

SERFF Tracking Number: GRWE-125692669 State: Arkansas
Filing Company: Great-West Life & Annuity Insurance Company State Tracking Number: 39285
Company Tracking Number:
TOI: L08 Life - Other Sub-TOI: L08.000 Life - Other
Product Name: J241A app & J242Dapp
Project Name/Number: /

Filing at a Glance

Company: Great-West Life & Annuity Insurance Company

Product Name: J241A app & J242Dapp

TOI: L08 Life - Other

Sub-TOI: L08.000 Life - Other

Filing Type: Form

SERFF Tr Num: GRWE-125692669 State: ArkansasLH

SERFF Status: Closed

State Tr Num: 39285

Co Tr Num:

State Status: Approved-Closed

Co Status:

Reviewer(s): Linda Bird

Author: DeNae Staeck

Disposition Date: 06/16/2008

Date Submitted: 06/11/2008

Disposition Status: Approved

Implementation Date Requested:

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: Exempt in the state of Colorado

Explanation for Combination/Other:

Market Type: Individual

Submission Type: New Submission

Group Market Size:

Overall Rate Impact:

Group Market Type:

Filing Status Changed: 06/16/2008

State Status Changed: 06/16/2008

Deemer Date:

Corresponding Filing Tracking Number:

Filing Description:

2 Life Application Filings

Company and Contact

Filing Contact Information

DeNae Staeck, Compliance Coordinator

denae.staeck@gwl.com

8515 E. Orchard Rd

(303) 737-2749 [Phone]

SERFF Tracking Number: GRWE-125692669 State: Arkansas
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Greenwood Village, CO 80110 (303) 737-5434[FAX]

Filing Company Information

Great-West Life & Annuity Insurance Company CoCode: 68322 State of Domicile: Colorado
8515 East Orchard Road Group Code: 769 Company Type:
Greenwood Village, CO 80111 Group Name: State ID Number:
(303) 737-3992 ext. [Phone] FEIN Number: 84-0467907

SERFF Tracking Number: GRWE-125692669 State: Arkansas
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Filing Fees

Fee Required? Yes
Fee Amount: \$40.00
Retaliatory? No
Fee Explanation: 2 applications x \$20.00= \$40.00
Per Company: No

| COMPANY | AMOUNT | DATE PROCESSED | TRANSACTION # |
|---|---------|----------------|---------------|
| Great-West Life & Annuity Insurance Company | \$40.00 | 06/11/2008 | 20799454 |

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Correspondence Summary

Dispositions

| Status | Created By | Created On | Date Submitted |
|----------|------------|------------|----------------|
| Approved | Linda Bird | 06/16/2008 | 06/16/2008 |

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Project Name/Number: /

Disposition

Disposition Date: 06/16/2008

Implementation Date:

Status: Approved

Comment:

Rate data does NOT apply to filing.

SERFF Tracking Number: GRWE-125692669 State: Arkansas
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 Company Tracking Number:
 TOI: L08 Life - Other Sub-TOI: L08.000 Life - Other
 Product Name: J241A app & J242Dapp
 Project Name/Number: /

| Item Type | Item Name | Item Status | Public Access |
|----------------------------|----------------------------|--------------------|----------------------|
| Supporting Document | Certification/Notice | | Yes |
| Supporting Document | Application | | Yes |
| Supporting Document | Cover Letter | | Yes |
| Form | Life Insurance Application | | Yes |
| Form | Life Insurance Application | | Yes |

SERFF Tracking Number: GRWE-125692669 State: Arkansas
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 Company Tracking Number:
 TOI: L08 Life - Other Sub-TOI: L08.000 Life - Other
 Product Name: J241A app & J242Dapp
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Form Schedule

Lead Form Number: J241Aapp & J242Dapp

| Review Status | Form Number | Form Type | Form Name | Action | Action Specific Data | Readability | Attachment |
|---------------|-------------|--------------|--|---------|----------------------|-------------|------------------|
| | J241Aapp | Application/ | Life Insurance Enrollment Application Form | Initial | | | J241Aapp.pdf |
| | J242Dapp | Application/ | Life Insurance Enrollment Application Form | Initial | | | J242Dapp (2).pdf |

GREAT-WEST LIFE & ANNUITY INSURANCE COMPANY, P.O. Box 173316, Denver, CO 80217
Life Insurance Application

INSURED: Name
First/Middle Initial/Last

If you have had a name change in the last 10 years, please provide your previous name below:

Previous Name
First/Middle Initial/Last

Date of Birth Male Female Social Security Number

Occupation

Home Address 1

Home Address 2

City State ZIP

Daytime Phone Evening Phone

Place of Birth
State/Country

COVERAGE: Term Coverage Type: 10-Year Term 20-Year Term
Term Coverage Amount: \$25,000 \$50,000 \$75,000 \$100,000 \$125,000
\$150,000 \$175,000 \$200,000 \$225,000 \$250,000

Whole Life Coverage Amount: \$10,000 \$15,000 \$20,000 \$25,000 \$50,000
\$75,000 \$100,000 \$125,000 \$150,000

Children's Coverage This insurance provides \$5,000 of coverage on the lives of each of your children (existing and future by birth or adoption, including stepchildren), ages 6 months to the child's 18th birthday, as long as your policy is in force. Check here if you would like to cover all of your children for just \$1.50 per month.

