

SERFF Tracking Number: OXFR-125626626 State: Arkansas  
Filing Company: Oxford Life Insurance Company State Tracking Number: 38809  
Company Tracking Number: SPL112AR  
TOI: L021 Individual Life - Endowment Sub-TOI: L021.002 Single Life - Single Premium  
Product Name: Advanced Wealth Transfer  
Project Name/Number: /

## Filing at a Glance

Company: Oxford Life Insurance Company

Product Name: Advanced Wealth Transfer

TOI: L021 Individual Life - Endowment

Sub-TOI: L021.002 Single Life - Single Premium

Filing Type: Form

SERFF Tr Num: OXFR-125626626 State: ArkansasLH

SERFF Status: Closed

Co Tr Num: SPL112AR

Co Status:

Author: Tamika Simmons

Date Submitted: 04/28/2008

State Tr Num: 38809

State Status: Approved-Closed

Reviewer(s): Linda Bird

Disposition Date: 05/02/2008

Disposition Status: Approved

Implementation Date Requested: On Approval

Implementation Date:

State Filing Description:

## General Information

Project Name:

Project Number:

Requested Filing Mode:

Explanation for Combination/Other:

Submission Type: New Submission

Overall Rate Impact:

Filing Status Changed: 05/02/2008

State Status Changed: 05/02/2008

Corresponding Filing Tracking Number:

Filing Description:

Status of Filing in Domicile: Authorized

Date Approved in Domicile: 04/24/2008

Domicile Status Comments:

Market Type: Individual

Group Market Size:

Group Market Type:

Deemer Date:

This form is being submitted to you for your review and approval. No part of this filing contains any unusual or possibly controversial items from normal company or industry standards. The document is a final printed version.

Form No. SPL112 is a new application and it will be used with policy SPE100, which was exempted in your state on 4/25/2006.

SERFF Tracking Number: OXFR-125626626 State: Arkansas  
 Filing Company: Oxford Life Insurance Company State Tracking Number: 38809  
 Company Tracking Number: SPL112AR  
 TOI: L021 Individual Life - Endowment Sub-TOI: L021.002 Single Life - Single Premium  
 Product Name: Advanced Wealth Transfer  
 Project Name/Number: /

## Company and Contact

### Filing Contact Information

Tamika Simmons, tamikasimmons@oxfordlife.com  
 2721 North Central Avenue (888) 757-3732 [Phone]  
 Phoenix, AZ 85004

### Filing Company Information

Oxford Life Insurance Company CoCode: 76112 State of Domicile: Arizona  
 2721 N. Central Avenue Group Code: Company Type:  
 Phoenix, AZ 85004-1172 Group Name: State ID Number:  
 (888) 757-3732 ext. [Phone] FEIN Number: 86-0216483  
 -----

## Filing Fees

Fee Required? Yes  
 Fee Amount: \$20.00  
 Retaliatory? No  
 Fee Explanation:  
 Per Company: No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Oxford Life Insurance Company	\$20.00	04/28/2008	19944639

SERFF Tracking Number: OXFR-125626626 State: Arkansas  
Filing Company: Oxford Life Insurance Company State Tracking Number: 38809  
Company Tracking Number: SPL112AR  
TOI: L021 Individual Life - Endowment Sub-TOI: L021.002 Single Life - Single Premium  
Product Name: Advanced Wealth Transfer  
Project Name/Number: /

## Correspondence Summary

### Dispositions

Status	Created By	Created On	Date Submitted
Approved	Linda Bird	05/02/2008	05/02/2008

*SERFF Tracking Number:* OXFR-125626626      *State:* Arkansas  
*Filing Company:* Oxford Life Insurance Company      *State Tracking Number:* 38809  
*Company Tracking Number:* SPL112AR  
*TOI:* L021 Individual Life - Endowment      *Sub-TOI:* L021.002 Single Life - Single Premium  
*Product Name:* Advanced Wealth Transfer  
*Project Name/Number:* /

## **Disposition**

Disposition Date: 05/02/2008

Implementation Date:

Status: Approved

Comment:

Rate data does NOT apply to filing.

SERFF Tracking Number: OXFR-125626626 State: Arkansas  
 Filing Company: Oxford Life Insurance Company State Tracking Number: 38809  
 Company Tracking Number: SPL112AR  
 TOI: L021 Individual Life - Endowment Sub-TOI: L021.002 Single Life - Single Premium  
 Product Name: Advanced Wealth Transfer  
 Project Name/Number: /

<b>Item Type</b>	<b>Item Name</b>	<b>Item Status</b>	<b>Public Access</b>
<b>Supporting Document</b>	Certification/Notice		Yes
<b>Supporting Document</b>	Application		No
<b>Supporting Document</b>	Life & Annuity - Acturial Memo		No
<b>Supporting Document</b>	NAIC Transmittal		Yes
<b>Form</b>	Application		Yes

