

SERFF Tracking Number: JACK-125829413 State: Arkansas
Filing Company: Jackson National Life Insurance Company State Tracking Number: 40395
Company Tracking Number: X3300 02/09 ET AL
TOI: L071 Individual Life - Whole Sub-TOI: L071.101 Fixed/Indeterminate Premium - Single Life
Product Name: Whole Life Application
Project Name/Number: Whole Life Application/X3300 02/09

Filing at a Glance

Company: Jackson National Life Insurance Company

Product Name: Whole Life Application SERFF Tr Num: JACK-125829413 State: ArkansasLH
TOI: L071 Individual Life - Whole SERFF Status: Closed State Tr Num: 40395
Sub-TOI: L071.101 Fixed/Indeterminate Co Tr Num: X3300 02/09 ET AL State Status: Approved-Closed
Premium - Single Life
Filing Type: Form Co Status: Reviewer(s): Linda Bird
Authors: Jamie Cook, Julie Hughes, Disposition Date: 10/08/2008
Lynda Neese, Lynne Gerding
Date Submitted: 09/29/2008 Disposition Status: Approved
Implementation Date Requested: 11/17/2008 Implementation Date:

State Filing Description:

General Information

Project Name: Whole Life Application
Project Number: X3300 02/09
Requested Filing Mode: Review & Approval

Status of Filing in Domicile: Not Filed
Date Approved in Domicile: 09/29/2008
Domicile Status Comments: The form is exempt from filing with Michigan, our State of domicile, by Order No. 97-010-M, which was issued and entered January 29, 1997, effective February 1, 1997.

Explanation for Combination/Other:
Submission Type: New Submission
Overall Rate Impact:
Filing Status Changed: 10/08/2008
State Status Changed: 10/08/2008
Corresponding Filing Tracking Number: X3300 02/09 ET AL

Market Type: Individual
Group Market Size:
Group Market Type:

Deemer Date:

Filing Description:

Submitted for review and general approval are the above referenced forms. These are new forms and will replace X3300 and X3305, which were approved by your Department on March 1, 2007 and August 14, 2007 respectively.

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Form X3300 02/09 is a new business application and form X3305 02/09 is a reinstatement application and both will be used with Whole Life policy, L1580, which was approved by your department on March 1, 2007.

The applications contain fraud language that is specific to individual states. The language is clearly identified as to those states.

These forms are exempt from filing with Michigan, our state of domicile, by Order No. 97 010 M, which was issued and entered January 29, 1997, effective February 1, 1997.

We have reviewed the enclosed forms and certify that to the best of our knowledge and belief the provisions of the forms comply with the applicable laws and regulations of your jurisdiction. With regard to Regulation 19, Jackson National Life hereby certifies that we do NOT discriminate based on sex in the sale of insurance. With regard to Regulation 6, we have reviewed and certify that we are in compliance.

Any variables within the forms have been bracketed and generally consist of names, dates and numbers. The policy forms, when issued, may vary in format, paper size, border and Company logo. The forms may also be used as a single-sided form. Additionally, a small square bar code may be placed in the far bottom left-hand corner.

If produced electronically, the forms may vary somewhat in format, such as the two-sided page format being printed as one-sided pages. However, the form's content will remain exactly as submitted.

I look forward to your favorable review. If I can be of any assistance to you, or if additional information is required, please contact me by telephone at 800/317-7989, by facsimile at 517/706-5522, or by email at pd&sf@jnli.com.

Company and Contact

Filing Contact Information

Jamie Cook, Filing Specialist
1 CORPORATE WAY
LANSING, MI 48951

pd&sf@jnli.com
(800) 317-7989 [Phone]
(517) 706-5522[FAX]

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Filing Company Information

Jackson National Life Insurance Company
1 Corporate Way
Lansing, MI 48915
(800) 317-7989 ext. [Phone]

CoCode: 65056
Group Code: 918
Group Name:
FEIN Number: 38-1659835

State of Domicile: Michigan
Company Type:
State ID Number:

SERFF Tracking Number: JACK-125829413 State: Arkansas
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Filing Fees

Fee Required? Yes
Fee Amount: \$40.00
Retaliatory? No
Fee Explanation: \$20.00 per form - 2 forms
Per Company: No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Jackson National Life Insurance Company	\$40.00	09/29/2008	22801601

