

SERFF Tracking Number: WDM-125928208 State: Arkansas
 Filing Company: Woodmen of the World Life Insurance Society State Tracking Number: 41049
 Company Tracking Number:
 TOI: L04I Individual Life - Term Sub-TOI: L04I.213 Specified Age or Duration - Fixed/Indeterminate Premium - Single Life
 Product Name: Family Term Life App & Related Forms
 Project Name/Number: /

Filing at a Glance

Company: Woodmen of the World Life Insurance Society
 Product Name: Family Term Life App & Related Forms SERFF Tr Num: WDM-125928208 State: ArkansasLH
 TOI: L04I Individual Life - Term SERFF Status: Closed State Tr Num: 41049
 Sub-TOI: L04I.213 Specified Age or Duration - Fixed/Indeterminate Premium - Single Life Co Tr Num: State Status: Approved-Closed
 Filing Type: Form Co Status: Reviewer(s): Linda Bird
 Author: Kathy Dollen Disposition Date: 12/10/2008
 Date Submitted: 12/04/2008 Disposition Status: Approved
 Implementation Date Requested: On Approval Implementation Date:
 State Filing Description:

General Information

Project Name: Status of Filing in Domicile: Not Filed
 Project Number: Date Approved in Domicile:
 Requested Filing Mode: Review & Approval Domicile Status Comments: These forms are being filed with the Interstate Insurance Product Regulation Commission for use in our domicile state of Nebraska.
 Explanation for Combination/Other: Market Type: Individual
 Submission Type: New Submission Group Market Size:
 Overall Rate Impact: Group Market Type:
 Filing Status Changed: 12/10/2008
 State Status Changed: 12/10/2008 Deemer Date:
 Corresponding Filing Tracking Number:
 Filing Description:
 Re: Fraternal Form Filing - Individual Life
 Form 8040 10/08 - Application for Individual Term Life Insurance With Child Benefits and Membership
 Form 601F 10/08 - Term Life Insurance with Child Benefits Adult Medical Supplementary Statement

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Form 943F 10/08 - Term Life Insurance with Child Benefits Administrative Supplementary Statement
Form 956F 10/08 - Term Life Insurance with Child Benefits Underwriting Supplementary Statement
Form 8079F 10/08 - Term Life Insurance with Child Benefits Children's Supplementary Statement
Form 835F 10/08 - Term Life Insurance with Child Benefits Aviation Questionnaire
Form 836F 10/08 - Term Life Insurance with Child Benefits Avocation Questionnaire
Form 7692F 10/08 - Term Life Insurance with Child Benefits Alcohol & Drug Questionnaire
Form 8070 10-08 - Ratification Form and Statement of Variability for Ratification Form

We are submitting the forms listed above for filing and/or approval. These forms are all new and will not replace any previously approved forms.

The enclosed forms will be used with the following forms which have been submitted by separate filing (SERFF Tracking #WDM-125925677):

Form 8063 10-08 - Term Life Insurance Certificate with Term Benefit for Children
Form 8064 10-08 - Other Insured Rider
Form 8065 10-08 - Children's Term Insurance Benefit Endorsement
Form 8066 10-08 - Disability Waiver of Premium Rider
Form 8067 10-08 - Accelerated Death Benefit Rider

The enclosed forms will be produced in both paper and electronic form. The electronic form may have an electronic signature. Individually licensed field representatives will solicit both the paper and electronic forms. The forms are not intended for Internet use.

Form 8040 10/08, Application for Individual Term Life Insurance With Child Benefits and Membership, is a fully underwritten application and will be used to apply for a new certificate, to reinstate a certificate, and to change an existing certificate. However, only one of these transactions can be done per application form.

Supplementary Statements, Form 601F 10/08, Form 943F 10/08, Form 956F 10/08, and Form 8079F 10/08, will be used with the Application Form 8040 10/08. The completion of a supplementary statement is required when, during the underwriting process, it is learned that on the original application an answer to a question was omitted or a question was

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answered "yes" but details were not given. The applicable proposed insured will be required to complete only the corresponding question(s) on the appropriate supplementary statement. We do not require the completion of the entire form.

Completion of a questionnaire, Form 835F 10/08, 836F 10/08, and 7692F 10/08 is required when on the original application an answer to the aviation, avocation, alcohol or drug question is "yes" and further details need to be gathered to underwrite the application.

Form 8070 10-08, Ratification Form and Statement of Variability for Ratification Form, will be used whenever the applicant requests a change in the application as described in the Statement of Variability.

The enclosed forms are submitted in final print and are subject to only minor modification in paper stock, ink, border, company logo, and adaptation to electronic media and computer printing.

Company and Contact

Filing Contact Information

Kathryn Dollen, Senior Compliance Analyst kdollen@woodmen.org
 1700 FARNAM STREET (402) 271-7885 [Phone]
 OMAHA, NE 68102 (402) 449-7732[FAX]

Filing Company Information

Woodmen of the World Life Insurance Society CoCode: 57320 State of Domicile: Nebraska
 1700 FARNAM STREET Group Code: Company Type:
 OMAHA, NE 68102 Group Name: State ID Number:
 (402) 271-7279 ext. [Phone] FEIN Number: 47-0339250

Filing Fees

Fee Required? Yes
 Fee Amount: \$180.00
 Retaliatory? No
 Fee Explanation: AR filing fee \$20.00 x NE filing fee \$0 x Number of forms 9 = \$180.00

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Fixed/Indeterminate Premium - Single Life

Product Name: *Family Term Life App & Related Forms*
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Per Company: **No**

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COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Woodmen of the World Life Insurance Society	\$180.00	12/04/2008	24321715

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Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved	Linda Bird	12/10/2008	12/10/2008

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Disposition

Disposition Date: 12/10/2008

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		No
Supporting Document	Life & Annuity - Actuarial Memo		No
Form	Application for Individual Term Life Insurance with Child Benefits and Membership		Yes
Form	Term Life Insurance with Child Benefits Adult Medical Supplementary Statement		Yes
Form	Term Life Insurance with Child Benefits Administrative Supplementary Statement		Yes
Form	Term Life Insurance with Child Benefits Underwriting Supplementary Statement		Yes
Form	Term Life Insurance with Child Benefits Children's Supplementary Statement		Yes
Form	Term Life Insurance with Child Benefits Aviation Questionnaire		Yes
Form	Term Life Insurance with Child Benefits Avocation Questionnaire		Yes
Form	Term Life Insurance with Child Benefits Alcohol & Drug Questionnaire		Yes
Form	Ratification Form		Yes

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Form Schedule

Lead Form Number: Form 8040 10/08

Review Status	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
	Form 8040 10/08	Application/ Enrollment Form	Application for Individual Term Life Insurance with Child Benefits and Membership	Initial		50	8040 10-08.pdf
	Form 601F 10/08	Other	Term Life Insurance with Child Benefits Adult Medical Supplementary Statement	Initial		51	601F 10-08.pdf
	Form 943F 10/08	Other	Term Life Insurance with Child Benefits Administrative Supplementary Statement	Initial		52	943F 10-08.pdf
	Form 956F 10/08	Other	Term Life Insurance with Child Benefits Underwriting Supplementary Statement	Initial		59	956F 10-08.pdf
	Form 8079F 10/08	Other	Term Life Insurance with Child Benefits Children's Supplementary Statement	Initial		51	8079F 10-08.pdf
	Form 835F 10/08	Other	Term Life Insurance with Child Benefits Aviation Questionnaire	Initial		69	835F 10-08.pdf
	Form 836F 10/08	Other	Term Life Insurance with Child Benefits	Initial		53	836F 10-08.pdf

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Avocation
Questionnaire

Form 7692F 10/08	Other	Term Life Insurance with Child Benefits Alcohol & Drug Questionnaire	Initial	53	7692F 10-08.pdf
Form 8070 10-08	Policy/Contract/Fraternal Certificate: Amendment, Insert Page, Endorsement or Rider	Ratification Form	Initial	61	8070 10-08.pdf 8070 10-08 Stmt of Variability.pdf

WOODMEN OF THE WORLD LIFE INSURANCE SOCIETY

1700 Farnam Street Omaha, Nebraska 68102

APPLICATION FOR INDIVIDUAL TERM
LIFE INSURANCE WITH CHILD
BENEFITS AND MEMBERSHIP

New Certificate Number: This Change to Affect Certificate Number:

Field Representative Code: 123456 New Certificate Change Existing Certificate Reinstatement

1 PROPOSED PRIMARY INSURED/APPLICANT (Proposed primary insured will be owner and must be ages 18 through 50.)

First	Middle Initial	Last	Suffix	Social Security Number
John	K	Woodmen		123-45-9876

Street Address (Residence of Proposed Primary Insured)	Apt/Unit #
1234 Main Street	

City	State	Zip
Omaha	NE	68102

Mailing Address if Different from Residence	City	State	Zip
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Sex	Date of Birth (MM/DD/YYYY)	Age Now	Rating Age	Birth Location	Telephone Day (402) 231-1234
M	11/01/1973	35	35	NE	Eve (402) 123-4321

Is the primary residence of all proposed insureds the same as that of the Proposed Primary Insured/Applicant? . . . YES NO

If "No", give name(s) and provide explanation:

2 PROPOSED OTHER INSURED/APPLICANT (Proposed other insured will be owner and must be ages 18 through 50.)

First	Middle Initial	Last	Suffix	Social Security Number
Mary	D	Woodmen		123-45-6789

Sex	Date of Birth (MM/DD/YYYY)	Age Now	Rating Age	Birth Location	Telephone Day (402) 231-1234
F	10/15/1973	35	35	NE	Eve (402) 123-4321

3 PROPOSED INSURED CHILDREN Number of children applying for insurance: 2
If more than FOUR children, complete supplementary statement in place of this section.

