

SERFF Tracking Number: PERR-125667167 State: Arkansas
Filing Company: USAA Life Insurance Company State Tracking Number: 39164
Company Tracking Number: USAA-ULCSO-AR-08-01F
TOI: L09I Individual Life - Flexible Premium Sub-TOI: L09I.001 Single Life
Adjustable Life
Product Name: Universal Life Policy
Project Name/Number: USAA-ULCSO-AR-08-01F/USAA-ULCSO-AR-08-01F

Filing at a Glance

Company: USAA Life Insurance Company

Product Name: Universal Life Policy

TOI: L09I Individual Life - Flexible Premium

Adjustable Life

Sub-TOI: L09I.001 Single Life

Filing Type: Form

Implementation Date Requested: On Approval

State Filing Description:

SERFF Tr Num: PERR-125667167 State: ArkansasLH

SERFF Status: Closed

State Tr Num: 39164

Co Tr Num: USAA-ULCSO-AR-08-01F State Status: Approved-Closed

Co Status:

Reviewer(s): Linda Bird

Authors: Ines Piquet, Laura
Jennette

Disposition Date: 06/11/2008

Date Submitted: 05/30/2008

Disposition Status: Approved

Implementation Date:

General Information

Project Name: USAA-ULCSO-AR-08-01F

Project Number: USAA-ULCSO-AR-08-01F

Requested Filing Mode: Review & Approval

Explanation for Combination/Other:

Submission Type: New Submission

Overall Rate Impact:

Filing Status Changed: 06/11/2008

State Status Changed: 06/11/2008

Corresponding Filing Tracking Number:

Filing Description:

On behalf of USAA Life Insurance Company (the Company), we are submitting new Universal Life Insurance Policy LUL88326AR 05-08 for your review. We are filing in 50 other locations, including their domicile state of Texas. This form will be modified only to meet respective state requirements. The Company plans to begin marketing this product upon approval.

Status of Filing in Domicile: Pending

Date Approved in Domicile:

Domicile Status Comments: File Concurrently

Market Type: Individual

Group Market Size:

Group Market Type:

Deemer Date:

<i>SERFF Tracking Number:</i>	<i>PERR-125667167</i>	<i>State:</i>	<i>Arkansas</i>
<i>Filing Company:</i>	<i>USAA Life Insurance Company</i>	<i>State Tracking Number:</i>	<i>39164</i>
<i>Company Tracking Number:</i>	<i>USAA-ULCSO-AR-08-01F</i>		
<i>TOI:</i>	<i>L09I Individual Life - Flexible Premium</i>	<i>Sub-TOI:</i>	<i>L09I.001 Single Life</i>
	<i>Adjustable Life</i>		
<i>Product Name:</i>	<i>Universal Life Policy</i>		
<i>Project Name/Number:</i>	<i>USAA-ULCSO-AR-08-01F/USAA-ULCSO-AR-08-01F</i>		

The Universal Life policy is an individual, flexible premium product which will be used with previously approved riders and applications and any relevant forms approved in the future.

USAA Life Insurance Company is a direct response company and as such conducts the majority of its business through licensed agents over the phone. Solicitation of the base policy is primarily by direct mail, not through mass media. Recipients of their direct mail advertising may respond by mail or by telephone. Their products are available to the membership of their parent United Services Automobile Association (USAA), reciprocal interinsurance exchange specializing in personal lines of business, including property and casualty insurance. These forms will be also be used on the Internet, including the use of electronic signature.

Enclosed is authorization for Perr&Knight to submit this filing on behalf of the Company. All correspondence related to this filing should be directed to Perr&Knight. The Company has prepared the form contained in this filing along with the explanatory memorandum. If there are any requests for additional information related to items prepared by the Company, we will forward the request immediately to the Company contact. The Company's response will be submitted to your attention as soon as we receive it.

Company and Contact

Filing Contact Information

(This filing was made by a third party - perrandknightactuaryconsultants)

Laura Jennette, State Filings Analyst	doi@perrknight.com
881 Alma Real Drive Suite 205	(310) 230-9339 [Phone]
Pacific Palisades, CA 90272	

Filing Company Information

USAA Life Insurance Company	CoCode: 69663	State of Domicile: Texas
9800 Fredericksburg Road	Group Code: 200	Company Type: Life
San Antonio, TX 78288	Group Name: USAA Life Group	State ID Number:
(800) 531-8000 ext. [Phone]	FEIN Number: 74-1472662	

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Filing Fees

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

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
USAA Life Insurance Company	\$0.00	05/30/2008	

CHECK NUMBER	CHECK AMOUNT	CHECK DATE
102894	\$50.00	05/29/2008

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Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved	Linda Bird	06/11/2008	06/11/2008

Objection Letters and Response Letters

Objection Letters				Response Letters		
Status	Created By	Created On	Date Submitted	Responded By	Created On	Date Submitted
Pending Industry Response	Linda Bird	06/04/2008	06/04/2008	Ines Piquet	06/10/2008	06/11/2008

SERFF Tracking Number: PERR-125667167 *State:* Arkansas
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Disposition

Disposition Date: 06/11/2008

Implementation Date:

Status: Approved

Comment:

Rate data does NOT apply to filing.

SERFF Tracking Number: PERR-125667167 *State:* Arkansas
Filing Company: USAA Life Insurance Company *State Tracking Number:* 39164
Company Tracking Number: USAA-ULCSO-AR-08-01F
TOI: L091 Individual Life - Flexible Premium *Sub-TOI:* L091.001 Single Life
Adjustable Life
Product Name: Universal Life Policy
Project Name/Number: USAA-ULCSO-AR-08-01F/USAA-ULCSO-AR-08-01F

Item Type	Item Name	Item Status	Public Access
Supporting Document	Certification/Notice		Yes
Supporting Document	Application		Yes
Supporting Document	Health - Actuarial Justification		No
Supporting Document	Outline of Coverage		No
Supporting Document	Supporting Documents		Yes
Supporting Document	Certifications		Yes
Form	Universal Life Insurance Policy		Yes

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Objection Letter

Objection Letter Status Pending Industry Response
Objection Letter Date 06/04/2008
Submitted Date 06/04/2008

Respond By Date

Dear Laura Jennette,

This will acknowledge receipt of the captioned filing.

Objection 1

- Certification/Notice (Supporting Document)

Comment: Ark. Code Ann. 23-79-138 requires that certain information accompany every policy. Please review your issue procedures and assure us that you are in compliance with Ark. Code Ann. 23-79-138.

Regulation 49 requires that a Life and Health guaranty notice be given to each policyowner. Please review your issue procedures and assure us that you are in compliance with Regulation 49.

Regulation 19s10B requires that all new or revised filings submitted must contain a certification that the submission meets the provisions of this rule as well as all applicable requirements of this Department.

Filings of "universal life" type contract are subject to Regulation 34. Please assure us that you are in compliance with Regulation 34. If cost of insurance may be changed by the company subject to a maximum and/or accumulation rates may be changed by the company subject to a minimum, then the contract must comply with Bulletin 11-83.

Please feel free to contact me if you have questions.

Sincerely,

Linda Bird

Response Letter

Response Letter Status Submitted to State
Response Letter Date 06/10/2008
Submitted Date 06/11/2008

Dear Linda Bird,

SERFF Tracking Number: PERR-125667167 State: Arkansas
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Comments:

Thanks you for your review of this filing and June 04, 2008 letter. USAA Life Insurance Company would like to offer the following response to your concerns in the same order they were presented in your letter.

Response 1

Comments: Please be assured that USAA Life is in compliance with Ark. Code Ann. 23-79-138.

Please be assured that USAA Life Insurance Company is in compliance with Regulation 49 and provides each policyowner with a Life and Health guaranty notice.

Attached is a certification of compliance with Regulation 19s10B.

Please be assured that USAA Life Insurance Company is in compliance with Regulation 34. Enclosed is a certification for Bulletin 11-83.

Related Objection 1

Applies To:

- Certification/Notice (Supporting Document)

Comment:

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Regulation 19s10B requires that all new or revised filings submitted must contain a certification that the submission meets the provisions of this rule as well as all applicable requirements of this Department.

Filings of "universal life" type contract are subject to Regulation 34. Please assure us that you are in compliance with Regulation 34. If cost of insurance may be changed by the company subject to a maximum and/or accumulation rates may be changed by the company subject to a minimum, then the contract must comply with Bulletin 11-83.

Changed Items:

Supporting Document Schedule Item Changes

Satisfied -Name: Certifications

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Comment:

No Form Schedule items changed.

No Rate/Rule Schedule items changed.

Please advise in case you need anything else.

Sincerely,
Ines Piquet, Laura Jennette

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Form Schedule

Lead Form Number: LUL88326AR 05-08

Review Status	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
	LUL88326AR 05-08	Policy/Contract	Universal Life Fraternal Insurance Policy Certificate	Initial		58	88326-0508, AR Ulife Contract.pdf



This notice is to advise you that should any questions arise regarding this insurance, you may contact the following:

ARKANSAS INSURANCE DEPARTMENT
Consumer Service Department
1200 West Third
Little Rock, Arkansas 72201
Telephone (501) 371-1813
(800) 852-5494

OR

USAA LIFE INSURANCE COMPANY
Customer Service Department
9800 Fredericksburg Road
San Antonio, Texas 78288
Telephone: (800) 531-USAA (8122)

USAA LIFE INSURANCE COMPANY
(A Stock Company)

UNIVERSAL LIFE INSURANCE POLICY

This life insurance policy is issued in consideration of the application and payment of premiums as provided.

While this policy is in effect, We will pay the death benefit to the Beneficiary if the Insured dies before the Maturity Date. We will pay the surrender value, if any, if the Insured is living on the Maturity Date and this policy is in effect. Any payment will be made subject to this policy's provisions.

This life insurance policy is a legal contract between the Owner and the Company. **READ YOUR POLICY CAREFULLY.** Its terms are contained on this page and those which follow.

Signed for the Company.

Kristi A. Matus
President

Mark S. Howard
Secretary

YOU HAVE PURCHASED A LIFE INSURANCE POLICY. CAREFULLY REVIEW IT FOR LIMITATIONS.

RIGHT TO CANCEL. If You decide not to keep this policy, return it within 31 days after You receive it. You may return it to any of Our representatives or You may mail it to Us. The return of this policy will void it from the beginning. After We receive the policy, We will refund any premium paid without interest.

This is a **FLEXIBLE PREMIUM, ADJUSTABLE DEATH BENEFIT UNIVERSAL LIFE INSURANCE POLICY.** Premiums are payable while the Insured is alive, but not beyond the Maturity Date. Death benefit is payable if the Insured dies before the Maturity Date. Surrender value, if any, is payable if the Insured is living on the Maturity Date.

Nonparticipating: Dividends are not payable.

NOTICE TO OWNER:

If you need information about this policy or assistance in resolving a question or complaint, please call us at 1-800-531-USAA (8722).

USAA LIFE INSURANCE COMPANY 9800 Fredericksburg Road San Antonio, Texas 78288

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TABLE OF CONTENTS

	Page		Page
BASIS OF POLICY VALUES	13	OWNERSHIP	7
BENEFICIARY	7-8	Change of Owner	7
Change of Beneficiary	7	Joint Owners	7
Irrevocable Beneficiary	7	Ownership Rights	7
Payment to Beneficiary	7	Ownership Succession	7
Minor Beneficiary	7-8	POLICY INFORMATION	2-3
DEATH BENEFIT	8-9	Policy Data	2
Death Benefit	8	Premium Information	2A
Death Benefit Option	8	Interest Information	2A
Minimum Death Benefit	8	Type of Coverage	2A
Payment of Death Benefit	8	Charges and Fees	2B
Interest Paid on Death Benefit	9	Table of Guaranteed Maximum	
Suicide Exclusion	9	Monthly Cost of Insurance Rates	3
DEATH BENEFIT CHANGES	9-10	Minimum Death Benefit Table	3A
General	9	POLICY LOANS	13-14
Death Benefit Options	9	Loans	13
Increasing Face Amount	9	Loan Value	13
Decreasing Face Amount	10	Loan Interest	13-14
DEFINITIONS	4	Repayment	14
GENERAL PROVISIONS	5-6	POLICY VALUES	11-13
Annual Report	5	Account Value	11
Assignment	5	Surrender Value	12
Change of Plan	5	Monthly Deduction	12
Choice of Law	5	Monthly Cost of Insurance	12
Claims of Creditors	5	Monthly Cost of Insurance Rate	12
Entire Contract	5	Interest	12
Good Health Requirement	5	Additional Interest	13
Incontestability	5-6	PREMIUMS	10-11
Misstatement of Birth Date or Gender	6	Premium Payments	10
Notification of Death	6	Planned and Unscheduled Premium Payments	10
Representations	6	Premium Limitation Provision	10
Payments	6	Continuation of Insurance	10
Policy Changes	6	Grace Period	11
Tax Laws	6	REINSTATEMENT	11
Termination of Policy	6	Reinstatement Requirements	11
METHODS OF SETTLEMENT	14-16	Effective Date of Reinstatement	11
Payment of Proceeds	14-15	Adjustment After Reinstatement	11
Amount of Payment	15	SURRENDER	14
Interest Paid on Proceeds	15	Full Surrender	14
Payee	15	Partial Surrender	14
Election of Option	15	Surrender Requirements	14
Settlement Options	15-16	Deferral of Payment	14
Commuted Value	16		
Death of Payee	16		
Table of Guaranteed Monthly Payments	16		

Any endorsements, restrictions, riders, or additional benefits follow Page 16.

**POLICY INFORMATION
POLICY DATA**

USAA Number – [123456789]

Contract Number – [123456789U1]

Owner – [JOHN M. DOE]

Insured – [JOHN M. DOE]

Age and Gender at issue – [35] [Male]

Effective Date – [01/01/2008]

Maturity Date* - [01/01/2093] <anniversary following insured's 120th birthday>

Initial Face Amount – [\$25,000]

Minimum Face Amount – [\$2,500]

Minimum Decrease Amount – [\$5,000]

Minimum Increase Amount – [\$25,000]

Death Benefit Option – [A]

****COVERAGE COULD END BEFORE THE MATURITY DATE IF PREMIUM(S) (INITIAL AND ANY ADDITIONAL) PAID PLUS INTEREST CREDITED ARE NOT SUFFICIENT TO CONTINUE COVERAGE TO THAT DATE.***

(OWNER INFORMATION IS SUBJECT TO ANY CHANGE SUBMITTED TO AND ON RECORD WITH US.)

POLICY INFORMATION (CONT'D)

USAA NUMBER - [123456789]

CONTRACT NUMBER - [123456789U1]

CHARGES AND FEES

Maximum Information Report Fee – [\$25.00]

Maximum Premium Expense Charge – [8%] of each premium payment received

Current Premium Expense Charge – [3%] of each premium payment received

Maximum Monthly Expense Charge -- [\$25.00] PER [MONTH]

Current Monthly Expense Charge -- [7.50] PER [MONTH]

Maximum Administrative Charge -- [\$100.00] PER [MONTH] [(first year only)]

Current Administrative Charge -- [\$5.00] PER [MONTH] [(first year only)]

Policy Change Service Charge – [\$25.00]

Partial Surrender Service Charge – [\$25.00]

Minimum Partial Surrender Amount – [\$500]

Minimum Account Value After Partial Surrender – [\$1,000]

Maximum Partial Surrenders Allowed Per Year – [5]

POLICY INFORMATION (CONT'D)

USAA NUMBER - [123456789]

CONTRACT NUMBER - [123456789U1]

**TABLE OF GUARANTEED MAXIMUM MONTHLY COST OF INSURANCE RATES*
(per \$1,000)**

Policy Year Beginning	Rate	Policy Year Beginning	Rate
1/1/2009	0.0975	1/1/2053	5.9767
1/1/2010	0.1033	1/1/2054	6.6525
1/1/2011	0.1108	1/1/2055	7.3683
1/1/2012	0.1175	1/1/2056	8.1500
1/1/2013	0.1267	1/1/2057	9.0192
1/1/2014	0.1375	1/1/2058	9.9858
1/1/2015	0.1508	1/1/2059	11.0492
1/1/2016	0.1667	1/1/2060	12.1983
1/1/2017	0.1842	1/1/2061	13.4200
1/1/2018	0.2033	1/1/2062	14.7017
1/1/2019	0.2225	1/1/2063	15.9783
1/1/2020	0.2383	1/1/2064	17.2350
1/1/2021	0.2508	1/1/2065	18.5517
1/1/2022	0.2667	1/1/2066	19.9400
1/1/2023	0.2875	1/1/2067	21.4025
1/1/2024	0.3142	1/1/2068	22.8508
1/1/2025	0.3467	1/1/2069	24.2650
1/1/2026	0.3842	1/1/2070	25.7717
1/1/2027	0.4317	1/1/2071	27.3783
1/1/2028	0.4850	1/1/2072	29.0925
1/1/2029	0.5400	1/1/2073	30.7300
1/1/2030	0.5933	1/1/2074	32.1825
1/1/2031	0.6467	1/1/2075	33.7275
1/1/2032	0.7092	1/1/2076	35.3700
1/1/2033	0.7850	1/1/2077	37.1058
1/1/2034	0.8775	1/1/2078	38.9342
1/1/2035	0.9850	1/1/2079	40.8750
1/1/2036	1.1025	1/1/2080	42.9342
1/1/2037	1.2250	1/1/2081	45.1192
1/1/2038	1.3525	1/1/2082	47.4350
1/1/2039	1.4817	1/1/2083	49.8875
1/1/2040	1.6167	1/1/2084	52.4858
1/1/2041	1.7592	1/1/2085	55.2358
1/1/2042	1.9192	1/1/2086	58.1458
1/1/2043	2.1058	1/1/2087	61.2208
1/1/2044	2.3325	1/1/2088	64.4692
1/1/2045	2.5975	1/1/2089	67.8937
1/1/2046	2.8767	1/1/2090	71.5108
1/1/2047	3.1767	1/1/2091	75.3167
1/1/2048	3.5033	1/1/2092	79.3058
1/1/2049	3.8717	1/1/2093	83.3333]
1/1/2050	4.3000		
1/1/2051	4.7975		
1/1/2052	5.3550		

*These rates are based on the [2001] Ultimate Commissioners Standard Ordinary Mortality Table as applied to the age and premium class of the Insured at issue.