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Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved	Linda Bird	10/08/2008	10/08/2008

SERFF Tracking Number: JACK-125829413 *State:* Arkansas
Filing Company: Jackson National Life Insurance Company *State Tracking Number:* 40395
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TOI: L071 Individual Life - Whole *Sub-TOI:* L071.101 Fixed/Indeterminate Premium - Single Life

Product Name: Whole Life Application
Project Name/Number: Whole Life Application/X3300 02/09

Disposition

Disposition Date: 10/08/2008

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 - Actuarial Memo		No
Supporting Document	Statement of Variability		Yes
Supporting Document	AR - Flesch Cert		Yes
Form	Whole Life Application		Yes
Form	Whole Life Reinstatement Application		Yes

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Form Schedule

Lead Form Number: X3300 02/09

Review Status	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
	X3300 02/09	Application/Whole Life Enrollment Form	Application	Initial		54	X3300 02-09 (FINAL - bracketed).pdf
	X3305 02/09	Application/Whole Life Enrollment Form	Reinstatement Application	Initial		50	X3305 02-09 (FINAL - bracketed).pdf

Whole Life Application



NATIONAL LIFE INSURANCE COMPANY

Home Office: 1 Corporate Way
Lansing, Michigan 48951
www.jackson.com

Part A1 - Proposed Insured

First Name		Middle Initial	Last Name	
Number and Street Address (a physical address must accompany any PO Box address)			City	State
SSN		DOB (mm/dd/yyyy)	U.S. State or Country of Birth	
Gender <input type="checkbox"/> M <input type="checkbox"/> F		Height ___ft. ___in. Weight _____lbs.	Phone Number (include area code)	
		Occupation		
U.S. Citizen <input type="checkbox"/> Y <input type="checkbox"/> N				

Part A2 - Owner (if other than Proposed Insured) Joint Owner with Proposed Insured

First Name		Middle Initial	Last Name	
Number and Street Address (a physical address must accompany any PO Box address)			City	State
SSN or TIN		DOB (mm/dd/yyyy)	Gender <input type="checkbox"/> M <input type="checkbox"/> F	
Relationship to Insured				

Part A3 - Beneficiary (Indicate additional Beneficiaries on a sheet of paper, signed and dated by the Owner(s) and a witness.)

Primary Name (first, middle initial, last)	SSN or TIN	Relationship to Insured	DOB (mm/dd/yyyy)	% Share
<input type="checkbox"/> Primary or <input type="checkbox"/> Contingent Name (first, middle initial, last)	SSN or TIN	Relationship to Insured	DOB (mm/dd/yyyy)	% Share

Part A4 - Plan: Whole Life Tier I Tier II Tier III (If applying for Tier II or III, please complete form X3350)

Specified Death Benefit \$ _____ Waiver of Premium (Tier I only) Accidental Death Benefit (Tier I only) \$ _____

Full Modal Premium Included \$ _____ or, Full Modal Premium Authorized with application \$ _____ (Payment Amount)

Payment Frequency:
 Monthly PAC Quarterly (PAC) Quarterly (Direct Bill) Semi-Annual Annual

Payment of Premiums on a basis other than annually will result in a higher total annual Premium. If PAC is selected, complete the Premium Payment Charge Authorization (PAC), Form X0300.

Part B1 - If any questions in Part B1 are answered "Yes" do not submit application.

1. Is the proposed Insured currently: hospitalized, confined to a nursing facility or hospice or hospice program, confined to bed at home for the past two months or longer, institutionalized, on parole or probation, awaiting organ transplant, scheduled for or recommended to have by any medical practitioner any consultation, examination, test or procedure not yet completed, requiring assistance with more than one of the activities of daily living (bathing, dressing, transferring, mobility, toileting or feeding) or unable to climb one flight of stairs?..... Yes No
2. Has the proposed Insured ever tested positive for exposure to the HIV (Human Immunodeficiency Virus) Infection or been diagnosed as having AIDS (Acquired Immune Deficiency Syndrome) caused by the HIV Infection?... Yes No
3. **Within the past two years**, has the proposed Insured been diagnosed with, been treated for or been prescribed medication for: cancer that has spread (metastatic) or for lung, liver or pancreatic cancer, any cognitive impairment, Alzheimer's disease or dementia, or use of illegal, restricted or controlled substances other than as prescribed by a Physician? Yes No

If all answers in Part B1 are NO, the proposed Insured may apply for at least Tier III Premium Classification.