First	Middle Initial	Last	Suffix	Social Security Number
Thomas	W	Woodmen		231-45-1111

Sex	Date of Birth (MM/DD/YYYY)	Age Now	Relationship of Proposed Primary Insured & Proposed Other Insured to Child	
M	01/15/1993	15	Primary Insured: Father	Other Insured: Mother

New Member Existing Member

First	Middle Initial	Last	Suffix	Social Security Number
Susan	J	Woodmen		231-45-1231

Sex	Date of Birth (MM/DD/YYYY)	Age Now	Relationship of Proposed Primary Insured & Proposed Other Insured to Child	
F	05/20/1996	12	Primary Insured: Father	Other Insured: Mother

New Member Existing Member

First	Middle Initial	Last	Suffix	Social Security Number
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Sex	Date of Birth (MM/DD/YYYY)	Age Now	Relationship of Proposed Primary Insured & Proposed Other Insured to Child	
			Primary Insured:	Other Insured:

New Member Existing Member

First	Middle Initial	Last	Suffix	Social Security Number
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Sex	Date of Birth (MM/DD/YYYY)	Age Now	Relationship of Proposed Primary Insured & Proposed Other Insured to Child	
			Primary Insured:	Other Insured:

New Member Existing Member

4 FAMILY LODGE MEMBERSHIP

Lodge membership assignments will be determined by the Home Office.

Proposed Primary Insured

Proposed Other Insured

New Member Existing Member

New Member Existing Member

5 TYPE OF CHANGE

Consider for possible rate reduction/removal Proposed Primary Insured Proposed Other Insured

Consider for non-tobacco classification Proposed Primary Insured Proposed Other Insured

90 day change Proposed Primary Insured Proposed Other Insured

6 TERM LIFE INSURANCE WITH CHILD BENEFITS

Proposed Primary Insured Face Amount:

Proposed Other Insured Face Amount:

\$50,000 \$100,000

\$50,000 \$100,000

◆ Face amount for Proposed Other Insured cannot exceed face amount applied for by Proposed Primary Insured.

◆ Face amount for all Proposed Insured Children will be \$10,000.

RIDERS

Accelerated Death Benefit Rider (included unless "No" checked here) No Add Remove

Disability Waiver of Premium Rider (For issue ages 18 through 50 years only) Add Remove

7 REFUND OPTION (Choose only one.)

Unless specifically stated otherwise in your contract, if no option, more than one option, or an unavailable option is checked, refunds will be left with Woodmen at interest.

Cash Apply to reduce annual premium (Not available with Pre-Authorized Collection)

Left with Woodmen at interest

8 BENEFICIARY

BENEFICIARY DESIGNATION FOR PROPOSED OTHER INSURED ONLY (If Applicable)

Proposed Primary Insured if living, otherwise the estate of the Other Insured. **This beneficiary designation cannot be changed.**

BENEFICIARY DESIGNATION FOR PROPOSED INSURED CHILDREN ONLY (If Applicable)

Owner who is the natural parent, adoptive parent, or permanent legal guardian, equally or to the survivor, otherwise the estate of the deceased insured child. **This beneficiary designation cannot be changed.**

BENEFICIARY DESIGNATION FOR PROPOSED PRIMARY INSURED ONLY

◆ For **changes**: Completion of this section will revoke all previous beneficiary designations for the Proposed Primary Insured.

Primary Beneficiary

Name	City	State	Relationship	Age or Date of Birth	Social Security No./ Tax ID Number
Joseph Woodmen	Omaha	NE	Brother	45	123-66-6866

Alternate Beneficiary

Name	City	State	Relationship	Age or Date of Birth	Social Security No./ Tax ID Number
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UNLESS OTHERWISE STATED IN WRITING, THE FOLLOWING CONDITIONS APPLY

- The death benefit, when paid to all surviving primary beneficiaries, is paid equally in one sum.
- If there are no surviving primary beneficiaries, the death benefit is paid equally in one sum to all surviving alternate beneficiaries.
- The beneficiary will have the right to change the method by which the death benefit is paid after the death of an insured.

9 TOBACCO USAGE

In the past **12 months**, has either proposed insured (Primary/Other) used tobacco in any form, such as cigarettes, pipes, cigars, snuff or chewing tobacco OR smoking cessation products such as nicotine patches or nicorette gum? YES NO YES NO

Proposed Primary Insured
 A. If "Yes", indicate date last used:
 Mo. _____ Yr. _____
 Indicate form(s) used: _____
 If cigarettes, how many packs per day? _____
 If cigars, indicate quantity and frequency: _____

Proposed Other Insured
 A. If "Yes", indicate date last used:
 Mo. _____ Yr. _____
 Indicate form(s) used: _____
 If cigarettes, how many packs per day? _____
 If cigars, indicate quantity and frequency: _____

B. If "No", has either proposed insured (Primary/Other) used tobacco in any form OR smoking cessation products in the last **36 months**? YES NO YES NO

10 OCCUPATION

Proposed Primary Insured

Occupation and Duties Teacher	Annual Income (Nearest \$10,000) 50000	How Long in Present Occupation? 10y
Name of Employer and Nature of Business Abc High School	Address of Business	Previous Occupation

Proposed Other Insured

Occupation and Duties Home Maker	Annual Income (Nearest \$10,000) 0	How Long in Present Occupation?
Name of Employer and Nature of Business	Address of Business	Previous Occupation Teacher

11 NONMEDICAL

A. Does the Proposed Primary Insured have a current driver's license/permit? Yes, Driver's License/Permit Number: 234567 State: NE
 No, explain why no license/permit: _____

A. Does the Proposed Other Insured have a current driver's license/permit? Yes, Driver's License/Permit Number: 345678 State: NE
 No, explain why no license/permit: _____

HAS OR IS THE PROPOSED PRIMARY INSURED OR THE PROPOSED OTHER INSURED:

	Proposed Primary Insured	Proposed Other Insured
	YES NO	YES NO
B. Currently a United States citizen?	<input checked="" type="checkbox"/> <input type="checkbox"/>	<input checked="" type="checkbox"/> <input type="checkbox"/>

If "No", give name and provide permanent resident card number: _____

- C. Ever had a license/permit suspended or revoked? YES NO YES NO
 - D. Had any moving traffic violations or traffic accidents within the past three years? YES NO YES NO
 - E. Been convicted of or pled guilty or no contest to driving while intoxicated or under the influence of a narcotic drug? YES NO YES NO
 - F. Been convicted of or pled guilty or no contest to a crime within the past 10 years, or is either proposed insured currently awaiting trial for any crime? YES NO YES NO
 - G. Currently on probation or parole? YES NO YES NO
 - H. A member of the U.S. Armed Services or active reserve? YES NO YES NO
- If "Yes" has either proposed insured been alerted of possible deployment? YES NO YES NO

If any question C-H has been answered "Yes", give dates and full details at the top of Page 4 of this application.

11 NONMEDICAL, Continued

Give dates and full details for the Proposed Primary Insured.

[Empty box for Proposed Primary Insured details]

Give dates and full details for the Proposed Other Insured.

