; (8) vocation; (9) Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC or Human Immunodeficiency Virus (HIV); (10) drug and alcohol treatment; (11) other personal information; (12) Motor Vehicle record; and (13) pharmaceutical information.

I understand the information obtained by use of the authorization will be used by Great American Life Insurance Company and its reinsurers to determine continued eligibility for insurance and eligibility for benefits under an existing policy. The insurance agent, producer, or broker may also use the information to help update my insurance program. Any information obtained will not be released by Great American Life Insurance Company to any person or organization EXCEPT to reinsuring companies, the Medical Information Bureau, or other persons or organizations, performing business or legal services in connection with my application, claim, or as may be otherwise lawfully allowed or required or as I may further authorize.

Information regarding your insurability will be treated as confidential. Great American 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].

Great American Life Insurance Company, or its reinsurers, may also release information from its file to other insurance companies to whom you may apply for life or 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.

I know I may request to receive a copy of this authorization. I agree a photographic copy of this authorization shall be as valid as the original. I agree this authorization shall be valid for two and one-half (2 1/2) years from the date shown below. Virginia Residents Only: I know I or my authorized representative may request to receive a copy of this authorization.

AGREEMENT

I, the Proposed Insured, represent the statements in Part I and Part II (if Part II is required by the Company) of this application are true and complete to the best of my knowledge and belief. It is agreed: (a) the only statements that are to be considered as the basis of the policy are those contained in the application or in any amendment to the application; (b) any prepayment made with this application will be subject to the provisions of the CONDITIONAL RECEIPT bearing the same date as this application; (c) the policy being applied for with this application will not take effect until the first premium is paid during the lifetime of the Proposed Insured and while his/her health and the facts and other conditions affecting his/her insurability are as described in Part I and Part II (if Part II Medical is required by the Company) of this application, and until the policy is delivered to the proposed owner; and (d) no one except the President, a Vice President or the Secretary can make, alter or discharge contracts or waive any of the Company's rights or requirements.

I have no intent to transfer ownership of the policy applied for as part of a senior, viatical or similar settlement.

I acknowledge receipt of NOTICE OF INSURANCE INFORMATION PRACTICES attached hereto and hereby authorize preparation of an investigative consumer report.

Date \_\_\_\_\_ City/State \_\_\_\_\_

Signature \_\_\_\_\_  
Proposed Insured

Witness \_\_\_\_\_  
Name

Signature \_\_\_\_\_  
Applicant/Owner, if other than Proposed Insured

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## **Rate Information**

Rate data does NOT apply to filing.

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## Supporting Document Schedules

**Review Status:** 10/15/2008  
**Satisfied -Name:** Certification/Notice  
**Comments:**  
**Attachment:**  
AR - READABILITY CERTIFICATION.PDF

**Review Status:** 10/15/2008  
**Satisfied -Name:** Cover Letter  
**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
A2201708NW	50

Signed:   
Name: John P. Gruber  
Title: Senior Vice President  
Date: 10/15/2008



LIFE INSURANCE COMPANY

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

October 15, 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  
A2201708NW Application For Term Life Insurance Exchange

Dear Insurance Commissioner Benafield Bowman:

Enclosed for your review and approval, please find the form referenced above. This form is a new form and does not replace any existing form, nor has it been previously submitted to your Department for preliminary review. 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. This form was filed in Ohio, our state of domicile, on October 10, 2008.

This application will be used with our current term life insurance policies that provide an "exchange" provision which allows the policyholder to exchange their current policy for a new policy of the same plan type of insurance. A new policy could be issued for a policyholder who, at anytime after the end of their policy's initial premium guaranty period, completes the application, provides proof of insurability acceptable to us and whose age is not greater than the maximum issue age for the new policy at the time of the exchange. No agent is involved in this process.

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

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](mailto:sessman@gafri.com).

Sincerely,

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

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