SERFF Tracking Number: OXFR-125626626      State: Arkansas  
 Filing Company: Oxford Life Insurance Company      State Tracking Number: 38809  
 Company Tracking Number: SPL112AR  
 TOI: L021 Individual Life - Endowment      Sub-TOI: L021.002 Single Life - Single Premium  
 Product Name: Advanced Wealth Transfer  
 Project Name/Number: /

## Form Schedule

### Lead Form Number:

Review Status	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
	SPL112AR	Other	Application	Initial		50	SPL112.pdf

**OXFORD**<sup>®</sup>  
LIFE INSURANCE COMPANY  
2721 NORTH CENTRAL AVENUE  
PHOENIX, AZ 85004



**Single Premium  
Life Insurance  
Application**

**CONTENTS:**

AGENT INSTRUCTIONS  
POINT OF SALE TELEPHONE INTERVIEW PROCEDURES  
FRAUD NOTICE  
APPLICATION  
HIPAA AUTHORIZATION RELEASE OF HEALTH RELATED INFORMATION  
PRIVACY NOTICE  
FAIR CREDIT REPORTING ACT NOTICE  
TEMPORARY LIFE INSURANCE AGREEMENT AND RECEIPT  
MIB PRE-NOTICE

## AGENT INSTRUCTIONS

- Do not solicit business until you are contracted and appointed by the Company.
- If a Non U.S. Citizen, please obtain the Permanent U.S. Resident (Green Card) I.D. number: \_\_\_\_\_
- The proposed insured must be either a U.S. citizen or a Permanent U.S. Resident with a Green Card.
- Please print clearly with black ink. No felt tip pens.
- Corrections should be initialed and dated by Proposed Insured/Owner. Do not use white out.
- The Proposed Insured's full name should be indicated and signature should be identical.
- If the Owner is a trust or business, please include full title and name of trust or business.  
Example:     Barbara James, Trustee                             Barbara James, President  
                  Barbara James Irrev Trust date 01-02-96         Barb's Bistro, Inc.
- Make sure that you have the complete name and date of the trust and if it is revocable or irrevocable.
- List all Social Security numbers for Beneficiaries, if available, and list each Beneficiary's percentage share.
- List all Owners' tax IDs on page 3. If all Owners' tax IDs are not included, we will require completed W-9s before issue.
- Submit all pages of the application even if information is not required.
- Explain the terms of the Company's Agreement prior to accepting any payment with the application.
- Leave the completed Temporary Life Insurance Agreement and Receipt with the Owner, if accepting payment with the application.
- Explain and review the appropriate state fraud warning, since it will be reviewed again in the telephone interview.
- Explain the Medical Information Bureau (MIB) Pre-Notice, Privacy Notice, Fair Credit Reporting Act Notice and leave it with the Proposed Insured.
- Review the application prior to mailing it to the Company to make certain it is complete and accurate. Include a cover memo with special instructions, if needed.
- Mail the original application with initial premium(s).
- We will not accept cash, counter (non-personalized) checks, or agent/agency checks.
- If this is a 1035 Exchange, an Authorization To Transfer Funds form and Replacement form is required.

## POINT OF SALE TELEPHONE INTERVIEW PROCEDURES

1. Complete the application, including the MIB Authorization, and ask all the health questions before initiating the phone interview.
2. Verify the personal information of the applicant(s) by viewing a state issued driver's license, state issued I.D. card, military I.D. card, Permanent U.S. Resident (Green Card), passport or other government issued picture I.D. card.
3. Non-English speaking applicants can be processed through Point of Sale Telephone Interview procedures through the use of a language interpreter. The Point of Sale **INTERVIEW SPECIALIST** will arrange for this service when you call.
4. Call **1-888-801-5123** from the applicant's home. Provide Oxford Life's name and your name.
5. The interviewer will review the fraud warning and will complete the Agent Checklist with you. Be sure to answer the questions accurately.
6. Have the applicant speak with the **INTERVIEW SPECIALIST** in order to confirm the answers to the application questions. When completed, the **INTERVIEW SPECIALIST** will speak with you again.
7. The **INTERVIEW SPECIALIST** will advise you whether or not to submit the application.
8. If approved, submit the application in the normal manner along with the premium, making sure that all questions on the application are answered completely.

If the application is written after normal business hours, the client will simply need to leave a voice message in the 24-hour mailbox for an **INTERVIEW SPECIALIST** to call the client back. Since the client will be completing the interview on the next business day, it will be indicated on the Agent Checklist as "Agent Not Present." After the Point-of-Sale Inspection has been completed, the **INTERVIEW SPECIALIST** will call the agent with the results.

**FOR YOUR PROTECTION**  
**THE LAW REQUIRES THE FOLLOWING TO APPEAR ON THIS FORM**

**ARKANSAS, LOUISIANA, AND TEXAS**

Any person who knowingly presents a false or fraudulent claim for payment of loss or benefit or knowingly presents false information in an application for insurance, is guilty of a crime and may be subject to fines and confinement in prison.