POLICY INFORMATION (CONT'D)

USAA NUMBER - [123456789]

CONTRACT NUMBER - [123456789U1]

MINIMUM DEATH BENEFIT TABLE

Attained Age	Account Value Percentage	Attained Age	Account Value Percentage	Attained Age	Account Value Percentage
0-40	250%	54	157%	68	117%
41	243%	55	150%	69	116%
42	236%	56	146%	70	115%
43	229%	57	142%	71	113%
44	222%	58	138%	72	111%
45	215%	59	134%	73	109%
46	209%	60	130%	74	107%
47	203%	61	128%	75-90	105%
48	197%	62	126%	91	104%
49	191%	63	124%	92	103%
50	185%	64	122%	93	102%
51	178%	65	120%	94	101%
52	171%	66	119%	95-99	100%
53	164%	67	118%	100 and up	100%

DEFINITIONS

Age	The Insured's age on his or her last birthday.
Anniversary	The same date each subsequent year as the Effective Date of the policy.
Attained Age	The Insured's Age on the last policy Anniversary.
Beneficiary	The person(s) named in the application or in the most recent change on record in Our Home Office to receive the death benefit.
Contingent Beneficiary	The person(s) named in the application or in the most recent change on record in Our Home Office to receive the death benefit if the Beneficiary is not alive at the Insured's death.
Effective Date	The date insurance coverage begins, as shown in the POLICY INFORMATION section. Premium due dates, policy months, years, and anniversaries are measured from this date.
Face Amount	The amount used to determine the death benefit. The Initial Face Amount is shown in the POLICY INFORMATION section.
Indebtedness	All outstanding loans on this policy plus any interest accrued thereon.
Initial Premium	The premium due on the Effective Date.
Insured	The person whose life is insured under this policy and who is shown in the POLICY INFORMATION section.
Maturity Date	The policy Anniversary on which We will pay the policy's cash value, less indebtedness, to the Owner as long as the policy has not terminated prior to that date. The Maturity Date is shown in the POLICY INFORMATION section.
Net Premium	The Net Premium is equal to: <ul style="list-style-type: none">• The premium paid; less• The Premium Expense Charge shown in the POLICY INFORMATION section.
Monthly Date	The same date each month as the Effective Date.
Owner	The person(s) named in the application or in the most recent change on record in Our Home Office. The Owner is entitled to all ownership rights stated in this policy.
Payee	A person who receives payments under this policy.
Successor Owner	The person(s) named in the application or in the most recent change on record in Our Home Office to become the Owner of this policy if the Owner dies before the Insured.
We, Our, Us, Company	USAA Life Insurance Company.
You, Your	The Owner.

GENERAL PROVISIONS

Any reference to Beneficiary, Contingent Beneficiary, Irrevocable Beneficiary, Owner, Successor Owner, and/or Payee, may include multiple persons.

- Annual Report** Once each year We will send You a report which shows the following:
- As of the date of the last report, the account value.
 - Since the date of the last report, the amount of any: premiums paid; monthly deductions; premium expense charges; interest credited; partial surrenders and any charges therefor; unpaid loans and loan interest; paid loans and loan interest.
 - As of the date of the current report: the account value; the surrender value; the Death Benefit Option; the Face Amount; and the current death benefit.
 - Other pertinent information required by any applicable law or regulation.
- On request, We will also send You a report which provides other information about this policy. If You request more than one report per policy year, We may charge a reasonable fee for each additional report. The Maximum Information Report Fee We will charge is shown in the POLICY INFORMATION section.
- Assignment** We will not be responsible for the validity or sufficiency of any assignment. To be binding on Us, an executed assignment must be by written request and consented to by any irrevocable Beneficiary and assignee of record. Your rights and any Beneficiary's interest will be subject to the assignment. Assignment of this policy may subject You to income and gift tax.
- Change of Plan** You may exchange this policy for another plan of insurance with Our approval. The exchange will be subject to requirements and costs as We determine.
- Choice of Law** This policy will be governed by the laws of the state in which it is delivered.
- Claims of Creditors** Only You can assign, encumber, or pledge any benefit paid under this contract. To the extent permitted by law and except to the extent You have assigned this policy, no benefit paid, or to become payable, will be subject to any claim or process of law by any creditor.
- Entire Contract** The entire contract consists of:
- This policy;
 - Any application (including supplemental applications or reinstatement applications), amendment, rider, endorsement, or revised POLICY INFORMATION page(s) which are attached or sent to Your last known address.
- Only an officer of the Company can agree to change or waive any provisions which are part of the entire contract. The change or waiver must be in writing.
- Good Health Requirement** No insurance under this policy will take effect unless the statement of health and insurability of the Insured continues to be as represented in the application when the policy is delivered and the first premium is paid.
- Incontestability** We will not contest this policy based on statements made in the application after this policy has been in effect during the Insured's lifetime for 2 years from the Effective Date. We can contest its validity at any time for fraud or if the surrender value is insufficient to cover the next monthly deduction and the required monthly deduction is not paid.
- A new period of contestability will apply if any one of the following events occurs:
- Reinstatement;
 - The Face Amount increases;
 - Death Benefit Option A changes to Option B; or
 - Additional coverage is added by rider.

GENERAL PROVISIONS (*Cont'd*)

- Incontestability (*Cont'd*)** We can contest this policy based on statements made in the application for any of these occurrences until this policy has been in effect during the Insured's lifetime for 2 years from the effective date of any such occurrence. For any increase in coverage, only the additional coverage will be contestable.
- This **Incontestability** provision applies to any rider unless that rider has its own Incontestability provision, in which case that rider's provision will apply.
- Misstatement of Birth Date or Gender** If the Insured's gender or birth date has been misstated, We will adjust the death benefit. We will use the then current monthly cost of insurance rate to determine what the death benefit should be for the correct gender or birth date.
- Notification of Death** The death of any Owner, Insured, or Payee must be reported to Us immediately. We are entitled to recover any overpayments made because of a failure to notify Us of any such death. We are not responsible for any incorrect payments which result from a failure to immediately notify Us of any such death. From time to time We may require proof that the Owner or Insured, or any other person to whom payment is due, is still alive. We may withhold any payments until We receive such proof.
- Representations** We will rely on all statements made in the application. We will consider those statements to be representations and not warranties. We will not use any statement in defense of a claim unless that statement is made in the application which is part of the entire contract.
- Payments** All payments We make will be in United States currency and will be sent to the recipient's last known address.
- Policy Changes** After We receive and record a request for a change in Owner, Successor Owner, Beneficiary, or Contingent Beneficiary, the change will take effect on the date the request was originally signed, even if the Owner who signed the request or the Insured has since died. However, the change will be subject to any payments made or actions taken by Us before the request for change was received and recorded.
- We reserve the right to issue revised POLICY INFORMATION pages in the event of any change to this policy.
- Tax Laws** This policy is intended to satisfy the definition of life insurance for federal income tax purposes under section 7702 of the Internal Revenue Code of 1986 as amended. We reserve the right to decline any change to the policy that We determine would cause this policy to fail to qualify as life insurance under the applicable tax law. This includes Face Amount changes, partial surrenders, and Death Benefit Option changes. We also reserve the right to change this policy, to require additional premium payments, or to make distributions from this policy to the extent necessary to continue to qualify this policy as life insurance.
- Termination of Policy** Coverage under this policy will end at the earliest of the following events:
- The Insured dies.
 - Your request for full surrender.
 - The grace period ends without receipt of required payment.
 - The Maturity Date.

OWNERSHIP

- Change of Owner** While the Insured is alive, You may transfer ownership by sending Us a request, subject to any applicable legal restrictions. A change in ownership will cancel any earlier choice of Successor Owner. A change in ownership may subject You to income and gift tax.
- Joint Owners** Two or more natural persons may be named as Joint Owners. They will own this policy as joint tenants with rights of survivorship. While any Joint Owners are alive, each must consent to any request made under this policy.
- Ownership Rights** While the Insured is alive, You may:
- Exercise any of the rights under this policy.
 - Assign this policy.
 - Subject to Our agreement, change or amend this policy.
- Exercise of any ownership right is subject to the consent of any Joint Owner.
- Ownership Succession** If You die before the Insured, at Your death, ownership of this policy will pass to the person(s) then living in the order which follows:
- Any surviving Joint Owner(s).
 - Any Successor Owner(s).
 - Estate of the last Owner to die, if no Joint Owner or Successor Owner is living.
- If more than one natural person succeeds to the ownership rights of this policy, then such persons will own this policy as Joint Owners. Any instructions or designations of the prior Owner(s) will continue unless changed in accordance with this policy by the succeeding Owner(s).
- If any subsequent Owner dies at the same time as the Owner or within 5 days after the death of the Owner, ownership of this policy will pass as if the Owner had survived such subsequent Owner.

BENEFICIARY

- Change of Beneficiary** While the Insured is alive, You may change the Beneficiary or any Contingent Beneficiary by sending Us a request. A Beneficiary named irrevocably must consent to any such change.
- Irrevocable Beneficiary** Any Beneficiary may be named an Irrevocable Beneficiary. The consent of any Irrevocable Beneficiary is required for You to exercise any ownership right, except the following:
- Change the frequency of premium payment.
 - Reinstate this policy.
- Payment to Beneficiary** Before making any payment, We may require evidence as to the identity, age, and other facts about any person or class designated as the Beneficiary. We are entitled to make payments based on that evidence.
- Minor Beneficiary** Unless otherwise provided, if any Beneficiary is a minor at the time the death benefit is to be paid, We may make any payment due to the minor Beneficiary to a parent, or any relative by blood or connection by marriage of the Insured, or to any other person who appears to Us to have some responsibility for the minor Beneficiary.

BENEFICIARY (Cont'd)

Minor Beneficiary (Cont'd)

We will make any such payment to the person as the custodian for the minor Beneficiary under the Uniform Transfers to Minors Act of the applicable state in the following order of preference:

- The state in which the minor Beneficiary lives at the time of payment.
- The state in which the custodian lives at the time of payment.

The state of domicile of the Company at the time of payment.

DEATH BENEFIT

Death Benefit

While this policy is in effect, We will pay a death benefit to the Beneficiary if the Insured dies before the Maturity Date. The amount of the death benefit will depend on the Death Benefit Option in effect on the date of death.

Death Benefit Options

Any time prior to the Insured's death, and while this policy is in effect, You may choose either of the following Death Benefit Options:

Option A. The Death Benefit is the greater of:

- The Face Amount shown; or
- The Minimum Death Benefit.

Option B. The Death Benefit is the greater of:

- The account value plus the Face Amount, or
- The Minimum Death Benefit.

Minimum Death Benefit

The minimum death benefit is the account value on the date of death multiplied by the percentage shown in the Minimum Death Benefit Table for the Insured's Age on the date of death. We reserve the right to change the minimum death benefit to comply with any applicable federal or state law or regulation. We will notify You of any such change.

Payment of Death Benefit

Any death benefit due will be paid to the person living on the date of such death in the order which follows:

- The Beneficiary.
- Any Contingent Beneficiary.
- The Insured's estate.

Payment of the death benefit will be made at Our Home Office.

We will require:

- That death occur while this policy is in effect and before the Maturity Date;
- Sufficient proof of the Insured's death on a form We accept; and
- A request for the death benefit is in a form satisfactory to Us.

The death benefit to be paid at the Insured's death will be:

- The amount payable under the Death Benefit Option in effect on the date of death; plus
- Any additional benefit provided by rider; less
- Any unpaid loans and loan interest; less
- Any amount required to fund the monthly deduction through the month in which death occurred, unless that monthly deduction was waived by rider.

If any Beneficiary or Contingent Beneficiary dies at the same time as the Insured or within 5 days after the death of the Insured, the death benefit will be paid as if the Insured had survived such Beneficiary or Contingent Beneficiary.

DEATH BENEFIT (Cont'd)

Interest Paid on Death Benefit

We will pay interest on the death benefit as required by state law.

Suicide Exclusion

If the Insured dies by suicide, while sane or insane, within 2 years from the Effective Date of the policy, We will pay a reduced death benefit equal to:

- The premiums paid; less
- The total monthly cost of insurance deducted for benefits on any person other than the Insured; less
- Any unpaid loans and loan interest; less
- Any partial surrender, including any charge therefor.

If the Insured dies by suicide within 2 years from the effective date of any increase in this policy's Face Amount, any death benefit paid will not include the amount of the increase.

We will limit payment to:

- Any death benefit in effect for more than 2 years which has been adjusted as described in the **Payment of Death Benefit** provision; plus
- The cost of insurance for such increase.

DEATH BENEFIT CHANGES

General

After the first policy year, but not more than once in any policy year, You may submit an application to change the Death Benefit Option or to increase or decrease the Face Amount.

The effective date of change will be the Monthly Date which falls on or next follows the date We approve the application for change.

We will issue a revised POLICY INFORMATION page reflecting any change in the Death Benefit Option or Face Amount. We reserve the right to issue a revised POLICY INFORMATION page in the event of any other change to this policy. Any policy change may be subject to a Policy Change Service Charge, as shown in the POLICY INFORMATION section.

Death Benefit Option

If Option A is changed to Option B, We will require evidence of insurability satisfactory to Us. We will decrease the Face Amount to equal the difference between the amount payable under Option A and the account value on the effective date of change. We will not make this change if the resulting Face Amount would be less than the minimum shown in the POLICY INFORMATION section.

If Option B is changed to Option A, We will increase the Face Amount to equal the amount payable under Option B on the effective date of change.

Increasing Face Amount

You may request an increase in the Face Amount at any time. Any request for an increase in the face amount will be subject to the Company's underwriting guidelines. We reserve the right to refuse a requested increase if the Insured's Attained Age at the effective date of the increase would be greater than the maximum issue age for new policies at that time. The amount of any increase must be at least equal to the Minimum Increase Amount shown in the POLICY INFORMATION section. We will require:

- Evidence of insurability satisfactory to Us;
- That there be enough surrender value to cover the monthly deduction as of the effective date of the increase, or that payment be made to cover the amount needed.

DEATH BENEFIT CHANGES (*Cont'd*)

Decreasing Face Amount

You may decrease the Face Amount. The amount of any decrease must be at least equal to the Minimum Decrease Amount shown in the POLICY INFORMATION section. We will apply a decrease:

- To the most recent increase; then
- To the next most recent increases; then
- To the Initial Face Amount shown in the POLICY INFORMATION section.

The Face Amount which remains in effect must be at least equal to the greater of the minimum shown in the POLICY INFORMATION section or the amount necessary to prevent a return of premium under the **Premium Limitation** provision.

A decrease in the Face Amount will not result in any change to the Planned Premium.

PREMIUMS

Premium Payments

The Initial Premium is due on the Effective Date and must be paid while the Insured is alive and before any insurance coverage becomes effective.

All premium payments:

- Must be paid to Us at Our Home Office or any administrative office that We maintain.
- Must be in the currency of the United States of America.
- May be made by electronic funds transfer or any other method We accept.

We will issue a receipt on request. No premium is to be paid on or after the Maturity Date shown in the POLICY INFORMATION section.

If the instrument provided for payment of the Initial Premium is not honored, this policy will be deemed void from the beginning. An instrument provided for payment of any premium, which is not honored, will not be considered a payment.

Planned and Unscheduled Premium Payments

You may pay Planned Premiums as scheduled in the POLICY INFORMATION section. You may change the amount and frequency of the Planned Premiums, but You must notify Us in advance of any change.

You may make unscheduled premium payments at any time. Unscheduled premiums may not be less than the Minimum Additional Premium Amount shown in the POLICY INFORMATION section.

Premium Limitation Provision

We have the right to refuse to accept any premium payment that would, in Our opinion, cause this policy to fail to qualify as life insurance under applicable tax law.

Continuation of Insurance

You may stop making Your Planned Premium payments at any time. If You stop making Your Planned Premium payments, policy coverage and any rider benefits will continue, unless otherwise terminated, so long as the surrender value is sufficient to cover the monthly deduction. Any remaining surrender value then will be used toward the amount required under the **Grace Period** provision.

This provision will not continue this policy beyond the Maturity Date or any rider beyond its termination date. On the Maturity Date, We will pay any remaining surrender value to You.

PREMIUMS (Cont'd)

Grace Period

We will allow a 61-day grace period when the surrender value is not enough to cover the monthly deduction. If the Insured dies during the grace period, We will pay the death benefit. However, that benefit will be reduced by the amount required to cover the monthly deduction through the month in which death occurred.

At least 31 days before the end of the grace period, We will provide notice of lapse to You and any assignee of record. We will send such notice to Your last known address or as otherwise specified in any agreement between You and Us. The notice will show the amount required to cover the monthly deduction. If that amount is not paid by the end of the grace period, this policy will terminate without value.

REINSTATEMENT

Reinstatement Requirements

If this policy terminates as provided in the **Grace Period** provision, it may be reinstated within 5 years after such termination and before the Maturity Date.

We will require for each life insured under this policy and any attached rider:

- Written application for reinstatement; and
- Evidence sufficient to establish that each insured is insurable at the Premium Class under which the policy was issued; and
- Repayment or reinstatement of any unpaid loans, including loan interest, and any unpaid cost of insurance which existed at the end of the **Grace Period**; and
- Premium sufficient to pay the monthly deductions for at least 3 policy months beginning with the effective date of reinstatement.

You may not reinstate this policy if the policy was surrendered for its surrender value.

Effective Date of Reinstatement

The effective date of reinstatement will be the later of:

- The Monthly Date which falls upon or next follows the date We approve the application for reinstatement; or
- The date We receive any required payment.

Adjustments After Reinstatement

On the effective date of reinstatement, the account value will be:

- The Net Premium received; plus
- The amount of any unpaid loan and loan interest reinstated; minus
- The monthly deduction for that month.

POLICY VALUES

Account Value

The account value on the Effective Date is the initial Net Premium paid less the monthly deduction for the month following the Effective Date.

The account value on any date after the Effective Date will be equal to:

1. The account value on the last Monthly Date; plus
2. Interest to date on (1); plus
3. Any Net Premium received since the last Monthly Date; plus
4. Interest to date on (3) from the date of receipt; minus
5. Any Partial Surrender made since the last Monthly Date; minus
6. Interest to date on (5) from the date of Partial Surrender; minus
7. Any Partial Surrender Service Charge; minus
8. The monthly deduction for the month which follows the last Monthly Date; minus
9. Any Policy Change Service Charge; minus
10. Any information Report Fee.

On any day between Monthly Dates, the account value will reflect interest, payments and partial surrenders to that date.

POLICY VALUES (*Cont'd*)

Surrender Value	The surrender value at any time will be: <ul style="list-style-type: none">• The account value; less• Any unpaid loans and loan interest.
Monthly Deduction	We will make a deduction from the account value on each Monthly Date. It will be: <ul style="list-style-type: none">• The monthly cost of insurance; plus• The cost of any additional benefit provided by rider; plus• The Monthly Expense Charge shown in the POLICY INFORMATION section; plus• Any applicable Administrative Charge as shown in the POLICY INFORMATION section.
Monthly Cost of Insurance	<p>This cost is determined on each Monthly Date. The cost will be equal to (A) multiplied by the result of (B) minus (C) where:</p> <ul style="list-style-type: none">• (A) is the monthly cost of insurance rate divided by 1,000.• (B) is the amount payable under the Death Benefit Option in effect on that date discounted by one month's interest at the Minimum Guaranteed Account Value Interest Rate shown in the POLICY INFORMATION section.• (C) is the account value on that date prior to the monthly deduction. <p>If the POLICY INFORMATION page shows Death Benefit Option A and there have been increases in the Face Amount, then the monthly cost of insurance is determined separately for the Initial Face Amount and any increases. The account value will first be considered a part of the Initial Face Amount. If the account value is more than the Initial Face Amount, the excess will be considered to be part of successive increases in the Face Amount, starting with the first increase.</p>
Monthly Cost of Insurance Rate	For the Initial Face Amount, the rate is based on Age as of the Effective Date, Attained Age, gender, and Premium Class. For any increase in the Face Amount, the rate is based on Age at the date of increase, Attained Age, gender, and Premium Class. We may change the rate from time to time based on Our expectations as to future mortality, investment earnings, expense, and persistency experience. Each change will be on the same basis for all policies of this type in effect for the same length of time issued to Insureds of the same Age, Attained Age, gender, and Premium Class. However, the rate will not be more than that shown in the TABLE OF GUARANTEED MAXIMUM MONTHLY COST OF INSURANCE RATES in the POLICY INFORMATION section.
Interest	<p>We guarantee that We will credit interest at an effective annual rate at least equal to the Minimum Guaranteed Account Value Interest Rate shown in the POLICY INFORMATION section. At Our discretion and acting by authority of Our Board of Directors, We may declare rates of interest in excess of that minimum rate.</p> <p>Subject to the Minimum Guaranteed Account Value Interest Rate, We reserve the right to declare any rate of interest at any time. As a result, the interest rate declared with respect to a particular Net Premium payment may change from time to time and may differ from rates declared with respect to Net Premium payments paid at different times.</p> <p>We will credit interest daily. Once credited, that interest will be guaranteed and become part of the account value.</p> <p>Regardless of the interest rate declared, We will credit the Minimum Guaranteed Account Value Interest Rate shown in the POLICY INFORMATION section to that part of the account value which equals any unpaid loans and loan interest.</p>

POLICY VALUES (*Cont'd*)

Additional Interest

On each policy Anniversary after the year shown under INTEREST INFORMATION in the POLICY INFORMATION section, We may declare and pay additional interest not less than the rate shown, multiplied by an amount equal to the average of (A) and (B) where:

- (A) is the surrender value determined as of the last policy Anniversary;
- (B) is the surrender value determined as of the current policy Anniversary, but before any additional interest due under this paragraph is credited.