[Empty box for Proposed Other Insured details]

HAS OR IS THE PROPOSED PRIMARY INSURED OR THE PROPOSED OTHER INSURED:	Proposed Primary Insured		Proposed Other Insured	
	YES	NO	YES	NO
I. Planning within the next 12 months to travel or reside outside of the U.S., Canada or any U.S. territories? If "Yes" submit details on Form 956F.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
J. Participated in aviation as a pilot, crew member or student in the past 3 years – to include sky diving, hang gliding, ballooning, ultralight, and other sky sports – or intends to within the next 2 years? If "Yes", submit an Aviation Questionnaire.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
K. Participated in racing of any type, skin or scuba diving, mountain climbing, other sports such as bungee jumping or extreme sports in the past 3 years – or intends to within the next 2 years? If "Yes", submit an Avocation Questionnaire.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>

12 MEDICAL

1. PHYSICIAN OR MEDICAL FACILITY THAT HAS THE MOST COMPLETE AND CURRENT MEDICAL RECORDS:

Proposed Primary Insured

Dr. Thomas Shepard				(402) 322-3241
Physician/Facility Name				Phone Number
111 Medical Street	Omaha	NE	68102	3/15/2007
Address	City	State	Zip	Date Last Seen

Proposed Other Insured

Dr. Thomas Shepard				(402) 322-3241
Physician/Facility Name				Phone Number
111 Medical Street	Omaha	NE	68102	5/20/2007
Address	City	State	Zip	Date Last Seen

2. HAS EITHER PROPOSED INSURED (PRIMARY/OTHER) HAD OR EVER BEEN DIAGNOSED, TREATED, TESTED POSITIVE FOR OR BEEN GIVEN MEDICAL ADVICE BY A MEMBER OF THE MEDICAL PROFESSION FOR ANY DISEASE OR DISORDER OF THE:	Proposed Primary Insured		Proposed Other Insured	
	YES	NO	YES	NO
A. Brain or Nervous System – such as epilepsy, paralysis or mental illness – to include treatment or counseling for depression or anxiety?	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
B. Respiratory System – such as emphysema, bronchitis or asthma – to include disorders of the eyes, ears, nose or throat?	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
C. Circulatory System – such as high blood pressure, chest pain, heart attack, heart surgery, heart murmur, stroke, or phlebitis?	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
D. Digestive or Urinary Tract Systems – such as ulcer, colitis, hepatitis, kidney infection, kidney stones, protein, blood or sugar in the urine – to include diabetes and thyroid disorders?	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
E. Musculoskeletal System – such as arthritis, gout, back disorders, or any connective tissue disorders?	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
F. Reproductive System – such as prostate, testes, breasts, ovaries or uterus disorders?	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
G. Immune System – such as lupus, multiple sclerosis or scleroderma except those related to the Human Immunodeficiency Virus?	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
3. HAS EITHER PROPOSED INSURED (PRIMARY/OTHER) EVER:				
A. Been diagnosed or treated for cancer or tumor of any kind?	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
B. Had or been advised to have any surgical operation?	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
C. Been treated or received counseling for alcohol use, alcoholism or drug addiction? If "Yes", submit an Alcohol & Drug Questionnaire	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
D. Used narcotics, barbiturates, excitant drugs, hallucinogens or tranquilizers without a prescription by a physician? If "Yes", submit an Alcohol & Drug Questionnaire.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>

If any medical question has been answered "Yes", give dates and full details on Page 5 of this application.

12 MEDICAL, Continued

- | | | Proposed
Primary Insured | | Proposed
Other Insured | |
|----|---|-----------------------------|-------------------------------------|---------------------------|-------------------------------------|
| | | YES | NO | YES | NO |
| 4. | HAS EITHER PROPOSED INSURED (PRIMARY/OTHER) BEEN DIAGNOSED BY A MEMBER OF THE MEDICAL PROFESSION OR TESTED POSITIVE FOR HUMAN IMMUNODEFICIENCY VIRUS (AIDS VIRUS) OR ACQUIRED IMMUNE DEFICIENCY SYNDROME (AIDS)? | 4. <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| 5. | AT ANY TIME IN THE PAST, HAS EITHER PROPOSED INSURED (PRIMARY/OTHER) HAD ANY OTHER ILLNESS OR INJURY NOT MENTIONED ABOVE? | 5. <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| 6. | DURING THE PAST FIVE YEARS HAS EITHER PROPOSED INSURED (PRIMARY/OTHER) | | | | |
| A. | Consulted, been examined by, treated by or received diagnostic tests (e.g., X-rays, ECG, or blood studies except those tests related to the Human Immunodeficiency Virus (AIDS Virus)) from a physician, hospital, clinic or similar institution? | A. <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| B. | Received a pension, applied for or been compensated for disability? If "Yes", please explain | B. <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| C. | Had an application for life, health, accident or disability insurance declined, postponed, rated up or modified? If "Yes", please explain what action was taken and why | C. <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| 7. | DOES EITHER PROPOSED INSURED (PRIMARY/OTHER) TAKE MEDICATION? If "Yes", state name of drug and condition requiring it | 7. <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| 8. | A. IS EITHER PROPOSED INSURED (PRIMARY/OTHER) NOW PREGNANT? If "Yes", indicate due date | A. <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| | B. Are there any complications? | B. <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 9. | A. PROPOSED PRIMARY INSURED'S HEIGHT: <u>6</u> ft. <u>0</u> in. WEIGHT: <u>210</u> lbs. | | | | |
| | B. PROPOSED OTHER INSURED'S HEIGHT: <u>5</u> ft. <u>2</u> in. WEIGHT: <u>110</u> lbs. | | | | |
| | C. Has weight changed more than 15 pounds for either proposed insured in the past year? | C. <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
- If "Yes", give name and indicate how much and by what means:

If any question 2-8 has been answered "Yes" by the Proposed Primary Insured, give full details below:

Question Number	Diagnosis/Treatment/Medication	Dates From/To	Name, Address & Phone Number Of Health Care Professional/Facility

If any question 2-8 has been answered "Yes" by the Proposed Other Insured, give full details below:

Question Number	Diagnosis/Treatment/Medication	Dates From/To	Name, Address & Phone Number Of Health Care Professional/Facility

If more space is needed for Medical details, include an additional page, signed, dated and witnessed.

13 FAMILY HISTORY

- | | | Proposed
Primary Insured | | Proposed
Other Insured | |
|--|--|-----------------------------|-------------------------------------|---------------------------|-------------------------------------|
| | | YES | NO | YES | NO |
| FOR EITHER PROPOSED INSURED (PRIMARY/OTHER): | | | | | |
| A. | Have parents or siblings been diagnosed or treated by a member of the medical profession for cardiovascular disease or cancer prior to age 60? | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| | If "Yes", give proposed insured's name and details _____ | | | | |
| B. | Did death of a parent or sibling occur prior to age 60 due to cardiovascular disease or cancer? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

14 CHILDREN MEDICAL If more than FOUR children, complete supplementary statement in place of this section.

1. Have any proposed insured children been diagnosed by a member of the medical profession or tested positive for Human Immunodeficiency Virus (AIDS Virus) or Acquired Immune Deficiency Syndrome (AIDS)? YES NO
 If "Yes", give child's name and details below.
2. Have any proposed insured children been diagnosed, treated, tested positive for or been given medical advice by a member of the medical profession for any of the following diseases or disorders: If "Yes", give child's name and details below.
- A. Any physical or mental impairment due to illness, injury or birth defect?
- B. Any heart condition or heart surgery of any kind?
- C. Any alcohol or drug abuse?
- D. Any cancer, including melanoma but excluding other types of skin cancers?
- E. Diabetes?
- F. Immune deficiency disorder such as lupus, multiple sclerosis or scleroderma except those related to the Human Immunodeficiency Virus (AIDS Virus)?
3. In the past 24 months, have any of the proposed insured children been seen by a physician or treated in a medical facility for an illness or disease? If "Yes", give child's name and details below.
4. Are any of the proposed insured children currently taking medication(s)? If "Yes", give child's name, name of drug and condition requiring it below.

If any question 1-4 has been answered "Yes", give child's name and full details below:

Question Number	Child's Name	Details

If more space is needed for Children's Medical details, include an additional page, signed, dated and witnessed.

15 INSURANCE NOW IN FORCE OR APPLIED FOR AND REPLACEMENT

♦ **If more than two policies, complete a supplementary statement.**

- | | | |
|---|--|--|
| | Proposed
Primary Insured | Proposed
Other Insured |
| | YES NO | YES NO |
| A. Does the proposed applicant have any existing life insurance or annuity contracts? | <input type="checkbox"/> <input checked="" type="checkbox"/> | <input type="checkbox"/> <input checked="" type="checkbox"/> |
| B. Will any existing life or annuity contracts be replaced if the proposed certificate is issued? | <input type="checkbox"/> <input checked="" type="checkbox"/> | <input type="checkbox"/> <input checked="" type="checkbox"/> |

If A or B is answered "Yes", provide policy number and company information below. Submit replacement forms, if required.

Proposed Primary Insured List all policies currently **in force** or **applied for**. **If none, check here.**

Company Name _____ Policy Number _____
 Address _____ City _____ State _____ Zip _____
 Kind _____ Life Amount _____ Replace YES NO

Company Name _____ Policy Number _____
 Address _____ City _____ State _____ Zip _____
 Kind _____ Life Amount _____ Replace YES NO

Proposed Other Insured List all policies currently **in force** or **applied for**. **If none, check here.**

Company Name _____ Policy Number _____
 Address _____ City _____ State _____ Zip _____
 Kind _____ Life Amount _____ Replace YES NO

Company Name _____ Policy Number _____
 Address _____ City _____ State _____ Zip _____
 Kind _____ Life Amount _____ Replace YES NO

16 PREMIUM DEPOSIT

- 1. Cash or Check Amount: \$ 65.00 2. Refunds on Deposit
 - 3. Cash Surrender Value Amount: \$ _____ 4. Credit Card 5. Express Check
- Total Amount Collected: \$ _____ 65.00

Includes premium and fraternal dues of [\$2.50] per month as payment for 6 months.

If 1-5 is selected on an application for a new certificate, give conditional receipt to applicant; if 2, 3 or 4 is selected, also submit proper authorization.

P.A.C. authorizations and List Bill to companies other than Woodmen are NOT premium deposits for RECEIPT AND CONDITIONAL INSURANCE AGREEMENT purposes.