**COLORADO**

It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

**DISTRICT OF COLUMBIA**

It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.

**FLORIDA**

Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

**GEORGIA, NEBRASKA, OREGON, AND WYOMING**

Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement, may be guilty of insurance fraud.

**KANSAS**

Any person who knowingly and with intent to defraud presents false information in an application for insurance may be guilty of a crime and may be subject to fines and confinement in prison.

**KENTUCKY**

Any person who knowingly, and with intent to defraud any insurance company or other person, files an application for insurance 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.

**MAINE, TENNESSEE, VIRGINIA, AND WASHINGTON**

It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines and denial of insurance benefits.

**MINNESOTA**

Any person who knowingly or willfully makes a false or fraudulent statement in, or relative to, any application for insurance or membership for any purpose shall be guilty of a gross misdemeanor.

**NEW JERSEY**

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

**NEW MEXICO**

Any person who knowingly presents a false or fraudulent claim for payment of loss or benefit, or knowingly presents false information in an application for insurance, is guilty of a crime and may be subject to civil fines and criminal penalties.

**OKLAHOMA**

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

**PENNSYLVANIA**

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

**IN ALL OTHER STATES**

Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

**Section A —**

PROPOSED INSURED "A"				
Name (First, MI, Last)			Address, City, State, Zip Code	
SSN	Gender	Date of Birth	Birth State	Phone Number (     )
U.S. Citizen <input type="checkbox"/> Yes <input type="checkbox"/> No or Permanent U.S. Resident <input type="checkbox"/> Yes <input type="checkbox"/> No				
OWNER "A" (If other than Proposed Insured "A")				
Owner "A" Name (First, MI, Last)			Owner's Address, City, State, Zip Code	
Owner's SSN, Tax I.D.# or Green Card Number		Relationship to "A"		Phone Number (     )
Does the Proposed Insured A and/or Owner A, have any existing life insurance or annuity coverage? <input type="checkbox"/> Yes <input type="checkbox"/> No Is this policy being purchased to replace any existing life insurance or annuity coverage? <input type="checkbox"/> Yes <input type="checkbox"/> No If "Yes," please list:				
Company		Policy No.		Address, City, State, Zip Code
BENEFICIARY				
Primary	Address, City, State, Zip Code		Relationship	SSN                      %
Primary	Address, City, State, Zip Code		Relationship	SSN                      %
Contingent	Address, City, State, Zip Code		Relationship	SSN                      %
Contingent	Address, City, State, Zip Code		Relationship	SSN                      %
PROPOSED INSURED "B"				
Name (First, MI, Last)			Address, City, State, Zip Code	
SSN	Gender	Date of Birth	Birth State	Phone Number (     )
U.S. Citizen <input type="checkbox"/> Yes <input type="checkbox"/> No or Permanent U.S. Resident <input type="checkbox"/> Yes <input type="checkbox"/> No				
OWNER "B" (If other than Proposed Insured "B")				
Owner "B" Name (First, MI, Last)			Owner's Address, City, State, Zip Code	
Owner's SSN, Tax I.D.# or Green Card Number		Relationship to "B"		Phone Number (     )
Does the Proposed Insured B and/or Owner B, have any existing life insurance or annuity coverage? <input type="checkbox"/> Yes <input type="checkbox"/> No Is this policy being purchased to replace any existing life insurance or annuity coverage? <input type="checkbox"/> Yes <input type="checkbox"/> No If "Yes," please list:				
Company		Policy No.		Address, City, State, Zip Code
BENEFICIARY				
Primary	Address, City, State, Zip Code		Relationship	SSN                      %
Primary	Address, City, State, Zip Code		Relationship	SSN                      %
Contingent	Address, City, State, Zip Code		Relationship	SSN                      %
Contingent	Address, City, State, Zip Code		Relationship	SSN                      %