If the Insured dies after the year shown in the POLICY INFORMATION section for Additional Account Value Interest and while this policy is in effect, prorated additional interest will be added to the account value based on the number of full policy months elapsed between the last policy Anniversary and the date of death. In this case, for purposes of the calculation above, "(B)" will be determined as of the last Monthly Date on or before the date of death.

No additional interest will be paid on any policy Anniversary if We did not declare an interest rate greater than the Minimum Guaranteed Account Value Interest Rate with respect to any new Net Premium payments paid since the last policy Anniversary.

BASIS OF POLICY VALUES

Cash values equal or exceed those required by the state in which this policy is delivered. A detailed statement of the method used to compute those values has been filed with the insurance department of that state.

POLICY LOANS

Loans

You may borrow against this policy while it is in effect. However, You may not borrow an amount in excess of the loan value.

This policy will be the sole security for any loan. We may delay making a loan for up to 6 months.

Total loans and loan interest together may not equal or exceed [90%] of the account value. Otherwise, this policy will terminate unless continued under the **Grace Period** provision.

Loan Value

The loan value of the contract is:

- The surrender value on the date of the new loan; minus
- Loan interest on the new loan to the next policy Anniversary.

Loan Interest

Loan Interest is charged daily. Annual loan interest is due at the beginning of each policy year. If not paid when due, We will add the interest to the loan and it will bear interest at the same rate.

We may adjust loan interest rates periodically. We will determine the loan interest rate at least once every 12 months, but not more frequently than once in any 3 month period. The loan interest rate will not be more than the higher of:

- The Moody's Corporate Bond Yield Average - Monthly Average Corporates, as published by Moody's Investors Service, Inc. or any successor thereto, for the calendar month ending 2 months before the date on which the loan interest rate is determined; or
- The Minimum Annual Loan Interest Rate shown in the POLICY INFORMATION section

POLICY LOANS (*Cont'd*)

Loan Interest (*Cont'd*) If the Moody's Corporate Bond Yield Average - Monthly Average Corporates is discontinued, We may substitute another substantially similar average, as permitted by the laws of the state where this policy is issued, to determine the loan interest rate.

Repayment You may repay all or part of a loan and loan interest at any time while this policy is in effect.

SURRENDER

Full Surrender You may surrender this policy for its surrender value at any time before the Maturity Date, subject to the terms, conditions and limitations found herein. If such surrender occurs within 30 days after a policy Anniversary, the value will not be less than the surrender value on that Anniversary, less any subsequent loans and partial surrenders.

Partial Surrender You may surrender part of this policy's surrender value after the first policy year but before the Maturity Date, subject to the terms, conditions and limitations found in the POLICY INFORMATION section. The partial surrender and any charge therefor will be made on a pro rata basis.

We will deduct the Partial Surrender Service Charge shown in the POLICY INFORMATION section from the amount surrendered.

For Death Benefit Option A, the Face Amount:

- Will be reduced by the amount of the partial surrender, including any charge therefor.
- Which remains in effect after any such surrender must be at least the minimum shown in the POLICY INFORMATION section.

For Death Benefit Option B, a partial surrender will not impact the face amount.

You may not:

- Request a partial surrender in an amount, including any Partial Surrender Service Charge, which would reduce the surrender value to less than Minimum Account Value After Partial Surrender as shown in the POLICY INFORMATION section.
- Request a partial surrender for an amount less than the Minimum Partial Surrender Amount, as shown in the POLICY INFORMATION section.
- For a policy with Death Benefit Option A, request a partial surrender which would reduce the Face Amount to less than the Minimum Death Benefit.
- Request more than the Maximum Partial Surrenders Allowed Per Year, as shown in the POLICY INFORMATION section.

Surrender Requirements Any full or partial surrender You request must be submitted in a form satisfactory to Us.

Deferral of Payment We reserve the right to defer payment of the surrender value for up to 6 months after We receive Your request. We will pay interest at a rate not less than the minimum rate required by state law if the deferral period is 30 days or more.

METHODS OF SETTLEMENT

Payment of Proceeds Proceeds will become payable under the selected settlement option when:

- The Insured dies; or
- A full surrender occurs; or
- The Maturity Date is reached.

METHODS OF SETTLEMENT (*Cont'd*)

Payment of Proceeds (*Cont'd*)

Payments for a settlement option will be made at Our Home Office. Before making any payment, We may require proof of the existence and identity, including but not limited to the date of birth, of any Payee or the Insured. We may issue an annuity contract to provide payments under a settlement option.

In all cases, We must consent to payment under any option other than Option 2 below if:

- Any Payee is a corporation, partnership, association, trustee, or assignee; or
- The amount left with Us is less than \$2,000; or
- Any annuity or interest payment is less than \$20.

Amount of Payment

The amount of payments received under a settlement option will depend on the:

- Amount of proceeds payable; and
- Settlement option chosen; and
- Payment frequency chosen; and
- Gender and date of birth of the person over whose lifetime payments are made if any life contingent annuity option We offer at that time is chosen.

At the time of payment, We will compare the mortality and interest rate factors reflected in the **Table of Guaranteed Monthly Payments** to the factors reflected in the current rates for any single premium immediate annuities which We may then offer and which the Payee would be eligible to purchase. The payments will be based on whichever factors result in greater payments.

Any annuity contract sent to the Payee will show the settlement option as well as the amount and frequency of annuity payments, all of which will be fixed as of the date the annuity contract is issued.

Interest Paid on Proceeds

We will pay interest on the proceeds as required by state law.

Payee

The Payee(s) will be:

- You, or Your designee, if proceeds are payable on a full surrender or on the Maturity Date; or
- The recipient of the death benefit, if proceeds are payable when the Insured dies.

Election of Option

While the Insured is alive, You may elect or change a settlement option to take effect at the Insured's death. The Payee may not change the election You make. If no option is in effect at the Insured's death, the Payee may elect one. We will make payment under Option 2 if no election is made within 60 days of the Insured's death.

An election to receive proceeds under a settlement option cannot be changed after payments start.

After We record any option election or change, it will take effect on the date the request was signed. That election or change will be subject to any payment made or action taken by Us before We receive the request and record the change.

Additional settlement options may be offered at the time proceeds are payable.

Settlement Option 1: Life Income with a Guaranteed Period

Payments are guaranteed for the number of years chosen which may be neither less than 5 years nor more than 20 years. Payments will continue for as long as the Payee is alive. If the Payee dies before the end of the guaranteed period, We will pay the remaining guaranteed payments as scheduled or a death benefit consisting of the commuted value.

METHODS OF SETTLEMENT (Cont'd)

**Settlement Option 2:
Lump Sum Payment** This option may be used only for proceeds payable upon the death of the Insured. If the Payee elects this lump sum payment option, We may make payment into an interest-bearing checking account established in the name of the Payee. The Payee will be able to withdraw all or part of proceeds in the account at any time. Payment under this option represents full and complete settlement and the Company thereafter maintains no control over the funds disbursed nor the bank account into which they are paid.

Commuted Value The commuted value is determined by discounting the remaining guaranteed payments under the settlement option at an annually compounded interest rate which is 1% more than the rate We used to determine those payments. The commuted value will always be less than the sum of the remaining guaranteed payments. We will calculate the commuted value as of the date We will make such payment.

Death of Payee If the Payee dies, any amount not yet paid, plus any accrued but unpaid interest, will be paid in one lump sum to the Payee's estate.

TABLE OF GUARANTEED MONTHLY PAYMENTS

Minimum Amount for Each \$1,000 Applied

Settlement Option 1. Life Income With a 10 Year Guaranteed Period

Age	Male	Female	Age	Male	Female	Age	Male	Female
50	\$3.76	\$3.53	55	\$4.13	\$3.85	60	\$4.61	\$4.26
51	\$3.83	\$3.59	56	\$4.22	\$3.92	65	\$5.21	\$4.80
52	\$3.90	\$3.65	57	\$4.31	\$4.00	70	\$5.96	\$5.51
53	\$3.97	\$3.71	58	\$4.40	\$4.08	75	\$6.82	\$6.41
54	\$4.05	\$3.78	59	\$4.50	\$4.17			

Payment amounts for other combinations of years, ages, gender, and rates will be furnished on request. Guaranteed Monthly Payments are based on a [2.5%] effective annual interest rate and the [2000 NAIC Individual Annuity Mortality Table].

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USAA LIFE INSURANCE COMPANY
(A Stock Company)

UNIVERSAL LIFE INSURANCE POLICY

NOTICE TO OWNER:

If you need information about this policy or assistance in resolving a question or complaint, please call us at 1-800-531-USAA (8722).

This is a **FLEXIBLE PREMIUM, ADJUSTABLE DEATH BENEFIT UNIVERSAL LIFE INSURANCE POLICY**. Premiums are payable while the Insured is alive, but not beyond the Maturity Date. Death benefit is payable if the Insured dies before the Maturity Date. Surrender value, if any, is payable if the Insured is living on the Maturity Date.

Nonparticipating: Dividends are not payable.

USAA LIFE INSURANCE COMPANY 9800 Fredericksburg Road San Antonio, Texas 78288

LUL88326AR 05-08

88326-0508
LUL291A8

SERFF Tracking Number: PERR-125667167 *State:* Arkansas
Filing Company: USAA Life Insurance Company *State Tracking Number:* 39164
Company Tracking Number: USAA-ULCSO-AR-08-01F
TOI: L09I Individual Life - Flexible Premium *Sub-TOI:* L09I.001 Single Life
Adjustable Life
Product Name: Universal Life Policy
Project Name/Number: USAA-ULCSO-AR-08-01F/USAA-ULCSO-AR-08-01F

Rate Information

Rate data does NOT apply to filing.

SERFF Tracking Number: PERR-125667167 State: Arkansas
Filing Company: USAA Life Insurance Company State Tracking Number: 39164
Company Tracking Number: USAA-ULCSO-AR-08-01F
TOI: L09I Individual Life - Flexible Premium Sub-TOI: L09I.001 Single Life
Adjustable Life
Product Name: Universal Life Policy
Project Name/Number: USAA-ULCSO-AR-08-01F/USAA-ULCSO-AR-08-01F

Supporting Document Schedules

Review Status:
Satisfied -Name: Certification/Notice 05/27/2008
Comments:
Attachment:
AR Certificate of Readability.pdf

Review Status:
Satisfied -Name: Application 05/27/2008
Comments:
Attachments:
LAP50588ST 06-05.pdf
LAP50589ST 06-05.pdf

Review Status:
Satisfied -Name: Supporting Documents 05/28/2008
Comments:
Attachments:
UL Act_memo UL5 NEW UL contract with Appendix - Feb 7.pdf
UL5 Statement of Variability Standard Version _Non-NY_.pdf
Guaranteed monthly COIs for the UL5 filing (2).pdf
USAA Letter of Authorization 2008.pdf
FLESC SCORE INFO FOR LUL88326AR 05-08.pdf

Review Status:
Satisfied -Name: Certifications 06/10/2008
Comments:
Attachments:
ARKANSAS CERTIFICATE OF COMPLIANCE.pdf
CONSENT TO SUBMIT RATES ANDOR COST BASES FOR APPROVAL.pdf

Transmittal Header

SERT-6GPLF7346/00-00/00-00/00
 Created by Tim Stoner on 09/29/2005
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Sent: 09/29/2005 02:05:04 PM
 Other Authors: None
 TOI: Life/Annuity-Individual
 SubTOI: Life-Whole

Filing Information:

Filing Action:	Initial	Filing Date:	09/29/2005
State:	Arkansas	State Instance:	None
State Domain:	None	Identifier:	
Type of Insurance:	Life/Annuity-Individual	Filing Type:	Form
Product Name:	Simplified Life Application	Sub TOI:	Life-Whole
Implementation Date Requested:	None	Effective Date Requested:	None
Project Name:	Simplified Life Application	Project #:	TKS08272005
Fee Required:	No	Fee Amount:	
Reference Filing:	No	Reference Org:	None
Reference #:	None	Advisory Org Circular #:	None

Components sent originally with filing:

SERT-6GPLF7346/00-01/00-00/00
 SERT-6GPLF7346/00-02/00-00/00
 SERT- 6GPLF7346/00-03/00-00/00
 SERT-6GPLF7346/00-04/00-00/00
 SERT-6GPLF7346/00-0 5/00-00/00

Company Contact:

Lead Company: USAA

Filing Company Info	Contact Info
USAA Life Insurance Company 9800 Fredericksburg Road, San Antonio, TX 78288 USA Phone: 800-531-8000 FAX: 210-498-0083 CoCode: 69663 Group Code: 200 FEIN: 74-1472662 State of Domicile: Texas State ID Number: None.	Timothy Stoner Compliance Analyst USAA 9800 Fredericksburg Road, B-1-E, Operations Compliance 47195, San Antonio, TX 78288 Phone: 800-531-8000 ext. 84612 FAX: 210-498-0083 Email: timothy.stoner@usaa.com

Submission Requirements:

Status	Requirement
Satisfied	Cover letter
Satisfied	L/font>
Bypassed	Lont>
Bypassed	L Justification

Tracking Information:

Transmittal Header SERT-6GPLF7346/00-00/00-00/00

Company Tracking #:	None	State Tracking #:	30737
Company Status:	None	State Status:	None
Date Company Status Changed:	None	Date State Status Changed:	None
SERFF Tracking #:	SERT-6GPLF7346/00	Delivery Date:	09/29/2005 02:11:36 PM
SERFF Status:	Closed - Approved	Disposition Date:	10/03/2005
Date SERFF Status Changed:	10/03/2005	Implementation Date:	None
Deemer Date:	None	Effective Date:	None
Reviewers:	Linda Bird, [Receiver]		

Additional State Tracking Numbers

USAA Life Insurance Company 30737

State-Specific Fields:

No State-Specific Fields present for this State.

Filing Description: None

File Attachments: None

Disposition Report

Report Type: Disposition Report

Filing Originally Sent: 09/29/2005 02:05:04 PM

Created by Linda Bird on 10/03/2005

Sent: 10/03/2005 03:03:37 PM

State: Arkansas
SERFF Tracking No.: SERT-6GPLF7346/00-00/00-01/00

Response To: TransmittalHeader
Response To No.: SERT-6GPLF7346/00-00/00-00/00
SERFF Tracking No.:

Lead Company: USAA
Product Name: Simplified Life Application
Filing Date: 09/29/2005 02:05:04 PM

Company: USAA Life Insurance Company
Project Name: Simplified Life Application
Project No.: TKS08272005

State Tracking No.: 30737

Company Tracking No.: None

TOI: Life/Annuity-Individual
Disposition: Approved
Reviewer Phone No.: None

Sub TOI: Life-Whole
SERFF Status: None

No disposition descriptions.

Disposition: Approved
Disposition Date: 10/03/2005
Effective Date: None
Type:
Effective Date: None
Implementation Date: None
Date:
Deemer Date: None
Comments: None

Applies to Components

CH 01/00 --- Cover letter
CH 02/00 --- LBR>CH 03/00 --- L>CH 04/00 --- LJustification
CH 05/00 --- Life Insurance Applications an

File Attachments: None

Component Header

Component 01 – Rev 00
Created by Tim Stoner on 09/29/2005
Assigned To: Linda Bird, [Receiver]
Company List: USAA Life Insurance Company

Sent: 09/29/2005 02:05:04 PM
Other Authors: None
TOI: Life/Annuity-Individual
SubTOI: Life-Whole

Tracking Information:

State: Arkansas
State Tracking #: 30737
Component Status (State): Approved
Disposition Date: None
Implementation Date: None
Deemer Date: None
Effective Date: None
Requirement Status: None

SERFF Tracking #: SERT-6GPLF7346/00-01/00-00/00
Component Status (SERFF): Closed – Approved
Delivery Date: 09/29/2005 02:11:37 PM
Reviewer: Linda Bird, [Receiver]
Reviewer Phone: None
Reviewer Fax: None
Primary Reviewer: None

Component Information:

Component Type: Supporting Documentation
Lead Form Number: LAP50570ST 06-05
Requirement Satisfied: Cover letter
Brief Description: Cover Letter
Filer's Notes: None
Document(s): None

Component Action: Initial
State Specific Code: 200-69663

Company Contact:

Lead Company: USAA

Company Information

USAA Life Insurance Company

Contact

Stoner, Timothy

File Attachments: Cvr Ltr.AR.pdf



9800 Fredericksburg Road
San Antonio, Texas 78288

September 29, 2005

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

USAA Life Insurance Company
NAIC No. 200-69663
FEIN 74-1472662

RE: Form No. LAP50570ST 06-05, *et al.* Life Insurance Application

Sir:

Enclosed please find the above referenced application forms submitted for approval. This is a new application intended for use with existing life policies previously approved by your department, as well as forms that will be used with the application in the underwriting process. We also plan to make this application available on life policies that would be submitted for approval in the future. We are filing the application in 50 other jurisdictions and will modify only to meet respective state requirements:

Form No.	Description	Status
LAP50570ST 06-05, LAP50571ST 06-05	Term Life Insurance Application	New
LAP50580ST 06-05, LAP50581ST 06-05	Whole Life Insurance Application	New
LAP50584ST 06-05, LAP50585ST 06-05	Simplified Whole Life Insurance Application	New
LAP50588ST 06-05, LAP50589ST 06-05	Universal Life Insurance Application	New
LAP50592ST 06-05	7 Year Term Life Insurance Application	New
MUF50593ST 06-05	Examiner's Report	New

LAP50594ST 06-05	Application for Life Insurance Policy Change	New
LUF18294ST 08-05	Foreign Travel Questionnaire	New
LUF07562ST 12-93	Personal Financial Statement	Revised

Notes to Aid in Your Review

The application consists of fixed-text forms that vary only by product, as shown above, and by an additional two pages of underwriting questions. In most cases the insured will receive the shorter form which will be pre-filled based on a telephone conversation with one of our licensed representatives. The insured must sign and return the application. Underwriting information would be obtained at a later date by means of a physical examination (paramed) using form number MUF50593ST 06-05, which would be considered as part of the application and the issued policy. For those insured that are unable to schedule an exam owing to a military deployment or other exigency, we will send the longer version of the application that contains two pages of underwriting questions. The underwriting evaluation will be based on that application without a physical exam.

The application forms will be used for the following life policies previously approved by your department:

Form numbers LAP50570ST 06-05 and LAP50571ST 06-05 will be used to apply for Level Term Life Insurance policy LLT30653AR 10-97, approved May 12, 1998.

Form numbers LAP50580ST 06-05 and LAP50581ST 06-05 will be used to apply for Whole Life Insurance policy LWL42068AR 08-02, approved January 4, 2003.

