

<i>SERFF Tracking Number:</i>	<i>AUWL-125919859</i>	<i>State:</i>	<i>Arkansas</i>
<i>Filing Company:</i>	<i>Century Life Assurance Company</i>	<i>State Tracking Number:</i>	<i>40988</i>
<i>Company Tracking Number:</i>	<i>FLEX TERM (09)</i>		
<i>TOI:</i>	<i>L04G Group Life - Term</i>	<i>Sub-TOI:</i>	<i>L04G.103 Renewable - Single Life - Fixed/Indeterminate Premium</i>
<i>Product Name:</i>	<i>Flex Term</i>		
<i>Project Name/Number:</i>	<i>Flex Term/</i>		

Filing at a Glance

Company: Century Life Assurance Company

Product Name: Flex Term

TOI: L04G Group Life - Term

Sub-TOI: L04G.103 Renewable - Single Life - Fixed/Indeterminate Premium

Filing Type: Form

SERFF Tr Num: AUWL-125919859 State: ArkansasLH

SERFF Status: Closed

Co Tr Num: FLEX TERM (09)

Co Status:

Author: Linda DeStasio

Date Submitted: 12/01/2008

State Tr Num: 40988

State Status: Approved-Closed

Reviewer(s): Linda Bird

Disposition Date: 12/05/2008

Disposition Status: Approved

Implementation Date:

Implementation Date Requested: On Approval

State Filing Description:

General Information

Project Name: Flex Term

Project Number:

Requested Filing Mode:

Explanation for Combination/Other:

Submission Type: New Submission

Overall Rate Impact:

Filing Status Changed: 12/05/2008

State Status Changed: 12/05/2008

Corresponding Filing Tracking Number:

Filing Description:

This is a group term insurance for a single insured. The master policy is issued to a financial institution with coverage being written by a licensed agent from the bank's insurance division. The face amount is variable and is determined by the applicant. It may be assigned, if desired. It is not credit insurance as it is not tied to any specific loan. The coverage is single premium for the first three years. After three years, the insured may choose to keep a level coverage for an increasing premium or choose a decreasing coverage for a level premium. A short-term disability income is also included.

Status of Filing in Domicile: Not Filed

Date Approved in Domicile:

Domicile Status Comments:

Market Type: Group

Group Market Size: Small and Large

Group Market Type: Other

Deemer Date:

<i>SERFF Tracking Number:</i>	<i>AUWL-125919859</i>	<i>State:</i>	<i>Arkansas</i>
<i>Filing Company:</i>	<i>Century Life Assurance Company</i>	<i>State Tracking Number:</i>	<i>40988</i>
<i>Company Tracking Number:</i>	<i>FLEX TERM (09)</i>		
<i>TOI:</i>	<i>L04G Group Life - Term</i>	<i>Sub-TOI:</i>	<i>L04G.103 Renewable - Single Life - Fixed/Indeterminate Premium</i>
<i>Product Name:</i>	<i>Flex Term</i>		
<i>Project Name/Number:</i>	<i>Flex Term/</i>		

Company and Contact

Filing Contact Information

Linda DeStasio, Administrative Asst.
PO Box 9510
Wichita, KS 67277

ldestasio@iai-online.com
(800) 333-2525 [Phone]
(316) 794-8470[FAX]

Filing Company Information

Century Life Assurance Company
PO Box 9510
Wichita, KS 67277
(800) 333-2525 ext. 125[Phone]

CoCode: 94447
Group Code:
Group Name:
FEIN Number: 73-1091065

State of Domicile: Oklahoma
Company Type: Life & Health
State ID Number:

Filing Fees

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

CHECK NUMBER	CHECK AMOUNT	CHECK DATE
2867	\$50.00	12/01/2008

SERFF Tracking Number: AUWL-125919859 State: Arkansas
Filing Company: Century Life Assurance Company State Tracking Number: 40988
Company Tracking Number: FLEX TERM (09)
TOI: L04G Group Life - Term Sub-TOI: L04G.103 Renewable - Single Life -
Fixed/Indeterminate Premium
Product Name: Flex Term
Project Name/Number: Flex Term/

Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved	Linda Bird	12/05/2008	12/05/2008

SERFF Tracking Number: AUWL-125919859

State: Arkansas

Filing Company: Century Life Assurance Company

State Tracking Number: 40988

Company Tracking Number: FLEX TERM (09)

TOI: L04G Group Life - Term

Sub-TOI: L04G.103 Renewable - Single Life -
Fixed/Indeterminate Premium

Product Name: Flex Term

Project Name/Number: Flex Term/

Disposition

Disposition Date: 12/05/2008

Implementation Date:

Status: Approved

Comment:

Rate data does NOT apply to filing.