REPLACEMENT: Do you have any life insurance policies or annuity contracts in force? Yes No
Will this policy replace or be financed by any life insurance or annuity contracts presently or previously owned? Yes No

QUALIFICATION: 1) Your Height: Feet Inches Your Weight: lbs. Yes No
2) Do you currently use or have you used any type of tobacco product within the past 12 months? Yes No
3) Are you a U.S. citizen? Yes No
3a) If no, are you currently residing in the U.S. as a permanent resident alien or have you applied for a permanent visa, Resident Alien Card, Permanent Resident Card or "Green Card" for which you are currently awaiting approval? Yes No



In the past three years, have you been charged with driving under the influence of alcohol or drugs (DUI), or have you had your driver's license suspended or revoked? Yes No

In the past five years, have you
1) used illegal drugs? Yes No
2) been convicted or incarcerated for a felony, or are you currently on probation or parole? Yes No

In the past 10 years, have you had, been medically advised that you have, or received any type of treatment for:
1) Alcoholism or substance abuse? Yes No
2) Any diseases or disorders of the central nervous system, brain or spinal cord? Examples include, but are not limited to: stroke, paralysis, multiple sclerosis, seizures and congenital disorders. Yes No
3) Cancer (other than basal cell carcinoma of the skin)? Yes No
4) Major depression, schizophrenia or any of the following disorders: panic, psychotic or bipolar? Yes No
5) Mental retardation, autism or Down syndrome? Yes No
6) A positive test for Human Immunodeficiency Virus (HIV), Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC)? Yes No
7) Asthma with associated hospitalizations or acute/emergency care visits? Yes No

QUALIFICATION CONTINUED:

In the past 10 years, have you had, been medically advised that you have, or received any type of treatment for any of the following:

| | Yes | No | | Yes | No |
|--|--------------------------|--------------------------|--------------------------------------|--------------------------|--------------------------|
| Heart disease or disorder? | <input type="checkbox"/> | <input type="checkbox"/> | Diabetes? | <input type="checkbox"/> | <input type="checkbox"/> |
| Lung disease or disorder? | <input type="checkbox"/> | <input type="checkbox"/> | Blood vessel disease, disorder or | | |
| Kidney disease, disorder or insufficiency? | <input type="checkbox"/> | <input type="checkbox"/> | high blood pressure? | <input type="checkbox"/> | <input type="checkbox"/> |
| Lupus? | <input type="checkbox"/> | <input type="checkbox"/> | Liver disease, disorder or | | |
| Ulcerative colitis or Crohn's disease? | <input type="checkbox"/> | <input type="checkbox"/> | hepatitis (other than Type A)? | <input type="checkbox"/> | <input type="checkbox"/> |
| Blood disorders including chronic anemia? | <input type="checkbox"/> | <input type="checkbox"/> | | | |

PAYMENT:

Please indicate your payment method below (check only one of the three boxes at left).

Automatic Monthly Account Deduction For your convenience, premium payments will be deducted from your bank account each month. Please complete the following information. If your application is accepted, your monthly premium will be deducted on the fifth day of each month, unless otherwise noted below. Enclose your first monthly premium payment with your signed application.

Name of Bank

City State

Account Number Routing Number

Account Type: Checking or Savings Account Withdrawal Date: 5th or 20th of month

Automatic Monthly Premium Amount (include Children's Coverage, if applicable) \$

Annual Direct Bill If selecting annual direct bill, enclose your first annual premium payment with your signed application.

Annual Premium Amount (Automatic Monthly Premium + Children's Coverage, if applicable x 11) \$

Payments with Credit Card Credit card payments may only be made by the Insured. \$

Card type: Visa Mastercard Payment frequency: Monthly Annually

Card Number Expiration Date on Card
(month/year)

Name
(if different than Insured name above; as it appears on Card)

BENEFICIARY:

Name

Relationship

Percentage Social Security Number

All primary beneficiary percentages must total 100% and (if named) all contingent beneficiary percentages must total 100%. If left blank, the application will assume an equal split among primary beneficiaries and an equal split among any contingent beneficiaries. Beneficiary details and payment are explained in the policy provisions.

SIGNATURE:

I certify: 1) All statements and answers to the questions in this application and any supplement to it are true. 2) This application will form a part of the insurance contract with Great-West Life & Annuity Insurance Company (the Company). 3) This application will not be in effect unless the first premium is paid **while the insured is still living**. 4) The policy applied for takes effect on the date of this application provided that a) questions on the application have been answered truthfully; and b) the application for coverage is not declined. 5) I hereby authorize the premium amount to be deducted or charged as specified in the payment section. This authorization is limited to payment to the Company for an insurance premium. 6) I authorize the Company to obtain all of my medical history in the event of my death within 2 1/2 years of this application date.

This insurance product is not a deposit or other obligation of, or guaranteed by, the [bank] or an affiliate of the [bank]; the insurance product is not insured by the [Federal Deposit Insurance Corporation (FDIC)] or any other agency of the United States, or an affiliate of the [bank]; and the approval or disapproval of any extension of credit by the [bank] or an affiliate is not based on whether or not I purchase this insurance through the [bank] or through any particular source.

ANY PERSON WHO KNOWINGLY AND WITH THE INTENT TO DEFRAUD ANY INSURANCE COMPANY OR OTHER PERSON FILES AN APPLICATION FOR INSURANCE OR STATEMENT OF CLAIM CONTAINING ANY MATERIALLY FALSE INFORMATION OR CONCEALS FOR THE PURPOSE OF MISLEADING, INFORMATION CONCERNING ANY FACT MATERIAL THERETO COMMITS A FRAUDULENT INSURANCE ACT WHICH IS A CRIME AND SUBJECTS SUCH PERSON TO CRIMINAL AND CIVIL PENALTIES.

Authorization to Obtain and Disclose Information

I have read or have been read, and understand the Notice of Insurance Information Practices and Notice Regarding Medical Information Bureau (MIB). Great-West Life & Annuity Insurance Company (the Company), its reinsurers and their authorized representatives, may obtain medical and other information in order to evaluate my application for life insurance. The Medical Information Bureau, Inc., consumer reporting agency, state motor vehicle department or insurance company who possesses medical or other information about me or my health may furnish such information to the Company upon presenting this authorization or a photocopy. The Company may make a brief report regarding me or my health to the MIB or to other Bureau Member companies to whom I have applied or may apply and have authorized to receive such information. I consent to a consumer report containing personal information that may be requested in connection with my application. This authorization is valid from the date signed for a period of 2 1/2 years. I have read or been read this authorization and understand I have the right to receive a copy.