Form numbers LAP50584ST 06-05 and LAP50585ST 06-05 will be used to apply for Simplified Whole Life Insurance policy LWL39088AR 07-01, approved August 2, 2001.

Form numbers LAP50588ST 06-05 and LAP50589ST 06-05 will be used to apply for Universal Life Insurance policy UL594-0825 6-87, approved December 11, 2001.

Form number LAP50592ST 06-05 will be used to apply for 7 Year Term Insurance policy SY594-0102 2-83, approved September 25, 2003.

The information to complete the application is based on our representative's telephone conversation with the proposed insured. This does not constitute taking an application over the phone. It is taking the information for the application so that when the form arrives in the mail it will have been completed as fully as possible for the convenience of the applicant. In most cases all that will be required is for the proposed insured to review and sign the application. The application will be delivered by regular mail or by email, and may be submitted with an e-signature using existing procedures for the delivery of our applications by email.

The Medical Examiner's Report (MUF50593ST 06-05) is a separate part of the application used to gather detailed information for underwriting, as described above. It will be used when the "short" form of the application is sent.

The Application for Policy Change (LAP50594ST 06-05) is used for changes to the policy after issue.

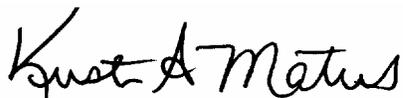
Both the Foreign Travel Questionnaire (LUF18294ST 08-05) and the Personal Financial Statement (LUF07562ST 12-93) will be used only when additional information is needed by underwriting; these forms will be sent out as needed and will not accompany every application.

In all cases the application will meet the readability requirements of our state.

We may modify the application for use with other products in the future, in which case we would notify you by informational filing.

Should you have any questions or concerns, please contact Timothy Stoner toll free at 1-800-531-8000, extension 84612. You may also dial direct at (210) 498-4612. Fax is available at (210) 498-0083, and Tim's email account is Timothy.Stoner@usaa.com.

Sincerely,

A handwritten signature in black ink that reads "Kristi Matus". The signature is written in a cursive style with a large initial "K" and "M".

Kristi Matus
President
USAA Life Insurance Company

Component Header

Component 02 – Rev 00
Created by Tim Stoner on 09/29/2005
Assigned To: Linda Bird, [Receiver]
Company List: USAA Life Insurance Company

Sent: 09/29/2005 02:05:04 PM
Other Authors: None
TOI: Life/Annuity-Individual
SubTOI: Life-Whole

Tracking Information:

State: Arkansas
State Tracking #: 30737
Component Status (State): Approved
Disposition Date: None
Implementation Date: None
Deemer Date: None
Effective Date: None
Requirement Status: None

SERFF Tracking #: SERT-6GPLF7346/00-02/00-00/00
Component Status (SERFF): Closed – Approved
Delivery Date: 09/29/2005 02:11:37 PM
Reviewer: Linda Bird, [Receiver]
Reviewer Phone: None
Reviewer Fax: None
Primary Reviewer: None

Component Information:

Component Type: Supporting Documentation
Component Action: Initial
Lead Form Number: LAP50570ST 06-05
State Specific Code: 200-69663
Requirement: L/FONT>
Satisfied:
Brief Description: Certification of Compliance with Reg 19 and Certification of Readability
Filer's Notes: None
Document(s): None

Company Contact:

Lead Company: USAA

Company Information

USAA Life Insurance Company

Contact

Stoner, Timothy

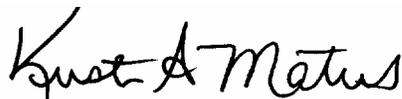
File Attachments: Certif of Compliance with Rule 19.pdf, Certificate of Readability.AR.pdf

Certificate of Compliance with Arkansas Rule and Regulation 19

Insurer: USAA Life Insurance Company

Form Number(s): LAP50570ST 06-05, LAP50571ST 06-05, LAP50580ST 06-05, LAP50581ST 06-05,
LAP50584ST 06-05, LAP50585ST 06-05, LAP50588ST 06-05, LAP50589ST 06-05,
LAP50592ST 06-05, MUF50593ST 06-05, LAP50594ST 06-05,
LUF18294ST 08-05, LUF07562ST 12-93

I hereby certify that the filing above meets all applicable Arkansas requirements including the requirements of Rule and Regulation 19.



Signature of Company Officer

Kristi A. Matus

Name

President

Title

September 29, 2005

Date

CERTIFICATE OF READABILITY

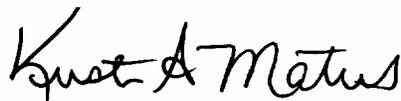
September 29, 2005

Form #	Description	Flesch Score
LAP50570ST 06-05	Term Life Insurance Application	41
LAP50571ST 06-05	Term Life Insurance Application	44
LAP50580ST 06-05	Whole Life Insurance Application	41
LAP50581ST 06-05	Whole Life Insurance Application	45
LAP50584ST 06-05	Simplified Whole Life Insurance Application	40
LAP50585ST 06-05	Simplified Whole Life Insurance Application	44
LAP50588ST 06-05	Universal Life Insurance Application	40
LAP50589ST 06-05	Universal Life Insurance Application	43
LAP50592ST 06-05	7 Year Term Life Insurance Application	42
MUF50593ST 06-05	Examiner's Report	51
LAP50594ST 06-05	Application for Life Insurance Policy Change	42
LUF18294ST 08-05	Foreign Travel Questionnaire	53
LUF07562ST 12-93	Personal Financial Statement	46

The print is ten point type, one point leaded.

The text was Flesch scored by computer.

I certify that to the best of my knowledge and belief, the above referenced forms meet or exceed the readability, legibility, and format requirements of any applicable laws and regulations of the state of Arkansas.



Kristi A. Matus
President
USAA Life Insurance Company

Component Header

Component 03 – Rev 00
Created by Tim Stoner on 09/29/2005
Assigned To: Linda Bird, [Receiver]
Company List: USAA Life Insurance Company

Sent: 09/29/2005 02:05:04 PM
Other Authors: None
TOI: Life/Annuity-Individual
SubTOI: Life-Whole

Tracking Information:

State: Arkansas
State Tracking #: 30737
Component Status (State): Approved
Disposition Date: None
Implementation Date: None
Deemer Date: None
Effective Date: None
Requirement Status: Bypassed
Reason: Please see Component 5 for all forms.

SERFF Tracking #: SERT-6GPLF7346/00-03/00-00/00
Component Status (SERFF): Closed – Approved
Delivery Date: 09/29/2005 02:11:36 PM
Reviewer: Linda Bird, [Receiver]
Reviewer Phone: None
Reviewer Fax: None
Primary Reviewer: None

Component Information:

Component Type: Form
Lead Form Number: LAP50570ST 06-05
Form Title: Term Life Insurance Application
Readability Score: None
Requirement Satisfied: LONT>
Brief Description: None
Filer's Notes: None
Document(s): None

Component Action: Initial
State Specific Code: 200-69663
Company Form Number: None
Replaces Form Number: None

Company Contact:

Lead Company: USAA

Company Information

USAA Life Insurance Company

Contact

Stoner, Timothy

File Attachments: None

Component Header

Component 04 – Rev 00
Created by Tim Stoner on 09/29/2005
Assigned To: Linda Bird, [Receiver]
Company List: USAA Life Insurance Company

Sent: 09/29/2005 02:05:04 PM
Other Authors: None
TOI: Life/Annuity-Individual
SubTOI: Life-Whole

Tracking Information:

State:	Arkansas	SERFF Tracking #:	SERT-6GPLF7346/00-04/00-00/00
State Tracking #:	30737	Component Status (SERFF):	Closed – Approved
Component Status (State):	Approved	Delivery Date:	09/29/2005 02:11:38 PM
Disposition Date:	None	Reviewer:	Linda Bird, [Receiver]
Implementation Date:	None	Reviewer Phone:	None
Deemer Date:	None	Reviewer Fax:	None
Effective Date:	None	Primary Reviewer:	None
Requirement Status:	Bypassed		
Reason:	Not required. This is application only, not policy.		

Component Information:

Component Type:	Form	Component Action:	Initial
Lead Form Number:	LAP50570ST 06-05	State Specific Code:	200-69663
Form Title:	Term Life Insurance Application	Company Form Number:	None
Readability Score:	None	Replaces Form Number:	None
Requirement Satisfied:	L Justification		
Brief Description:	None		
Filer's Notes:	None		
Document(s):	None		

Company Contact:

Lead Company: USAA

Company Information

USAA Life Insurance Company

Contact

Stoner, Timothy

File Attachments: None

Component Header

Component 05 – Rev 00
Created by Tim Stoner on 09/29/2005
Assigned To: Linda Bird, [Receiver]
Company List: USAA Life Insurance Company

Sent: 09/29/2005 02:05:04 PM
Other Authors: None
TOI: Life/Annuity-Individual
SubTOI: Life-Whole

Tracking Information:

State: Arkansas
State Tracking #: 30737
Component Status (State): Approved
Disposition Date: None
Implementation Date: None
Deemer Date: None
Effective Date: None
Requirement Status: None

SERFF Tracking #: SERT-6GPLF7346/00-05/00-00/00
Component Status (SERFF): Closed – Approved
Delivery Date: 09/29/2005 02:11:38 PM
Reviewer: Linda Bird, [Receiver]
Reviewer Phone: None
Reviewer Fax: None
Primary Reviewer: None

Component Information:

Component Type: Form
Lead Form Number: LAP50570ST 06-05
Form Title: Term Life Insurance Application
Readability Score: None
Requirement Satisfied: N/A
Brief Description: Life Insurance Applications and associated forms
Filer's Notes: None
Document(s): None

Component Action: Initial
State Specific Code: 200-69663
Company Form Number: None
Replaces Form Number: None

Company Contact:

Lead Company: USAA

Company Information

USAA Life Insurance Company

Contact

Stoner, Timothy

File Attachments:

LAP50570ST 06-05.PDF, LAP50571ST 06-05.PDF, LAP50580ST 06-05.PDF, LAP50581ST 06-05.PDF, LAP50584ST 06-05.PDF, LAP50585ST 06-05.PDF, LAP50588ST 06-05.PDF, LAP50589ST 06-05.PDF, LAP50592ST 06-05.PDF, MUF50593ST 06-05.pdf, LAP50594ST 06-05.pdf, LUF07652ST 12-93.pdf, LUF18294ST 08-05.pdf



9800 Fredericksburg Road
San Antonio, Texas 78288

Term Life Insurance Application

Step 1. Verify and complete the following information. Make changes to incorrect information directly on this application. Initial each change.

Step 2. Return completed and signed application to USAA Life.

IMPORTANT INFORMATION. Federal law requires us to obtain, verify and record your name, address, date of birth and other information that will allow us to identify you when you open an account and in certain other circumstances.

Personal Information

A. Insured

USAA Number _____ Social Security Number _____ / / _____
Date of Birth (mm/dd/yyyy)

Name _____

Mailing Address _____

Physical/Residence Address _____

Residence Phone Number (include area code) _____ E-mail Address _____

Occupation _____ \$
Annual Income _____

Branch of Service _____ Rank _____ Military Status _____

Female Male

Gender _____ State of Birth _____ Driver's License Number _____ State of Issue _____

Are you a U.S. citizen? Yes No

What is your total amount of life insurance protection, current and pending, excluding this application? _____

Is this application for insurance intended to replace, discontinue or change any life insurance or annuities?

Yes No If yes, list details. (Attach an additional sheet of paper if more space is needed.)

Annuity

Life Insurance \$

Company Name _____ Amount _____ Policy/ Contract Number _____

Annuity

Life Insurance \$

Company Name _____ Amount _____ Policy/ Contract Number _____

B. Owner

USAA Number _____ Social Security Number _____ / / _____
(or Tax ID Number) (If trust, provide date of inception.)

Name (If trust, provide name of trust and trustee.) _____ Relationship to Insured _____

Mailing Address _____

Physical/Residence Address _____

Residence Phone Number (include area code) _____ E-mail Address _____

Are you a U.S. citizen? Yes No

USAA Life Insurance Company ▪ (888) 275-5330 ▪ Fax (877) 435-7099 ▪ usaa.com

C. Payor

USAA Number _____ Social Security Number (or Tax ID Number) _____ Date of Birth (mm/dd/yyyy) (If trust, provide date of inception.) _____ / _____ / _____

Name (If trust, provide name of trust and trustee.) _____

Mailing Address _____

Physical/Residence Address _____

Residence Phone Number (include area code) _____

E-mail Address _____

Are you a U.S. citizen? Yes No

Product and Optional Coverages

A. Product

Insurance Product Name _____ \$ Insurance Amount _____

B. Optional Coverage

Disability Waiver of Premium (age 55 or younger) Accidental Death Benefit (ADB) (age 60 or younger) \$ _____ Amount _____

C. Child Protection Plan \$ _____ Amount of Child Rider Insurance (age 17 or younger)

Child's Name _____ Social Security Number _____ Date of Birth (mm/dd/yyyy) _____ / _____ / _____

What is this child's total amount of life insurance protection, current and pending, excluding this application? \$ _____

Is this application for insurance intended to replace, discontinue or change any life insurance or annuities? Yes No If yes, list details. (Attach an additional sheet of paper if more space is needed.)

Annuity Life Insurance \$ _____

Company Name _____ Amount _____ Policy/ Contract Number _____

Child's Name _____ Social Security Number _____ Date of Birth (mm/dd/yyyy) _____ / _____ / _____

What is this child's total amount of life insurance protection, current and pending, excluding this application? \$ _____

Is this application for insurance intended to replace, discontinue or change any life insurance or annuities? Yes No If yes, list details. (Attach an additional sheet of paper if more space is needed.)

Annuity Life Insurance \$ _____

Company Name _____ Amount _____ Policy/ Contract Number _____

Attach an additional sheet of paper if more than two children.

Beneficiary Information

Primary Beneficiary Name (If trust, provide name of trust.) Social Security Number (or Tax ID Number) Date of Birth (mm/dd/yyyy) Relationship to Insured (If trust, provide date of inception.)

Contingent Beneficiary Name (If trust, provide name of trust.) Social Security Number (or Tax ID Number) Date of Birth (mm/dd/yyyy) Relationship to Insured (If trust, provide date of inception.)

Attach an additional sheet of paper if more space is needed.

Payment Information

A. Method

Automatic Payment Plan (APP): \$ (For APP, complete section C. Financial Information) Direct Billing: \$ Monthly Government Allotment : \$

B. Frequency of Payment

Monthly (not available with Direct Billing) Quarterly Semi-Annually Annually

C. Financial Information (Complete only if APP is selected.)

I authorize USAA Life Insurance Company to make electronic withdrawals and deposits to my account listed below until I notify USAA Life that I terminate authorization and USAA Life has reasonable time to act. I acknowledge that the origination of Automated Clearing House (ACH) transactions to my account must comply with U.S. law.

Specify a day between the 1st and 28th of the month for payment. Day

Checking Savings

Name of Financial Institution Name(s) of Account Holder Type of Account

Transit Routing Number (the nine-digit number in the lower-left corner of check or deposit slip) Account Number

X Signature of Account Holder Date (mm/dd/yyyy)

Additional Information

Provide any additional information or details you want considered below.

Four horizontal lines for providing additional information.

Read and Sign

Effective Date of Coverage: I agree that, except as provided in the company's Temporary Insurance Agreement, no insurance coverage will take effect prior to delivery of the policy to the Owner and then only if all of the following conditions have been met:

- (1) the health and insurability of each person is as stated in this application and in additional parts (if applicable), and the company is immediately notified in writing of any changes; and
- (2) the company has received the first full premium payment while each person is alive.

If the above conditions have been met, coverage under the policy will be effective on the date the policy is delivered to the Owner; provided however, that if a later effective date has been requested, coverage under the policy will be effective on that later date. I understand that any insurance coverage issued will be subject to the suicide and incontestability provisions of the policy. These provisions begin on the effective date.

Insurance Fraud Warning

Arkansas, Louisiana, New Mexico, Ohio, West Virginia:

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

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 or a denial of insurance benefits.

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.

Kentucky, 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.

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.

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.

Authorization: I understand the information obtained by use of this Authorization will be used by USAA Life to determine my eligibility for life insurance. I understand that information released pursuant to this Authorization may no longer be protected by federal privacy regulations and could be subject to redisclosure. I understand that although this authorization is voluntary, USAA Life reserves the right to decline to issue the insurance applied for if I refuse to grant this authorization.

I authorize the following persons and organizations to provide information to USAA Life Insurance Company ("USAA Life"): (a) any licensed physician; (b) any medical practitioner; (c) any hospital; (d) any insurance company; (e) any clinic, Veteran's Administration clinic, or medically-related facility; (f) Medical Information Bureau (MIB); (g) any psychiatrist or psychologist; (h) any health facility; (i) any consumer reporting agency.

For purposes of this Authorization, "information" means any records or knowledge concerning any insured's health or mental condition, general character and driving record.

This includes the release of the entire medical record of any Insured including all information about AIDS, HIV, drugs, alcoholism, or mental illness. This Authorization overrides any existing agreement to restrict information pursuant to 45 CFR 164.522.

I further authorize a consumer reporting agency to make an investigative report on me if it is requested by USAA Life and expect to be interviewed if a report is prepared.

I authorize the above listed sources to provide records or knowledge to any agency employed by USAA Life to collect and transmit such information. A reproduction of this Authorization shall be as valid as the original. I agree this Authorization shall be valid for twenty-four (24) months from the date signed, and upon request I or my authorized representative can receive a copy of this Authorization. I understand that I may revoke this Authorization by sending a written request to USAA Life. A revocation does not affect any action taken by USAA Life in reliance on the authorization prior to the revocation, nor does it have any effect on any right of contestability under the policy.

I have read and understand this authorization. I have received, read and understand the enclosed Notice of Privacy and Disclosure Practices.

Acknowledgment: I have read the questions and answers in this application. I represent that all statements and answers provided in this application and as part of the application process are true, complete and correctly recorded and will be relied upon by USAA Life Insurance Company to form the basis of any policy which may be issued. I agree that a copy of this application, if approved, will be a part of any policy issued. I understand I may not receive an illustration until the policy is issued.

Printed Name of Insured

X
Signature of Insured _____ Date (mm/dd/yyyy) _____ City _____ State _____

X
Signature of Owner (if different than Insured) _____ Date (mm/dd/yyyy) _____

X
Signature of Custodial Parent of Child (if Child Protection Plan selected) _____ Date (mm/dd/yyyy) _____



9800 Fredericksburg Road
San Antonio, Texas 78288

Term Life Insurance Application

Step 1. Verify and complete the following information. Make changes to incorrect information directly on this application. Initial each change.

Step 2. Return completed and signed application to USAA Life.

IMPORTANT INFORMATION. Federal law requires us to obtain, verify and record your name, address, date of birth and other information that will allow us to identify you when you open an account and in certain other circumstances.

Personal Information

A. Insured

USAA Number _____ Social Security Number _____ Date of Birth (mm/dd/yyyy) _____ / _____ / _____

Name _____

Mailing Address _____

Physical/Residence Address _____

Residence Phone Number (include area code) _____ E-mail Address _____

Occupation _____ Annual Income \$ _____

Branch of Service _____ Rank _____ Military Status _____

Female Male

Gender _____ State of Birth _____ Driver's License Number _____ State of Issue _____

Are you a U.S. citizen? Yes No

What is your total amount of life insurance protection, current and pending, excluding this application? _____

Is this application for insurance intended to replace, discontinue or change any life insurance or annuities?