Part B2 (continued on page 2)

1. **Within the past five years**, has the proposed Insured been diagnosed with, been treated for or been prescribed medication for any of the following:..... Yes No
 - Congestive heart failure
 - Cardiomyopathy
 - More than one heart attack or stroke
 - Diabetes treated with insulin in combination with high blood pressure and treated cholesterol or other lipids
 - Suicide attempt
 - Chronic or recurrent pancreatitis
 - Cirrhosis
 - Systemic lupus involving kidneys or brain
 - Sickle cell anemia
 - ALS (Lou Gehrig's Disease)
 - Down's syndrome
 - Muscular dystrophy
 - Cancer that has spread (metastatic)
 - Any cancer of the digestive tract, breast, female organs, kidney, bladder, lung, pancreas, liver or brain; melanoma, lymphoma, leukemia
 - Alcohol or drug abuse
 - Kidney failure

Part B2 - (continued from page 1)

2. **Within the past two years**, has the proposed Insured:..... Yes No
- Had or been prescribed kidney dialysis or use of oxygen
 - Had heart surgery
 - Had an amputation due to disease
 - Been wheelchair-bound
 - Been convicted more than once of driving while impaired or reckless driving
3. If the proposed Insured is **25 years old or younger**, has the proposed Insured **ever** been diagnosed with, been treated for or been prescribed medication for:..... Yes No
- Cerebral palsy
 - Schizophrenia
 - Diabetes treated with insulin
 - Muscular dystrophy
 - Mental retardation requiring constant supervision
 - Use of illegal, restricted or controlled substances other than as prescribed by a Physician

If all answers in Parts B1 & B2 are NO, the proposed Insured may apply for at least Tier II Premium Classification.

Part B3

1. **Within the past five years**, has the proposed Insured been diagnosed with, been treated for or been prescribed medication for any of the following:..... Yes No
- Heart attack
 - Coronary artery disease
 - Stroke
 - Diabetes treated with insulin
 - Bipolar disorder
 - Schizophrenia
 - Mental retardation requiring supervision
 - Cerebral palsy with epilepsy
 - Cancer other than of the skin
 - Chronic asthma
 - Chronic or recurrent bronchitis
 - Emphysema
 - Chronic liver disease or chronic hepatitis
2. **Within the past five years**, has the proposed Insured:..... Yes No
- Had or been prescribed kidney dialysis or use of oxygen
 - Had heart surgery
 - Had an amputation due to disease
 - Taken oral steroids such as prednisone repeatedly or constantly
 - Been convicted of driving while impaired or reckless driving
 - Been convicted of a felony
 - Used illegal, restricted or controlled substances other than as prescribed by a Physician
3. If the proposed Insured is **35 years old or younger**, has the proposed Insured **within the past two years** participated in motorized racing with a top speed of more than 160 miles per hour, scuba diving more than 100 feet deep, sky diving, B.A.S.E. jumping, aerial acrobatics or aviation unless having more than 100 solo hours and a certificate other than Student?..... Yes No
4. As part of employment, does the proposed Insured handle explosives, work in underground mines, work with radioactive materials, work in steel or metal construction or work in the logging industry?..... Yes No

If all answers in Parts B1, B2 & B3 are NO, the proposed Insured may apply for Tier I Premium Classification.

Disclosure Statement for Terminal Illness Accelerated Benefit

The Policy will terminate if an accelerated benefit is paid.

This Disclosure Statement provides you with a summary of the unique accelerated benefit feature that is available on your Policy. A terminal illness (the **covered condition**) is defined as a non-correctable medical condition that will result in the death of the Insured within twelve months or less from the date of the Physician's statement.

This feature provides a benefit payment **to the policyowner, in the event the Insured is diagnosed with a covered condition**, equal to 100% of the Specified Death Benefit less 1) an interest discount for 12 months; and 2) any Premium due and unpaid during a Policy's grace period which applies to a period before the date of entitlement; and 3) an administrative expense charge not to exceed \$100.

	Premium	Cash Surrender Value	Specified Death Benefit	Interest Discount	Admin. Fee	Benefit Amount
Before accelerated payment:	\$1,000	\$5,000	\$50,000	— \$3,704	— \$100	= \$46,196
After accelerated payment:	\$0	\$0	\$0			

This example assumes a Policy with Cash Surrender Value, a Specified Death Benefit of \$50,000, an interest discount rate of 8% and an administrative fee of \$100.