**Section B —**

Tier 1 (A)	ANSWER FOR PROPOSED INSURED	
	"A"	"B"
<b>If any question in Tier 1 (A) is answered "Yes", NO COVERAGE CAN BE ISSUED. If height and weight exceeds maximum range for this product, no coverage can be issued.</b>		
1. What is your height and weight?	H____W____ <input type="checkbox"/> Yes <input type="checkbox"/> No	H____ W____ <input type="checkbox"/> Yes <input type="checkbox"/> No
2. Have you had, or been medically advised to have, an organ transplant, or have you been medically diagnosed as having a terminal illness or life expectancy of 12 months or less, or have you been diagnosed, treated (including dialysis) or taken medication for kidney or liver failure?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
3. Have you been medically treated or diagnosed by a medical professional as having Acquired Immune Deficiency Syndrome (AIDS), AIDS related complex (ARC), or any immune deficiency related disorder or tested positive for the Human Immunodeficiency Virus (HIV)?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
4. Are you currently: hospitalized, confined to a bed or nursing facility, or using oxygen equipment to assist in breathing, or receiving hospice care?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
5. Have you been treated for insulin shock, diabetic coma, or ever taken insulin shots prior to the age of 50?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
6. Have you ever been medically diagnosed, treated, or taken medication for: congestive heart failure, Alzheimer's, dementia, schizophrenia, bipolar disorder, mental incapacity, Lou Gehrig's disease (ALS), or Huntington's disease?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
7. Within the past 24 months, have you been confined more than twice to a hospital, nursing facility, convalescent care facility, assisted living facility, mental facility or Hospice Care?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
8. Within the past 12 months have you been diagnosed with internal cancer or melanoma or have had more than one occurrence of any cancer in your lifetime (excluding basal or squamous cell skin cancer), or are you currently being treated for cancer, amputation caused by disease, stroke or transient ischemic attack (TIA), or leukemia.	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
9. Within the past 24 months have you:		
a. been medically diagnosed, treated or taken medication for: angina, chronic hepatitis, cystic fibrosis, chronic obstructive pulmonary disease (COPD), emphysema or required oxygen equipment to assist in breathing?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
b. been diagnosed as having, been treated for or hospitalized for: heart attack, heart disease, cardiomyopathy, heart or circulatory surgery (including pacemaker, by-pass, heart valve replacement, angioplasty, stent implant), uncontrolled high blood pressure or any procedure to improve circulation to the heart or brain?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
c. had Hodgkin's Disease, cirrhosis, liver disease, lymphoma, or systemic lupus (SLE)?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
10. Within the past 10 years, have you been convicted of a felony or are you currently on probation?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
11. Within the past 5 years have you been treated for, been advised to have treatment for, or excessively used, alcohol or any drugs of abuse, or have you been convicted of operating a vehicle while intoxicated or impaired, or had your driver's license suspended or revoked, or attempted suicide?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
12. Have you been declined or postponed for life or health insurance in the past two years?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

Tier 2 (B)	ANSWER FOR PROPOSED INSURED	
	"A"	"B"
<b>If any question in Tier 2 (B) is answered "Yes" and the height and weight within Tier 1 parameters, the Applicant is eligible for Tier 2 (B) rates.</b>		
13. Are you, or have you been disabled in the last 6 months?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
14. Within the past 24 months have you been medically diagnosed or treated, or taken medication for:		
a. Stroke or transient ischemic attack (TIA)	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
b. Internal cancer, melanoma, or leukemia	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
c. Amputation of a body part caused by disease, paralysis of two or more extremities or any neuromuscular disease (including cerebral palsy, multiple sclerosis, grand mal seizures) or Parkinson's disease?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

**Section C —**

15. Has the Proposed Insured used nicotine based products in the past 12 months?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
16. Have you applied for life insurance with any other insurance companies in the last two years?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
17. Driver's License number _____, State _____	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

**Section D —**

**PROPOSED INSURED'S STATEMENT**

I have read the completed application. I agree that this application will be the basis for, and will become part of, the policy that is issued. The above representations are true to the best of my knowledge and belief. I agree the policy shall not be in effect until it has been issued by Oxford Life Insurance Company ("the Company") and all premiums have been paid. I understand that the information on this application will be relied upon to determine insurability and that incorrect information may result in coverage being voided, subject to the policy's Incontestability provision. I understand that the agent has no authority to approve the application, change the policy, or waive any policy provisions. I understand no insurance will be effective until the date stated in the policy and all eligibility requirements are met.

**MEDICAL AUTHORIZATION**

I authorize any physician, medical practitioner, hospital, medical care facility, the Veteran's Administration, insurance company, the Medical Information Bureau, pharmacy manager, insurance laboratories, my employer or consumer reporting agency, to give Oxford Life Insurance Company or its reinsurers any information they have about my health, including confidential HIV-related information, for use in underwriting risk selection purposes only. I acknowledge receipt of the Medical Information Bureau Pre-Notice. I agree that a copy of this authorization is as valid as the original and I can obtain a copy on request. This authorization is valid for use in underwriting risk selection purposes only and is valid for 24 months, except for HIV-related information, which is only valid for 180 days from the date below.

\_\_\_\_\_  
Signature of Proposed Insured "A"      Date  
(Personal Representative)

\_\_\_\_\_  
Signature of Policy Owner "A"      Date

\_\_\_\_\_  
Signature of Proposed Insured "B"      Date  
(Personal Representative)

\_\_\_\_\_  
Signature of Policy Owner "B"      Date

**Section E —**

**AGENT'S STATEMENT**

To the best of my knowledge and belief the Proposed Insured and/or Owner  **does**  **does not** have any existing life insurance or annuity coverage and the life insurance applied for  **will**  **will not** replace any existing life insurance or annuity coverage.