17 FUTURE BILLING

Billing Method		Frequency
<input checked="" type="checkbox"/> New P.A.C. plan (submit Form 98D)	<input type="checkbox"/> Direct Bill	<input type="checkbox"/> Annually
<input type="checkbox"/> Add to present P.A.C. plan (list one certificate number currently being paid on plan)	<input type="checkbox"/> List Bill *	<input checked="" type="checkbox"/> Semiannually
CERTIFICATE NO. _____	Group Number: _____	<input type="checkbox"/> Quarterly
Payor's Name: _____	* Submit proper authorizations	<input type="checkbox"/> Monthly *
Bank Acct. No.: _____		* Not Available for direct bill.

18 PAYOR INFORMATION (Complete if not the proposed primary insured/applicant.)

First	Middle Initial	Last	Suffix
Address		Apt/Unit #	
City	State	Zip	
Relationship to Proposed Primary Insured		Date of Birth (MM/DD/YYYY)	Social Security No./ Tax ID Number

19 ACKNOWLEDGEMENT AND AGREEMENT

The following statements must be read by or to the applicant(s): I have received a copy of the "Notice Relating to the MIB (Medical Information Bureau)", "Notice Required Under the Fair Credit Reporting Act" and if applicable the "Notice of Information Practices". The Accelerated Death Benefit Disclosure Statement has been given to me, the applicant, if applicable.

I have read this application. I represent that each of the answers and the information given therein is full, complete and true, to the best of my knowledge and belief with the understanding that they shall be considered as representations and not warranties. I agree as follows:

1. Notice to or knowledge of any field representative or medical examiner as to information which relates to any proposed insured will not be notice to Woodmen unless it is in writing in this application.
2. Field Representatives do not have authority to (a) determine insurability; (b) change any terms of this application; (c) make or change a contract for Woodmen; (d) waive any rights or requirements of Woodmen. I understand that oral statements between the Field Representative and myself regarding such matters of limited authority are not binding on Woodmen unless accepted by Woodmen in writing.

I agree to be bound by the terms of this application and the life insurance certificate for which I am applying. I also agree to be bound by all obligations of membership set forth in Woodmen's Articles of Incorporation and its Constitution and Laws and acknowledge Woodmen's common bond and purpose.

Applications for New Certificate:

Except for coverage which may be provided in the RECEIPT AND CONDITIONAL INSURANCE AGREEMENT, no insurance will be in force because of this application until it has been approved and at least one monthly premium has been paid to Woodmen.

Applications for Reinstatement or Change to Existing Certificate:

I agree this application shall not be construed as extending temporary insurance coverage on the life of any proposed insured. Reinstatement of or change to existing insurance will be effective and coverage will commence on the date this application is approved in the Home Office of Woodmen.

Any person who knowingly presents a false statement in an application for insurance may be guilty of a criminal offense and subject to penalties under state law.

Proposed Primary Insured

Certification Instructions - You must cross out the language in item (2) within this box if you have been notified by the IRS that you are currently subject to backup withholding because of underreporting interest or dividends on a tax return.

Under penalties of perjury, I, the undersigned, certify:

- (1) the number(s) shown on this application represents my correct Taxpayer Identification Number (TIN) AND
(2) I am not subject to backup withholding because: (a) I am exempt from backup withholding, or (b) I have not been notified by the IRS that I am subject to backup withholding as a result of a failure to report all interest or dividends, or (c) the IRS has notified me that I am no longer subject to backup withholding, AND
(3) I am a United States person (including a United States resident alien).

Proposed Other Insured

Certification Instructions - You must cross out the language in item (2) within this box if you have been notified by the IRS that you are currently subject to backup withholding because of underreporting interest or dividends on a tax return.

Under penalties of perjury, I, the undersigned, certify:

- (1) the number(s) shown on this application represents my correct Taxpayer Identification Number (TIN) AND
(2) I am not subject to backup withholding because: (a) I am exempt from backup withholding, or (b) I have not been notified by the IRS that I am subject to backup withholding as a result of a failure to report all interest or dividends, or (c) the IRS has notified me that I am no longer subject to backup withholding, AND
(3) I am a United States person (including a United States resident alien).

The Internal Revenue Service does not require your consent to any provision of this document other than the certifications required to avoid backup withholding.

Signed at Omaha NE
City State

By checking this box, I, the proposed applicant(s), acknowledge this application was signed in a different state than the state in which I reside.

John K Woodmen 11/10/2008
Signature of Proposed Primary Date
Insured/Applicant

Mary D Woodmen 11/10/2008
Signature of Proposed Other Date
Insured/Applicant

Thomas K Smith 11/10/2008
Signature of Witness Date

Additional Witness if Required Date

20 FIELD REPRESENTATIVE'S CERTIFICATION

- 1. Were you present when this application was signed? (If "No", submit a full explanation with the application) . . . [X] Yes [] No
2. Does either proposed applicant have any existing life insurance or annuity contracts? . . . [] Yes [X] No
3. Do you have knowledge or reason to believe that replacement of existing insurance or annuities for either applicant was or may be involved? (If "Yes", submit replacement forms, if required) . . . [] Yes [X] No

Thomas K Smith 11/10/2008
Signature of Field Representative Date

Thomas K Smith
Field Representative's Name Printed

WOODMEN OF THE WORLD LIFE INSURANCE SOCIETY
 OMAHA WOODMEN LIFE INSURANCE SOCIETY
OMAHA, NEBRASKA

CERTIFICATE NUMBER

TERM LIFE INSURANCE
 WITH CHILD BENEFITS
 ADULT MEDICAL
 SUPPLEMENTARY
 STATEMENT

New Certificate Reinstatement

Change Existing Certificate

Field Representative Code: 123456

PROPOSED PRIMARY INSURED/APPLICANT (Proposed primary insured will be owner and must be ages 18 through 50.)

First John	Middle Initial K	Last Woodmen	Suffix
---------------	---------------------	-----------------	--------

Date of Birth (MM/DD/YYYY) 11/01/1973	Social Security Number 123-45-9876
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PROPOSED OTHER INSURED/APPLICANT (Proposed other insured will be owner and must be ages 18 through 50.)

First Mary	Middle Initial D	Last Woodmen	Suffix
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Date of Birth (MM/DD/YYYY) 10/15/1973	Social Security Number 123-45-6789
--	---------------------------------------

MEDICAL

1. PHYSICIAN OR MEDICAL FACILITY THAT HAS THE MOST COMPLETE AND CURRENT MEDICAL RECORDS:

Proposed Primary Insured

Physician/Facility Name				Phone Number
Address	City	State	Zip	Date Last Seen

Proposed Other Insured

Physician/Facility Name				Phone Number
Address	City	State	Zip	Date Last Seen

2. HAS EITHER PROPOSED INSURED (PRIMARY/OTHER) HAD OR EVER BEEN DIAGNOSED, TREATED, TESTED POSITIVE FOR OR BEEN GIVEN MEDICAL ADVICE BY A MEMBER OF THE MEDICAL PROFESSION FOR ANY DISEASE OR DISORDER OF THE:

	Proposed Primary Insured		Proposed Other Insured	
	YES	NO	YES	NO
A. Brain or Nervous System – such as epilepsy, paralysis or mental illness – to include treatment or counseling for depression or anxiety?	A. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
B. Respiratory System – such as emphysema, bronchitis or asthma – to include disorders of the eyes, ears, nose or throat?	B. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
C. Circulatory System – such as high blood pressure, chest pain, heart attack, heart surgery, heart murmur, stroke, or phlebitis?	C. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
D. Digestive or Urinary Tract Systems – such as ulcer, colitis, hepatitis, kidney infection, kidney stones, protein, blood or sugar in the urine – to include diabetes and thyroid disorders?	D. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
E. Musculoskeletal System – such as arthritis, gout, back disorders, or any connective tissue disorders?	E. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
F. Reproductive System – such as prostate, testes, breasts, ovaries or uterus disorders?	F. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
G. Immune System – such as lupus, multiple sclerosis or scleroderma except those related to the Human Immunodeficiency Virus?	G. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

3. HAS EITHER PROPOSED INSURED (PRIMARY/OTHER) EVER:

A. Been diagnosed or treated for cancer or tumor of any kind?	A. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
B. Had or been advised to have any surgical operation?	B. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
C. Been treated or received counseling for alcohol use, alcoholism or drug addiction? If "Yes", submit an Alcohol & Drug Questionnaire	C. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
D. Used narcotics, barbiturates, excitant drugs, hallucinogens or tranquilizers without a prescription by a physician? If "Yes", submit an Alcohol & Drug Questionnaire.	D. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

4. HAS EITHER PROPOSED INSURED (PRIMARY/OTHER) BEEN DIAGNOSED BY A MEMBER OF THE MEDICAL PROFESSION OR TESTED POSITIVE FOR HUMAN IMMUNODEFICIENCY VIRUS (AIDS VIRUS) OR ACQUIRED IMMUNE DEFICIENCY SYNDROME (AIDS)?

4.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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If any medical question has been answered "Yes", give dates and full details on Page 2 of this supplementary statement.