SERFF Tracking Number: AUWL-125919859

State: Arkansas

Filing Company: Century Life Assurance Company

State Tracking Number: 40988

Company Tracking Number: FLEX TERM (09)

TOI: L04G Group Life - Term

Sub-TOI: L04G.103 Renewable - Single Life -
Fixed/Indeterminate Premium

Product Name: Flex Term

Project Name/Number: Flex Term/

Item Type	Item Name	Item Status	Public Access
Supporting Document	Certification/Notice		Yes
Supporting Document	Application		Yes
Supporting Document	Actuarial		No
Form	Master Policy		Yes
Form	Certificate		Yes
Form	Application		Yes

SERFF Tracking Number: AUWL-125919859 State: Arkansas
 Filing Company: Century Life Assurance Company State Tracking Number: 40988
 Company Tracking Number: FLEX TERM (09)
 TOI: L04G Group Life - Term Sub-TOI: L04G.103 Renewable - Single Life -
 Fixed/Indeterminate Premium
 Product Name: Flex Term
 Project Name/Number: Flex Term/

Form Schedule

Lead Form Number: FLXTP(09)

Review Status	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
	FLXTP(09)	Policy/Cont	Master Policy ract/Fratern al Certificate	Initial		41	Flex Policy CLA.pdf
	FLXTC(09)	Advertising	Certificate	Initial		41	Flex Certificate CLA.pdf
	92004- FLXTR(08)	Application/ Enrollment	Application Form	Initial		40	92004FlexCL A(08).pdf

CENTURY LIFE ASSURANCE COMPANY

Home Office: Oklahoma City, Oklahoma
Administrative Offices: 1035 S. 183rd Street, Goddard, Kansas 67052
Mailing Address: P.O. box 9510, Wichita, Kansas 67277

We, the company named above, have issued Group Policy Number [00000]
to [THE POLICYHOLDER] , hereinafter called the Policyholder.

In consideration of the applications of the Policyholder and Insured and the payment of premiums, We agree to pay death and/or disability benefits as provided by the policy. We will issue a certificate that outlines coverage to each insured.

Death and/or disability payments may not be enough to pay off a debt. Pre-existing conditions may not be covered.

The certificate is renewable at the option of the Insured while the group policy remains in force.

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

**Group Insurance Certificate
Renewable Term
Nonparticipating**

Blank page

INSURANCE BENEFITS

We will pay, upon receipt of due proof of the Insured's death, the amount of insurance then in force.

The death benefit applies only if a life insurance premium has been paid.

Unless changed by the Insured, the amount of insurance in force shall be the original amount of insurance as stated in the Schedule of Benefits.

The Insured may elect in writing to change the original amount of insurance. If changed, the amount of insurance in force will decrease in equal amounts on the last day of each certificate month. The decrease will start at the end of the first certificate month in the certificate year in which the Insured makes the change so as to reduce the amount of insurance to zero at the end of the last certificate month in the term of coverage.

The term of coverage is determined by the attained age of the Insured on the date of conversion.

The Insured's age at the time of change.	Term of Coverage
Age 21 through 34	240 months
Age 35 through 60	180 months
Age 61 through 80	120 months

SUICIDE

If the Insured dies by suicide, whether sane or insane, within one year from the effective date of coverage, and while the certificate of insurance is in force, the death benefit payable hereunder is the amount of the life premiums paid.

EXCLUSIONS FROM DEATH BENEFITS

No death benefits will be paid if death results from: 1) committing or attempting to commit a felony; 2) voluntary use of a controlled substance as defined in Title II of the Comprehensive Drug Abuse Prevention and Control Act of 1970, as now or hereafter amended, except as prescribed by a physician.

NOTICE OF CLAIM

Written notice of claim must be given to Us within thirty days after the occurrence of any covered loss as soon as reasonably possible. Notice given by or for the Insured or beneficiary to Us at Our Administrative Offices, Wichita, Kansas, with information sufficient to identify the Insured shall be deemed notice to Us.

DISABILITY BENEFITS

MONTHLY DISABILITY BENEFIT

We will pay disability benefits, upon receipt of due notice and proof in writing that the Insured, while insured hereunder, has become totally disabled. We will pay the monthly disability benefit shown in the Schedule of Benefits. Disability benefits apply only if a disability premium has been paid. Such benefits will be paid only if the disability continues for more than the waiting period shown in the schedule of benefits. Payments will begin with the first day following the elimination period in the Schedule of Benefits. We will pay for the number of days said disability falls within the period of coverage shown by the certificate at one-thirtieth (1/30th) of the rate of the monthly disability benefit.

Disability benefits are payable for only one Limited Benefit Period during the entire time of coverage. Disability benefits will include all amounts paid for total disability, whether during one or more periods of disability. In the event that the maximum benefit has been paid, Our liability shall end with respect to any further disability benefits.

Disability benefits will not be paid beyond the expiration or termination of coverage.

Only one monthly disability benefit is payable during any period of total disability even though such total disability is caused by or results from both injury and sickness.

DEFINITIONS

Injury means bodily injury sustained directly and independently of all other causes and resulting from an accident. The accident must occur after the effective date and cause loss while the certificate is in force. Such injury must require regular care from a physician other than the Insured or a family member.

Sickness means a bodily disorder first manifested after the effective date and causing loss while the certificate is in force. Such sickness must require regular care from a physician other than the Insured or a family member.