I certify that I have verified the personal information of the applicant(s) by viewing a state issued driver's license, state issued I.D. card, military I.D. card, Permanent U.S. Resident (Green Card), passport or other government issued picture I.D. card.

I further certify that any information recorded by me on this application is true and accurate to the best of my knowledge and that I witnessed the signing of the application by the Proposed Insured(s) and owner(s) at \_\_\_\_\_

City      State

\_\_\_\_\_  
Licensed Agent's Signature      Agent's Printed Name

\_\_\_\_\_  
Agent's Number      Date

\_\_\_\_\_  
Second Licensed Agent's Signature      Agent's Printed Name

\_\_\_\_\_  
Agent's Number      Date

**MAIL POLICY TO:**     **Owner**     **Agent**

**HIPAA Authorization  
for Release of Health  
Related Information**

**This authorization complies with the HIPAA Privacy Rule**

Name(s) of Primary proposed insured  
\_\_\_\_\_

Date(s) of birth  
\_\_\_\_\_

Name(s) of secondary proposed insured  
\_\_\_\_\_

Date(s) of birth  
\_\_\_\_\_

I authorize any health plan, physician, health care professional, hospital, clinic, laboratory, pharmacy, pharmacy benefit manager, medical facility, insurance company, insurance support organization (such as MIB Group, Inc. or any of its members or affiliates), or other health care provider that has provided payment, treatment or services to me (collectively, "My Providers") to disclose the entire medical record and any other protected health information concerning me to the company referenced on this authorization ("the Company") and their agents, employees, and representatives. This includes information on the diagnosis or treatment of Human Immunodeficiency Virus (HIV) infection and sexually transmitted diseases. This also includes information on the diagnosis and treatment of mental illness and the use of alcohol, drugs, and tobacco, but excludes psychotherapy notes.

By my signature below, I acknowledge that any agreements I have made to restrict my protected health information do not apply to this authorization and I instruct My Providers to release and disclose the entire medical record without restriction for use in underwriting risk selection purposes.

This protected health information is to be disclosed under the Authorization at my request, as permitted by § 164.508 of the privacy regulations issued pursuant to the Health Insurance Portability and Accountability Act ("HIPAA Privacy Rule").

This authorization shall remain in force for 24 months following the date of my signature below, regardless of my condition and whether living or deceased, and a copy of this authorization is as valid as the original. I understand that I have the right to revoke this authorization in writing, at any time, by sending a written request for revocation to the Company addressed, **Attention: Oxford Life Insurance Company, Policyholder Service Department, 2721 North Central Avenue, Phoenix, AZ 85004**. I understand that a revocation is not effective to the extent that any of My Providers has relied on this Authorization or to the extent that the Company has a legal right to contest a claim under an insurance policy or to contest the policy itself. I understand that any information disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal regulations governing privacy and confidentiality of health information (such as the HIPAA Privacy Rule). However, the Company will protect the privacy of health information in accordance with other applicable state and/or federal privacy laws and its own privacy policies.

I understand that My Providers may not refuse to provide treatment or payment for health care services because I refuse to sign this authorization. I further understand that if I refuse to sign this authorization to release my complete medical record, the Company may not be able to process my application, or if coverage has been issued, may not be able to make any benefit payments. I acknowledge that I have received a copy of this authorization.

\_\_\_\_\_  
Signature of Primary Proposed Insured/Personal Representative

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Primary Proposed Insured/Personal Representative

\_\_\_\_\_  
Date

If signed by an individual's Personal Representative, describe authority to sign on behalf of the individual:

Legal Guardian       Power of Attorney       Other (please describe): \_\_\_\_\_

(NOTE: If more than one individual is named above, please specify the individual(s) to whom the Personal Representative applies.)

Policy or contract number (If known): \_\_\_\_\_

**PRIVACY NOTICE**

Your privacy is protected...

Oxford Life Insurance Company, like other insurance companies, sometimes evaluates the medical history and other personal information about applicants to determine their eligibility for certain policies. (Personal information includes information such as age, occupation, physical condition, health history, habits, general reputation, credit and avocation.) We also use this information for the administration of Your insurance coverage after it is in force.

We rely heavily on information provided by You. We may also supplement this information from other sources, such as medical professionals or institutions that have treated You or family members covered under Your policy, insurance support organizations, other insurance companies to which You have applied, and employers.

Any information You give Us regarding Your insurability and any information received from other sources will be treated as strictly confidential. In some situations, and in compliance with applicable law, We may disclose necessary items of information to third parties, who may retain a copy and disclose the information to others for whom they perform such services, without Your specific authorization. Unless You request otherwise, Your name, address, date of birth and phone number may be used by Us or Our affiliates to inform you of other insurance products or services which are available. We may also disclose this information to: (1) an organization performing administrative, business or professional services for Us; (2) other insurance companies to which You apply; and (3) your physician or medical professional.