Insured's Signature _____

Date _____

Signed at _____
City/State

AGENT:

Does the applicant have existing life insurance policies or annuity contracts? Yes No
Will this policy replace or be financed by any life insurance or annuity contracts presently or previously owned? Yes No

Agent's Name _____

Agent's Signature _____

Date _____

Business Phone _____

FOR INTERNAL USE ONLY

Rep ID # _____

Branch # _____

Branch Name _____

Notice of Insurance Information Practices and Notice Regarding Medical Information Bureau

This is to inform you that, as part of our procedure for processing your application, an investigative consumer report may be prepared. 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 within a reasonable period of time to receive additional detailed information about the nature and scope of this investigation. You have the right to access information upon written request. You may request correction, amendment, or deletion of any information, which you believe to be inaccurate. In connection with your application for insurance you may receive a telephone call from an authorized person to obtain some personal and financial information. You may be assured that the information is considered confidential and will be used to assess your eligibility for insurance. The interview normally takes from five to ten minutes and will be conducted at a time convenient for you. In the event you are not in when the interviewer calls, the interviewer will leave his or her name and telephone number so that you can return the call at no charge to you and supply the necessary information. Inquiries on the above notices should be addressed to:

Great-West Life & Annuity Insurance Company
P.O. Box 1470
Denver, CO 80201-9606

Information regarding your insurability will be treated as confidential. The Company, or its reinsurers, may, however, make a brief report thereon to the Medical Information Bureau, a non-profit membership organization of 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 disclosure of any information it may have in your file. 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.

Please contact MIB at:

Medical Information Bureau
Post Office Box 105, Essex Station
Boston, MA 02112
Phone: 866-692-6901 (TTY 866-346-3642)

The Company, or its reinsurers, may also release information in its file to other life insurance companies to whom you may apply for life or health insurance, or to whom a claim for benefits may be submitted.

THIS STANDARD DISCLOSURE IS REQUIRED OF ALL LIFE INSURANCE PROVIDERS. BE ASSURED THAT GREAT-WEST'S BUSINESS PRACTICES MEET THE HIGHEST INDUSTRY STANDARDS.

GREAT-WEST LIFE & ANNUITY INSURANCE COMPANY, P.O. Box 173316, Denver, CO 80217
Life Insurance Application

INSURED: Name
First/Middle Initial/Last

If you have had a name change in the last 10 years, please provide your previous name below:

Previous Name
First/Middle Initial/Last

Date of Birth Male Female Social Security Number

Occupation

Home Address 1

Home Address 2

City State ZIP

Daytime Phone Evening Phone

Place of Birth
State/Country

| | | | | | | |
|-----------|-----------------------------|---------------------------------------|---------------------------------------|------------------------------------|------------------------------------|------------------------------------|
| COVERAGE: | Term Coverage Type: | 10-Year Term <input type="checkbox"/> | 20-Year Term <input type="checkbox"/> | | | |
| | Term Coverage Amount: | \$25,000 <input type="checkbox"/> | \$50,000 <input type="checkbox"/> | \$75,000 <input type="checkbox"/> | \$100,000 <input type="checkbox"/> | \$125,000 <input type="checkbox"/> |
| | | \$150,000 <input type="checkbox"/> | \$175,000 <input type="checkbox"/> | \$200,000 <input type="checkbox"/> | \$225,000 <input type="checkbox"/> | \$250,000 <input type="checkbox"/> |
| | Whole Life Coverage Amount: | \$10,000 <input type="checkbox"/> | \$15,000 <input type="checkbox"/> | \$20,000 <input type="checkbox"/> | \$25,000 <input type="checkbox"/> | \$50,000 <input type="checkbox"/> |
| | | \$75,000 <input type="checkbox"/> | \$100,000 <input type="checkbox"/> | \$125,000 <input type="checkbox"/> | \$150,000 <input type="checkbox"/> | <input type="checkbox"/> |

Children's Coverage This insurance provides \$5,000 of coverage on the lives of each of your children (existing and future by birth or adoption, including stepchildren), ages 6 months to the child's 18th birthday, as long as your policy is in force. Check here if you would like to cover all of your children for just \$1.50 per month.

REPLACEMENT: Will this policy replace any life insurance or annuity policies you presently own? Yes No

- QUALIFICATION:
- 1) Your Height: Feet Inches Your Weight: lbs. Yes No
- 2) Do you currently use or have you used any type of tobacco product within the past 12 months? Yes No
- 3) Are you a U.S. citizen? Yes No
- 3a) If no, are you currently residing in the U.S. as a permanent resident alien or have you applied for a permanent visa, Resident Alien Card, Permanent Resident Card or "Green Card" for which you are currently awaiting approval? Yes No
- In the past three years**, have you been charged with driving under the influence of alcohol or drugs (DUI), or have you had your driver's license suspended or revoked? Yes No
- In the past five years**, have you
- 1) used illegal drugs? Yes No
- 2) been convicted or incarcerated for a felony, or are you currently on probation or parole? Yes No
- In the past 10 years**, have you had, been medically advised that you have, or received any type of treatment for:
- 1) Alcoholism or substance abuse? Yes No
- 2) Any diseases or disorders of the central nervous system, brain or spinal cord? Examples include, but are not limited to: stroke, paralysis, multiple sclerosis, seizures and congenital disorders. Yes No
- 3) Cancer (other than basal cell carcinoma of the skin)? Yes No
- 4) Major depression, schizophrenia or any of the following disorders: panic, psychotic or bipolar? Yes No
- 5) Mental retardation, autism or Down syndrome? Yes No
- 6) A positive test for Human Immunodeficiency Virus (HIV), Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC)? Yes No
- 7) Asthma with associated hospitalizations or acute/emergency care visits? Yes No