Total Disability means the Insured's complete inability for the first 12 months of continuous disability to engage in the material and substantial duties of the Insured's occupation due to injury or sickness. After the first 12 months, total disability means the Insured's complete inability to engage in any occupation or employment for compensation or profit for which the Insured is reasonably qualified by reason of education, training or experience.

EXCLUSIONS FROM DISABILITY BENEFITS

No disability benefits are payable if the Insured's disability results from, was caused by or contributed to by: 1) any intentionally self-inflicted injury, whether sane or insane; 2) an accident or sickness or disease which first required medical diagnosis or treatment (or would have caused a reasonably prudent person to have sought medical diagnosis or treatment) within six months preceding the effective date of coverage and which causes loss within six months following the effective date of coverage; provided, however, that disability commencing thereafter resulting from such conditions shall be covered; 3) normal pregnancy, common childbirth or miscarriage; 4) committing or attempting to commit a felony; 5) voluntary use of a controlled substance as defined in Title II of the Comprehensive Drug Abuse Prevention and Control Act of 1970, as now or hereafter amended, except as prescribed by a physician; 6) an accident suffered by the Insured for which intoxication of the Insured was a contributing factor.

CLAIM FORMS

We, upon receipt of notice of claim, will furnish forms that are usually furnished for filing proof of loss. We will send the claim forms within fifteen days after We are notified of the claim. If We do not send the forms in fifteen days, the Insured can simply send Us written proof of disability. The proof must show the date and cause of the total disability; and it must be signed by a physician other than the Insured or a family member.

PROOF OF LOSS

Written proof of loss must be furnished to Us at Our Administrative Offices at the Insured's expense. The proof of loss must be sent to Us no later than ninety days after the total disability begins. Failure to furnish such proof within the time required shall not invalidate nor reduce any claim if it was not reasonably possible to give proof within such time; provided such proof is furnished as soon as reasonably possible. Except in the absence of legal capacity, proof must be furnished no later than one year from the time proof is otherwise required.

TIME PAYMENT OF CLAIMS

Subject to due written proof of loss, all accrued benefits for loss for which the policy provides periodic payments, will be paid monthly. Any accrued benefits remaining unpaid upon the end of disability will be paid immediately upon receipt of due written proof.

APPLICABLE TO LIFE AND DISABILITY BENEFITS

BENEFITS PAYABLE

Any benefits payable will be paid in the following order: 1) to the insured, if living; to the beneficiary, if living; 3) to the estate of the insured. If the policy has been assigned, benefits will be paid to the assignee, as their interests may appear and then in the order listed above.

BENEFICIARY

The Insured, while living, may change the named beneficiary by filing satisfactory written notice with Us. The change will be effective on the date it is recorded by Us. However, We will not be liable for any action taken or payment made before the change is recorded. If any beneficiary is named irrevocable, the beneficiary may not be changed without the irrevocable beneficiary's consent in writing.

LIFE AND DISABILITY PROVISIONS

PREMIUMS

During the initial term, a single premium, as scheduled, shall be payable in advance; thereafter, premiums shall be payable annually to Us at our Administrative Offices before renewal dates.

Premiums will be based on the original amount of insurance at the Insured's attained age on each renewal date. If the Insured elects to decrease the original amount of insurance, the premium will remain level at the current renewal premium at the time the request for change in coverage is made, subject to any increase in premium as explained below.

Any premium which falls due during a period of disability and is not paid by the end of the grace period will be deducted from any benefits payable.

After the Initial Term, We may change the premium from time to time, subject to the following: 1) the premium may be increased or decreased on any certificate anniversary. Written notice of premium change will be provided to the policyholder prior to the anniversary; 2) a change in premium will apply to all certificates issued to the same policyholder, for the same policy form, for the same age group, sex and risk class of the certificate. Any change in premium will be based on Our determination of Our expected future experience with regard to earnings, mortality, morbidity, terminations and expenses. The premium will never be changed to recover losses or to distribute gains realized by Us before the date of change.

GRACE PERIOD

A grace period of 31 days will be allowed for payment of any premium, except the first. The term of coverage for any Insured shall be the date through which premium payments have been made, plus 31 days.

RENEWAL

The certificate is renewable at the option of the Insured while the group master policy is in force, prior to the Insured's age 90. If the Insured has elected to decrease the original amount of insurance, the certificate is renewable only until the end of the term of coverage. Once the amount of insurance in force has reduced to zero, the certificate cannot be renewed.

TERMINATION OF COVERAGE

We may end coverage under the master policy by giving 31 days advance written notice to the Policyholder. The Policyholder may cancel at any time by written notice to Us. Upon termination of the master policy, the certificate shall continue in full force and effect until the end of the term of coverage for which premium has been paid. Once notice requesting master policy termination is received by either the policyholder or Us, the term of the certificate may not be extended by payment of additional premium. If coverage under the master policy is terminated by the policyholder or Us, the policyholder will notify the Insured at least 31 days prior to the date through which premium has been paid that coverage will end.

Any cancellation of coverage will be without prejudice to any disability claim in progress.