I/We understand, agree and acknowledge:

- The accelerated benefit provision does not become effective unless the covered condition first manifests itself on or after the 30th day following the Policy Issue Date for Tier I and Tier II Premium Classifications.
- The accelerated benefit is not available for Tier III Premium Classification.
- No producer/representative has the authority to alter or add to the provisions of the accelerated benefit.
- I/We have received a copy of this Disclosure Statement.
- **Payment of an accelerated benefit could adversely affect your eligibility for Medicaid or other government benefits or entitlements. Because accelerated benefits may be taxable, you should consult with your personal tax advisor.**

Acknowledgement

I (We) acknowledge that I (we) have read and understand this application in its entirety. I (We) represent to the best of my (our) knowledge that all information in this application, and all additions to this application, including but not limited to, examination reports, questionnaires, supplements, and amendments, is true, complete, and correctly recorded. I (We) acknowledge that the Company will rely on this information to determine whether, and on what terms, to issue a Policy. I (We) understand that if any information is false, incomplete or incorrectly recorded, any Policy issued may be void. I (We) agree that insurance coverage under the Policy for which I (we) am (are) applying will not take effect until the Policy Issue Date and then only if all of the information provided in the application, and all additions to the application as referenced above, continues to be true and complete as of the Issue Date. Commencement of coverage is also subject to the following conditions: (1) if the Company does not receive the first full modal Premium within 30 days after the Issue Date, coverage will not take effect until the full Premium is received by the Company, and then only if all the information provided in the application, and any additions to the application as referenced above, continues to be true and complete as of that date; (2) if a health certificate is required, coverage will not take effect until the certificate has been truthfully and accurately completed and signed by the Insured, and reviewed and approved by the Company; (3) if the Policy Date is later than the Issue Date, coverage will not take effect until the Policy Date, and then only if all the information provided in the application, and any additions to the application as referenced above, continues to be true and complete as of the Policy Date; (4) if the Policy is issued without a Temporary Insurance Agreement (TIA) in place, then coverage begins on the Issue Date. I (We) understand that if any of the information provided in the application, or any

additions to the application, including but not limited to, examination reports, questionnaires, supplements, and amendments, changes prior to coverage becoming effective as set forth above, I (we) must inform the Company in writing, and no coverage will be in effect until the Company determines whether to provide coverage and on what terms. I (We) understand that no producer/representative is authorized to accept risks or bind coverage, decide insurability, modify the application or the Policy, or waive any of the Company's rights or requirements. I (We) acknowledge that I (we) have read and understand the Notice of Company Information Practices in its entirety. I (We) authorize any Physician, medical practitioner, hospital or medically related facility, pharmacy benefit manager, prescription database, insurance company, the Medical Information Bureau ("MIB"), credit bureau(s), Department of Motor Vehicles, friends, neighbors, employers, or any other institution or person having any records or knowledge of my (our): mental or physical health, including, but not limited to information regarding my (our) HIV status, and all test records and results; other insurance coverage; hazardous activities; character; general reputation; mode of living; finances; or vocation; to release said information to Jackson National Life Insurance Company® or its reinsurers if they choose to request such information for the purpose of verifying information on this application or to determine eligibility for insurance. I (We) understand that information obtained will be released by the Company only to reinsurers, the MIB, persons performing services in connection with my application or claim, or as lawfully required. No information collected concerning my (our) sexual orientation will be used to determine my (our) eligibility for insurance. I (We) agree that this authorization is valid for 24 months, that a photocopy of it is as valid as the original and that I (we) may request a copy of this authorization. In the case where the authorization is used in connection with a claim, the authorization is valid for the duration of the claim.

Fraud Warnings

Arkansas, Kentucky, Louisiana, Ohio, Oklahoma and Pennsylvania residents please note: 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.

Colorado residents, please note: 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 and Tennessee residents, please note: 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 and/or a denial of insurance benefits.

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

New Mexico residents, please note: 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 fines and criminal penalties.

Signature Required on Page 4.