You have the right to be told about, and to copy, if you wish, items of personal information which appear in our files. You also have the right to seek correction of information you believe to be inaccurate.

**THE ABOVE IS A GENERAL DESCRIPTION OF OUR PRIVACY PRACTICES. IF YOU WOULD LIKE A MORE DETAILED EXPLANATION OF OUR PRACTICES AND THE CIRCUMSTANCES UNDER WHICH WE MAY USE OR DISCLOSE INFORMATION, PLEASE WRITE TO OUR PRIVACY OFFICER AT OXFORD LIFE INSURANCE COMPANY, 2721 NORTH CENTRAL AVENUE, PHOENIX, AZ 85004-1172, OR VISIT WWW.OXFORDLIFE.COM.**

**FAIR CREDIT REPORTING ACT NOTICE**

With regard to your application, we may have requested an investigative consumer report. These reports contain information about Your character, general reputation, mode of living and health except as may be related directly or indirectly to Your sexual orientation. The information may have been obtained through interviews with You, Your neighbors, friends and others who know You. Upon request, we will give You the name and address of the consumer reporting firm so that You may request a copy of the report.

**LEAVE THIS NOTICE WITH OWNER**



2721 North Central Avenue • Phoenix, Arizona 85004 • (866) 641-9999

**TEMPORARY LIFE INSURANCE AGREEMENT AND RECEIPT**

**PLEASE READ THIS CAREFULLY.** All premium checks must be made payable to Oxford Life Insurance Company (“the Company”). Do not make check payable to agent/producer or leave payee blank.

This receipt provides temporary insurance coverage as of the date of this receipt. In the event of an adverse underwriting decision, the Company will mail notice to the applicant of the rejection of the application for insurance and refund the premium, thereby terminating this receipt.

Received from \_\_\_\_\_ a check in the amount of \$ \_\_\_\_\_

paid with a life insurance Application to the Company. The Application bears the same date as this Receipt. I have advised each proposed insured of the terms, conditions, and limitations of this Conditional Receipt.

Dated at (City & State)

On (Date)

Agent’s Signature

If there is any material misrepresentation in any request for life insurance, application, telephone or other interviews, or medical examinations or tests submitted to the Company related to any person proposed to be insured, this temporary life insurance coverage will be void from the beginning.

If any question in Tier 1 (A) of the Application is answered “Yes,” the proposed insured is not eligible for the single premium life policy.

If all requirements are not met, or the person(s) to be insured dies by suicide, the liability of the Company shall be limited to a full refund to the Applicant of the payment received by the Company.

The aggregate amount of life insurance provided on the life of any person proposed to be insured which may become effective under the Receipt and any other conditional receipt issued by the Company on the life of that person, shall be the lesser of the amount applied for or \$5,000.

This Receipt provides no insurance for riders or additional benefits.

No agent or broker is authorized to alter the terms of this Receipt, waive any terms or conditions, or pass on insurability.

I have read this Receipt and understand and agree to its terms. I understand this Receipt provides no insurance unless all conditions are met. I declare that the answers to the questions in the Application are true and complete to the best of my knowledge.

\_\_\_\_\_  
Date                      Signature of Proposed Insured “A”                      Agent                      Owner (If other than Proposed Insured “A”)

\_\_\_\_\_  
Date                      Signature of Proposed Insured “B”                      Agent                      Owner (If other than Proposed Insured “B”)

SPL112

**LEAVE THIS PAGE WITH OWNER IF PAYMENT IS MADE WITH APPLICATION.**

**OXFORD LIFE INSURANCE COMPANY**

2721 North Central Avenue • Phoenix, Arizona 85004 • (866) 641-9999

**MIB PRE-NOTICE**

—PROPOSED INSURED—

Information regarding your insurability will be treated as confidential. Oxford Life Insurance Company, or its reinsurers, may, however, make a brief report thereon to the Medical Information Bureau (MIB), a not-for-profit membership organization of insurance companies, which operates an information exchange on behalf of its members. If you apply to another MIB member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, the MIB, upon request, will supply such company with the information in its file.

Upon receipt of a request from you, the MIB will arrange disclosure of any information it may have in your file. Please contact MIB at 866-692-6901 (TTY: 866-346-3642). If you question the accuracy of information in the MIB’s file, you may contact the MIB and seek a correction in accordance with the procedures set forth in the federal Fair Credit Reporting Act. The address of the Bureau’s information office is: P.O. Box 105, Essex Station, Boston, Massachusetts 02112.

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

**LEAVE THIS NOTICE WITH OWNER**

*SERFF Tracking Number:*      *OXFR-125626626*                      *State:*                      *Arkansas*  
*Filing Company:*              *Oxford Life Insurance Company*                      *State Tracking Number:*      *38809*  
*Company Tracking Number:*      *SPL112AR*  
*TOI:*                      *L021 Individual Life - Endowment*                      *Sub-TOI:*                      *L021.002 Single Life - Single Premium*  
*Product Name:*              *Advanced Wealth Transfer*  
*Project Name/Number:*      /

## **Rate Information**

Rate data does NOT apply to filing.