WOODMEN OF THE WORLD LIFE INSURANCE SOCIETY
 OMAHA WOODMEN LIFE INSURANCE SOCIETY
OMAHA, NEBRASKA

CERTIFICATE NUMBER
[]

TERM LIFE INSURANCE
WITH CHILD BENEFITS
ADMINISTRATIVE
SUPPLEMENTARY
STATEMENT

Field Representative Code: 123456

New Certificate Reinstatement
 Change Existing Certificate

PROPOSED PRIMARY INSURED/APPLICANT (Proposed primary insured will be owner and must be ages 18 through 50.)

First Middle Initial Last Suffix
John K Woodmen

Date of Birth (MM/DD/YYYY) Social Security Number
11/01/1973 123-45-9876

Is the primary residence of all proposed insureds the same as that of the Proposed Primary Insured/Applicant? . . . YES NO

If "No", give name(s) and provide explanation:

[]

PROPOSED OTHER INSURED/APPLICANT (Proposed other insured will be owner and must be ages 18 through 50.)

First Middle Initial Last Suffix
Mary D Woodmen

Date of Birth (MM/DD/YYYY) Social Security Number
10/15/1973 123-45-6789

1 CLARIFICATION OF PROPOSED INSURED'S NAME

Please provide the correct full name of the Proposed Primary Insured.

First Middle Initial Last Suffix
John K Woodmen

Please provide the correct full name of the Proposed Other Insured.

First Middle Initial Last Suffix
Mary D Woodmen

2 INSURANCE NOW IN FORCE OR APPLIED FOR AND REPLACEMENT

	Proposed Primary Insured		Proposed Other Insured	
FOR EITHER PROPOSED INSURED (PRIMARY/OTHER):	YES	NO	YES	NO
A. Does the proposed applicant have any existing life insurance or annuity contracts?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
B. Will any existing life or annuity contracts be replaced if the proposed certificate is issued?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

If A or B is answered "Yes", provide policy number and company information below. Submit replacement forms, if required.

Proposed Primary Insured List all policies currently **in force** or **applied for**. **If none, check here.**

Company Name _____ Policy Number _____
Address _____ City _____ State _____ Zip _____
Kind _____ Life Amount _____ Replace YES NO

Company Name _____ Policy Number _____
Address _____ City _____ State _____ Zip _____
Kind _____ Life Amount _____ Replace YES NO

Proposed Other Insured List all policies currently **in force** or **applied for**. **If none, check here.**

Company Name _____ Policy Number _____
Address _____ City _____ State _____ Zip _____
Kind _____ Life Amount _____ Replace YES NO

Company Name _____ Policy Number _____
Address _____ City _____ State _____ Zip _____
Kind _____ Life Amount _____ Replace YES NO

3 VERIFICATION OF STATE SIGNED

The state in which I signed the application was: _____

4 VERIFICATION OF THE DATE OF APPLICATION

The date I signed the application was: _____

5 FIELD REPRESENTATIVE'S CERTIFICATION

- 1. Were you present when this application was signed? (If "No", submit a full explanation with the application) . . . Yes No
- 2. Does either proposed applicant have any existing life insurance or annuity contracts? Yes No
- 3. Do you have knowledge or reason to believe that replacement of existing insurance or annuities for either applicant was or may be involved? (If "Yes", submit replacement forms, if required) Yes No

Signature of Field Representative	Date	Field Representative's Name Printed
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I have read the answers written above. I ratify and agree to be bound by such answers and agree that they are true and complete to the best of my knowledge and belief. I agree they shall form part of this application.

<i>John K Woodmen</i>	11/10/208
Signature of Proposed Primary Insured/Applicant	Date

<i>Mary D Woodmen</i>	11/10/208
Signature of Proposed Other Insured/Applicant	Date

<i>Thomas K Smith</i>	11/10/208
Signature of Witness	Date

Additional Witness if Required	Date
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WOODMEN OF THE WORLD LIFE INSURANCE SOCIETY
 OMAHA WOODMEN LIFE INSURANCE SOCIETY
OMAHA, NEBRASKA

CERTIFICATE NUMBER

TERM LIFE INSURANCE
 WITH CHILD BENEFITS
 UNDERWRITING
 SUPPLEMENTARY
 STATEMENT

New Certificate Reinstatement
 Change Existing Certificate

Field Representative Code: 123456

PROPOSED PRIMARY INSURED/APPLICANT (Proposed primary insured will be owner and must be ages 18 through 50.)

First John	Middle Initial K	Last Woodmen	Suffix
---------------	---------------------	-----------------	--------

Date of Birth (MM/DD/YYYY) 11/01/1973	Social Security Number 123-45-9876
--	---------------------------------------

Is the primary residence of all proposed insureds the same as that of the Proposed Primary Insured/Applicant? . . . YES NO

If "No", give name(s) and provide explanation:

PROPOSED OTHER INSURED/APPLICANT (Proposed other insured will be owner and must be ages 18 through 50.)

First Mary	Middle Initial D	Last Woodmen	Suffix
---------------	---------------------	-----------------	--------

Date of Birth (MM/DD/YYYY) 10/15/1973	Social Security Number 123-45-6789
--	---------------------------------------

1 TOBACCO USAGE

In the past 12 months , has either proposed insured (Primary/Other) used tobacco in any form, such as cigarettes, pipes, cigars, snuff or chewing tobacco OR smoking cessation products such as nicotine patches or nicorette gum?	Proposed Primary Insured	Proposed Other Insured
	YES NO	YES NO
	<input type="checkbox"/> <input checked="" type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>

Proposed Primary Insured

A. If "Yes", indicate date last used:
 Mo. _____ Yr. _____
 Indicate form(s) used: _____
 If cigarettes, how many packs per day? _____
 If cigars, indicate quantity and frequency: _____

Proposed Other Insured

A. If "Yes", indicate date last used:
 Mo. _____ Yr. _____
 Indicate form(s) used: _____
 If cigarettes, how many packs per day? _____
 If cigars, indicate quantity and frequency: _____

B. If "No", has either proposed insured (Primary/Other) used tobacco in any form OR smoking cessation products in the last **36 months**? YES NO YES NO

2 OCCUPATION

Proposed Primary Insured		
Occupation and Duties	Annual Income (Nearest \$10,000)	How Long in Present Occupation?
Name of Employer and Nature of Business	Address of Business	Previous Occupation

Proposed Other Insured		
Occupation and Duties	Annual Income (Nearest \$10,000)	How Long in Present Occupation?
Name of Employer and Nature of Business	Address of Business	Previous Occupation

3 NONMEDICAL

A. Does the Proposed Primary Insured have a current driver's license/permit? Yes, Driver's License/Permit Number: _____ State: _____
 No, explain why no license/permit: _____

A. Does the Proposed Other Insured have a current driver's license/permit? Yes, Driver's License/Permit Number: _____ State: _____
 No, explain why no license/permit: _____

HAS OR IS THE PROPOSED PRIMARY INSURED OR THE PROPOSED OTHER INSURED:	Proposed Primary Insured		Proposed Other Insured	
	YES	NO	YES	NO
B. Currently a United States citizen?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
If "No", give name and provide permanent resident card number: _____				
C. Ever had a license/permit suspended or revoked?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
D. Had any moving traffic violations or traffic accidents within the past three years?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
E. Been convicted of or pled guilty or no contest to driving while intoxicated or under the influence of a narcotic drug?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
F. Been convicted of or pled guilty or no contest to a crime within the past 10 years, or is either proposed insured currently awaiting trial for any crime?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
G. Currently on probation or parole?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
H. A member of the U.S. Armed Services or active reserve?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
If "Yes" has either proposed insured been alerted of possible deployment?				

If any question C-H has been answered "Yes", give dates and full details.

Give dates and full details for the Proposed Primary Insured.

Give dates and full details for the Proposed Other Insured.

HAS OR IS THE PROPOSED PRIMARY INSURED OR THE PROPOSED OTHER INSURED:	Proposed Primary Insured		Proposed Other Insured	
	YES	NO	YES	NO
I. Planning within the next 12 months to travel or reside outside of the U.S., Canada or any U.S. territories? If "Yes" complete Section 5 on this form.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
J. Participated in aviation as a pilot, crew member or student in the past 3 years – to include sky diving, hang gliding, ballooning, ultralight, and other sky sports – or intends to within the next 2 years? If "Yes", submit an Aviation Questionnaire.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
K. Participated in racing of any type, skin or scuba diving, mountain climbing, other sports such as bungee jumping or extreme sports in the past 3 years – or intends to within the next 2 years? If "Yes", submit an Avocation Questionnaire.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

4 FAMILY HISTORY

FOR EITHER PROPOSED INSURED (PRIMARY/OTHER):	Proposed Primary Insured		Proposed Other Insured	
	YES	NO	YES	NO
A. Have parents or siblings been diagnosed or treated by a member of the medical profession for cardiovascular disease or cancer prior to age 60?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
If "Yes", give proposed insured's name and details _____				
B. Did death of a parent or sibling occur prior to age 60 due to cardiovascular disease or cancer?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

5 TRAVEL

FOR EITHER PROPOSED INSURED (PRIMARY/OTHER):

Please provide the following details for any travel plans you have to locations other than the United States (and its territories or Canada):

1. What country, or countries, do you plan on traveling to?

Proposed Primary Insured: _____

Proposed Other Insured: _____

2. What city or cities do you plan to visit?

Proposed Primary Insured: _____

Proposed Other Insured: _____

3. When do you plan on going?

Proposed Primary Insured: _____

Proposed Other Insured: _____

4. How long do you plan on being there?

Proposed Primary Insured: _____

Proposed Other Insured: _____

5. What is the purpose of the trip?

Proposed Primary Insured: _____

Proposed Other Insured: _____

6. Will medical and sanitation facilities be accessible?

Proposed Primary Insured: _____

Proposed Other Insured: _____

Provide any additional information relating to the above questions that would be helpful in consideration of the application.