Replacement

Do you have any existing life insurance policies or annuity contracts? Yes No
 Will this Policy replace any existing life insurance or annuity? Yes No If "Yes", please enter:
 Company Name: _____ Policy/Contract No.: _____
 Replaced Policy Date (mm/dd/yyyy): _____ Death Benefit: \$_____

Producer/Representative: If the Applicant does have existing life insurance policies or annuity contracts you must present and read to the Applicant the Notice Regarding Replacement (X0512) - state variations may apply and return the Notice, signed by both the Producer and the Applicant, with the Application.

All accompanying requirements for "GOOD ORDER" must be dated on or before the application sign date.

This Policy will be issued without a Temporary Insurance Agreement (TIA), unless state insurance law requires otherwise. If there is no TIA, your coverage will not begin until the Policy has been issued.

CALIFORNIA RESIDENTS, AGE 65 OR OLDER: Prior to purchasing any life insurance or annuity product, you should understand that the sale or liquidation of any stock, bond, IRA, certificate of deposit, mutual fund, annuity, or other asset to fund the purchase of this product may have tax consequences, early withdrawal penalties, or other costs or penalties as a result of the sale or liquidation. You or your representative may wish to consult an independent legal or financial advisor before selling or liquidating any assets prior to the purchase of any life or annuity product.

Signatures

Proposed Insured's Signature	Signed at (city, state)	Date Signed (mm/dd/yyyy)
Policy Owner's Signature (if other than the Proposed Insured)	Signed at (city, state)	Date Signed (mm/dd/yyyy)
Parent or Guardian's Signature (if applicable)	Signed at (city, state)	Date Signed (mm/dd/yyyy)

Producer/Representative: Check the applicable statement:

- I did not use sales material(s) during the presentation of this JacksonSM product to the Applicant.
 I used only Jackson-approved sales material(s) during the presentation of this Jackson product to the Applicant. In addition, copies of all approved sales material(s) used during the presentation were left with the Applicant.

I acknowledge and represent: (1) I read each question on the application to the proposed Insured, in English or in another language understood by the proposed Insured, and accurately recorded his/her responses. (2) I am not aware of any requested information that was not disclosed or was misrepresented on the application. (3) All information provided on this report or in response to Company inquiries about the application, or the proposed Insured, is true and correct to the best of my knowledge and belief. (4) I have read the Company's Position With Respect to the Acceptability of Replacements, and this application, if a

replacement, is consistent with that position. (5) I have complied with requirements for disclosures and/or replacements as necessary. (6) To the best of my knowledge and belief the applicant's statement as to whether or not an existing life insurance Policy or annuity contract is being replaced is true and accurate. (7) To the best of my knowledge, the applicant **does** **does not** have any existing life insurance policies or annuity contracts. (If a replacement, please provide a replacement form or other special forms where required by state law.)

Producer/Representative's Signature	Date (mm/dd/yyyy)
Print Producer/Representative's Name	Producer/Representative's E-mail Address
Jackson Producer/Representative's Number	

If more than one producer/representative is to receive compensation on this case, please provide all producer/representative names, Jackson producer/representative numbers and percentages for each (totaling 100%):

Name	Jackson Producer/Representative No.	Percent
Name	Jackson Producer/Representative No.	Percent

Mailing Address and Contact Information

Regular Mail: Jackson Service Center, P.O. Box 30099, Lansing, MI 48909-7599
Overnight Mail: Jackson Service Center, 1 Corporate Way, Lansing, MI 48951
Customer Care: 800/873-5654 (8:00 a.m. to 8:00 p.m. ET) or contactus@jackson.com
Fax: 517/706-5542

Not FDIC/NCUA insured • Not Bank/CU guaranteed • May lose value • Not a deposit • Not insured by any federal agency

Whole Life Reinstatement Application

Home Office: 1 Corporate Way
Lansing, MI 48951
www.jackson.com

For reinstatement of policy number:	Premium was due:
Insured:	Premium amount due to reinstate policy:

Personal History - Please Answer all questions.

Height: _____ (ft./in.) Weight: _____ (lbs.)