QUALIFICATION CONTINUED:

In the past 10 years, have you had, been medically advised that you have, or received any type of treatment for any of the following:

| | Yes | No | | Yes | No |
|--|--------------------------|--------------------------|--------------------------------------|--------------------------|--------------------------|
| Heart disease or disorder? | <input type="checkbox"/> | <input type="checkbox"/> | Diabetes? | <input type="checkbox"/> | <input type="checkbox"/> |
| Lung disease or disorder? | <input type="checkbox"/> | <input type="checkbox"/> | Blood vessel disease, disorder or | | |
| Kidney disease, disorder or insufficiency? | <input type="checkbox"/> | <input type="checkbox"/> | high blood pressure? | <input type="checkbox"/> | <input type="checkbox"/> |
| Lupus? | <input type="checkbox"/> | <input type="checkbox"/> | Liver disease, disorder or | | |
| Ulcerative colitis or Crohn's disease? | <input type="checkbox"/> | <input type="checkbox"/> | hepatitis (other than Type A)? | <input type="checkbox"/> | <input type="checkbox"/> |
| Blood disorders including chronic anemia? | <input type="checkbox"/> | <input type="checkbox"/> | | | |

PAYMENT:

Please indicate your payment method below (**check only one of the two boxes at left**).

Automatic Monthly Account Deduction For your convenience, premium payments will be deducted from your bank account each month. Please complete the following information. If your application is accepted, your monthly premium will be deducted on the fifth day of each month, unless otherwise noted below. Enclose your first monthly premium payment with your signed application.

Name of Bank

City State

Account Number Routing Number

Account Type: Checking or Savings Account Withdrawal Date: 5th or 20th of month

Automatic Monthly Premium Amount (include Children's Coverage, if applicable) \$

Payments with Credit Card *Credit card payments may only be made by the Insured.* \$

Card type: Visa Mastercard Payment frequency: Monthly Annually

Card Number Expiration Date on Card
(month/year)

Name
(if different than Insured name above; as it appears on Card)

BENEFICIARY:

Name

Relationship

Percentage Social Security Number

All primary beneficiary percentages must total 100% and (if named) all contingent beneficiary percentages must total 100%. If left blank, the application will assume an equal split among primary beneficiaries and an equal split among any contingent beneficiaries. Beneficiary details and payment are explained in the policy provisions.

SIGNATURE:

I certify: 1) All statements and answers to the questions in this application and any supplement to it are true. 2) This application will form a part of the insurance contract with Great-West Life & Annuity Insurance Company (the Company). 3) This application will not be in effect unless the first premium is paid **while the insured is still living**. 4) The policy applied for takes effect on the date of this application provided that a) questions on the application have been answered truthfully; and b) the application for coverage is not declined. 5) I hereby authorize the premium amount to be deducted or charged as specified in the payment section. This authorization is limited to payment to the Company for an insurance premium. 6) I authorize the Company to obtain all of my medical history in the event of my death within 2 1/2 years of this application date.

This insurance product is not a deposit or other obligation of, or guaranteed by, the [bank] or an affiliate of the [bank]; the insurance product is not insured by the [Federal Deposit Insurance Corporation (FDIC)] or any other agency of the United States, or an affiliate of the [bank]; and the approval or disapproval of any extension of credit by the [bank] or an affiliate is not based on whether or not I purchase this insurance through the [bank] or through any particular source.

ANY PERSON WHO KNOWINGLY AND WITH THE INTENT TO DEFRAUD ANY INSURANCE COMPANY OR OTHER PERSON FILES AN APPLICATION FOR INSURANCE OR STATEMENT OF CLAIM CONTAINING ANY MATERIALLY FALSE INFORMATION OR CONCEALS FOR THE PURPOSE OF MISLEADING, INFORMATION CONCERNING ANY FACT MATERIAL THERETO COMMITS A FRAUDULENT INSURANCE ACT WHICH IS A CRIME AND SUBJECTS SUCH PERSON TO CRIMINAL AND CIVIL PENALTIES.

Authorization to Obtain and Disclose Information

I have read or have been read, and understand the Notice of Insurance Information Practices and Notice Regarding Medical Information Bureau (MIB). Great-West Life & Annuity Insurance Company (the Company), its reinsurers and their authorized representatives, may obtain medical and other information in order to evaluate my application for life insurance. The Medical Information Bureau, Inc., consumer reporting agency, state motor vehicle department or insurance company who possesses medical or other information about me or my health may furnish such information to the Company upon presenting this authorization or a photocopy. The Company may make a brief report regarding me or my health to the MIB or to other Bureau Member companies to whom I have applied or may apply and have authorized to receive such information. I consent to a consumer report containing personal information that may be requested in connection with my application. This authorization is valid from the date signed for a period of 2 1/2 years. I have read or been read this authorization and understand I have the right to receive a copy.

Insured's Signature

Date

Notice of Insurance Information Practices and Notice Regarding Medical Information Bureau

This is to inform you that, as part of our procedure for processing your application, an investigative consumer report may be prepared. 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 within a reasonable period of time to receive additional detailed information about the nature and scope of this investigation. You have the right to access information upon written request. You may request correction, amendment, or deletion of any information, which you believe to be inaccurate. In connection with your application for insurance you may receive a telephone call from an authorized person to obtain some personal and financial information. You may be assured that the information is considered confidential and will be used to assess your eligibility for insurance. The interview normally takes from five to ten minutes and will be conducted at a time convenient for you. In the event you are not in when the interviewer calls, the interviewer will leave his or her name and telephone number so that you can return the call at no charge to you and supply the necessary information. Inquiries on the above notices should be addressed to:

Great-West Life & Annuity Insurance Company
P.O. Box 1470
Denver, CO 80201-9606

Information regarding your insurability will be treated as confidential. The Company, or its reinsurers, may, however, make a brief report thereon to the Medical Information Bureau, a non-profit membership organization of 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 disclosure of any information it may have in your file. 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.