Yes No If yes, list details. (Attach an additional sheet of paper if more space is needed.)

Annuity

Life Insurance \$ _____

Company Name _____ Amount _____ Policy/ Contract Number _____

Annuity

Life Insurance \$ _____

Company Name _____ Amount _____ Policy/ Contract Number _____

B. Owner

USAA Number _____ Social Security Number (or Tax ID Number) _____ Date of Birth (mm/dd/yyyy) (If trust, provide date of inception.) _____ / _____ / _____

Name (If trust, provide name of trust and trustee.) _____ Relationship to Insured _____

Mailing Address _____

Physical/Residence Address _____

Residence Phone Number (include area code) _____ E-mail Address _____

Are you a U.S. citizen? Yes No

USAA Life Insurance Company ▪ (888) 275-5330 ▪ Fax (877) 435-7099 ▪ usaa.com

C. Payor

USAA Number _____ Social Security Number (or Tax ID Number) _____ Date of Birth (mm/dd/yyyy) (If trust, provide date of inception.) _____ / _____ / _____

Name (If trust, provide name of trust and trustee.) _____

Mailing Address _____

Physical/Residence Address _____

Residence Phone Number (include area code) _____

E-mail Address _____

Are you a U.S. citizen? Yes No

Product and Optional Coverages

A. Product

Insurance Product Name _____ \$ Insurance Amount _____

B. Optional Coverage

Disability Waiver of Premium (age 55 or younger) Accidental Death Benefit (ADB) \$ _____ (age 60 or younger) Amount _____

C. Child Protection Plan \$ _____ (age 17 or younger) Amount of Child Rider Insurance _____

Child's Name _____ Social Security Number _____ Date of Birth (mm/dd/yyyy) _____ / _____ / _____

What is this child's total amount of life insurance protection, current and pending, excluding this application? \$ _____

Is this application for insurance intended to replace, discontinue or change any life insurance or annuities? Yes No If yes, list details. (Attach an additional sheet of paper if more space is needed.)

Annuity Life Insurance \$ _____

Company Name _____ Amount _____ Policy/ Contract Number _____

Child's Name _____ Social Security Number _____ Date of Birth (mm/dd/yyyy) _____ / _____ / _____

What is this child's total amount of life insurance protection, current and pending, excluding this application? \$ _____

Is this application for insurance intended to replace, discontinue or change any life insurance or annuities? Yes No If yes, list details. (Attach an additional sheet of paper if more space is needed.)

Annuity Life Insurance \$ _____

Company Name _____ Amount _____ Policy/ Contract Number _____

Attach an additional sheet of paper if more than two children.

Beneficiary Information

Primary Beneficiary Name (If trust, provide name of trust.) Social Security Number (or Tax ID Number) Date of Birth (mm/dd/yyyy) (If trust, provide date of inception.) Relationship to Insured

Contingent Beneficiary Name (If trust, provide name of trust.) Social Security Number (or Tax ID Number) Date of Birth (mm/dd/yyyy) (If trust, provide date of inception.) Relationship to Insured

Attach an additional sheet of paper if more space is needed.

Payment Information

A. Method

Automatic Payment Plan (APP): \$ _____ (For APP, complete section C. Financial Information) Direct Billing: \$ _____
 Monthly Government Allotment : \$ _____

B. Frequency of Payment

Monthly (not available with Direct Billing) Quarterly Semi-Annually Annually

C. Financial Information (Complete only if APP is selected.)

I authorize USAA Life Insurance Company to make electronic withdrawals and deposits to my account listed below until I notify USAA Life that I terminate authorization and USAA Life has reasonable time to act. I acknowledge that the origination of Automated Clearing House (ACH) transactions to my account must comply with U.S. law.

Specify a day between the 1st and 28th of the month for payment. _____
Day

Checking
 Savings

Name of Financial Institution Name(s) of Account Holder Type of Account

Transit Routing Number (the nine-digit number in the lower-left corner of check or deposit slip) Account Number

X
Signature of Account Holder Date (mm/dd/yyyy)

Additional Information

Provide any additional information or details you want considered below.

Medical Information (This section must be completed to acquire life insurance.)

A. Medical Questionnaire

Complete this section for all Insured individuals, including any person to be covered by the Child Protection Plan. Provide details for any "Yes" answer in the Medical Details section.

		Insured	Insured Children (If Child Protection Plan is selected)
1. What is your current height and weight? _____ Feet _____ Inches _____ Lbs.			
2. Has there been any change in weight during the last 12 months for any Insured? If yes, indicate gain or loss. Gain _____ Lbs. Loss _____ Lbs.		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
3. Is any Insured currently receiving regular medical consultation?		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
4. Has any Insured consulted with a health care provider for a routine physical in the last 12 months?		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
5. Has any Insured ever consulted with a health care provider for:			
a.	seizures, paralysis, stroke, depression, anxiety or other mental or nervous system disorder?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
b.	asthma, emphysema, pneumonia or other respiratory system disorder?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
c.	chest pain, high blood pressure, murmur, heart attack or other heart or blood vessel disorder?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
d.	disorder of the throat, esophagus, stomach, intestines, rectum, liver or pancreas?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
e.	abnormal urine test or other disorder of the kidney, ureter or bladder?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
f.	diabetes or other endocrine or thyroid disorder?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
g.	arthritis, collagen vascular disease or disorder of the muscles, bones or skin?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
h.	any cancer or tumor?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
i.	disorder of the prostate or reproductive system?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
j.	hepatitis, anemia, disorder of the blood or lymph glands?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
6. Is any Insured currently taking prescription medication not previously disclosed?		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
7. Has any Insured been diagnosed for Human Immunodeficiency Virus (HIV) Infection, Acquired Immune Deficiency Syndrome (AIDS), AIDS-related complex (ARC), AIDS-related condition, or a sexually transmitted disease?		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
8. Has any Insured, within the past five years:			
a.	had an electrocardiogram, X-ray or any other diagnostic test or procedure that was not previously disclosed?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
b.	been advised to have any diagnostic test, hospitalization or surgery which was not completed?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
9. Has any Insured had an application for life or health insurance declined, postponed, modified or rated?		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
10. Has any Insured ever used an illegal drug or used a controlled substance without a physician's approval?		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
11. Has any Insured been diagnosed or treated for alcohol or drug abuse or been advised by a health care professional to discontinue the use of alcohol or to seek treatment for drug or alcohol dependency?		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
12. Has any Insured consulted a health care provider for any reason not previously disclosed?		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
13. Did your biological mother or father die before the age of 60 from cardiovascular disease or cancer?		<input type="checkbox"/> Yes <input type="checkbox"/> No	Not Applicable

B. Medical Details - Attach an additional sheet of paper if more space is needed.

Question Insured's name Date of Visit Physician's Name

Physician's Address

Reason For Visit

Type of Treatment Medication Prescribed (if any)

B. Medical Details - Attach an additional sheet of paper if more space is needed.

Question Insured's name

Personal Profile (This section must be completed to acquire life insurance.)

Complete this section for all Insured individuals, including any person to be covered by the Child Protection Plan.

	Insured	Insured Children (If Child Protection Plan is selected)	
1. Have you ever used any form of tobacco or nicotine substitute?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Not Applicable	
Form of Tobacco or Nicotine Substitute Date of Last Use How Often Used			
2. Has any Insured flown as a pilot, crew member or student pilot in the past two years or does any Insured plan to do so in the next year?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
DESCRIPTION	TYPE(S) OF AIRCRAFT	HOURS FLOWN	
MILITARY		NEXT 12 MOS LAST 12 MOS 13-24 MOS AGO	
COMMERCIAL			
CIVILIAN/PLEASURE			
TOTAL PILOT-IN-COMMAND HOURS: _____ MILITARY _____ CIVILIAN/PLEASURE			
3. Has any Insured participated in any of the following activities in the past three years or does any Insured plan to do so in the next year?	Automobile Racing	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No	
	Ballooning	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No	
	Hang-Gliding	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No	
	Motorcycle Racing	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No	
	Powerboat Racing	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No	
	Rock/Mountain Climbing	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No	
	Scuba Diving	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No	
	Skydiving/Parachuting	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No	
Ultralight Flying	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No		
Activity	Last Activity Date	Frequency	Details (speeds attained, depths/heights reached, etc.)
4. Does any Insured plan to travel to or reside in a foreign country within the next 12 months?		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Country's Name	Purpose of Visit		Length of Stay
5. Has any Insured ever been convicted of Driving While Intoxicated or Driving Under the Influence or ever had a driver's license suspended or revoked or had any moving violations within the last three years?		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Violation Type	Date	Details (speeds, length of suspension/revocation, etc.)	

Attach an additional sheet of paper if more space is needed.

Read and Sign

Effective Date of Coverage: I agree that, except as provided in the company's Temporary Insurance Agreement, no insurance coverage will take effect prior to delivery of the policy to the Owner and then only if all of the following conditions have been met:

- (1) the health and insurability of each person is as stated in this application and in additional parts (if applicable), and the company is immediately notified in writing of any changes; and
- (2) the company has received the first full premium payment while each person is alive.

If the above conditions have been met, coverage under the policy will be effective on the date the policy is delivered to the Owner; provided however, that if a later effective date has been requested, coverage under the policy will be effective on that later date. I understand that any insurance coverage issued will be subject to the suicide and incontestability provisions of the policy. These provisions begin on the effective date.

Insurance Fraud Warning

Arkansas, Louisiana, New Mexico, Ohio, West Virginia:

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

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 or a denial of insurance benefits.

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.

Kentucky, 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.

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.

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.

Authorization: I understand the information obtained by use of this Authorization will be used by USAA Life to determine my eligibility for life insurance. I understand that information released pursuant to this Authorization may no longer be protected by federal privacy regulations and could be subject to redisclosure. I understand that although this authorization is voluntary, USAA Life reserves the right to decline to issue the insurance applied for if I refuse to grant this authorization.

I authorize the following persons and organizations to provide information to USAA Life Insurance Company ("USAA Life"): (a) any licensed physician; (b) any medical practitioner; (c) any hospital; (d) any insurance company; (e) any clinic, Veteran's Administration clinic, or medically-related facility; (f) Medical Information Bureau (MIB); (g) any psychiatrist or psychologist; (h) any health facility; (i) any consumer reporting agency.

For purposes of this Authorization, "information" means any records or knowledge concerning any insured's health or mental condition, general character and driving record.

This includes the release of the entire medical record of any Insured including all information about AIDS, HIV, drugs, alcoholism, or mental illness. This Authorization overrides any existing agreement to restrict information pursuant to 45 CFR 164.522.

I further authorize a consumer reporting agency to make an investigative report on me if it is requested by USAA Life and expect to be interviewed if a report is prepared.

I authorize the above listed sources to provide records or knowledge to any agency employed by USAA Life to collect and transmit such information. A reproduction of this Authorization shall be as valid as the original. I agree this Authorization shall be valid for twenty-four (24) months from the date signed, and upon request I or my authorized representative can receive a copy of this Authorization. I understand that I may revoke this Authorization by sending a written request to USAA Life. A revocation does not affect any action taken by USAA Life in reliance on the authorization prior to the revocation, nor does it have any effect on any right of contestability under the policy.

I have read and understand this authorization. I have received, read and understand the enclosed Notice of Privacy and Disclosure Practices.

Acknowledgment: I have read the questions and answers in this application. I represent that all statements and answers provided in this application and as part of the application process are true, complete and correctly recorded and will be relied upon by USAA Life Insurance Company to form the basis of any policy which may be issued. I agree that a copy of this application, if approved, will be a part of any policy issued. I understand I may not receive an illustration until the policy is issued.

Printed Name of Insured

X
Signature of Insured _____ Date (mm/dd/yyyy) _____ City _____ State _____

X
Signature of Owner (if different than Insured) _____ Date (mm/dd/yyyy) _____

X
Signature of Custodial Parent of Child (if Child Protection Plan selected) _____ Date (mm/dd/yyyy) _____



9800 Fredericksburg Road
San Antonio, Texas 78288

Competitive Whole Life Insurance Application

Step 1. Verify and complete the following information. Make changes to incorrect information directly on this application. Initial each change.

Step 2. Return completed and signed application to USAA Life.

IMPORTANT INFORMATION. Federal law requires us to obtain, verify and record your name, address, date of birth and other information that will allow us to identify you when you open an account and in certain other circumstances.

Personal Information

A. Insured

USAA Number _____ Social Security Number _____ Date of Birth (mm/dd/yyyy) _____ / _____ / _____

Name _____

Mailing Address _____

Physical/Residence Address _____

Residence Phone Number (include area code) _____ E-mail Address _____

Occupation _____ Annual Income \$ _____

Branch of Service _____ Rank _____ Military Status _____

Female Male

Gender _____ State of Birth _____ Driver's License Number _____ State of Issue _____

Are you a U.S. citizen? Yes No

What is your total amount of life insurance protection, current and pending, excluding this application? _____

Is this application for insurance intended to replace, discontinue or change any life insurance or annuities?

Yes No If yes, list details. (Attach an additional sheet of paper if more space is needed.)

Annuity

Life Insurance \$ _____

Company Name _____ Amount _____ Policy/ Contract Number _____

Annuity

Life Insurance \$ _____

Company Name _____ Amount _____ Policy/ Contract Number _____

B. Owner

USAA Number _____ Social Security Number (or Tax ID Number) _____ Date of Birth (mm/dd/yyyy) (If trust, provide date of inception.) _____ / _____ / _____

Name (If trust, provide name of trust and trustee.) _____ Relationship to Insured _____

Mailing Address _____

Physical/Residence Address _____

Residence Phone Number (include area code) _____ E-mail Address _____

Are you a U.S. citizen? Yes No

USAA Life Insurance Company ▪ (888) 275-5330 ▪ Fax (877) 435-7099 ▪ usaa.com

C. Payor

USAA Number _____ Social Security Number (or Tax ID Number) _____ Date of Birth (mm/dd/yyyy) (If trust, provide date of inception.) _____ / _____ / _____

Name (If trust, provide name of trust and trustee.) _____

Mailing Address _____

Physical/Residence Address _____

Residence Phone Number (include area code) _____

E-mail Address _____

Are you a U.S. citizen? Yes No

Product and Optional Coverages

A. Product

Insurance Product Name _____ Insurance Amount \$ _____

Applied to Purchase Paid up Additions Applied to Reduce Premiums Paid in Cash Left to Accumulate at Interest Applied to Purchase 1 Year Term Additions

Dividend Option _____

B. Optional Coverage

Disability Waiver of Premium (age 55 or younger) Accidental Death Benefit (ADB) (age 60 or younger) \$ _____ Amount Paid-Up Additions Rider (PUAR)

C. Child Protection Plan \$ _____ Amount of Child Rider Insurance (age 17 or younger)

Child's Name _____ Social Security Number _____ Date of Birth (mm/dd/yyyy) _____ / _____ / _____

What is this child's total amount of life insurance protection, current and pending, excluding this application? \$ _____

Is this application for insurance intended to replace, discontinue or change any life insurance or annuities? Yes No If yes, list details. (Attach an additional sheet of paper if more space is needed.)

Annuity Life Insurance \$ _____

Company Name _____ Amount _____ Policy/ Contract Number _____

Child's Name _____ Social Security Number _____ Date of Birth (mm/dd/yyyy) _____ / _____ / _____

What is this child's total amount of life insurance protection, current and pending, excluding this application? \$ _____

Is this application for insurance intended to replace, discontinue or change any life insurance or annuities? Yes No If yes, list details. (Attach an additional sheet of paper if more space is needed.)

Annuity Life Insurance \$ _____

Company Name _____ Amount _____ Policy/ Contract Number _____

Attach an additional sheet of paper if more than two children.

Beneficiary Information

Primary Beneficiary Name (If trust, provide name of trust.)	Social Security Number (or Tax ID Number)	Date of Birth (mm/dd/yyyy) (If trust, provide date of inception.)	Relationship to Insured
Contingent Beneficiary Name (If trust, provide name of trust.)	Social Security Number (or Tax ID Number)	Date of Birth (mm/dd/yyyy) (If trust, provide date of inception.)	Relationship to Insured

Attach an additional sheet of paper if more space is needed.

Payment Information

A. Method

Automatic Payment Plan (APP): \$ _____
(For APP, complete section D. Financial Information)

Direct Billing: \$ _____

Monthly Government Allotment : \$ _____

B. Frequency of Payment

Monthly (not available with Direct Billing) Quarterly Semi-Annually Annually

C. Paid Up Additions Rider (PUAR) Payment Method (If Paid Up Additions Rider was selected.)

PUAR Payment: \$ _____ Initial Lump Sum: \$ _____

1035 Exchange: \$ _____

D. Financial Information (Complete only if APP is selected.)

I authorize USAA Life Insurance Company to make electronic withdrawals and deposits to my account listed below until I notify USAA Life that I terminate authorization and USAA Life has reasonable time to act. I acknowledge that the origination of Automated Clearing House (ACH) transactions to my account must comply with U.S. law.

Specify a day between the 1st and 28th of the month for payment. _____ Day

Name of Financial Institution	Name(s) of Account Holder	Type of Account
		<input type="checkbox"/> Checking <input type="checkbox"/> Savings

Transit Routing Number (the nine-digit number in the lower-left corner of check or deposit slip) Account Number

Signature of Account Holder Date (mm/dd/yyyy)

E. Automatic Premium Loan

If you check "Yes" below for Automatic Premium Loan, USAA Life is authorized to make a policy loan against any cash value to pay any overdue premiums. If you do not select an option, "Yes" is selected for you.

Is Automatic Premium Loan to be authorized? Yes No

Additional Information

Provide any additional information or details you want considered below.

Read and Sign

Effective Date of Coverage: I agree that, except as provided in the company's Temporary Insurance Agreement, no insurance coverage will take effect prior to delivery of the policy to the Owner and then only if all of the following conditions have been met:

- (1) the health and insurability of each person is as stated in this application and in additional parts (if applicable), and the company is immediately notified in writing of any changes; and
- (2) the company has received the first full premium payment while each person is alive.

If the above conditions have been met, coverage under the policy will be effective on the date the policy is delivered to the Owner; provided however, that if a later effective date has been requested, coverage under the policy will be effective on that later date. I understand that any insurance coverage issued will be subject to the suicide and incontestability provisions of the policy. These provisions begin on the effective date.

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Kentucky, 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.

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Authorization: I understand the information obtained by use of this Authorization will be used by USAA Life to determine my eligibility for life insurance. I understand that information released pursuant to this Authorization may no longer be protected by federal privacy regulations and could be subject to redisclosure. I understand that although this authorization is voluntary, USAA Life reserves the right to decline to issue the insurance applied for if I refuse to grant this authorization.

I authorize the following persons and organizations to provide information to USAA Life Insurance Company ("USAA Life"): (a) any licensed physician; (b) any medical practitioner; (c) any hospital; (d) any insurance company; (e) any clinic, Veteran's Administration clinic, or medically-related facility; (f) Medical Information Bureau (MIB); (g) any psychiatrist or psychologist; (h) any health facility; (i) any consumer reporting agency.

For purposes of this Authorization, "information" means any records or knowledge concerning any insured's health or mental condition, general character and driving record.

This includes the release of the entire medical record of any Insured including all information about AIDS, HIV, drugs, alcoholism, or mental illness. This Authorization overrides any existing agreement to restrict information pursuant to 45 CFR 164.522.