CONFORMITY WITH STATE STATUTES

If, on the effective date, any part of the master policy or certificate is in conflict with the statutes of the state where it is issued, then it is automatically amended to meet the minimum requirements of those statutes.

CONSIDERATION

The certificate has been issued in consideration of the statements in the applications of the Insured and policyholder, and payment of the initial premium.

ENTIRE CONTRACT

The entire contract between the policyholder and Us consists of: 1) the master policy and 2) applications of the policyholder and Insured.

INCONTESTABILITY

The validity of the group policy shall not be contested, except for non-payment of premiums, after it has been in force for two years from the date of issue. All statements made by the policyholder or the Insured shall be deemed representations and not warranties. We may not contest the coverage evidenced by the certificate after it has been in force during the lifetime of the Insured for two years from the effective date, except for failure to pay premiums. No statement made by the Insured shall be used in any contest unless a copy of the instrument containing the statement is or has been furnished to the Insured or the beneficiary.

PHYSICAL EXAMINATION AND AUTOPSY

We shall have the right and opportunity to: 1) examine the Insured when and as often as We may reasonably require during a claim; and 2) to make an autopsy where it is not forbidden by law.

MISSTATEMENT OF AGE

The Insured's misstatement of age shall not invalidate any insurance if the Insured was eligible for insurance according to the application. If the age or sex of the Insured as shown on the application is not correct, the benefit will be adjusted. This adjusted benefit will be an amount which the premium paid would have purchased for the correct age and sex.

CHANGES

Only the President and Secretary have the authority to change the policy. Any change must be in writing.

ASSIGNMENT

Coverage may be assigned without the consent of the beneficiary.

NONPARTICIPATING

The policy and certificate do not share in the profits of the Company.

CONVERSION

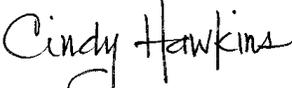
If coverage ends because the group policy is terminated, the Insured is entitled to convert coverage to an individual policy subject to the following terms:

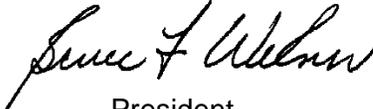
- 1) A written request for a converted coverage along with payment of the first premium shall be made by the Insured within 31 days after the end of coverage;
- 2) We may choose any policy of life or endowment insurance regularly issued by Us for individuals of the same age and sex of the Insured;
- 3) The coverage under the converted policy will not be greater than the insurance in force at the time conversion is requested. Decreases in the coverage will be the same as was permitted under the converted coverage;
- 4) The individual policy will contain provisions similar to those found in regular life policies then being issued by Us. The premium will be the rate charged by Us for the plan selected according to the rates then applicable to the risk class to which the Insured then belongs at the Insured's then attained age. Risk class will not be determined by reference to the Insured's current health status, unless such status is the result of previously supplied health information.

If the Insured dies during the 31 day period mentioned in "1", but before a converted policy has been issued, the insurance under the certificate is payable to the beneficiary. The beneficiary shall not be entitled to any further benefits.

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 five (5) years after the time written proof of loss is required to be furnished.


Secretary


President

AMENDMENTS

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

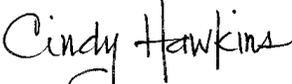
You may also contact your agent or any of our agents for additional help.

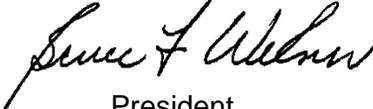
If we fail to provide you with reasonable and adequate service, feel free to contact:

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

Issue State - Idaho

Surrendering this contract – If there is a cash value and you request surrender of this contract, we will send you the cash surrender value within 30 days of our receipt of your request. If we defer your payment for more than 30 days, we will pay you interest. Interest will be from the day we receive your request until we make payment to you. The interest rate will be the rate declared by the Idaho State Treasurer in accordance with Idaho Code 28-22-1 04 on July 1st of every year.


Secretary


President

Blank page

INSURANCE BENEFITS

We will pay, upon receipt of due proof of the Insured's death, the amount of insurance then in force.

The death benefit applies only if a life insurance premium has been paid.

Unless changed by the Insured, the amount of insurance in force shall be the original amount of insurance as stated in the Schedule of Benefits.

The Insured may elect in writing to change the original amount of insurance. If changed, the amount of insurance in force will decrease in equal amounts on the last day of each certificate month. The decrease will start at the end of the first certificate month in the certificate year in which the Insured makes the change so as to reduce the amount of insurance to zero at the end of the last certificate month in the term of coverage.

The term of coverage is determined by the attained age of the Insured on the date of conversion.

The Insured's age at the time of change.	Term of Coverage
Age 21 through 34	240 months
Age 35 through 60	180 months
Age 61 through 80	120 months

SUICIDE

If the Insured dies by suicide, whether sane or insane, within one year from the effective date of coverage, and while the certificate of insurance is in force, the death benefit payable hereunder is the amount of the life premiums paid.

EXCLUSIONS FROM DEATH BENEFITS

No death benefits will be paid if death results from: 1) committing or attempting to commit a felony; 2) voluntary use of a controlled substance as defined in Title II of the Comprehensive Drug Abuse Prevention and Control Act of 1970, as now or hereafter amended, except as prescribed by a physician.