Please contact MIB at:

Medical Information Bureau
Post Office Box 105, Essex Station
Boston, MA 02112
Phone: 866-692-6901 (TTY 866-346-3642)

The Company, or its reinsurers, may also release information in its file to other life insurance companies to whom you may apply for life or health insurance, or to whom a claim for benefits may be submitted.

THIS STANDARD DISCLOSURE IS REQUIRED OF ALL LIFE INSURANCE PROVIDERS. BE ASSURED THAT GREAT-WEST'S BUSINESS PRACTICES MEET THE HIGHEST INDUSTRY STANDARDS.

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TOI: L08 Life - Other Sub-TOI: L08.000 Life - Other
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Rate Information

Rate data does NOT apply to filing.

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Company Tracking Number:
TOI: L08 Life - Other Sub-TOI: L08.000 Life - Other
Product Name: J241A app & J242Dapp
Project Name/Number: /

Supporting Document Schedules

Review Status:
Satisfied -Name: Certification/Notice 06/11/2008
Comments:
Attachment:
ar compliance cert.pdf

Review Status:
Satisfied -Name: Application 06/11/2008
Comments:
Application Filing only
Attachments:
J242Dapp (2).pdf
J241Aapp.pdf

Review Status:
Satisfied -Name: Cover Letter 06/11/2008
Comments:
Attachment:
ARletter.pdf

**STATE OF ARKANSAS
INSURANCE DEPARTMENT**

CERTIFICATE OF COMPLIANCE WITH RULE AND REGULATION 19

RE: Life Insurance Application, J241Aapp
Life Insurance Application, J242Dapp

We hereby certify that the guidelines established in Arkansas Rule and Regulation 19 have been reviewed and the policy form designated above complies with these guidelines.

Great-West Life & Annuity Insurance Company



Susan Gile

Vice President, Individual Markets Operation

June 11, 2008

Date

GREAT-WEST LIFE & ANNUITY INSURANCE COMPANY, P.O. Box 173316, Denver, CO 80217
Life Insurance Application

INSURED: Name
First/Middle Initial/Last

If you have had a name change in the last 10 years, please provide your previous name below:

Previous Name
First/Middle Initial/Last

Date of Birth Male Female Social Security Number

Occupation

Home Address 1

Home Address 2

City State ZIP

Daytime Phone Evening Phone

Place of Birth
State/Country

| | | | | | | |
|-----------|-----------------------------|---------------------------------------|---------------------------------------|------------------------------------|------------------------------------|------------------------------------|
| COVERAGE: | Term Coverage Type: | 10-Year Term <input type="checkbox"/> | 20-Year Term <input type="checkbox"/> | | | |
| | Term Coverage Amount: | \$25,000 <input type="checkbox"/> | \$50,000 <input type="checkbox"/> | \$75,000 <input type="checkbox"/> | \$100,000 <input type="checkbox"/> | \$125,000 <input type="checkbox"/> |
| | | \$150,000 <input type="checkbox"/> | \$175,000 <input type="checkbox"/> | \$200,000 <input type="checkbox"/> | \$225,000 <input type="checkbox"/> | \$250,000 <input type="checkbox"/> |
| | Whole Life Coverage Amount: | \$10,000 <input type="checkbox"/> | \$15,000 <input type="checkbox"/> | \$20,000 <input type="checkbox"/> | \$25,000 <input type="checkbox"/> | \$50,000 <input type="checkbox"/> |
| | | \$75,000 <input type="checkbox"/> | \$100,000 <input type="checkbox"/> | \$125,000 <input type="checkbox"/> | \$150,000 <input type="checkbox"/> | <input type="checkbox"/> |

Children's Coverage This insurance provides \$5,000 of coverage on the lives of each of your children (existing and future by birth or adoption, including stepchildren), ages 6 months to the child's 18th birthday, as long as your policy is in force. Check here if you would like to cover all of your children for just \$1.50 per month.

REPLACEMENT: Will this policy replace any life insurance or annuity policies you presently own? Yes No

- QUALIFICATION: 1) Your Height: Feet Inches Your Weight: lbs. Yes No
- 2) Do you currently use or have you used any type of tobacco product within the past 12 months? Yes No
- 3) Are you a U.S. citizen? Yes No
- 3a) If no, are you currently residing in the U.S. as a permanent resident alien or have you applied for a permanent visa, Resident Alien Card, Permanent Resident Card or "Green Card" for which you are currently awaiting approval? Yes No
- In the past three years, have you been charged with driving under the influence of alcohol or drugs (DUI), or have you had your driver's license suspended or revoked? Yes No
- In the past five years, have you
- 1) used illegal drugs? Yes No
- 2) been convicted or incarcerated for a felony, or are you currently on probation or parole? Yes No
- In the past 10 years, have you had, been medically advised that you have, or received any type of treatment for:
- 1) Alcoholism or substance abuse? Yes No
- 2) Any diseases or disorders of the central nervous system, brain or spinal cord? Examples include, but are not limited to: stroke, paralysis, multiple sclerosis, seizures and congenital disorders. Yes No
- 3) Cancer (other than basal cell carcinoma of the skin)? Yes No
- 4) Major depression, schizophrenia or any of the following disorders: panic, psychotic or bipolar? Yes No
- 5) Mental retardation, autism or Down syndrome? Yes No
- 6) A positive test for Human Immunodeficiency Virus (HIV), Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC)? Yes No
- 7) Asthma with associated hospitalizations or acute/emergency care visits? Yes No