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I authorize the above listed sources to provide records or knowledge to any agency employed by USAA Life to collect and transmit such information. A reproduction of this Authorization shall be as valid as the original. I agree this Authorization shall be valid for twenty-four (24) months from the date signed, and upon request I or my authorized representative can receive a copy of this Authorization. I understand that I may revoke this Authorization by sending a written request to USAA Life. A revocation does not affect any action taken by USAA Life in reliance on the authorization prior to the revocation, nor does it have any effect on any right of contestability under the policy.

I have read and understand this authorization. I have received, read and understand the enclosed Notice of Privacy and Disclosure Practices.

Internal Revenue Service Certification For Policyowner

The following certification is required by the Internal Revenue Service (IRS) and does not affect your insurability. Under penalties of perjury, I certify that:

1. The number shown on this form is my correct taxpayer identification number (or I am waiting for a number to be issued to me), and
2. I am not subject to backup withholding either because I have not been notified by the IRS that I am subject to backup withholding as a result of failure to report all interest or dividends, or the IRS has notified me that I am no longer subject to backup withholding (does not apply to real estate transactions, mortgage interest paid, the acquisition or abandonment of secured property, contributions to an Individual Retirement Arrangement (IRA), and payments other than interest and dividends).

Instructions - You must cross out item (2) above if you have been notified by IRS that you are currently subject to backup withholding because of underreporting interest or dividends on your tax return. The IRS does not require your consent to any provision of this document other than the certifications required to avoid backup withholding.

Acknowledgment: I have read the questions and answers in this application. I represent that all statements and answers provided in this application and as part of the application process are true, complete and correctly recorded and will be relied upon by USAA Life Insurance Company to form the basis of any policy which may be issued. I agree that a copy of this application, if approved, will be a part of any policy issued. I understand I may not receive an illustration until the policy is issued.

Printed Name of Insured

X
Signature of Insured _____ Date (mm/dd/yyyy) _____ City _____ State _____

X
Signature of Owner (if different than Insured) _____ Date (mm/dd/yyyy) _____

X
Signature of Custodial Parent of Child (if Child Protection Plan selected) _____ Date (mm/dd/yyyy) _____



9800 Fredericksburg Road
San Antonio, Texas 78288

Competitive Whole Life Insurance Application

Step 1. Verify and complete the following information. Make changes to incorrect information directly on this application. Initial each change.

Step 2. Return completed and signed application to USAA Life.

IMPORTANT INFORMATION. Federal law requires us to obtain, verify and record your name, address, date of birth and other information that will allow us to identify you when you open an account and in certain other circumstances.

Personal Information

A. Insured

USAA Number _____ Social Security Number _____ Date of Birth (mm/dd/yyyy) _____ / _____ / _____

Name _____

Mailing Address _____

Physical/Residence Address _____

Residence Phone Number (include area code) _____ E-mail Address _____

Occupation _____ Annual Income \$ _____

Branch of Service _____ Rank _____ Military Status _____

Female Male

Gender _____ State of Birth _____ Driver's License Number _____ State of Issue _____

Are you a U.S. citizen? Yes No

What is your total amount of life insurance protection, current and pending, excluding this application? _____

Is this application for insurance intended to replace, discontinue or change any life insurance or annuities?

Yes No If yes, list details. (Attach an additional sheet of paper if more space is needed.)

Annuity

Life Insurance \$ _____

Company Name _____ Amount _____ Policy/ Contract Number _____

Annuity

Life Insurance \$ _____

Company Name _____ Amount _____ Policy/ Contract Number _____

B. Owner

USAA Number _____ Social Security Number (or Tax ID Number) _____ Date of Birth (mm/dd/yyyy) (If trust, provide date of inception.) _____ / _____ / _____

Name (If trust, provide name of trust and trustee.) _____ Relationship to Insured _____

Mailing Address _____

Physical/Residence Address _____

Residence Phone Number (include area code) _____ E-mail Address _____

Are you a U.S. citizen? Yes No

USAA Life Insurance Company ▪ (888) 275-5330 ▪ Fax (877) 435-7099 ▪ usaa.com

C. Payor

USAA Number _____ Social Security Number (or Tax ID Number) _____ Date of Birth (mm/dd/yyyy) (If trust, provide date of inception.) _____ / _____ / _____

Name (If trust, provide name of trust and trustee.) _____

Mailing Address _____

Physical/Residence Address _____

Residence Phone Number (include area code) _____ E-mail Address _____

Are you a U.S. citizen? Yes No

Product and Optional Coverages

A. Product

Insurance Product Name _____ Insurance Amount \$ _____
 Applied to Purchase Applied to Paid in Left to Accumulate Applied to Purchase
 Paid up Additions Reduce Premiums Cash at Interest 1 Year Term Additions

Dividend Option _____

B. Optional Coverage

Disability Waiver of Premium (age 55 or younger) Accidental Death Benefit (ADB) (age 60 or younger) \$ _____ Amount Paid-Up Additions Rider (PUAR)

C. Child Protection Plan \$ _____ Amount of Child Rider Insurance
(age 17 or younger)

Child's Name _____ Social Security Number _____ Date of Birth (mm/dd/yyyy) _____ / _____ / _____

What is this child's total amount of life insurance protection, current and pending, excluding this application? \$ _____

Is this application for insurance intended to replace, discontinue or change any life insurance or annuities? Yes No If yes, list details. (Attach an additional sheet of paper if more space is needed.)

Annuity
 Life Insurance \$ _____

Company Name _____ Amount _____ Policy/ Contract Number _____

Child's Name _____ Social Security Number _____ Date of Birth (mm/dd/yyyy) _____ / _____ / _____

What is this child's total amount of life insurance protection, current and pending, excluding this application? \$ _____

Is this application for insurance intended to replace, discontinue or change any life insurance or annuities? Yes No If yes, list details. (Attach an additional sheet of paper if more space is needed.)

Annuity
 Life Insurance \$ _____

Company Name _____ Amount _____ Policy/ Contract Number _____

Attach an additional sheet of paper if more than two children.

Beneficiary Information

Primary Beneficiary Name (If trust, provide name of trust.)	Social Security Number (or Tax ID Number)	Date of Birth (mm/dd/yyyy) (If trust, provide date of inception.)	Relationship to Insured
Contingent Beneficiary Name (If trust, provide name of trust.)	Social Security Number (or Tax ID Number)	Date of Birth (mm/dd/yyyy) (If trust, provide date of inception.)	Relationship to Insured

Attach an additional sheet of paper if more space is needed.

Payment Information

A. Method

Automatic Payment Plan (APP): \$ _____ (For APP, complete section D. Financial Information) Direct Billing: \$ _____

Monthly Government Allotment : \$ _____

B. Frequency of Payment

Monthly (not available with Direct Billing) Quarterly Semi-Annually Annually

C. Paid Up Additions Rider (PUAR) Payment Method (If Paid Up Additions Rider was selected.)

PUAR Payment: \$ _____ Initial Lump Sum: \$ _____

1035 Exchange: \$ _____

D. Financial Information (Complete only if APP is selected.)

I authorize USAA Life Insurance Company to make electronic withdrawals and deposits to my account listed below until I notify USAA Life that I terminate authorization and USAA Life has reasonable time to act. I acknowledge that the origination of Automated Clearing House (ACH) transactions to my account must comply with U.S. law.

Specify a day between the 1st and 28th of the month for payment. _____ Day

Name of Financial Institution	Name(s) of Account Holder	Type of Account
		<input type="checkbox"/> Checking <input type="checkbox"/> Savings

Transit Routing Number (the nine-digit number in the lower-left corner of check or deposit slip) Account Number

X
Signature of Account Holder Date (mm/dd/yyyy)

E. Automatic Premium Loan

If you check "Yes" below for Automatic Premium Loan, USAA Life is authorized to make a policy loan against any cash value to pay any overdue premiums. If you do not select an option, "Yes" is selected for you.

Is Automatic Premium Loan to be authorized? Yes No

Additional Information

Provide any additional information or details you want considered below.

Medical Information (This section must be completed to acquire life insurance.)

A. Medical Questionnaire

Complete this section for all Insured individuals, including any person to be covered by the Child Protection Plan. Provide details for any "Yes" answer in the Medical Details section.

		Insured	Insured Children (If Child Protection Plan is selected)
1. What is your current height and weight? _____ Feet _____ Inches _____ Lbs.			
2. Has there been any change in weight during the last 12 months for any Insured? If yes, indicate gain or loss. Gain _____ Lbs. Loss _____ Lbs.		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
3. Is any Insured currently receiving regular medical consultation?		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
4. Has any Insured consulted with a health care provider for a routine physical in the last 12 months?		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
5. Has any Insured ever consulted with a health care provider for:			
a.	seizures, paralysis, stroke, depression, anxiety or other mental or nervous system disorder?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
b.	asthma, emphysema, pneumonia or other respiratory system disorder?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
c.	chest pain, high blood pressure, murmur, heart attack or other heart or blood vessel disorder?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
d.	disorder of the throat, esophagus, stomach, intestines, rectum, liver or pancreas?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
e.	abnormal urine test or other disorder of the kidney, ureter or bladder?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
f.	diabetes or other endocrine or thyroid disorder?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
g.	arthritis, collagen vascular disease or disorder of the muscles, bones or skin?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
h.	any cancer or tumor?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
i.	disorder of the prostate or reproductive system?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
j.	hepatitis, anemia, disorder of the blood or lymph glands?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
6. Is any Insured currently taking prescription medication not previously disclosed?		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
7. Has any Insured been diagnosed for Human Immunodeficiency Virus (HIV) Infection, Acquired Immune Deficiency Syndrome (AIDS), AIDS-related complex (ARC), AIDS-related condition, or a sexually transmitted disease?		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
8. Has any Insured, within the past five years:			
a.	had an electrocardiogram, X-ray or any other diagnostic test or procedure that was not previously disclosed?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
b.	been advised to have any diagnostic test, hospitalization or surgery which was not completed?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
9. Has any Insured had an application for life or health insurance declined, postponed, modified or rated?		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
10. Has any Insured ever used an illegal drug or used a controlled substance without a physician's approval?		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
11. Has any Insured been diagnosed or treated for alcohol or drug abuse or been advised by a health care professional to discontinue the use of alcohol or to seek treatment for drug or alcohol dependency?		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
12. Has any Insured consulted a health care provider for any reason not previously disclosed?		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
13. Did your biological mother or father die before the age of 60 from cardiovascular disease or cancer?		<input type="checkbox"/> Yes <input type="checkbox"/> No	Not Applicable

B. Medical Details - Attach an additional sheet of paper if more space is needed.

Question Insured's name / / Date of Visit Physician's Name

Physician's Address

Reason For Visit

Type of Treatment Medication Prescribed (if any)

B. Medical Details - Attach an additional sheet of paper if more space is needed.

Question	Insured's name

Personal Profile (This section must be completed to acquire life insurance.)

Complete this section for all Insured individuals, including any person to be covered by the Child Protection Plan.

	Insured	Insured Children (If Child Protection Plan is selected)	
1. Have you ever used any form of tobacco or nicotine substitute?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Not Applicable	
Form of Tobacco or Nicotine Substitute	Date of Last Use	How Often Used	
2. Has any Insured flown as a pilot, crew member or student pilot in the past two years or does any Insured plan to do so in the next year?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
DESCRIPTION	TYPE(S) OF AIRCRAFT	HOURS FLOWN	
MILITARY		NEXT 12 MOS LAST 12 MOS 13-24 MOS AGO	
COMMERCIAL			
CIVILIAN/PLEASURE			
TOTAL PILOT-IN-COMMAND HOURS:	_____ MILITARY	_____ CIVILIAN/PLEASURE	
3. Has any Insured participated in any of the following activities in the past three years or does any Insured plan to do so in the next year?	Automobile Racing <input type="checkbox"/> Yes <input type="checkbox"/> No Ballooning <input type="checkbox"/> Yes <input type="checkbox"/> No Hang-Gliding <input type="checkbox"/> Yes <input type="checkbox"/> No Motorcycle Racing <input type="checkbox"/> Yes <input type="checkbox"/> No Powerboat Racing <input type="checkbox"/> Yes <input type="checkbox"/> No Rock/Mountain Climbing <input type="checkbox"/> Yes <input type="checkbox"/> No Scuba Diving <input type="checkbox"/> Yes <input type="checkbox"/> No Skydiving/Parachuting <input type="checkbox"/> Yes <input type="checkbox"/> No Ultralight Flying <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No	
Activity	Last Activity Date	Frequency	Details (speeds attained, depths/heights reached, etc.)
4. Does any Insured plan to travel to or reside in a foreign country within the next 12 months?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Country's Name	Purpose of Visit	Length of Stay	
5. Has any Insured ever been convicted of Driving While Intoxicated or Driving Under the Influence or ever had a driver's license suspended or revoked or had any moving violations within the last three years?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Violation Type	Date	Details (speeds, length of suspension/revocation, etc.)	

Attach an additional sheet of paper if more space is needed.

Read and Sign

Effective Date of Coverage: I agree that, except as provided in the company's Temporary Insurance Agreement, no insurance coverage will take effect prior to delivery of the policy to the Owner and then only if all of the following conditions have been met:

- (1) the health and insurability of each person is as stated in this application and in additional parts (if applicable), and the company is immediately notified in writing of any changes; and
- (2) the company has received the first full premium payment while each person is alive.

If the above conditions have been met, coverage under the policy will be effective on the date the policy is delivered to the Owner; provided however, that if a later effective date has been requested, coverage under the policy will be effective on that later date. I understand that any insurance coverage issued will be subject to the suicide and incontestability provisions of the policy. These provisions begin on the effective date.

Insurance Fraud Warning

Arkansas, Louisiana, New Mexico, Ohio, West Virginia:

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

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 or a denial of insurance benefits.

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.

Kentucky, 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.

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.

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.

Authorization: I understand the information obtained by use of this Authorization will be used by USAA Life to determine my eligibility for life insurance. I understand that information released pursuant to this Authorization may no longer be protected by federal privacy regulations and could be subject to redisclosure. I understand that although this authorization is voluntary, USAA Life reserves the right to decline to issue the insurance applied for if I refuse to grant this authorization.

I authorize the following persons and organizations to provide information to USAA Life Insurance Company ("USAA Life"): (a) any licensed physician; (b) any medical practitioner; (c) any hospital; (d) any insurance company; (e) any clinic, Veteran's Administration clinic, or medically-related facility; (f) Medical Information Bureau (MIB); (g) any psychiatrist or psychologist; (h) any health facility; (i) any consumer reporting agency.

For purposes of this Authorization, "information" means any records or knowledge concerning any insured's health or mental condition, general character and driving record.

This includes the release of the entire medical record of any Insured including all information about AIDS, HIV, drugs, alcoholism, or mental illness. This Authorization overrides any existing agreement to restrict information pursuant to 45 CFR 164.522.

I further authorize a consumer reporting agency to make an investigative report on me if it is requested by USAA Life and expect to be interviewed if a report is prepared.

I authorize the above listed sources to provide records or knowledge to any agency employed by USAA Life to collect and transmit such information. A reproduction of this Authorization shall be as valid as the original. I agree this Authorization shall be valid for twenty-four (24) months from the date signed, and upon request I or my authorized representative can receive a copy of this Authorization. I understand that I may revoke this Authorization by sending a written request to USAA Life. A revocation does not affect any action taken by USAA Life in reliance on the authorization prior to the revocation, nor does it have any effect on any right of contestability under the policy.

I have read and understand this authorization. I have received, read and understand the enclosed Notice of Privacy and Disclosure Practices.

Internal Revenue Service Certification For Policyowner

The following certification is required by the Internal Revenue Service (IRS) and does not affect your insurability. Under penalties of perjury, I certify that:

1. The number shown on this form is my correct taxpayer identification number (or I am waiting for a number to be issued to me), and
2. I am not subject to backup withholding either because I have not been notified by the IRS that I am subject to backup withholding as a result of failure to report all interest or dividends, or the IRS has notified me that I am no longer subject to backup withholding (does not apply to real estate transactions, mortgage interest paid, the acquisition or abandonment of secured property, contributions to an Individual Retirement Arrangement (IRA), and payments other than interest and dividends).

Instructions - You must cross out item (2) above if you have been notified by IRS that you are currently subject to backup withholding because of underreporting interest or dividends on your tax return. The IRS does not require your consent to any provision of this document other than the certifications required to avoid backup withholding.

Acknowledgment: I have read the questions and answers in this application. I represent that all statements and answers provided in this application and as part of the application process are true, complete and correctly recorded and will be relied upon by USAA Life Insurance Company to form the basis of any policy which may be issued. I agree that a copy of this application, if approved, will be a part of any policy issued. I understand I may not receive an illustration until the policy is issued.

Printed Name of Insured

X
Signature of Insured _____ Date (mm/dd/yyyy) _____ City _____ State _____

X
Signature of Owner (if different than Insured) _____ Date (mm/dd/yyyy) _____

X
Signature of Custodial Parent of Child (if Child Protection Plan selected) _____ Date (mm/dd/yyyy) _____



9800 Fredericksburg Road
San Antonio, Texas 78288

Simplified Whole Life Insurance Application

Step 1. Verify and complete the following information. Make changes to incorrect information directly on this application. Initial each change.

Step 2. Return completed and signed application to USAA Life.

IMPORTANT INFORMATION. Federal law requires us to obtain, verify and record your name, address, date of birth and other information that will allow us to identify you when you open an account and in certain other circumstances.

Personal Information

A. Insured

USAA Number _____ Social Security Number _____ Date of Birth (mm/dd/yyyy) _____ / _____ / _____

Name _____

Mailing Address _____

Physical/Residence Address _____

Residence Phone Number (include area code) _____ E-mail Address _____

Occupation _____ Annual Income \$ _____

Branch of Service _____ Rank _____ Military Status _____

Female Male

Gender _____ State of Birth _____ Driver's License Number _____ State of Issue _____

Are you a U.S. citizen? Yes No

What is your total amount of life insurance protection, current and pending, excluding this application? _____

Is this application for insurance intended to replace, discontinue or change any life insurance or annuities?

Yes No If yes, list details. (Attach an additional sheet of paper if more space is needed.)

Annuity

Life Insurance \$ _____

Company Name _____ Amount _____ Policy/ Contract Number _____

Annuity

Life Insurance \$ _____

Company Name _____ Amount _____ Policy/ Contract Number _____

B. Owner

USAA Number _____ Social Security Number (or Tax ID Number) _____ Date of Birth (mm/dd/yyyy) (If trust, provide date of inception.) _____ / _____ / _____

Name (If trust, provide name of trust and trustee.) _____ Relationship to Insured _____

Mailing Address _____

Physical/Residence Address _____

Residence Phone Number (include area code) _____ E-mail Address _____

Are you a U.S. citizen? Yes No

USAA Life Insurance Company • (888) 275-5330 • Fax (877) 435-7099 • usaa.com

C. Payor

USAA Number _____ Social Security Number (or Tax ID Number) _____ / / Date of Birth (mm/dd/yyyy) (If trust, provide date of inception.) _____

Name (If trust, provide name of trust and trustee.) _____

Mailing Address _____

Physical/Residence Address _____

Residence Phone Number (include area code) _____

E-mail Address _____

Are you a U.S. citizen? Yes No

Product and Optional Coverages

A. Product

Insurance Product Name _____ \$ Insurance Amount _____

B. Optional Coverage

Disability Waiver of Premium (age 55 or younger) Accidental Death Benefit (ADB) \$ _____ Amount (age 60 or younger)

C. Child Protection Plan \$ _____ Amount of Child Rider Insurance (age 17 or younger)

Child's Name _____ Social Security Number _____ / / Date of Birth (mm/dd/yyyy)

What is this child's total amount of life insurance protection, current and pending, excluding this application? \$ _____

Is this application for insurance intended to replace, discontinue or change any life insurance or annuities? Yes No If yes, list details. (Attach an additional sheet of paper if more space is needed.)