SERFF Tracking Number: OXFR-125626626 State: Arkansas  
Filing Company: Oxford Life Insurance Company State Tracking Number: 38809  
Company Tracking Number: SPL112AR  
TOI: L021 Individual Life - Endowment Sub-TOI: L021.002 Single Life - Single Premium  
Product Name: Advanced Wealth Transfer  
Project Name/Number: /

## Supporting Document Schedules

**Review Status:** 04/28/2008  
**Satisfied -Name:** Certification/Notice  
**Comments:**  
**Attachments:**  
CCompSPL112.pdf  
FLCERTAR.pdf

**Review Status:** 04/28/2008  
**Bypassed -Name:** Application  
**Bypass Reason:** This filing for an application only and it is included in the Form Schedule.  
**Comments:**

**Review Status:** 04/28/2008  
**Bypassed -Name:** Life & Annuity - Acturial Memo  
**Bypass Reason:** Previously filed.  
**Comments:**

**Review Status:** 04/28/2008  
**Satisfied -Name:** NAIC Transmittal  
**Comments:**  
**Attachment:**  
Copy of NAIC TransmittalSPL112.pdf

## CERTIFICATE OF COMPLIANCE

I, Gregory D. Morris, Secretary certify that the forms in this submission comply with all laws, rules, bulletins, and published guidelines applicable to this particular type of form in the State of Arkansas.



---

Gregory D. Morris  
Secretary

4/28/08

---

Date

# READABILITY CERTIFICATION

To Whom It May Concern:

This is to certify that the attached form SP112 achieved a Flesch Reading Ease Score of 50.0 and is in compliance with the requirements of Ark. Stat. Ann. §§66-3251 through 66-3258, cited as the Life and Disability Insurance Policy Language Simplification Act.

Oxford Life Insurance Company



---

Gregory D. Morris

Secretary

---

Title

4/28/08

---

Date

**Life, Accident & Health, Annuity, Credit Transmittal Document (Revised 1/1/06)**

<b>1.</b>	<b>Prepared for the State of</b>	Arkansas
-----------	----------------------------------	----------

<b>2.</b>	<b>Department Use Only</b>	
	<b>State Tracking ID</b>	

3.	Insurer Name & Address	Domicile	Insurer License Type	NAIC Group #	NAIC #	FEIN #
	Oxford Life Insurance Company 2721 North Central Avenue Phoenix, AZ 85004-1172	AZ		0574	76112	86-0216483

4.	Contact Name & Address	Telephone #	Fax #	E-mail Address
	Tamika Simmons Compliance Coordinator (same as above)	888.757.3732, ext. 5779	602.277.5901	tamikasimmons@oxfordlife.com

<b>5.</b>	<b>Requested Filing Mode</b>	<input checked="" type="checkbox"/> Review & Approval <input type="checkbox"/> File & Use <input type="checkbox"/> Informational <input type="checkbox"/> Combination (please explain): _____ <input type="checkbox"/> Other (please explain): _____
-----------	------------------------------	--

<b>6.</b>	<b>Company Tracking Number</b>	SPL112AR
-----------	--------------------------------	----------

<b>7.</b>	<input checked="" type="checkbox"/> <b>New Submission</b> <input type="checkbox"/> <b>Resubmission</b>	Previous file # _____
-----------	--	-----------------------

<b>8.</b>	<b>Market</b>	<input checked="" type="checkbox"/> Individual <input type="checkbox"/> Franchise  Group: <input type="checkbox"/> Small <input type="checkbox"/> Large <input type="checkbox"/> Small and Large <input type="checkbox"/> Employer <input type="checkbox"/> Association <input type="checkbox"/> Blanket <input type="checkbox"/> Discretionary <input type="checkbox"/> Trust <input type="checkbox"/> Other: _____
-----------	---------------	---

<b>9.</b>	<b>Type of Insurance</b>	L021 Individual Life – Endowment
-----------	--------------------------	----------------------------------

<b>10.</b>	<b>Product Coding Matrix Filing Code</b>	L021.002 Single Life – Single Premium
------------	--	---------------------------------------

<b>11.</b>	<b>Submitted Documents</b>	<input checked="" type="checkbox"/> <b>FORMS</b> <input type="checkbox"/> Policy <input type="checkbox"/> Outline of Coverage <input type="checkbox"/> Certificate <input checked="" type="checkbox"/> Application/Enrollment <input type="checkbox"/> Rider/Endorsement <input type="checkbox"/> Advertising <input type="checkbox"/> Schedule of Benefits <input type="checkbox"/> Other  <b>Rates</b> <input type="checkbox"/> New Rate <input type="checkbox"/> Revised Rate  <input type="checkbox"/> <b>FILING OTHER THAN FORM OR RATE:</b> Please explain: _____  <b>SUPPORTING DOCUMENTATION</b> <input type="checkbox"/> Articles of Incorporation <input type="checkbox"/> Third Party Authorization <input type="checkbox"/> Association Bylaws <input type="checkbox"/> Trust Agreements <input type="checkbox"/> Statement of Variability <input type="checkbox"/> Certifications <input type="checkbox"/> Actuarial Memorandum <input type="checkbox"/> Other: _____
------------	----------------------------	--