QUALIFICATION CONTINUED:

In the past 10 years, have you had, been medically advised that you have, or received any type of treatment for any of the following:

| | Yes | No | | Yes | No |
|--|--------------------------|--------------------------|--------------------------------------|--------------------------|--------------------------|
| Heart disease or disorder? | <input type="checkbox"/> | <input type="checkbox"/> | Diabetes? | <input type="checkbox"/> | <input type="checkbox"/> |
| Lung disease or disorder? | <input type="checkbox"/> | <input type="checkbox"/> | Blood vessel disease, disorder or | | |
| Kidney disease, disorder or insufficiency? | <input type="checkbox"/> | <input type="checkbox"/> | high blood pressure? | <input type="checkbox"/> | <input type="checkbox"/> |
| Lupus? | <input type="checkbox"/> | <input type="checkbox"/> | Liver disease, disorder or | | |
| Ulcerative colitis or Crohn's disease? | <input type="checkbox"/> | <input type="checkbox"/> | hepatitis (other than Type A)? | <input type="checkbox"/> | <input type="checkbox"/> |
| Blood disorders including chronic anemia? | <input type="checkbox"/> | <input type="checkbox"/> | | | |

PAYMENT:

Please indicate your payment method below (**check only one of the two boxes at left**).

Automatic Monthly Account Deduction For your convenience, premium payments will be deducted from your bank account each month. Please complete the following information. If your application is accepted, your monthly premium will be deducted on the fifth day of each month, unless otherwise noted below. Enclose your first monthly premium payment with your signed application.

Name of Bank

City State

Account Number Routing Number

Account Type: Checking or Savings Account Withdrawal Date: 5th or 20th of month

Automatic Monthly Premium Amount (include Children's Coverage, if applicable) \$

Payments with Credit Card *Credit card payments may only be made by the Insured.* \$

Card type: Visa Mastercard Payment frequency: Monthly Annually

Card Number Expiration Date on Card
(month/year)

Name
(if different than Insured name above; as it appears on Card)

BENEFICIARY:

Name

Relationship

Percentage Social Security Number

All primary beneficiary percentages must total 100% and (if named) all contingent beneficiary percentages must total 100%. If left blank, the application will assume an equal split among primary beneficiaries and an equal split among any contingent beneficiaries. Beneficiary details and payment are explained in the policy provisions.

SIGNATURE:

I certify: 1) All statements and answers to the questions in this application and any supplement to it are true. 2) This application will form a part of the insurance contract with Great-West Life & Annuity Insurance Company (the Company). 3) This application will not be in effect unless the first premium is paid **while the insured is still living**. 4) The policy applied for takes effect on the date of this application provided that a) questions on the application have been answered truthfully; and b) the application for coverage is not declined. 5) I hereby authorize the premium amount to be deducted or charged as specified in the payment section. This authorization is limited to payment to the Company for an insurance premium. 6) I authorize the Company to obtain all of my medical history in the event of my death within 2 1/2 years of this application date.

This insurance product is not a deposit or other obligation of, or guaranteed by, the [bank] or an affiliate of the [bank]; the insurance product is not insured by the [Federal Deposit Insurance Corporation (FDIC)] or any other agency of the United States, or an affiliate of the [bank]; and the approval or disapproval of any extension of credit by the [bank] or an affiliate is not based on whether or not I purchase this insurance through the [bank] or through any particular source.

ANY PERSON WHO KNOWINGLY AND WITH THE INTENT TO DEFRAUD ANY INSURANCE COMPANY OR OTHER PERSON FILES AN APPLICATION FOR INSURANCE OR STATEMENT OF CLAIM CONTAINING ANY MATERIALLY FALSE INFORMATION OR CONCEALS FOR THE PURPOSE OF MISLEADING, INFORMATION CONCERNING ANY FACT MATERIAL THERETO COMMITS A FRAUDULENT INSURANCE ACT WHICH IS A CRIME AND SUBJECTS SUCH PERSON TO CRIMINAL AND CIVIL PENALTIES.

Authorization to Obtain and Disclose Information

I have read or have been read, and understand the Notice of Insurance Information Practices and Notice Regarding Medical Information Bureau (MIB). Great-West Life & Annuity Insurance Company (the Company), its reinsurers and their authorized representatives, may obtain medical and other information in order to evaluate my application for life insurance. The Medical Information Bureau, Inc., consumer reporting agency, state motor vehicle department or insurance company who possesses medical or other information about me or my health may furnish such information to the Company upon presenting this authorization or a photocopy. The Company may make a brief report regarding me or my health to the MIB or to other Bureau Member companies to whom I have applied or may apply and have authorized to receive such information. I consent to a consumer report containing personal information that may be requested in connection with my application. This authorization is valid from the date signed for a period of 2 1/2 years. I have read or been read this authorization and understand I have the right to receive a copy.

Insured's Signature

Date

Notice of Insurance Information Practices and Notice Regarding Medical Information Bureau

This is to inform you that, as part of our procedure for processing your application, an investigative consumer report may be prepared. 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 within a reasonable period of time to receive additional detailed information about the nature and scope of this investigation. You have the right to access information upon written request. You may request correction, amendment, or deletion of any information, which you believe to be inaccurate. In connection with your application for insurance you may receive a telephone call from an authorized person to obtain some personal and financial information. You may be assured that the information is considered confidential and will be used to assess your eligibility for insurance. The interview normally takes from five to ten minutes and will be conducted at a time convenient for you. In the event you are not in when the interviewer calls, the interviewer will leave his or her name and telephone number so that you can return the call at no charge to you and supply the necessary information. Inquiries on the above notices should be addressed to:

Great-West Life & Annuity Insurance Company
P.O. Box 1470
Denver, CO 80201-9606

Information regarding your insurability will be treated as confidential. The Company, or its reinsurers, may, however, make a brief report thereon to the Medical Information Bureau, a non-profit membership organization of 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 disclosure of any information it may have in your file. 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.