Annuity Life Insurance \$ _____

Company Name _____ Amount _____ Policy/ Contract Number _____

Child's Name _____ Social Security Number _____ / / Date of Birth (mm/dd/yyyy)

What is this child's total amount of life insurance protection, current and pending, excluding this application? \$ _____

Is this application for insurance intended to replace, discontinue or change any life insurance or annuities? Yes No If yes, list details. (Attach an additional sheet of paper if more space is needed.)

Annuity Life Insurance \$ _____

Company Name _____ Amount _____ Policy/ Contract Number _____

Attach an additional sheet of paper if more than two children.

Read and Sign

Effective Date of Coverage: I agree that, except as provided in the company's Temporary Insurance Agreement, no insurance coverage will take effect prior to delivery of the policy to the Owner and then only if all of the following conditions have been met:

- (1) the health and insurability of each person is as stated in this application and in additional parts (if applicable), and the company is immediately notified in writing of any changes; and
- (2) the company has received the first full premium payment while each person is alive.

If the above conditions have been met, coverage under the policy will be effective on the date the policy is delivered to the Owner; provided however, that if a later effective date has been requested, coverage under the policy will be effective on that later date. I understand that any insurance coverage issued will be subject to the suicide and incontestability provisions of the policy. These provisions begin on the effective date.

Insurance Fraud Warning

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Kentucky, 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.

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.

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.



9800 Fredericksburg Road
San Antonio, Texas 78288

Simplified Whole Life Insurance Application

Step 1. Verify and complete the following information. Make changes to incorrect information directly on this application. Initial each change.

Step 2. Return completed and signed application to USAA Life.

IMPORTANT INFORMATION. Federal law requires us to obtain, verify and record your name, address, date of birth and other information that will allow us to identify you when you open an account and in certain other circumstances.

Personal Information

A. Insured

USAA Number _____ Social Security Number _____ Date of Birth (mm/dd/yyyy) _____ / _____ / _____

Name _____

Mailing Address _____

Physical/Residence Address _____

Residence Phone Number (include area code) _____ E-mail Address _____

Occupation _____ Annual Income \$ _____

Branch of Service _____ Rank _____ Military Status _____

Female Male

Gender _____ State of Birth _____ Driver's License Number _____ State of Issue _____

Are you a U.S. citizen? Yes No

What is your total amount of life insurance protection, current and pending, excluding this application? _____

Is this application for insurance intended to replace, discontinue or change any life insurance or annuities?

Yes No If yes, list details. (Attach an additional sheet of paper if more space is needed.)

Annuity

Life Insurance \$ _____

Company Name _____ Amount _____ Policy/ Contract Number _____

Annuity

Life Insurance \$ _____

Company Name _____ Amount _____ Policy/ Contract Number _____

B. Owner

USAA Number _____ Social Security Number (or Tax ID Number) _____ Date of Birth (mm/dd/yyyy) (If trust, provide date of inception.) _____ / _____ / _____

Name (If trust, provide name of trust and trustee.) _____ Relationship to Insured _____

Mailing Address _____

Physical/Residence Address _____

Residence Phone Number (include area code) _____ E-mail Address _____

Are you a U.S. citizen? Yes No

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C. Payor

USAA Number _____ Social Security Number (or Tax ID Number) _____ / / Date of Birth (mm/dd/yyyy) (If trust, provide date of inception.) _____

Name (If trust, provide name of trust and trustee.) _____

Mailing Address _____

Physical/Residence Address _____

Residence Phone Number (include area code) _____

E-mail Address _____

Are you a U.S. citizen? Yes No

Product and Optional Coverages

A. Product

Insurance Product Name _____ \$ Insurance Amount _____

B. Optional Coverage

Disability Waiver of Premium (age 55 or younger) Accidental Death Benefit (ADB) \$ _____ Amount _____ (age 60 or younger)

C. Child Protection Plan \$ _____ Amount of Child Rider Insurance _____ (age 17 or younger)

Child's Name _____ Social Security Number _____ / / Date of Birth (mm/dd/yyyy) _____

What is this child's total amount of life insurance protection, current and pending, excluding this application? \$ _____

Is this application for insurance intended to replace, discontinue or change any life insurance or annuities? Yes No If yes, list details. (Attach an additional sheet of paper if more space is needed.)

Annuity
 Life Insurance \$ _____

Company Name _____ Amount _____ Policy/ Contract Number _____

Child's Name _____ Social Security Number _____ / / Date of Birth (mm/dd/yyyy) _____

What is this child's total amount of life insurance protection, current and pending, excluding this application? \$ _____

Is this application for insurance intended to replace, discontinue or change any life insurance or annuities? Yes No If yes, list details. (Attach an additional sheet of paper if more space is needed.)

Annuity
 Life Insurance \$ _____

Company Name _____ Amount _____ Policy/ Contract Number _____

Attach an additional sheet of paper if more than two children.

Beneficiary Information

_____/_____/_____
Primary Beneficiary Name (If trust, provide name of trust.) Social Security Number (or Tax ID Number) Date of Birth (mm/dd/yyyy) Relationship to Insured (If trust, provide date of inception.)

_____/_____/_____
Contingent Beneficiary Name (If trust, provide name of trust.) Social Security Number (or Tax ID Number) Date of Birth (mm/dd/yyyy) Relationship to Insured (If trust, provide date of inception.)

Attach an additional sheet of paper if more space is needed.

Payment Information

A. Method

Automatic Payment Plan (APP): \$ _____ Direct Billing: \$ _____
(For APP, complete section C. Financial Information)

Monthly Government Allotment: \$ _____

Single Premium: \$ _____

1035 Exchange: \$ _____

B. Frequency of Payment

Monthly (not available with Direct Billing) Quarterly Semi-Annually Annually

C. Financial Information (Complete only if APP is selected.)

I authorize USAA Life Insurance Company to make electronic withdrawals and deposits to my account listed below until I notify USAA Life that I terminate authorization and USAA Life has reasonable time to act. I acknowledge that the origination of Automated Clearing House (ACH) transactions to my account must comply with U.S. law.

Specify a day between the 1st and 28th of the month for payment. _____
Day

Checking
 Savings

Name of Financial Institution Name(s) of Account Holder Type of Account

Transit Routing Number (the nine-digit number in the lower-left corner of check or deposit slip) Account Number

x _____
Signature of Account Holder Date (mm/dd/yyyy)

D. Automatic Premium Loan

If you check "Yes" below for Automatic Premium Loan, USAA Life is authorized to make a policy loan against any cash value to pay any overdue premiums. If you do not select an option, "Yes" is selected for you.

Is Automatic Premium Loan to be authorized? Yes No

Additional Information

Provide any additional information or details you want considered below.

Medical Information (This section must be completed to acquire life insurance.)

A. Medical Questionnaire

Complete this section for all Insured individuals, including any person to be covered by the Child Protection Plan. Provide details for any "Yes" answer in the Medical Details section.

		Insured	Insured Children (If Child Protection Plan is selected)
1. What is your current height and weight? ____ Feet ____ Inches ____ Lbs.			
2. Has there been any change in weight during the last 12 months for any Insured? If yes, indicate gain or loss. Gain ____ Lbs. Loss ____ Lbs.		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
3. Is any Insured currently receiving regular medical consultation?		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
4. Has any Insured consulted with a health care provider for a routine physical in the last 12 months?		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
5. Has any Insured ever consulted with a health care provider for:			
a.	seizures, paralysis, stroke, depression, anxiety or other mental or nervous system disorder?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
b.	asthma, emphysema, pneumonia or other respiratory system disorder?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
c.	chest pain, high blood pressure, murmur, heart attack or other heart or blood vessel disorder?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
d.	disorder of the throat, esophagus, stomach, intestines, rectum, liver or pancreas?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
e.	abnormal urine test or other disorder of the kidney, ureter or bladder?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
f.	diabetes or other endocrine or thyroid disorder?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
g.	arthritis, collagen vascular disease or disorder of the muscles, bones or skin?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
h.	any cancer or tumor?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
i.	disorder of the prostate or reproductive system?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
j.	hepatitis, anemia, disorder of the blood or lymph glands?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
6. Is any Insured currently taking prescription medication not previously disclosed?		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
7. Has any Insured been diagnosed for Human Immunodeficiency Virus (HIV) Infection, Acquired Immune Deficiency Syndrome (AIDS), AIDS-related complex (ARC), AIDS-related condition, or a sexually transmitted disease?		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
8. Has any Insured, within the past five years:			
a.	had an electrocardiogram, X-ray or any other diagnostic test or procedure that was not previously disclosed?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
b.	been advised to have any diagnostic test, hospitalization or surgery which was not completed?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
9. Has any Insured had an application for life or health insurance declined, postponed, modified or rated?		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
10. Has any Insured ever used an illegal drug or used a controlled substance without a physician's approval?		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
11. Has any Insured been diagnosed or treated for alcohol or drug abuse or been advised by a health care professional to discontinue the use of alcohol or to seek treatment for drug or alcohol dependency?		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
12. Has any Insured consulted a health care provider for any reason not previously disclosed?		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
13. Did your biological mother or father die before the age of 60 from cardiovascular disease or cancer?		<input type="checkbox"/> Yes <input type="checkbox"/> No	Not Applicable

B. Medical Details- Attach an additional sheet of paper if more space is needed.

Question Insured's name Date of Visit Physician's Name

Physician's Address

Reason For Visit

Type of Treatment Medication Prescribed (if any)
 LAP50585ST 06-05 50585-0805
 Page 4 of 7 LAP145ST

B. Medical Details - Attach an additional sheet of paper if more space is needed.

Question Insured's name

Personal Profile (This section must be completed to acquire life insurance.)

Complete this section for all Insured individuals, including any person to be covered by the Child Protection Plan.

		Insured	Insured Children (If Child Protection Plan is selected)	
1. Have you ever used any form of tobacco or nicotine substitute?		<input type="checkbox"/> Yes <input type="checkbox"/> No	Not Applicable	
Form of Tobacco or Nicotine Substitute	Date of Last Use	How Often Used		
2. Has any Insured flown as a pilot, crew member or student pilot in the past two years or does any Insured plan to do so in the next year?		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
DESCRIPTION	TYPE(S) OF AIRCRAFT	HOURS FLOWN		
MILITARY		NEXT 12 MOS	LAST 12 MOS	13-24 MOS AGO
COMMERCIAL				
CIVILIAN/PLEASURE				
TOTAL PILOT-IN-COMMAND HOURS: _____ MILITARY _____ CIVILIAN/PLEASURE				
3. Has any Insured participated in any of the following activities in the past three years or does any Insured plan to do so in the next year?		Automobile Racing	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
		Ballooning	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
		Hang-Gliding	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
		Motorcycle Racing	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
		Powerboat Racing	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
		Rock/Mountain Climbing	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
		Scuba Diving	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
		Skydiving/Parachuting	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
		Ultralight Flying	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Activity	Last Activity Date	Frequency	Details (speeds attained, depths/heights reached, etc.)	
4. Does any Insured plan to travel to or reside in a foreign country within the next 12 months?		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Country's Name	Purpose of Visit		Length of Stay	
5. Has any Insured ever been convicted of Driving While Intoxicated or Driving Under the Influence or ever had a driver's license suspended or revoked or had any moving violations within the last three years?		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Violation Type	Date	Details (speeds, length of suspension/revocation, etc.)		

Attach an additional sheet of paper if more space is needed.

Read and Sign

Effective Date of Coverage: I agree that, except as provided in the company's Temporary Insurance Agreement, no insurance coverage will take effect prior to delivery of the policy to the Owner and then only if all of the following conditions have been met:

- (1) the health and insurability of each person is as stated in this application and in additional parts (if applicable), and the company is immediately notified in writing of any changes; and
- (2) the company has received the first full premium payment while each person is alive.

If the above conditions have been met, coverage under the policy will be effective on the date the policy is delivered to the Owner; provided however, that if a later effective date has been requested, coverage under the policy will be effective on that later date. I understand that any insurance coverage issued will be subject to the suicide and incontestability provisions of the policy. These provisions begin on the effective date.

Insurance Fraud Warning

Arkansas, Louisiana, New Mexico, Ohio, West Virginia:

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

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 or a denial of insurance benefits.

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.

Kentucky, 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.

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.

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.

Authorization: I understand the information obtained by use of this Authorization will be used by USAA Life to determine my eligibility for life insurance. I understand that information released pursuant to this Authorization may no longer be protected by federal privacy regulations and could be subject to redisclosure. I understand that although this authorization is voluntary, USAA Life reserves the right to decline to issue the insurance applied for if I refuse to grant this authorization.

I authorize the following persons and organizations to provide information to USAA Life Insurance Company ("USAA Life"): (a) any licensed physician; (b) any medical practitioner; (c) any hospital; (d) any insurance company; (e) any clinic, Veteran's Administration clinic, or medically-related facility; (f) Medical Information Bureau (MIB); (g) any psychiatrist or psychologist; (h) any health facility; (i) any consumer reporting agency.

For purposes of this Authorization, "information" means any records or knowledge concerning any insured's health or mental condition, general character and driving record.

This includes the release of the entire medical record of any Insured including all information about AIDS, HIV, drugs, alcoholism, or mental illness. This Authorization overrides any existing agreement to restrict information pursuant to 45 CFR 164.522.

I further authorize a consumer reporting agency to make an investigative report on me if it is requested by USAA Life and expect to be interviewed if a report is prepared.

I authorize the above listed sources to provide records or knowledge to any agency employed by USAA Life to collect and transmit such information. A reproduction of this Authorization shall be as valid as the original. I agree this Authorization shall be valid for twenty-four (24) months from the date signed, and upon request I or my authorized representative can receive a copy of this Authorization. I understand that I may revoke this Authorization by sending a written request to USAA Life. A revocation does not affect any action taken by USAA Life in reliance on the authorization prior to the revocation, nor does it have any effect on any right of contestability under the policy.

I have read and understand this authorization. I have received, read and understand the enclosed Notice of Privacy and Disclosure Practices.

Internal Revenue Service Certification For Policyowner

The following certification is required by the Internal Revenue Service (IRS) and does not affect your insurability. Under penalties of perjury, I certify that:

1. The number shown on this form is my correct taxpayer identification number (or I am waiting for a number to be issued to me), and
2. I am not subject to backup withholding either because I have not been notified by the IRS that I am subject to backup withholding as a result of failure to report all interest or dividends, or the IRS has notified me that I am no longer subject to backup withholding (does not apply to real estate transactions, mortgage interest paid, the acquisition or abandonment of secured property, contributions to an Individual Retirement Arrangement (IRA), and payments other than interest and dividends).

Instructions - You must cross out item (2) above if you have been notified by IRS that you are currently subject to backup withholding because of underreporting interest or dividends on your tax return. The IRS does not require your consent to any provision of this document other than the certifications required to avoid backup withholding.

Acknowledgment: I have read the questions and answers in this application. I represent that all statements and answers provided in this application and as part of the application process are true, complete and correctly recorded and will be relied upon by USAA Life Insurance Company to form the basis of any policy which may be issued. I agree that a copy of this application, if approved, will be a part of any policy issued. I understand I may not receive an illustration until the policy is issued.

Printed Name of Insured

X
Signature of Insured Date (mm/dd/yyyy) City State

X
Signature of Owner (if different than Insured) Date (mm/dd/yyyy)

X
Signature of Custodial Parent of Child (if Child Protection Plan selected) Date (mm/dd/yyyy)



9800 Fredericksburg Road
San Antonio, Texas 78288

Universal Life Insurance Application

Step 1. Verify and complete the following information. Make changes to incorrect information directly on this application. Initial each change.

Step 2. Return completed and signed application to USAA Life.

IMPORTANT INFORMATION. Federal law requires us to obtain, verify and record your name, address, date of birth and other information that will allow us to identify you when you open an account and in certain other circumstances.

Personal Information

A. Insured

USAA Number _____ Social Security Number _____ Date of Birth (mm/dd/yyyy) _____ / ____ / ____

Name _____

Mailing Address _____

Physical/Residence Address _____

Residence Phone Number (include area code) _____ E-mail Address _____

Occupation _____ Annual Income \$ _____

Branch of Service _____ Rank _____ Military Status _____

Female Male

Gender _____ State of Birth _____ Driver's License Number _____ State of Issue _____

Are you a U.S. citizen? Yes No

What is your total amount of life insurance protection, current and pending, excluding this application? _____

Is this application for insurance intended to replace, discontinue or change any life insurance or annuities?

Yes No If yes, list details. (Attach an additional sheet of paper if more space is needed.)

Annuity

Life Insurance \$ _____

Company Name _____ Amount _____ Policy/ Contract Number _____

Annuity

Life Insurance \$ _____

Company Name _____ Amount _____ Policy/ Contract Number _____

B. Owner

USAA Number _____ Social Security Number (or Tax ID Number) _____ Date of Birth (mm/dd/yyyy) _____ (If trust, provide date of inception.) _____ / ____ / ____

Name (If trust, provide name of trust and trustee.) _____ Relationship to Insured _____

Mailing Address _____

Physical/Residence Address _____

Residence Phone Number (include area code) _____ E-mail Address _____

Are you a U.S. citizen? Yes No

USAA Life Insurance Company ▪ (888) 275-5330 ▪ Fax (877) 435-7099 ▪ usaa.com

C. Payor

USAA Number _____ Social Security Number (or Tax ID Number) _____ Date of Birth (mm/dd/yyyy) (If trust, provide date of inception.) _____ / /

Name (If trust, provide name of trust and trustee.) _____

Mailing Address _____

Physical/Residence Address _____

Residence Phone Number (include area code) _____ E-mail Address _____

Are you a U.S. citizen? Yes No

Product and Optional Coverages

A. Product

Insurance Product Name _____ \$ Insurance Amount _____

- Option A: Provides fixed insurance protection.
- Option B: Provides increasing insurance protection.

B. Optional Coverage

Waiver of Monthly Deduction (age 55 or younger) Accidental Death Benefit (ADB) \$ _____ (age 60 or younger) Amount _____

C. Child Protection Plan \$ _____ (age 17 or younger) Amount of Child Rider Insurance _____

Child's Name _____ Social Security Number _____ Date of Birth (mm/dd/yyyy) _____ / /

What is this child's total amount of life insurance protection, current and pending, excluding this application? \$ _____

Is this application for insurance intended to replace, discontinue or change any life insurance or annuities? Yes No If yes, list details. (Attach an additional sheet of paper if more space is needed.)

- Annuity
- Life Insurance \$ _____

Company Name _____ Amount _____ Policy/ Contract Number _____

Child's Name _____ Social Security Number _____ Date of Birth (mm/dd/yyyy) _____ / /

What is this child's total amount of life insurance protection, current and pending, excluding this application? \$ _____

Is this application for insurance intended to replace, discontinue or change any life insurance or annuities? Yes No If yes, list details. (Attach an additional sheet of paper if more space is needed.)

- Annuity
- Life Insurance \$ _____

Company Name _____ Amount _____ Policy/ Contract Number _____

Attach an additional sheet of paper if more than two children.

Beneficiary Information

Primary Beneficiary Name (If trust, provide name of trust.) Social Security Number (or Tax ID Number) Date of Birth (mm/dd/yyyy) (If trust, provide date of inception.) Relationship to Insured

Contingent Beneficiary Name (If trust, provide name of trust.) Social Security Number (or Tax ID Number) Date of Birth (mm/dd/yyyy) (If trust, provide date of inception.) Relationship to Insured

Attach an additional sheet of paper if more space is needed.