- 1a. Is the proposed Insured currently; hospitalized, confined to a nursing facility or hospice or hospice program, confined to bed at home for the past two months or longer, institutionalized, on parole or probation, awaiting organ transplant, scheduled for or recommended to have by any medical practitioner any consultation, examination, test or procedure not yet completed, requiring assistance with more than one of the activities of daily living (bathing, dressing, transferring, mobility, toileting or feeding) or unable to climb one flight of stairs..... Yes No
- b. Has the proposed Insured ever tested positive for exposure to the HIV (Human Immunodeficiency Virus) Infection or been diagnosed as having AIDS (Acquired Immune Deficiency Syndrome) caused by the HIV Infection? Yes No
- c. **Within the past two years**, has the proposed Insured been diagnosed with, been treated for or been prescribed medication for: cancer that has spread (metastatic) or for lung, liver or pancreatic cancer, any cognitive impairment, Alzheimer's disease or dementia, or use of illegal, restricted or controlled substances other than as prescribed by a Physician?..... Yes No

- 2a. **Within the past five years**, has the proposed Insured been diagnosed with, been treated for or been prescribed medication for any of the following:..... Yes No

- | | | |
|---|--|--|
| <ul style="list-style-type: none"> • Congestive heart failure • Cardiomyopathy • More than one heart attack or stroke • Diabetes treated with insulin in combination with high blood pressure and treated cholesterol or other lipids • Suicide attempt • Chronic or recurrent pancreatitis | <ul style="list-style-type: none"> • Cirrhosis • Systemic lupus involving kidneys or brain • Sickle cell anemia • ALS (Lou Gehrig's Disease) • Down's syndrome • Muscular dystrophy • Cancer that has spread (metastatic) | <ul style="list-style-type: none"> • Any cancer of the digestive tract, breast, female organs, kidney, bladder, lung, pancreas, liver or brain; melanoma, lymphoma, leukemia • Alcohol or drug abuse • Kidney failure |
|---|--|--|

- b. **Within the past two years**, has the proposed Insured:..... Yes No

- | | |
|--|--|
| <ul style="list-style-type: none"> • Had or been prescribed kidney dialysis or use of oxygen • Had heart surgery • Had an amputation due to disease | <ul style="list-style-type: none"> • Been wheelchair-bound • Been convicted more than once of driving while impaired or reckless driving |
|--|--|
- c. If the proposed Insured is **25 years old or younger**, has the proposed Insured **ever** been diagnosed with, been treated for or been prescribed medication for:..... Yes No
- | | | |
|--|---|---|
| <ul style="list-style-type: none"> • Cerebral palsy • Schizophrenia • Diabetes treated with insulin | <ul style="list-style-type: none"> • Muscular dystrophy • Mental retardation requiring constant supervision | <ul style="list-style-type: none"> • Use of illegal, restricted or controlled substances other than as prescribed by a Physician |
|--|---|---|

- 3a. **Within the past five years**, has the proposed Insured been diagnosed with, been treated for or been prescribed medication for any of the following:..... Yes No

- | | | |
|--|--|--|
| <ul style="list-style-type: none"> • Heart attack • Coronary artery disease • Stroke • Diabetes treated with insulin • Bipolar disorder | <ul style="list-style-type: none"> • Schizophrenia • Mental retardation requiring supervision • Cerebral palsy with epilepsy • Cancer other than of the skin | <ul style="list-style-type: none"> • Chronic asthma • Chronic or recurrent bronchitis • Emphysema • Chronic liver disease or chronic hepatitis |
|--|--|--|

- b. **Within the past five years**, has the proposed Insured:..... Yes No

- | | |
|---|---|
| <ul style="list-style-type: none"> • Had or been prescribed kidney dialysis or use of oxygen • Had heart surgery • Had an amputation due to disease • Taken oral steroids such as prednisone repeatedly or constantly | <ul style="list-style-type: none"> • Been convicted of driving while impaired or reckless driving • Been convicted of a felony • Used illegal, restricted or controlled substances other than as prescribed by a Physician |
|---|---|

- c. If the proposed Insured is **35 years old or younger**, has the proposed Insured **within the past two years** participated in motorized racing with a top speed of more than 160 miles per hour, scuba diving more than 100 feet deep, sky diving, B.A.S.E. jumping, aerial acrobatics or aviation unless having more than 100 solo hours and a certificate other than Student?..... Yes No

- d. As part of employment, does the proposed Insured handle explosives, work in underground mines, work with radioactive materials, work in steel or metal construction or work in the logging industry?..... Yes No