I have read the answers written above. I ratify and agree to be bound by such answers and agree that they are true and complete to the best of my knowledge and belief. I agree they shall form part of this application.

John K Woodmen

Signature of Proposed Primary Insured/Applicant

11/10/2008

Date

Mary D Woodmen

Signature of Proposed Other Insured/Applicant

11/10/2008

Date

Thomas K Smith

Signature of Witness

11/10/2008

Date

Additional Witness if Required

Date

WOODMEN OF THE WORLD LIFE INSURANCE SOCIETY
 OMAHA WOODMEN LIFE INSURANCE SOCIETY
OMAHA, NEBRASKA

CERTIFICATE NUMBER

TERM LIFE INSURANCE
WITH CHILD BENEFITS
CHILDREN'S
SUPPLEMENTARY
STATEMENT

New Certificate Reinstatement
 Change Existing Certificate

Field Representative Code: 123456

PROPOSED PRIMARY INSURED/APPLICANT (Proposed primary insured will be owner and must be ages 18 through 50.)

First John	Middle Initial K	Last Woodmen	Suffix
Date of Birth (MM/DD/YYYY) 11/01/1973		Social Security Number 123-45-9876	

PROPOSED OTHER INSURED/APPLICANT (Proposed other insured will be owner and must be ages 18 through 50.)

First Mary	Middle Initial D	Last Woodmen	Suffix
Date of Birth (MM/DD/YYYY) 10/15/1973		Social Security Number 123-45-6789	

1 PROPOSED INSURED CHILDREN Number of children applying for insurance: _____

First Thomas	Middle Initial W	Last Woodmen	Suffix	Social Security Number 231-45-1111
-----------------	---------------------	-----------------	--------	---------------------------------------

Sex M	Date of Birth (MM/DD/YYYY) 01/15/1993	Age Now 15	Relationship of Proposed Primary Insured & Proposed Other Insured to Child Primary Insured: FATHER Other Insured: MOTHER
----------	--	---------------	--

New Member Existing Member

First Susan	Middle Initial J	Last Woodmen	Suffix	Social Security Number 231-45-1231
----------------	---------------------	-----------------	--------	---------------------------------------

Sex F	Date of Birth (MM/DD/YYYY) 05/20/1996	Age Now 12	Relationship of Proposed Primary Insured & Proposed Other Insured to Child Primary Insured: FATHER Other Insured: MOTHER
----------	--	---------------	--

New Member Existing Member

First James	Middle Initial S	Last Woodmen	Suffix	Social Security Number 232-45-1223
----------------	---------------------	-----------------	--------	---------------------------------------

Sex M	Date of Birth (MM/DD/YYYY) 03/01/1998	Age Now 10	Relationship of Proposed Primary Insured & Proposed Other Insured to Child Primary Insured: FATHER Other Insured: MOTHER
----------	--	---------------	--

New Member Existing Member

First David	Middle Initial A	Last Woodmen	Suffix	Social Security Number 232-45-3221
----------------	---------------------	-----------------	--------	---------------------------------------

Sex M	Date of Birth (MM/DD/YYYY) 03/10/2000	Age Now 8	Relationship of Proposed Primary Insured & Proposed Other Insured to Child Primary Insured: FATHER Other Insured: MOTHER
----------	--	--------------	--

New Member Existing Member

First Julie	Middle Initial M	Last Woodmen	Suffix	Social Security Number 231-45-2113
----------------	---------------------	-----------------	--------	---------------------------------------

Sex F	Date of Birth (MM/DD/YYYY) 02/14/2003	Age Now 5	Relationship of Proposed Primary Insured & Proposed Other Insured to Child Primary Insured: FATHER Other Insured: MOTHER
----------	--	--------------	--

New Member Existing Member

1 PROPOSED INSURED CHILDREN, Continued

First	Middle Initial	Last	Suffix	Social Security Number
Sex	Date of Birth (MM/DD/YYYY)	Age Now	Relationship of Proposed Primary Insured & Proposed Other Insured to Child Primary Insured: Other Insured:	
<input type="checkbox"/> New Member <input type="checkbox"/> Existing Member				

First	Middle Initial	Last	Suffix	Social Security Number
Sex	Date of Birth (MM/DD/YYYY)	Age Now	Relationship of Proposed Primary Insured & Proposed Other Insured to Child Primary Insured: Other Insured:	
<input type="checkbox"/> New Member <input type="checkbox"/> Existing Member				

First	Middle Initial	Last	Suffix	Social Security Number
Sex	Date of Birth (MM/DD/YYYY)	Age Now	Relationship of Proposed Primary Insured & Proposed Other Insured to Child Primary Insured: Other Insured:	
<input type="checkbox"/> New Member <input type="checkbox"/> Existing Member				

First	Middle Initial	Last	Suffix	Social Security Number
Sex	Date of Birth (MM/DD/YYYY)	Age Now	Relationship of Proposed Primary Insured & Proposed Other Insured to Child Primary Insured: Other Insured:	
<input type="checkbox"/> New Member <input type="checkbox"/> Existing Member				

First	Middle Initial	Last	Suffix	Social Security Number
Sex	Date of Birth (MM/DD/YYYY)	Age Now	Relationship of Proposed Primary Insured & Proposed Other Insured to Child Primary Insured: Other Insured:	
<input type="checkbox"/> New Member <input type="checkbox"/> Existing Member				

First	Middle Initial	Last	Suffix	Social Security Number
Sex	Date of Birth (MM/DD/YYYY)	Age Now	Relationship of Proposed Primary Insured & Proposed Other Insured to Child Primary Insured: Other Insured:	
<input type="checkbox"/> New Member <input type="checkbox"/> Existing Member				

First	Middle Initial	Last	Suffix	Social Security Number
Sex	Date of Birth (MM/DD/YYYY)	Age Now	Relationship of Proposed Primary Insured & Proposed Other Insured to Child Primary Insured: Other Insured:	
<input type="checkbox"/> New Member <input type="checkbox"/> Existing Member				

2 CHILDREN MEDICAL

1. Have any proposed insured children been diagnosed by a member of the medical profession or tested positive for Human Immunodeficiency Virus (AIDS Virus) or Acquired Immune Deficiency Syndrome (AIDS)? YES NO
 If "Yes", give child's name and details below.
2. Have any proposed insured children been diagnosed, treated, tested positive for or been given medical advice by a member of the medical profession for any of the following diseases or disorders: If "Yes", give child's name and details below.
- A. Any physical or mental impairment due to illness, injury or birth defect?
- B. Any heart condition or heart surgery of any kind?
- C. Any alcohol or drug abuse?
- D. Any cancer, including melanoma but excluding other types of skin cancers?
- E. Diabetes?
- F. Immune deficiency disorder such as lupus, multiple sclerosis or scleroderma except those related to the Human Immunodeficiency Virus (AIDS Virus)?
3. In the past 24 months, have any of the proposed insured children been seen by a physician or treated in a medical facility for an illness or disease? If "Yes", give child's name and details below.
4. Are any of the proposed insured children currently taking medication(s)? If "Yes", state child's name, name of drug and condition requiring it below.

If any question 1-4 has been answered "Yes", give child's name and full details below:

Question Number	Child's Name	Details

If more space is needed for Children's Medical details, include an additional page, signed, dated and witnessed.

I have read the answers written above. I ratify and agree to be bound by such answers and agree that they are true and complete to the best of my knowledge and belief. I agree they shall form part of this application.

John K Woodmen 11/10/2008
 Signature of Proposed Primary Date
 Insured/Applicant

Mary D Woodmen 11/10/2008
 Signature of Proposed Other Date
 Insured/Applicant

Thomas K Smith 11/10/2008
 Signature of Witness Date

 Additional Witness if Required Date

4A. WITH RESPECT TO CIVILIAN FLYING - **PROPOSED PRIMARY INSURED**

What type(s) of certificate or license do you have? Student Commercial Private ATR IFR

If IFR, how many SOLO hours of instrument time have you flown in the past 12 months? _____

Have you flown, or do you intend to fly outside the U.S.? Yes No If "Yes", explain in No. 6 below.

What type of aircraft do you fly? Single engine Multi-engine

Do you engage in or do you contemplate engaging in any type of flying not indicated above? Yes No
If "Yes", explain in No. 6 below.