NOTICE OF CLAIM

Written notice of claim must be given to Us within thirty days after the occurrence of any covered loss as soon as reasonably possible. Notice given by or for the Insured or beneficiary to Us at Our Administrative Offices, Wichita, Kansas, with information sufficient to identify the Insured shall be deemed notice to Us.

DISABILITY BENEFITS

MONTHLY DISABILITY BENEFIT

We will pay disability benefits, upon receipt of due notice and proof in writing that the Insured, while insured hereunder, has become totally disabled. We will pay the monthly disability benefit shown in the Schedule of Benefits. Disability benefits apply only if a disability premium has been paid. Such benefits will be paid only if the disability continues for more than the waiting period shown in the schedule of benefits. Payments will begin with the first day following the elimination period in the Schedule of Benefits. We will pay for the number of days said disability falls within the period of coverage shown by the certificate at one-thirtieth (1/30th) of the rate of the monthly disability benefit.

Disability benefits are payable for only one Limited Benefit Period during the entire time of coverage. Disability benefits will include all amounts paid for total disability, whether during one or more periods of disability. In the event that the maximum benefit has been paid, Our liability shall end with respect to any further disability benefits.

Disability benefits will not be paid beyond the expiration or termination of coverage.

Only one monthly disability benefit is payable during any period of total disability even though such total disability is caused by or results from both injury and sickness.

DEFINITIONS

Injury means bodily injury sustained directly and independently of all other causes and resulting from an accident. The accident must occur after the effective date and cause loss while the certificate is in force. Such injury must require regular care from a physician other than the Insured or a family member.

Sickness means a bodily disorder first manifested after the effective date and causing loss while the certificate is in force. Such sickness must require regular care from a physician other than the Insured or a family member.

Total Disability means the Insured's complete inability for the first 12 months of continuous disability to engage in the material and substantial duties of the Insured's occupation due to injury or sickness. After the first 12 months, total disability means the Insured's complete inability to engage in any occupation or employment for compensation or profit for which the Insured is reasonably qualified by reason of education, training or experience.

EXCLUSIONS FROM DISABILITY BENEFITS

No disability benefits are payable if the Insured's disability results from, was caused by or contributed to by: 1) any intentionally self-inflicted injury, whether sane or insane; 2) an accident or sickness or disease which first required medical diagnosis or treatment (or would have caused a reasonably prudent person to have sought medical diagnosis or treatment) within six months preceding the effective date of coverage and which causes loss within six months following the effective date of coverage; provided, however, that disability commencing thereafter resulting from such conditions shall be covered; 3) normal pregnancy, common childbirth or miscarriage; 4) committing or attempting to commit a felony; 5) voluntary use of a controlled substance as defined in Title II of the Comprehensive Drug Abuse Prevention and Control Act of 1970, as now or hereafter amended, except as prescribed by a physician; 6) an accident suffered by the Insured for which intoxication of the Insured was a contributing factor.

CLAIM FORMS

We, upon receipt of notice of claim, will furnish forms that are usually furnished for filing proof of loss. We will send the claim forms within fifteen days after We are notified of the claim. If We do not send the forms in fifteen days, the Insured can simply send Us written proof of disability. The proof must show the date and cause of the total disability; and it must be signed by a physician other than the Insured or a family member.

PROOF OF LOSS

Written proof of loss must be furnished to Us at Our Administrative Offices at the Insured's expense. The proof of loss must be sent to Us no later than ninety days after the total disability begins. Failure to furnish such proof within the time required shall not invalidate nor reduce any claim if it was not reasonably possible to give proof within such time; provided such proof is furnished as soon as reasonably possible. Except in the absence of legal capacity, proof must be furnished no later than one year from the time proof is otherwise required.

TIME PAYMENT OF CLAIMS

Subject to due written proof of loss, all accrued benefits for loss for which the policy provides periodic payments, will be paid monthly. Any accrued benefits remaining unpaid upon the end of disability will be paid immediately upon receipt of due written proof.

APPLICABLE TO LIFE AND DISABILITY BENEFITS

BENEFITS PAYABLE

Any benefits payable will be paid in the following order: 1) to the insured, if living; to the beneficiary, if living; 3) to the estate of the insured. If the policy has been assigned, benefits will be paid to the assignee, as their interests may appear and then in the order listed above.

BENEFICIARY

The Insured, while living, may change the named beneficiary by filing satisfactory written notice with Us. The change will be effective on the date it is recorded by Us. However, We will not be liable for any action taken or payment made before the change is recorded. If any beneficiary is named irrevocable, the beneficiary may not be changed without the irrevocable beneficiary's consent in writing.

LIFE AND DISABILITY PROVISIONS

PREMIUMS

During the initial term, a single premium, as scheduled, shall be payable in advance; thereafter, premiums shall be payable annually to Us at our Administrative Offices before renewal dates.

Premiums will be based on the original amount of insurance at the Insured's attained age on each renewal date. If the Insured elects to decrease the original amount of insurance, the premium will remain level at the current renewal premium at the time the request for change in coverage is made, subject to any increase in premium as explained below.