Please contact MIB at:

Medical Information Bureau
Post Office Box 105, Essex Station
Boston, MA 02112
Phone: 866-692-6901 (TTY 866-346-3642)

The Company, or its reinsurers, may also release information in its file to other life insurance companies to whom you may apply for life or health insurance, or to whom a claim for benefits may be submitted.

THIS STANDARD DISCLOSURE IS REQUIRED OF ALL LIFE INSURANCE PROVIDERS. BE ASSURED THAT GREAT-WEST'S BUSINESS PRACTICES MEET THE HIGHEST INDUSTRY STANDARDS.

GREAT-WEST LIFE & ANNUITY INSURANCE COMPANY, P.O. Box 173316, Denver, CO 80217
 Life Insurance Application

INSURED: Name
First/Middle Initial/Last

If you have had a name change in the last 10 years, please provide your previous name below:

Previous Name
First/Middle Initial/Last

Date of Birth Male Female Social Security Number

Occupation

Home Address 1

Home Address 2

City State ZIP

Daytime Phone Evening Phone

Place of Birth
State/Country

COVERAGE: Term Coverage Type: 10-Year Term 20-Year Term
 Term Coverage Amount: \$25,000 \$50,000 \$75,000 \$100,000 \$125,000
 \$150,000 \$175,000 \$200,000 \$225,000 \$250,000

Whole Life Coverage Amount: \$10,000 \$15,000 \$20,000 \$25,000 \$50,000
 \$75,000 \$100,000 \$125,000 \$150,000

Children's Coverage This insurance provides \$5,000 of coverage on the lives of each of your children (existing and future by birth or adoption, including stepchildren), ages 6 months to the child's 18th birthday, as long as your policy is in force. Check here if you would like to cover all of your children for just \$1.50 per month.

REPLACEMENT: Do you have any life insurance policies or annuity contracts in force? Yes No
 Will this policy replace or be financed by any life insurance or annuity contracts presently or previously owned? Yes No

QUALIFICATION: 1) Your Height: Feet Inches Your Weight: lbs. Yes No
 2) Do you currently use or have you used any type of tobacco product within the past 12 months? Yes No
 3) Are you a U.S. citizen? Yes No
 3a) If no, are you currently residing in the U.S. as a permanent resident alien or have you applied for a permanent visa, Resident Alien Card, Permanent Resident Card or "Green Card" for which you are currently awaiting approval? Yes No



In the past three years, have you been charged with driving under the influence of alcohol or drugs (DUI), or have you had your driver's license suspended or revoked? Yes No

In the past five years, have you
 1) used illegal drugs? Yes No
 2) been convicted or incarcerated for a felony, or are you currently on probation or parole? Yes No

In the past 10 years, have you had, been medically advised that you have, or received any type of treatment for:
 1) Alcoholism or substance abuse? Yes No
 2) Any diseases or disorders of the central nervous system, brain or spinal cord? Examples include, but are not limited to: stroke, paralysis, multiple sclerosis, seizures and congenital disorders. Yes No
 3) Cancer (other than basal cell carcinoma of the skin)? Yes No
 4) Major depression, schizophrenia or any of the following disorders: panic, psychotic or bipolar? Yes No
 5) Mental retardation, autism or Down syndrome? Yes No
 6) A positive test for Human Immunodeficiency Virus (HIV), Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC)? Yes No
 7) Asthma with associated hospitalizations or acute/emergency care visits? Yes No

QUALIFICATION CONTINUED:

In the past 10 years, have you had, been medically advised that you have, or received any type of treatment for any of the following:

| | Yes | No | | Yes | No |
|--|--------------------------|--------------------------|--------------------------------------|--------------------------|--------------------------|
| Heart disease or disorder? | <input type="checkbox"/> | <input type="checkbox"/> | Diabetes? | <input type="checkbox"/> | <input type="checkbox"/> |
| Lung disease or disorder? | <input type="checkbox"/> | <input type="checkbox"/> | Blood vessel disease, disorder or | | |
| Kidney disease, disorder or insufficiency? | <input type="checkbox"/> | <input type="checkbox"/> | high blood pressure? | <input type="checkbox"/> | <input type="checkbox"/> |
| Lupus? | <input type="checkbox"/> | <input type="checkbox"/> | Liver disease, disorder or | | |
| Ulcerative colitis or Crohn's disease? | <input type="checkbox"/> | <input type="checkbox"/> | hepatitis (other than Type A)? | <input type="checkbox"/> | <input type="checkbox"/> |
| Blood disorders including chronic anemia? | <input type="checkbox"/> | <input type="checkbox"/> | | | |

PAYMENT:

Please indicate your payment method below (check only one of the three boxes at left).

Automatic Monthly Account Deduction For your convenience, premium payments will be deducted from your bank account each month. Please complete the following information. If your application is accepted, your monthly premium will be deducted on the fifth day of each month, unless otherwise noted below. Enclose your first monthly premium payment with your signed application.

Name of Bank

City State

Account Number Routing Number

Account Type: Checking or Savings Account Withdrawal Date: 5th or 20th of month

Automatic Monthly Premium Amount (include Children's Coverage, if applicable) \$

Annual Direct Bill If selecting annual direct bill, enclose your first annual premium payment with your signed application.