4B. WITH RESPECT TO CIVILIAN FLYING - **PROPOSED OTHER INSURED**

What type(s) of certificate or license do you have? Student Commercial Private ATR IFR

If IFR, how many SOLO hours of instrument time have you flown in the past 12 months? _____

Have you flown, or do you intend to fly outside the U.S.? Yes No If "Yes", explain in No. 6 below.

What type of aircraft do you fly? Single engine Multi-engine

Do you engage in or do you contemplate engaging in any type of flying not indicated above? Yes No
If "Yes", explain in No. 6 below.

5A. WITH RESPECT TO MILITARY FLYING - **PROPOSED PRIMARY INSURED**

Specify capacity in which you fly: Pilot Co-Pilot Navigator Crew

HOURS FLOWN Total Hours: _____ Past 12 months: _____ Contemplated next 12 months: _____

To what type of military organization do you belong? Army Navy Air Force Marines ROTC
 National Guard/Reserves Other Explain in No. 6 below.

What type of aircraft do you fly in? (Specify alphabetic and numeric code, e.g., B-1) _____

Do you fly from an aircraft carrier? Yes No

5B. WITH RESPECT TO MILITARY FLYING - **PROPOSED OTHER INSURED**

Specify capacity in which you fly: Pilot Co-Pilot Navigator Crew

HOURS FLOWN Total Hours: _____ Past 12 months: _____ Contemplated next 12 months: _____

To what type of military organization do you belong? Army Navy Air Force Marines ROTC
 National Guard/Reserves Other Explain in No. 6 below.

What type of aircraft do you fly in? (Specify alphabetic and numeric code, e.g., B-1) _____

Do you fly from an aircraft carrier? Yes No

6. DETAILS (Specify Question Number):

7. Based on full analysis of the information you provided above, an extra premium rate may be assessed. You have the option to choose to pay the extra premium or accept coverage exclusion/limitations for aviation risks. Which option do you select?

Proposed Primary Insured Extra Rate Coverage exclusion/limitations for aviation risks

Proposed Other Insured Extra Rate Coverage exclusion/limitations for aviation risks

I have read the answers written above. I ratify and agree to be bound by such answers and agree that they are true and complete to the best of my knowledge and belief. I agree they shall form part of this application.

John K Woodmen 11/10/2008
Signature of Proposed Primary Insured/Applicant Date

Mary D Woodmen 11/10/2008
Signature of Proposed Other Insured/Applicant Date

Thomas K Smith 11/10/2008
Signature of Witness Date

Additional Witness if Required Date

WOODMEN OF THE WORLD LIFE INSURANCE SOCIETY
 OMAHA WOODMEN LIFE INSURANCE SOCIETY
OMAHA, NEBRASKA

CERTIFICATE NUMBER

TERM LIFE INSURANCE
 WITH CHILD BENEFITS
 AVOCATION
 QUESTIONNAIRE

New Certificate Reinstatement
 Change Existing Certificate

Field Representative Code: 123456

PROPOSED PRIMARY INSURED/APPLICANT (Proposed primary insured will be owner and must be ages 18 through 50.)

First Middle Initial Last Suffix
 John K Woodmen

Date of Birth (MM/DD/YYYY) Social Security Number
 11/01/1973 123-45-9876

PROPOSED OTHER INSURED/APPLICANT (Proposed other insured will be owner and must be ages 18 through 50.)

First Middle Initial Last Suffix
 Mary D Woodmen

Date of Birth (MM/DD/YYYY) Social Security Number
 10/15/1973 123-45-6789

1 SCUBA DIVING

Proposed Primary Insured

TYPE: Open Water Photography Spear Fishing Cave Salvage/Treasure Wreck diving with penetration

Depth →	To 75 Ft.	76-100 Ft.	101-130 Ft.	OVER 130 Ft.	Avg. time under water per dive
No. of dives next 12 months	7				
No. of dives past 12 months	6				
No. of dives in previous 13-24 months	8				

Have you received one of the following National Certifications? PADI NAUI NASDS YMCA

Have you received one of the following diving certifications: Diving with an instructor Basic Cert. Open Water Cert.
 Adv. Open Water Cert. Specialty Course Cave Specialty Course Wreck Specialty Course Other _____
 Dive Master Cert. Ass't. Instructor or Instructor Master Instructor Master Scuba Diver

If diving over 75 ft., please describe location, type of dive and if it was supervised: _____

Do you use the buddy system? Yes No

Location of dives: Oceans Pools Lakes/Rivers Bays/Inlets

Proposed Other Insured

TYPE: Open Water Photography Spear Fishing Cave Salvage/Treasure Wreck diving with penetration

Depth →	To 75 Ft.	76-100 Ft.	101-130 Ft.	OVER 130 Ft.	Avg. time under water per dive
No. of dives next 12 months					
No. of dives past 12 months					
No. of dives in previous 13-24 months					

Have you received one of the following National Certifications? PADI NAUI NASDS YMCA

Have you received one of the following diving certifications: Diving with an instructor Basic Cert. Open Water Cert.
 Adv. Open Water Cert. Specialty Course Cave Specialty Course Wreck Specialty Course Other _____
 Dive Master Cert. Ass't. Instructor or Instructor Master Instructor Master Scuba Diver

If diving over 75 ft., please describe location, type of dive and if it was supervised: _____

Do you use the buddy system? Yes No

Location of dives: Oceans Pools Lakes/Rivers Bays/Inlets

2 RACING SPORTS

Proposed Primary Insured

TYPE: Drag Indy Car Kart Midget Formula GT Rally Production Sprint Stock Motorcycle Boat Other _____ Vehicle Category _____ Racing Division _____

Make: _____ Model: _____ Engine Displacement: _____

Horsepower: _____ Type of Fuel: _____ Highest attained speed during race _____ mph.

Through what organization is vehicle sanctioned? _____ In what class do you race? _____

Track: Oval Track Closed Circuit Drag Strip Hill Climb Other: _____ Track Length _____

Yrs. of experience _____ Number of races last 12 mos. _____ Avg. length of race _____ Number of races next 12 mos. _____

Proposed Other Insured

TYPE: Drag Indy Car Kart Midget Formula GT Rally Production Sprint Stock Motorcycle Boat Other _____ Vehicle Category _____ Racing Division _____

Make: _____ Model: _____ Engine Displacement: _____

Horsepower: _____ Type of Fuel: _____ Highest attained speed during race _____ mph.

Through what organization is vehicle sanctioned? _____ In what class do you race? _____

Track: Oval Track Closed Circuit Drag Strip Hill Climb Other: _____ Track Length _____

Yrs. of experience _____ Number of races last 12 mos. _____ Avg. length of race _____ Number of races next 12 mos. _____

3 OTHER SPORTS

Proposed Primary Insured

1. Please identify which of the activities you participate in:

Bungee Jumping Other (Explain in No. 5 below) _____

2. Are you a member of a club? Yes No

3. Usual location or type of terrain: _____

4. Number of jumps: Last 12 mos. _____ Past 13-24 mos. _____ Est. next 12 mos. _____

5. Details:

Proposed Other Insured

1. Please identify which of the activities you participate in:

Bungee Jumping Other (Explain in No. 5 below) _____

2. Are you a member of a club? Yes No

3. Usual location or type of terrain: _____

4. Number of jumps: Last 12 mos. _____ Past 13-24 mos. _____ Est. next 12 mos. _____

5. Details:

4 MOUNTAIN CLIMBING

Proposed Primary Insured

How many years of experience climbing do you have? _____ How many times per year do you climb? _____

Usual duration of climb? Hours: _____ Days: _____ Average Height? _____

Have you had any climbing accidents? Yes No

Do you plan on climbing outside the U.S.? Yes No

Do you climb alone? Yes No

Is the insurance coverage being used to cover any type of climbing event? Yes No

For any "Yes" answers in Section 4, please explain (regarding nature, location, frequency and degree of participation).

Proposed Other Insured

How many years of experience climbing do you have? _____ How many times per year do you climb? _____

Usual duration of climb? Hours: _____ Days: _____ Average Height? _____

Have you had any climbing accidents? Yes No

Do you plan on climbing outside the U.S.? Yes No

Do you climb alone? Yes No

Is the insurance coverage being used to cover any type of climbing event? Yes No

For any "Yes" answers in Section 4, please explain (regarding nature, location, frequency and degree of participation).

I have read the answers written above. I ratify and agree to be bound by such answers and agree that they are true and complete to the best of my knowledge and belief. I agree they shall form part of this application.

John K Woodmen

Signature of Proposed Primary Insured/Applicant

11/10/2008

Date

Mary D Woodmen

Signature of Proposed Other Insured/Applicant

11/10/2008

Date

Thomas K Smith

Signature of Witness

11/10/2008

Date

Additional Witness if Required

Date

New Certificate Reinstatement
 Change Existing Certificate

Field Representative Code: 123456

PROPOSED PRIMARY INSURED/APPLICANT (Proposed primary insured will be owner and must be ages 18 through 50.)