I acknowledge that I have read and understand this application in its entirety. I represent, to the best of my knowledge, that the answers and statements in the Personal History Section of this Application are true, complete and correctly recorded. I acknowledge that the Company will rely on these answers and statements to determine whether, and on what terms, to reinstate the Policy. I understand and agree that the contestable period for the Policy will begin anew on the date it is reinstated, and that if any answers and/or statements are false, incomplete or incorrectly recorded, the reinstatement may be void. **I agree that the Policy will not be reinstated and coverage will not take effect until the reinstatement date, and then only if all of the information provided in the application continues to be true and complete as of the reinstatement date. Commencement of coverage is also subject to the following conditions: a) this Reinstatement Application is approved by the Company; and b) all required premiums are received by the Company, and then only if information provided in the reinstatement application continues to be true and complete as of the reinstatement date. I understand that if any of the Personal History information provided in this Reinstatement Application changes prior to coverage becoming effective, as set forth above, I must inform the Company in writing, and no coverage will be in effect until the Company determines whether to provide coverage and on what terms. I further understand that if I fail to so advise the Company, any**

coverage provided by the reinstated Policy may be void.

I understand that no producer/representative is authorized to accept risks or bind coverage, decide insurability, modify the application or the Policy, or waive any of the Company's rights or requirements.

Medical Information Bureau disclaimer: I authorize any Physician, medical practitioner, hospital or medically related facility, pharmacy benefit manager, prescription database, insurance company, the Medical Information Bureau ("MIB"), credit bureau(s), Department of Motor Vehicles, friends, neighbors, employers, or any other institution or person having any records or knowledge of my: mental or physical health, including, but not limited to information regarding my HIV status, and all test records and results; other insurance coverage; hazardous activities; character; general reputation; mode of living; finances; or vocation; to release said information to Jackson National Life Insurance Company® or its reinsurers if they choose to request such information for the purpose of verifying information of this reinstatement application or to determine eligibility for insurance. No information collected concerning my sexual orientation will be used to determine my eligibility for insurance. I understand information obtained will be released by the Company only to reinsurers, the MIB, persons performing services in connection with my application or claim or as lawfully required. I agree that this authorization is valid for 24 months, that a photocopy of it is as valid as the original and that I may request a copy of this authorization.

Arkansas, Kentucky, Louisiana, Ohio, Oklahoma, and Pennsylvania residents, please note: 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.

Colorado residents, please note: 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, Tennessee and Washington residents, please note: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company or any other person. Penalties may include imprisonment, fines and/or a denial of insurance benefits.

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

New Mexico residents, please note: 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 fines and criminal penalties.

Insured's Signature	Signed at (city and state)	Date (mm/dd/yyyy)
Owner's Signature (if other than Insured)	Signed at (city and state)	Date (mm/dd/yyyy)
Parent or Guardian's Signature (if applicable)	Signed at (city and state)	Date (mm/dd/yyyy)

Mailing Address and Contact Information

Regular Mail: JacksonSM Service Center, P.O. Box 30302, Lansing, MI 48909-7802
Overnight Mail: Jackson Service Center, 1 Corporate Way, Lansing, MI 48951
Customer Care: 800/644-4565 (8:00 a.m. to 8:00 p.m. ET) or contactus@jackson.com
 Fax 517/706-5552

SERFF Tracking Number: JACK-125829413 *State:* Arkansas
Filing Company: Jackson National Life Insurance Company *State Tracking Number:* 40395
Company Tracking Number: X3300 02/09 ET AL
TOI: L071 Individual Life - Whole *Sub-TOI:* L071.101 Fixed/Indeterminate Premium - Single Life

Product Name: Whole Life Application
Project Name/Number: Whole Life Application/X3300 02/09

Rate Information

Rate data does NOT apply to filing.

SERFF Tracking Number: JACK-125829413 State: Arkansas
Filing Company: Jackson National Life Insurance Company State Tracking Number: 40395
Company Tracking Number: X3300 02/09 ET AL
TOI: L071 Individual Life - Whole Sub-TOI: L071.101 Fixed/Indeterminate Premium - Single Life
Product Name: Whole Life Application
Project Name/Number: Whole Life Application/X3300 02/09

Supporting Document Schedules

Review Status:
Satisfied -Name: Certification/Notice 09/23/2008
Comments:
Attachment:
AR - Cert Notice.pdf

Review Status:
Satisfied -Name: Application 09/23/2008
Comments:
See Form Schedule Tab

Review Status:
Satisfied -Name: Statement of Variability 09/23/2008
Comments:
Attachments:
X3300 Statement of Variability (base).pdf
X3305 Statement of Variability (base).pdf