Annual Premium Amount (Automatic Monthly Premium + Children's Coverage, if applicable x 11) \$

Payments with Credit Card Credit card payments may only be made by the Insured. \$

Card type: Visa Mastercard Payment frequency: Monthly Annually

Card Number Expiration Date on Card
(month/year)

Name
(if different than Insured name above; as it appears on Card)

BENEFICIARY:

Name

Relationship

Percentage Social Security Number

All primary beneficiary percentages must total 100% and (if named) all contingent beneficiary percentages must total 100%. If left blank, the application will assume an equal split among primary beneficiaries and an equal split among any contingent beneficiaries. Beneficiary details and payment are explained in the policy provisions.

SIGNATURE:

I certify: 1) All statements and answers to the questions in this application and any supplement to it are true. 2) This application will form a part of the insurance contract with Great-West Life & Annuity Insurance Company (the Company). 3) This application will not be in effect unless the first premium is paid **while the insured is still living**. 4) The policy applied for takes effect on the date of this application provided that a) questions on the application have been answered truthfully; and b) the application for coverage is not declined. 5) I hereby authorize the premium amount to be deducted or charged as specified in the payment section. This authorization is limited to payment to the Company for an insurance premium. 6) I authorize the Company to obtain all of my medical history in the event of my death within 2 1/2 years of this application date.

This insurance product is not a deposit or other obligation of, or guaranteed by, the [bank] or an affiliate of the [bank]; the insurance product is not insured by the [Federal Deposit Insurance Corporation (FDIC)] or any other agency of the United States, or an affiliate of the [bank]; and the approval or disapproval of any extension of credit by the [bank] or an affiliate is not based on whether or not I purchase this insurance through the [bank] or through any particular source.

ANY PERSON WHO KNOWINGLY AND WITH THE INTENT TO DEFRAUD ANY INSURANCE COMPANY OR OTHER PERSON FILES AN APPLICATION FOR INSURANCE OR STATEMENT OF CLAIM CONTAINING ANY MATERIALLY FALSE INFORMATION OR CONCEALS FOR THE PURPOSE OF MISLEADING, INFORMATION CONCERNING ANY FACT MATERIAL THERETO COMMITS A FRAUDULENT INSURANCE ACT WHICH IS A CRIME AND SUBJECTS SUCH PERSON TO CRIMINAL AND CIVIL PENALTIES.

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Insured's Signature _____

Date _____

Signed at _____
City/State

AGENT: Does the applicant have existing life insurance policies or annuity contracts? Yes No
Will this policy replace or be financed by any life insurance or annuity contracts presently or previously owned? Yes No

Agent's Name _____

Agent's Signature _____

Date _____

Business Phone _____

Notice of Insurance Information Practices and Notice Regarding Medical Information Bureau

This is to inform you that, as part of our procedure for processing your application, an investigative consumer report may be prepared. 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 within a reasonable period of time to receive additional detailed information about the nature and scope of this investigation. You have the right to access information upon written request. You may request correction, amendment, or deletion of any information, which you believe to be inaccurate. In connection with your application for insurance you may receive a telephone call from an authorized person to obtain some personal and financial information. You may be assured that the information is considered confidential and will be used to assess your eligibility for insurance. The interview normally takes from five to ten minutes and will be conducted at a time convenient for you. In the event you are not in when the interviewer calls, the interviewer will leave his or her name and telephone number so that you can return the call at no charge to you and supply the necessary information. Inquiries on the above notices should be addressed to:

Great-West Life & Annuity Insurance Company
P.O. Box 1470
Denver, CO 80201-9606

Information regarding your insurability will be treated as confidential. The Company, or its reinsurers, may, however, make a brief report thereon to the Medical Information Bureau, a non-profit membership organization of 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 disclosure of any information it may have in your file. 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.

Please contact MIB at:

Medical Information Bureau
Post Office Box 105, Essex Station
Boston, MA 02112
Phone: 866-692-6901 (TTY 866-346-3642)

The Company, or its reinsurers, may also release information in its file to other life insurance companies to whom you may apply for life or health insurance, or to whom a claim for benefits may be submitted.

THIS STANDARD DISCLOSURE IS REQUIRED OF ALL LIFE INSURANCE PROVIDERS. BE ASSURED THAT GREAT-WEST'S BUSINESS PRACTICES MEET THE HIGHEST INDUSTRY STANDARDS.



8515 East Orchard Road
Greenwood Village, CO 80111 Tel. (303) 737-3000
Address mail to: P.O. Box 1700, Denver, CO 80201
www.gwla.com

June 11, 2008

Arkansas Department of Insurance
1200 West Third Street
Little Rock, AR 72201-1904

NAIC #769-68322

RE: Individual Life Insurance Application Submission
J241Aapp – Life insurance Application
J242Dapp – Life Insurance Application

We are submitting the above referenced applications for your review and approval. These are new applications and will not replace any applications previously approved by your Department.

Application J241Aapp will initially be used with previously approved policies J374 (10 year term life) approved 08/14/2003, J374-20 (20 year term life) approved 07/07/2005 and J278 (whole life) approved 03/29/2005. Application J242Dapp will initially be used with previously approved forms J3375 (10 year term life) approved 08/14/2003, and J3375-20 (20 year term life) approved 12/18/2006. The J241Aapp will be used by our duly-licensed agents and the J242Dapp will be used on direct basis.

These applications, when scored separately, achieve a Flesch score of 51.69.

The appropriate certifications, transmittal forms, checklist and filing fee are included (as applicable). To the best of our knowledge and belief, this filing complies with the laws and regulations of your State. This submission contains no unusual or possibly controversial items from the standpoint of normal company or industry standards.

If we can be of further assistance please do not hesitate to contact me directly.

We trust that the information provided is satisfactory and look forward to your approval.

Sincerely,

A handwritten signature in black ink that reads "Tanya D. Gonzales". The signature is written in a cursive, flowing style.

Tanya Gonzales
Associate Manager, Regulatory Services
Great-West Life & Annuity Insurance Company.
(800) 537-2033 x 75829
Tanya.gonzales@gwl.com