First John	Middle Initial K	Last Woodmen	Suffix
Date of Birth (MM/DD/YYYY) 11/01/1973		Social Security Number 123-45-9876	

PROPOSED OTHER INSURED/APPLICANT (Proposed other insured will be owner and must be ages 18 through 50.)

First Mary	Middle Initial D	Last Woodmen	Suffix
Date of Birth (MM/DD/YYYY) 10/15/1973		Social Security Number 123-45-6789	

1. ALCOHOL USAGE For purposes of this questionnaire, **one drink is defined** as 12 oz. of beer, 4 oz. of wine or 1/2 oz. of pure alcohol.

Proposed
Primary Insured Proposed
Other Insured

A. In the past 12 months, has either proposed insured (Primary/Other) consumed alcoholic beverages? If "Yes", list number of drinks consumed below: YES NO YES NO

Proposed Primary Insured

Daily _____ Weekly _____ Date of last drink: _____

Proposed Other Insured

Daily _____ Weekly _____ Date of last drink: _____

B. Past use - from 13 months to 8 years - has either proposed insured (Primary/Other) consumed alcoholic beverages? YES NO YES NO

Proposed Primary Insured

If "Yes", number of drinks consumed: Weekly _____ Date of last drink: _____

Proposed Other Insured

If "Yes", number of drinks consumed: Weekly _____ Date of last drink: _____

Proposed
Primary Insured Proposed
Other Insured

2. DRUG USAGE

A. Has either proposed insured (Primary/Other) ever used IV (intravenous) drugs? YES NO YES NO

B. Within the past seven (7) years, except as prescribed by a licensed health professional, has either proposed insured (Primary/Other) used or currently use any of the following? Give details below to all "Yes" answers.

- | | | | | |
|---|-------------------------------------|-------------------------------------|--------------------------|--------------------------|
| 1. Marijuana (e.g., Hashish, Cannabis, THC) | <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Amphetamines or Stimulants (e.g., Cocaine, Speed, Ecstasy, Dexedrine, Methamphetamine) | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Hallucinogens (e.g., LSD, PCP, Mescaline, Peyote) | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Barbiturates or Sedatives (e.g., Amytal, Librium, Valium) | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Opiates or Narcotics (e.g., Heroin, Morphine, Methadone) | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Other (e.g., glue, ether, paint thinners) | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

Name of Drug	Usual Quantity	Frequency of Use Daily, Weekly, Monthly	Dates From: To:
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Proposed Primary Insured

Marijuana		Monthly	06/01/2004 09/01/2007

Proposed Other Insured

**WOODMEN OF THE WORLD LIFE INSURANCE SOCIETY
HOME OFFICE - OMAHA, NEBRASKA**

PRIMARY INSURED [JOHN X WOODMEN]

[OTHER INSURED] [JANE L WOODMEN]

EFFECTIVE DATE [JULY 1, 2009]

CERTIFICATE [123456789]

RATIFICATION OF CHANGE IN COVERAGE APPLIED FOR AND/OR APPLICATION DATED [date application signed]

I hereby agree to the following changes in certificate [123456789]

① [The waiver rider has not been included on this certificate.]

I understand and agree that the foregoing changes are made part of the application and of the certificate issued thereunder. These changes shall be binding on any person who shall have or claim any interest under such certificate.

SIGNATURE OF [JOHN X WOODMEN] - _____

[SIGNATURE OF [JANE L WOODMEN] - _____]

SIGNATURE OF WITNESS - _____

DATE - _____

② **[IMPORTANT** - If this form is signed and the required premium has been paid, this certificate will be in force as of the date shown on the certificate, or as of the date this form is signed, whichever comes first. In any event, this form must be signed not later than [August 1, 2009] and returned to the Home Office or the certificate will be canceled.]

If this form is signed, it will be on file. You may request a copy from the Home Office.

Statement of Variability

The following is the statement of variability for Form 8070 10-08 which will be attached to the certificate if one or more of the following situations apply.

Section 1 – One or more of the following statements will print.

The waiver rider has been issued at a special class rate on this certificate. This special rating class will increase premiums.

The waiver rider has not been included on this certificate.

The waiver rider has been added to this certificate. Please see the certificate rider for details.

The Accelerated Death Benefit Rider has not been included in this certificate.

The Primary Insured has been issued at a special class rate. This special rating class will increase premiums.

The Other Insured Rider has been issued at a special class rate. This special rating class will increase premiums.

The face amount of insurance for the Primary Insured for this certificate has been changed. The face amount on the copy of the application has been compared with the new face amount on the certificate.

The face amount of insurance for the Other Insured Rider has been changed. The face amount on the copy of the application has been compared with the new face amount on the rider.

The Other Insured Rider has not been included in this certificate.

The Primary Insured's age for this certificate has been changed.

The Other Insured's age for this certificate has been changed.

The Insured Children's age(s) for this certificate has/have been changed.

This certificate has been issued with a tobacco rating class based on the underwriting findings for the Primary Insured. This classification will increase premiums. It will also affect the refunds.

The Other Insured Rider has been issued with a tobacco rating class based on the underwriting findings for the Other Insured. This classification will increase premiums. It will also affect the refunds.

The Proposed Insured Children listed on the application have been changed. The following child(ren) is/are not covered under the Children's Term Insurance Benefit Endorsement.

[Child's Name]

Section 2: One of the following statements will print.

“IMPORTANT – If this form is signed and the required premium has been paid, this certificate will be in force as of the date shown on the certificate, or as of the date this form is signed, whichever comes first. In any event, this form must be signed not later than [August 1, 2009] and returned to the Home Office or the certificate will be canceled.”

“IMPORTANT – If this form is signed and the required premium has been paid, this certificate will be in force as of the date shown on the certificate, or as of the date this form is signed, whichever comes first. This certificate was issued upon exchange for one or more certificates issued by Woodmen, and coverage under the exchanged certificate(s) continues until this ratification form is signed, but will automatically cease when coverage under this certificate starts. In any event, this form must be signed not later than [August 1, 2009] and returned to the Home Office or the certificate will be cancelled, and the certificate(s) exchanged will continue according to the terms of the certificate(s) as though no exchange had occurred.”

SERFF Tracking Number: *WDMM-125928208* *State:* *Arkansas*
Filing Company: *Woodmen of the World Life Insurance Society* *State Tracking Number:* *41049*
Company Tracking Number:
TOI: *L04I Individual Life - Term* *Sub-TOI:* *L04I.213 Specified Age or Duration -*
Fixed/Indeterminate Premium - Single Life

Product Name: *Family Term Life App & Related Forms*
Project Name/Number: /

Rate Information

Rate data does NOT apply to filing.

SERFF Tracking Number: WDMM-125928208 State: Arkansas
Filing Company: Woodmen of the World Life Insurance Society State Tracking Number: 41049
Company Tracking Number:
TOI: L041 Individual Life - Term Sub-TOI: L041.213 Specified Age or Duration -
Fixed/Indeterminate Premium - Single Life
Product Name: Family Term Life App & Related Forms
Project Name/Number: /

Supporting Document Schedules

Review Status:

Satisfied -Name: Certification/Notice

12/02/2008

Comments:

Attachments:

Rule 19 CtfnA.pdf

Readability Ctfn. App..pdf

WOODMEN OF THE WORLD LIFE INSURANCE SOCIETY
1700 Farnam Street, Omaha, Nebraska 68102

CERTIFICATION

I certify that to the best of my knowledge and belief the form(s) in this submission meets the provisions of Rule and Regulation 19 as well as all applicable requirements of the Arkansas Insurance Department.

December 4, 2008

Date

Vice President & Chief Actuary

Form(s):

Form 8040 10/08
Form 601F 10/08
Form 943F 10/08
Form 956F 10/08
Form 8079F 10/08
Form 835F 10/08
Form 836F 10/08
Form 7692F 10/08
Form 8070 10-08

WOODMEN OF THE WORLD LIFE INSURANCE SOCIETY
1700 Farnam Street, Omaha, Nebraska 68102-2007

FLESCH CERTIFICATION

<u>Form Number(s)</u>	<u>Description</u>	<u>Flesch Score</u>
Form 8040 10/08	Application for Individual Term Life Insurance with Child Benefits and Membership	50.4
Form 601F 10/08	Term Life Insurance with Child Benefits Adult Medical Supplementary Statement	51
Form 943F 10/08	Term Life Insurance with Child Benefits Administrative Supplementary Statement	52.3
Form 956F 10/08	Term Life Insurance with Child Benefits Underwriting Supplementary Statement	58.7
Form 8079F 10/08	Term Life Insurance with Child Benefits Children's Supplementary Statement	51
Form 835F 10/08	Term Life Insurance with Child Benefits Aviation Questionnaire	69.3
Form 836F 10/08	Term Life Insurance with Child Benefits Avocation Questionnaire	52.9
Form 7692F 10/08	Term Life Insurance with Child Benefits Alcohol & Drug Questionnaire	53.2
Form 8070 10-08	Ratification Form	61.3

I certify that these Flesch Index numbers are accurate in accordance with the published rules of application of the test.

Randall P. Rotschafer
Vice President and Chief Actuary