Any premium which falls due during a period of disability and is not paid by the end of the grace period will be deducted from any benefits payable.

After the Initial Term, We may change the premium from time to time, subject to the following: 1) the premium may be increased or decreased on any certificate anniversary. Written notice of premium change will be provided to the policyholder prior to the anniversary; 2) a change in premium will apply to all certificates issued to the same policyholder, for the same policy form, for the same age group, sex and risk class of the certificate. Any change in premium will be based on Our determination of Our expected future experience with regard to earnings, mortality, morbidity, terminations and expenses. The premium will never be changed to recover losses or to distribute gains realized by Us before the date of change.

GRACE PERIOD

A grace period of 31 days will be allowed for payment of any premium, except the first. The term of coverage for any Insured shall be the date through which premium payments have been made, plus 31 days.

RENEWAL

The certificate is renewable at the option of the Insured while the group master policy is in force, prior to the Insured's age 90. If the Insured has elected to decrease the original amount of insurance, the certificate is renewable only until the end of the term of coverage. Once the amount of insurance in force has reduced to zero, the certificate cannot be renewed.

TERMINATION OF COVERAGE

We may end coverage under the master policy by giving 31 days advance written notice to the Policyholder. The Policyholder may cancel at any time by written notice to Us. Upon termination of the master policy, the certificate shall continue in full force and effect until the end of the term of coverage for which premium has been paid. Once notice requesting master policy termination is received by either the policyholder or Us, the term of the certificate may not be extended by payment of additional premium. If coverage under the master policy is terminated by the policyholder or Us, the policyholder will notify the Insured at least 31 days prior to the date through which premium has been paid that coverage will end.

Any cancellation of coverage will be without prejudice to any disability claim in progress.

CONFORMITY WITH STATE STATUTES

If, on the effective date, any part of the master policy or certificate is in conflict with the statutes of the state where it is issued, then it is automatically amended to meet the minimum requirements of those statutes.

CONSIDERATION

The certificate has been issued in consideration of the statements in the applications of the Insured and policyholder, and payment of the initial premium.

ENTIRE CONTRACT

The entire contract between the policyholder and Us consists of: 1) the master policy and 2) applications of the policyholder and Insured.

INCONTESTABILITY

The validity of the group policy shall not be contested, except for non-payment of premiums, after it has been in force for two years from the date of issue. All statements made by the policyholder or the Insured shall be deemed representations and not warranties. We may not contest the coverage evidenced by the certificate after it has been in force during the lifetime of the Insured for two years from the effective date, except for failure to pay premiums. No statement made by the Insured shall be used in any contest unless a copy of the instrument containing the statement is or has been furnished to the Insured or the beneficiary.

PHYSICAL EXAMINATION AND AUTOPSY

We shall have the right and opportunity to: 1) examine the Insured when and as often as We may reasonably require during a claim; and 2) to make an autopsy where it is not forbidden by law.

MISSTATEMENT OF AGE

The Insured's misstatement of age shall not invalidate any insurance if the Insured was eligible for insurance according to the application. If the age or sex of the Insured as shown on the application is not correct, the benefit will be adjusted. This adjusted benefit will be an amount which the premium paid would have purchased for the correct age and sex.

CHANGES

Only the President and Secretary have the authority to change the policy. Any change must be in writing.

ASSIGNMENT

Coverage may be assigned without the consent of the beneficiary.

NONPARTICIPATING

The policy and certificate do not share in the profits of the Company.

CONVERSION

If coverage ends because the group policy is terminated, the Insured is entitled to convert coverage to an individual policy subject to the following terms:

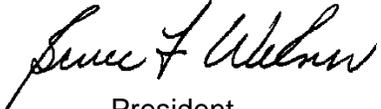
- 1) A written request for a converted coverage along with payment of the first premium shall be made by the Insured within 31 days after the end of coverage;
- 2) We may choose any policy of life or endowment insurance regularly issued by Us for individuals of the same age and sex of the Insured;
- 3) The coverage under the converted policy will not be greater than the insurance in force at the time conversion is requested. Decreases in the coverage will be the same as was permitted under the converted coverage;
- 4) The individual policy will contain provisions similar to those found in regular life policies then being issued by Us. The premium will be the rate charged by Us for the plan selected according to the rates then applicable to the risk class to which the Insured then belongs at the Insured's then attained age. Risk class will not be determined by reference to the Insured's current health status, unless such status is the result of previously supplied health information.

If the Insured dies during the 31 day period mentioned in "1", but before a converted policy has been issued, the insurance under the certificate is payable to the beneficiary. The beneficiary shall not be entitled to any further benefits.

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 five (5) years after the time written proof of loss is required to be furnished.


Secretary


President

AMENDMENTS

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

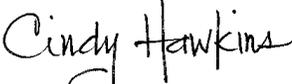
You may also contact your agent or any of our agents for additional help.