12.	<b>Filing Submission Date</b>	<b>4/28/2008</b>	
13	<b>Filing Fee (If required)</b>	Amount <u>    N/A    </u>	Check Date <u>                    </u>
		Retaliatory <input type="checkbox"/> Yes <input type="checkbox"/> No	Check Number <u>                    </u>
14.	<b>Date of Domiciliary Approval</b>	<b>4/24/2008</b>	
15.	<b>Filing Description:</b>		
<p>This form is being submitted to you for your review and approval. No part of this filing contains any unusual or possibly controversial items from normal company or industry standards. The document is a final printed version.</p> <p>Form No. SPL112 is a new application and it will be used with policy SPE100, which was exempted in your state on 4/25/2006.</p>			

16.	<b>Certification (If required)</b>		
<p><b>I HEREBY CERTIFY</b> that I have reviewed the applicable filing requirements for this filing, and the filing complies with all applicable statutory and regulatory provisions for the state of <u>                    Arkansas                    </u>.</p>			
Print Name <u>    <b>Gregory D. Morris</b>    </u>		Title: <u>    <b>Secretary</b>    </u>	
Signature <u>    </u>		Date: <u>    April 28, 2008    </u>	

<b>17.</b>	<b>Form Filing Attachment</b>	
This filing transmittal is part of company tracking number		<b>SPL112AR</b>
This filing corresponds to rate filing company tracking number		

	Document Name	Form Number		Replaced Form Number
	Description			Previous State Filing Number
01	Application	SPL112AR	<input checked="" type="checkbox"/> Initial <input type="checkbox"/> Revised <input type="checkbox"/> Other _____	
02			<input checked="" type="checkbox"/> Initial <input type="checkbox"/> Revised <input type="checkbox"/> Other _____	
03			<input type="checkbox"/> Initial <input type="checkbox"/> Revised <input type="checkbox"/> Other _____	
04			<input type="checkbox"/> Initial <input type="checkbox"/> Revised <input type="checkbox"/> Other _____	
05			<input type="checkbox"/> Initial <input type="checkbox"/> Revised <input type="checkbox"/> Other _____	
06			<input type="checkbox"/> Initial <input type="checkbox"/> Revised <input type="checkbox"/> Other _____	
07			<input type="checkbox"/> Initial <input type="checkbox"/> Revised <input type="checkbox"/> Other _____	
08			<input type="checkbox"/> Initial <input type="checkbox"/> Revised <input type="checkbox"/> Other _____	
09			<input type="checkbox"/> Initial <input type="checkbox"/> Revised <input type="checkbox"/> Other _____	
10			<input type="checkbox"/> Initial <input type="checkbox"/> Revised <input type="checkbox"/> Other _____	

LH FFA-1

18.		Rate Filing Attachment		
This filing transmittal is part of company tracking number				
This filing corresponds to form filing company tracking number				
Overall percentage rate impact for this filing		%		
	Document Name	Affected Form Numbers		Previous State Filing Number
	Description			
01			<input type="checkbox"/> New <input type="checkbox"/> Revised Request +____% -____% <input type="checkbox"/> Other _____	
02			<input type="checkbox"/> New <input type="checkbox"/> Revised Request +____% -____% <input type="checkbox"/> Other _____	
03			<input type="checkbox"/> New <input type="checkbox"/> Revised Request +____% -____% <input type="checkbox"/> Other _____	
04			<input type="checkbox"/> New <input type="checkbox"/> Revised Request +____% -____% <input type="checkbox"/> Other _____	
05			<input type="checkbox"/> New <input type="checkbox"/> Revised Request +____% -____% <input type="checkbox"/> Other _____	
06			<input type="checkbox"/> New <input type="checkbox"/> Revised Request +____% -____% <input type="checkbox"/> Other _____	
07			<input type="checkbox"/> New <input type="checkbox"/> Revised Request +____% -____% <input type="checkbox"/> Other _____	
08			<input type="checkbox"/> New <input type="checkbox"/> Revised Request +____% -____% <input type="checkbox"/> Other _____	
09			<input type="checkbox"/> New <input type="checkbox"/> Revised Request +____% -____% <input type="checkbox"/> Other _____	
10			<input type="checkbox"/> New <input type="checkbox"/> Revised Request +____% -____% <input type="checkbox"/> Other _____	

LH RFA-1