Review Status:
Satisfied -Name: AR - Flesch Cert 09/23/2008
Comments:
Attachment:
AR - Flesch Cert.pdf

CONSENT TO SUBMIT RATES
AND/OR COST BASIS FOR APPROVAL

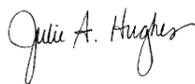
The Jackson National Life Insurance Company of Lansing, Michigan does hereby consent and agree:

A) that all premium rates and/or cost basis both “maximum” and “current or projected,” used in relation to form numbers X3300 02/09 and X3305 02/09 must be filed with the Insurance Commissioner for the State of Arkansas (“Commissioner”) at least sixty (60) days prior to their proposed effective date. Such rates and/or cost basis shall be deemed effective sixty (60) days after they are filed with the Commissioner, unless the Commissioner shall approve or disapprove such rates and/or cost basis prior to the expiration of sixty (60) days.

or

B) that where the policy is a flexible or indeterminate premium whole life policy which provides for frequent changes in interest rates based on financial market conditions, the company may file a range of rates it will stay within and will notify the Department at least sixty (60) days prior to any change in the range of rates. The company must also document the method used to calculate its premium and range of rates.

Jackson National Life Insurance Company

By : 

Julie Hughes
Assistant Vice-President
Product Drafting and State Filing Department

Date: September 29, 2008

**JACKSON NATIONAL LIFE INSURANCE COMPANY
STATEMENT OF VARIABILITY**

**Form Number: X3300 02/09
Whole Life Application**

Page(s)	Bracketed (Variable)	Range of Variables
1	[Home Office: 1 Corporate Way Lansing, Michigan 48951 www.jackson.com]	This is the current home office address, city/state and website of Jackson National Life. In the future, if changed, this will reflect a different, valid address within the confines of the United States, as well as a valid Company website.
1-4	Internal Control Number [X3300 02/09]	This number would change if there were a change to the bracketed information on the application requiring revision of the application. If changed this will reflect a revised control number and/or revision date.
1 & 4	MEC Acknowledgement form [X3350], or Premium Payment Charge Authorization form [X0300], or Notice Regarding Replacement form [X0512]	These are the current form numbers for the administrative forms listed. It is possible these form numbers will be changed in the future, therefore it is appropriate to bracket the information as variable.
3	Fraud Notice Disclosures	Bracketed for changes required by states for disclosure regarding fraud notice.
4	Service Center Mailing Address and Contact Information	These are the current post office boxes and toll-free telephone numbers of Jackson National Life's Service Centers. In the future, if changed, this will reflect a valid street address within the confines of the United States, as well as a valid telephone number and email address.

**JACKSON NATIONAL LIFE INSURANCE COMPANY
STATEMENT OF VARIABILITY**

**Form Number: X3305 02/09
Whole Life Reinstatement Application**

Page(s)	Bracketed (Variable)	Range of Variables
1	[Home Office: 1 Corporate Way Lansing, Michigan 48951 www.jackson.com]	This is the current home office address, city/state and website of Jackson National Life. In the future, if changed, this will reflect a different, valid address within the confines of the United States, as well as a valid Company website.
1-2	Internal Control Number [X3305 02/09]	This number would change if there were a change to the bracketed information on the application requiring revision of the application. If changed this will reflect a revised control number and/or revision date.
2	Fraud Notice Disclosures	Bracketed for changes required by states for disclosure regarding fraud notice.
2	Service Center Mailing Address and Contact Information	These are the current post office boxes and toll-free telephone numbers of Jackson National Life's Service Centers. In the future, if changed, this will reflect a valid street address within the confines of the United States, as well as a valid telephone number and email address.

CERTIFICATION

This is to certify that X3300 02/09 has achieved a Flesch Reading Ease Score of 53.8 and complies with the requirements of Arkansas State Ann. §66-3251 through §66-3258, cited as the Life and Disability Insurance Policy Language Simplification Act.

This is to certify that X3305 02/09 has achieved a Flesch Reading Ease Score of 50.5 and complies with the requirements of Arkansas State Ann. §66-3251 through §66-3258, cited as the Life and Disability Insurance Policy Language Simplification Act.

Jackson National Life Insurance Company



By: _____

Julie Hughes
Assistant Vice-President
Product Drafting and State Filing Department

Date: September 29, 2008

Arkansas