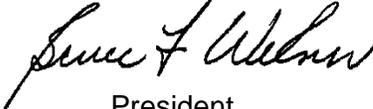
If we fail to provide you with reasonable and adequate service, feel free to contact:

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

Issue State - Idaho

Surrendering this contract – If there is a cash value and you request surrender of this contract, we will send you the cash surrender value within 30 days of our receipt of your request. If we defer your payment for more than 30 days, we will pay you interest. Interest will be from the day we receive your request until we make payment to you. The interest rate will be the rate declared by the Idaho State Treasurer in accordance with Idaho Code 28-22-1 04 on July 1st of every year.


Secretary


President

CENTURY LIFE ASSURANCE COMPANY

Home Office: Oklahoma City, Oklahoma; Administrative Offices: P.O. Box 9510, Wichita, Kansas 67277

NAME OF PROPOSED INSURED [JOHN DOE]		ADDRESS (include city, state, zip) [123 NORTH MAIN, ANYTOWN, ANYSTATE00000]	
COVERAGE REQUESTED <input type="checkbox"/> Level Term <input type="checkbox"/> Critical Period Disability			
Effective Date 01/01/00	Amount of Life Insurance \$1,000 Monthly Disability Benefit \$ 2,00	Premium submitted for a term of: ___[3]___ Years ___[3]___ Years	PREMIUM \$ \$ [XXX.XX]
Creditor/Agent Name and Address			TOTAL PREMIUMS \$
DATE OF BIRTH: MO [00] DAY [00] YR [00] STATE OF BIRTH [AS] Social Security Number: _____			
HEIGHT [6'] WEIGHT [190]		AVERAGE MONTHLY EARNED INCOME [\$50,000]	
PRESENT OCCUPATION [ACCOUNTANT] Explain duties fully			Are you now employed full time? [YES]

1. Have you had or been told you had: Any disease of the heart, lungs, brain, kidneys, or disorder of the back; any disease or condition of the stomach, intestines, liver, gall bladder or spleen; cancer, tumor, diabetes, high blood pressure or paralysis; epilepsy or any nervous or mental disorder? If yes, circle disorder and explain below.	YES	NO
2. Have you had or been told you had: a. An immune deficiency disorder? b. AIDS or the AIDS related complex (ARC)? or c) test results indicating exposure to the AIDS virus?		
3. Do you know of any impairment, disease or disorder now existing in your health or physical condition?		
4. Have you consulted a physician or other practitioner for any illness or injury during the past five years?		
5. Have you smoked cigarettes within the last 12 months?		
6. If the answer to any questions 1, 2, 3, or 4 is Yes, give details. Include the name, address, and telephone number of any attending physician or other practitioner. _____		
7. Give complete name, address, and telephone number of primary care physician. _____		
8. Revocable Beneficiary _____ (Name) (Address) (Relationship)		

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

92004-FLXTR(08)

NOTICE TO APPLICANT FOR INSURANCE

Thank you for considering Century Life Assurance Company as your insurance carrier.

One of the prime objectives of our Company is to provide insurance at the lowest possible cost. The underwriting process (evaluation of risks) is necessary not only to assure this low cost, but also to assure that each policyholder contributes his fair share of the cost. In considering your application, information from various sources must, therefore, be considered. These include the results of your physical examination, if required, and any reports we may receive from doctors and hospitals who have attended you.

As part of our normal underwriting procedure, an investigative consumer report may be prepared where information is obtained through personal interviews with your neighbors, friends or others, with whom you are acquainted. This inquiry includes information as to your character, general reputation, personal characteristics and mode of living. You have the right to make a written request to the Underwriting Department of CENTURY LIFE ASSURANCE COMPANY at its ADMINISTRATIVE OFFICES, P.O. BOX 9510, WICHITA, KANSAS 67277, within a reasonable period of time to receive additional detailed information about the nature and scope of this investigation, if one is made.

The Company may make a brief report of the information you provide to us to the Medical Information Bureau, a nonprofit membership organization of life insurance companies, which operates an information exchange on behalf of its members. If you apply to another Bureau member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, the Bureau, upon request, will supply such company with the information it may have in its file.

Upon receipt of a request from you, the Bureau will arrange a disclosure of any information it may have in your file. (The Bureau will disclose medical information only to your attending physician.) If you question the accuracy of information in the Bureau's file, you may contact the Bureau and seek a correction in accordance with the procedures set forth in the federal Fair Credit Reporting Act. The address of the Bureau's information office is Post Office Box 105, Essex Station, Boston, Massachusetts 02112, telephone number (617) 426-3660.

Without further consent from you, we may also release information in our file to other insurance companies to which you apply for life or health insurance or to which a claim for benefits may be submitted.

The purpose of the Bureau is to protect its members and their policyholders from bearing the expense created by those who would conceal facts relevant to their insurability. Information furnished by the Bureau may alert the insurer to the possible need for further investigation, but under Bureau rules cannot be used as the basis for evaluating risks. The Bureau is not a repository of medical reports from hospitals and physicians and information in the Bureau file does not reveal whether applications for insurance are accepted, rated or declined.

92004-FLXTR(08)

I hereby declare that to the best of my knowledge and belief the foregoing answers are full, true and correct. I further understand and agree that this application is offered subject to final acceptance or rejection by the Company and shall form a part of any policy of insurance issued as a result of this application. I further understand that any policy issued shall not take effect unless and until the full first premium has been paid and the policy delivered while I am in sound health and free of injury.

I hereby authorize all health care providers named above and any physician, pharmacy, psychologist, medical practitioner, hospital, clinic, other medical or medically related facility, insurance or reinsuring company, agent, Health Claims Index, credit bureau or other consumer reporting agency, employer, Medical Information Bureau (MIB), Social Security Administration, Educational Institution, Government Agency or the Veterans Administration, or other entity presented with a copy of this authorization, to furnish the Insurance Company or their authorized representative, any and all information in their possession regarding my treatment, medical history, benefits, or other applicable information for the purpose of obtaining life or disability insurance, this includes, but is not limited to information concerning HIV, AIDS, and mental health information, and/or financial, consumer report, or any other non-medical information regarding me.

I am entitled to receive a copy of any investigative report and to be interviewed in connection with such a report, if I desire and one is obtained. I also have the right to obtain a copy of any personal information the Insurance Company has about me. The Company must comply with my request within 30 days after receipt of the request. I understand that there are specific instances that the Insurance Company may give this information to a qualified medical provider instead of me. The Company may charge a fee for providing this information, except in the case of an adverse underwriting decision. The right to such personal information does not apply if the information is gathered in anticipation of a claim, or civil or criminal proceeding. If I believe the information the Company has is incorrect, I will be told how to correct it.

The Company may release my personal information to other insurance companies which they have business dealings with, other medical professionals if they are to examine me, and claims personnel. All information submitted shall be used in conjunction with the evaluation of my application/claim. I understand that this authorization may be withdrawn by me at any time except to the extent that action has been taken in reliance upon it, or as otherwise specified by law. This authorization shall expire 30 months from the date it is signed, unless I revoke it in writing prior to that date by sending notice to the address shown above. I understand that once this information is received by the authorized person/organization, then this information may be subject to redisclosure and may no longer be protected by federal privacy laws. I or my authorized representative am (is) entitled to a photocopy of this authorization. A photocopy of this authorization shall be as valid as the original.

Signed at _____ this _____ day of _____ 20____
(city) (state)

X _____
Signature of Proposed Insured) Signature of Owner if other than Proposed Insured & Relationship

Do not assign this policy. If issued, I hereby assign this Policy and its proceeds to _____, (Creditor), as their interests may appear. I understand that this is limited insurance and may not pay off my loan.

X _____
(Signature of Owner) Date (Address of owner if other than proposed insured)

SEND TO:
CENTURY LIFE ASSURANCE COMPANY
P.O. Box 9510, Wichita, Kansas 67277
CONDITIONAL RECEIPT AND TEMPORARY INSURANCE AGREEMENT

\$ _____ has been received from _____ as payment for the life and disability insurance applied for on this date. Temporary life insurance is provided under the same conditions as the policy, subject to the limits and conditions below. If no coverage is issued as a result of this application, a full refund of all premiums paid will be made.

1. No disability insurance is provided by this conditional receipt.
2. Temporary life insurance is limited to \$50,000 or the amount applied for, if less.
3. No temporary life insurance is provided by this conditional receipt if the applicant has answered "Yes" to questions 1-4 above.
4. No temporary life insurance is provided by this conditional receipt: 1) if the applicant dies by suicide while sane or insane; or 2) if there is fraud or misrepresentation in the answers in the application that is material to the underwriter's acceptance of the risk.
5. Temporary life insurance provided by this conditional receipt stops when the company: 1) approves your application; 2) declines your application; or 3) offers to issue you insurance other than applied for in this application.

No one may waive or change any of the terms of this receipt.

_____ Date X _____ Company representative

SERFF Tracking Number: AUWL-125919859

State: Arkansas

Filing Company: Century Life Assurance Company

State Tracking Number: 40988

Company Tracking Number: FLEX TERM (09)

TOI: L04G Group Life - Term

Sub-TOI: L04G.103 Renewable - Single Life -
Fixed/Indeterminate Premium

Product Name: Flex Term

Project Name/Number: Flex Term/

Rate Information

Rate data does NOT apply to filing.

SERFF Tracking Number: AUWL-125919859

State: Arkansas

Filing Company: Century Life Assurance Company

State Tracking Number: 40988

Company Tracking Number: FLEX TERM (09)

TOI: L04G Group Life - Term

Sub-TOI: L04G.103 Renewable - Single Life -
Fixed/Indeterminate Premium

Product Name: Flex Term

Project Name/Number: Flex Term/

Supporting Document Schedules

Review Status:

Satisfied -Name: Certification/Notice

11/25/2008

Comments:

attached

Attachment:

AR Compliance.pdf

Review Status:

Satisfied -Name: Application

11/25/2008

Comments:

Application attached under the Form Schedule tab.

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 of Arkansas Codes and Statutes listed above that specifically provide for group life insurance.

(Signed by an officer of the company)



Bruce F. Welner

President

Century Life Assurance Company

November 25, 2008