Payment Information

A. Method

- Automatic Payment Plan (APP): \$ _____ (For APP, complete section C. Financial Information) Direct Billing: \$ _____
- Monthly Government Allotment: \$ _____
- Initial Lump Sum: \$ _____ 1035 Exchange: \$ _____

B. Frequency of Payment

- Monthly (not available with Direct Billing) Quarterly Semi-Annually Annually

C. Financial Information (Complete only if APP is selected.)

I authorize USAA Life Insurance Company to make electronic withdrawals and deposits to my account listed below until I notify USAA Life that I terminate authorization and USAA Life has reasonable time to act. I acknowledge that the origination of Automated Clearing House (ACH) transactions to my account must comply with U.S. law.

Specify a day between the 1st and 28th of the month for payment. _____
Day

- Checking
- Savings

Name of Financial Institution Name(s) of Account Holder Type of Account

Transit Routing Number (the nine-digit number in the lower-left corner of check or deposit slip) Account Number

^x
Signature of Account Holder Date (mm/dd/yyyy)

Additional Information

Provide any additional information or details you want considered below.

Read and Sign

Effective Date of Coverage: I agree that, except as provided in the company's Temporary Insurance Agreement, no insurance coverage will take effect prior to delivery of the policy to the Owner and then only if all of the following conditions have been met:

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I authorize the following persons and organizations to provide information to USAA Life Insurance Company ("USAA Life"): (a) any licensed physician; (b) any medical practitioner; (c) any hospital; (d) any insurance company; (e) any clinic, Veteran's Administration clinic, or medically-related facility; (f) Medical Information Bureau (MIB); (g) any psychiatrist or psychologist; (h) any health facility; (i) any consumer reporting agency.

For purposes of this Authorization, "information" means any records or knowledge concerning any insured's health or mental condition, general character and driving record.

This includes the release of the entire medical record of any Insured including all information about AIDS, HIV, drugs, alcoholism, or mental illness. This Authorization overrides any existing agreement to restrict information pursuant to 45 CFR 164.522.

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1. The number shown on this form is my correct taxpayer identification number (or I am waiting for a number to be issued to me), and
2. I am not subject to backup withholding either because I have not been notified by the IRS that I am subject to backup withholding as a result of failure to report all interest or dividends, or the IRS has notified me that I am no longer subject to backup withholding (does not apply to real estate transactions, mortgage interest paid, the acquisition or abandonment of secured property, contributions to an Individual Retirement Arrangement (IRA), and payments other than interest and dividends).

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Printed Name of Insured

X

Signature of Insured

Date (mm/dd/yyyy)

City

State

X

Signature of Owner (if different than Insured)

Date (mm/dd/yyyy)

X

Signature of Custodial Parent of Child (if Child Protection Plan selected)

Date (mm/dd/yyyy)



9800 Fredericksburg Road
San Antonio, Texas 78288

Universal Life Insurance Application

Step 1. Verify and complete the following information. Make changes to incorrect information directly on this application. Initial each change.

Step 2. Return completed and signed application to USAA Life.

IMPORTANT INFORMATION. Federal law requires us to obtain, verify and record your name, address, date of birth and other information that will allow us to identify you when you open an account and in certain other circumstances.

Personal Information

A. Insured

USAA Number _____ Social Security Number _____ Date of Birth (mm/dd/yyyy) _____ / ____ / ____

Name _____

Mailing Address _____

Physical/Residence Address _____

Residence Phone Number (include area code) _____ E-mail Address _____

Occupation _____ Annual Income \$ _____

Branch of Service _____ Rank _____ Military Status _____

Female Male

Gender _____ State of Birth _____ Driver's License Number _____ State of Issue _____

Are you a U.S. citizen? Yes No

What is your total amount of life insurance protection, current and pending, excluding this application? _____

Is this application for insurance intended to replace, discontinue or change any life insurance or annuities?

Yes No If yes, list details. (Attach an additional sheet of paper if more space is needed.)

Annuity

Life Insurance \$ _____

Company Name _____ Amount _____ Policy/ Contract Number _____

Annuity

Life Insurance \$ _____

Company Name _____ Amount _____ Policy/ Contract Number _____

B. Owner

USAA Number _____ Social Security Number (or Tax ID Number) _____ Date of Birth (mm/dd/yyyy) _____ / ____ / ____
(If trust, provide date of inception.)

Name (If trust, provide name of trust and trustee.) _____ Relationship to Insured _____

Mailing Address _____

Physical/Residence Address _____

Residence Phone Number (include area code) _____ E-mail Address _____

Are you a U.S. citizen? Yes No

USAA Life Insurance Company • (888) 275-5330 • Fax (877) 435-7099 • usaa.com

C. Payor

USAA Number _____ Social Security Number (or Tax ID Number) _____ Date of Birth (mm/dd/yyyy) (If trust, provide date of inception.) _____ / /

Name (If trust, provide name of trust and trustee.) _____

Mailing Address _____

Physical/Residence Address _____

Residence Phone Number (include area code) _____ E-mail Address _____

Are you a U.S. citizen? Yes No

Product and Optional Coverages

A. Product

Insurance Product Name _____ \$ Insurance Amount _____

- Option A: Provides fixed insurance protection.
- Option B: Provides increasing insurance protection.

B. Optional Coverage

Waiver of Monthly Deduction (age 55 or younger) Accidental Death Benefit (ADB) \$ _____ (age 60 or younger) Amount _____

C. Child Protection Plan \$ _____ (age 17 or younger) Amount of Child Rider Insurance _____

Child's Name _____ Social Security Number _____ Date of Birth (mm/dd/yyyy) _____ / /

What is this child's total amount of life insurance protection, current and pending, excluding this application? \$ _____

Is this application for insurance intended to replace, discontinue or change any life insurance or annuities? Yes No If yes, list details. (Attach an additional sheet of paper if more space is needed.)

- Annuity
- Life Insurance \$ _____

Company Name _____ Amount _____ Policy/ Contract Number _____

Child's Name _____ Social Security Number _____ Date of Birth (mm/dd/yyyy) _____ / /

What is this child's total amount of life insurance protection, current and pending, excluding this application? \$ _____

Is this application for insurance intended to replace, discontinue or change any life insurance or annuities? Yes No If yes, list details. (Attach an additional sheet of paper if more space is needed.)

- Annuity
- Life Insurance \$ _____

Company Name _____ Amount _____ Policy/ Contract Number _____

Attach an additional sheet of paper if more than two children.

Beneficiary Information

Primary Beneficiary Name (If trust, provide name of trust.)	Social Security Number (or Tax ID Number)	Date of Birth (mm/dd/yyyy) (If trust, provide date of inception.)	Relationship to Insured
Contingent Beneficiary Name (If trust, provide name of trust.)	Social Security Number (or Tax ID Number)	Date of Birth (mm/dd/yyyy) (If trust, provide date of inception.)	Relationship to Insured

Attach an additional sheet of paper if more space is needed.

Payment Information

A. Method

Automatic Payment Plan (APP): \$ _____ (For APP, complete section C. Financial Information)
 Direct Billing: \$ _____

Monthly Government Allotment: \$ _____

Initial Lump Sum: \$ _____ 1035 Exchange: \$ _____

B. Frequency of Payment

Monthly (not available with Direct Billing)
 Quarterly
 Semi-Annually
 Annually

C. Financial Information (Complete only if APP is selected.)

I authorize USAA Life Insurance Company to make electronic withdrawals and deposits to my account listed below until I notify USAA Life that I terminate authorization and USAA Life has reasonable time to act. I acknowledge that the origination of Automated Clearing House (ACH) transactions to my account must comply with U.S. law.

Specify a day between the 1st and 28th of the month for payment. _____
Day

Name of Financial Institution	Name(s) of Account Holder	Type of Account
		<input type="checkbox"/> Checking <input type="checkbox"/> Savings

Transit Routing Number (the nine-digit number in the lower-left corner of check or deposit slip) _____ Account Number _____

Signature of Account Holder _____ Date (mm/dd/yyyy) _____

Additional Information

Provide any additional information or details you want considered below.

Medical Information (This section must be completed to acquire life insurance.)

A. Medical Questionnaire

Complete this section for all Insured individuals, including any person to be covered by the Child Protection Plan. Provide details for any "Yes" answer in the Medical Details section.

		Insured	Insured Children (If Child Protection Plan is selected)
1. What is your current height and weight? ___ Feet ___ Inches ___ Lbs.			
2. Has there been any change in weight during the last 12 months for any Insured? If yes, indicate gain or loss. Gain ___ Lbs. Loss ___ Lbs.		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
3. Is any Insured currently receiving regular medical consultation?		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
4. Has any Insured consulted with a health care provider for a routine physical in the last 12 months?		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
5. Has any Insured ever consulted with a health care provider for:			
a.	seizures, paralysis, stroke, depression, anxiety or other mental or nervous system disorder?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
b.	asthma, emphysema, pneumonia or other respiratory system disorder?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
c.	chest pain, high blood pressure, murmur, heart attack or other heart or blood vessel disorder?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
d.	disorder of the throat, esophagus, stomach, intestines, rectum, liver or pancreas?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
e.	abnormal urine test or other disorder of the kidney, ureter or bladder?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
f.	diabetes or other endocrine or thyroid disorder?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
g.	arthritis, collagen vascular disease or disorder of the muscles, bones or skin?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
h.	any cancer or tumor?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
i.	disorder of the prostate or reproductive system?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
j.	hepatitis, anemia, disorder of the blood or lymph glands?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
6. Is any Insured currently taking prescription medication not previously disclosed?		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
7. Has any Insured been diagnosed for Human Immunodeficiency Virus (HIV) Infection, Acquired Immune Deficiency Syndrome (AIDS), AIDS-related complex (ARC), AIDS-related condition, or a sexually transmitted disease?		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
8. Has any Insured, within the past five years:			
a.	had an electrocardiogram, X-ray or any other diagnostic test or procedure that was not previously disclosed?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
b.	been advised to have any diagnostic test, hospitalization or surgery which was not completed?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
9. Has any Insured had an application for life or health insurance declined, postponed, modified or rated?		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
10. Has any Insured ever used an illegal drug or used a controlled substance without a physician's approval?		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
11. Has any Insured been diagnosed or treated for alcohol or drug abuse or been advised by a health care professional to discontinue the use of alcohol or to seek treatment for drug or alcohol dependency?		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
12. Has any Insured consulted a health care provider for any reason not previously disclosed?		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
13. Did your biological mother or father die before the age of 60 from cardiovascular disease or cancer?		<input type="checkbox"/> Yes <input type="checkbox"/> No	Not Applicable

B. Medical Details - Attach an additional sheet of paper if more space is needed.

/ /

Question Insured's name Date of Visit Physician's Name

Physician's Address

Reason For Visit

Type of Treatment Medication Prescribed (if any)

B. Medical Details - Attach an additional sheet of paper if more space is needed.

Question	Insured's name

Personal Profile (This section must be completed to acquire life insurance.)

Complete this section for all Insured individuals, including any person to be covered by the Child Protection Plan.

	Insured	Insured Children (If Child Protection Plan is selected)
1. Have you ever used any form of tobacco or nicotine substitute?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Not Applicable
Form of Tobacco or Nicotine Substitute Date of Last Use How Often Used		
2. Has any Insured flown as a pilot, crew member or student pilot in the past two years or does any Insured plan to do so in the next year?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
DESCRIPTION	TYPE(S) OF AIRCRAFT	HOURS FLOWN
MILITARY		NEXT 12 MOS LAST 12 MOS 13-24 MOS AGO
COMMERCIAL		
CIVILIAN/PLEASURE		
TOTAL PILOT-IN-COMMAND HOURS: _____ MILITARY _____ CIVILIAN/PLEASURE		
3. Has any Insured participated in any of the following activities in the past three years or does any Insured plan to do so in the next year?	Automobile Racing	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No
	Ballooning	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No
	Hang-Gliding	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No
	Motorcycle Racing	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No
	Powerboat Racing	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No
	Rock/Mountain Climbing	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No
	Scuba Diving	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No
	Skydiving/Parachuting	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No
	Ultralight Flying	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No
Activity	Last Activity Date	Frequency Details (speeds attained, depths/heights reached, etc.)
4. Does any Insured plan to travel to or reside in a foreign country within the next 12 months?		<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No
Country's Name	Purpose of Visit	Length of Stay
5. Has any Insured ever been convicted of Driving While Intoxicated or Driving Under the Influence or ever had a driver's license suspended or revoked or had any moving violations within the last three years?		<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No
Violation Type	Date	Details (speeds, length of suspension/revocation, etc.)

Attach an additional sheet of paper if more space is needed.

Read and Sign

Effective Date of Coverage: I agree that, except as provided in the company's Temporary Insurance Agreement, no insurance coverage will take effect prior to delivery of the policy to the Owner and then only if all of the following conditions have been met:

- (1) the health and insurability of each person is as stated in this application and in additional parts (if applicable), and the company is immediately notified in writing of any changes; and
- (2) the company has received the first full premium payment while each person is alive.

If the above conditions have been met, coverage under the policy will be effective on the date the policy is delivered to the Owner; provided however, that if a later effective date has been requested, coverage under the policy will be effective on that later date. I understand that any insurance coverage issued will be subject to the suicide and incontestability provisions of the policy. These provisions begin on the effective date.

Insurance Fraud Warning

Arkansas, Louisiana, New Mexico, Ohio, West Virginia:

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

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 or a denial of insurance benefits.

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.

Kentucky, 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.

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.

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.

Authorization: I understand the information obtained by use of this Authorization will be used by USAA Life to determine my eligibility for life insurance. I understand that information released pursuant to this Authorization may no longer be protected by federal privacy regulations and could be subject to redisclosure. I understand that although this authorization is voluntary, USAA Life reserves the right to decline to issue the insurance applied for if I refuse to grant this authorization.

I authorize the following persons and organizations to provide information to USAA Life Insurance Company ("USAA Life"): (a) any licensed physician; (b) any medical practitioner; (c) any hospital; (d) any insurance company; (e) any clinic, Veteran's Administration clinic, or medically-related facility; (f) Medical Information Bureau (MIB); (g) any psychiatrist or psychologist; (h) any health facility; (i) any consumer reporting agency.

For purposes of this Authorization, "information" means any records or knowledge concerning any insured's health or mental condition, general character and driving record.

This includes the release of the entire medical record of any Insured including all information about AIDS, HIV, drugs, alcoholism, or mental illness. This Authorization overrides any existing agreement to restrict information pursuant to 45 CFR 164.522.

I further authorize a consumer reporting agency to make an investigative report on me if it is requested by USAA Life and expect to be interviewed if a report is prepared.

I authorize the above listed sources to provide records or knowledge to any agency employed by USAA Life to collect and transmit such information. A reproduction of this Authorization shall be as valid as the original. I agree this Authorization shall be valid for twenty-four (24) months from the date signed, and upon request I or my authorized representative can receive a copy of this Authorization. I understand that I may revoke this Authorization by sending a written request to USAA Life. A revocation does not affect any action taken by USAA Life in reliance on the authorization prior to the revocation, nor does it have any effect on any right of contestability under the policy.

I have read and understand this authorization. I have received, read and understand the enclosed Notice of Privacy and Disclosure Practices.

Internal Revenue Service Certification For Policyowner

The following certification is required by the Internal Revenue Service (IRS) and does not affect your insurability. Under penalties of perjury, I certify that:

1. The number shown on this form is my correct taxpayer identification number (or I am waiting for a number to be issued to me), and
2. I am not subject to backup withholding either because I have not been notified by the IRS that I am subject to backup withholding as a result of failure to report all interest or dividends, or the IRS has notified me that I am no longer subject to backup withholding (does not apply to real estate transactions, mortgage interest paid, the acquisition or abandonment of secured property, contributions to an Individual Retirement Arrangement (IRA), and payments other than interest and dividends).

Instructions - You must cross out item (2) above if you have been notified by IRS that you are currently subject to backup withholding because of underreporting interest or dividends on your tax return. The IRS does not require your consent to any provision of this document other than the certifications required to avoid backup withholding.

Acknowledgment: I have read the questions and answers in this application. I represent that all statements and answers provided in this application and as part of the application process are true, complete and correctly recorded and will be relied upon by USAA Life Insurance Company to form the basis of any policy which may be issued. I agree that a copy of this application, if approved, will be a part of any policy issued. I understand I may not receive an illustration until the policy is issued.

Printed Name of Insured

X
Signature of Insured _____ Date (mm/dd/yyyy) _____ City _____ State _____

X
Signature of Owner (if different than Insured) _____ Date (mm/dd/yyyy) _____

X
Signature of Custodial Parent of Child (if Child Protection Plan selected) _____ Date (mm/dd/yyyy) _____



9800 Fredericksburg Road
San Antonio, Texas 78288

7-Year Term Life Insurance Application

Step 1. Verify and complete the following information. Make changes to incorrect information directly on this application. Initial each change.

Step 2. Return completed and signed application to USAA Life.

IMPORTANT INFORMATION. Federal law requires us to obtain, verify and record your name, address, date of birth and other information that will allow us to identify you when you open an account and in certain other circumstances.

Personal Information

A. Insured

USAA Number _____ Social Security Number _____ Date of Birth (mm/dd/yyyy) _____ / _____ / _____

Name _____

Mailing Address _____

Physical/Residence Address _____

Residence Phone Number (include area code) _____ E-mail Address _____

Occupation _____ Annual Income \$ _____

Branch of Service _____ Rank _____ Military Status _____

Female Male

Gender _____ State of Birth _____ Driver's License Number _____ State of Issue _____

Are you a U.S. citizen? Yes No

What is your total amount of life insurance protection, current and pending, excluding this application? _____

Is this application for insurance intended to replace, discontinue or change any life insurance or annuities?

Yes No If yes, list details. (Attach an additional sheet of paper if more space is needed.)

Annuity

Life Insurance \$ _____

Company Name _____ Amount _____ Policy/Contract Number _____

Annuity

Life Insurance \$ _____

Company Name _____ Amount _____ Policy/Contract Number _____

B. Owner

USAA Number _____ Social Security Number (or Tax ID Number) _____ Date of Birth (mm/dd/yyyy) (If trust, provide date of inception.) _____ / _____ / _____

Name (If trust, provide name of trust and trustee) _____ Relationship to Insured _____

Mailing Address _____

Physical/Residence Address _____

Residence Phone Number (include area code) _____ E-mail Address _____

Are you a U.S. citizen? Yes No

USAA Life Insurance Company • (888) 275-5330 • Fax (877) 435-7099 • usaa.com

C. Payor

USAA Number _____ Social Security Number (or Tax ID Number) _____ Date of Birth (mm/dd/yyyy) (If trust, provide date of inception.) _____ / /

Name (If trust, provide name of trust and trustee.) _____

Mailing Address _____

Physical/Residence Address _____

Residence Phone Number (include area code) _____ E-mail Address _____

Are you a U.S. citizen? Yes No

Product

Insurance Product Name _____ \$ Insurance Amount _____

Beneficiary Information

Primary Beneficiary Name (If trust, provide name of trust.) _____ Social Security Number (or Tax ID Number) _____ Date of Birth (mm/dd/yyyy) (If trust, provide date of inception.) _____ Relationship to Insured _____ / /

Contingent Beneficiary Name (If trust, provide name of trust.) _____ Social Security Number (or Tax ID Number) _____ Date of Birth (mm/dd/yyyy) (If trust, provide date of inception.) _____ Relationship to Insured _____ / /

Attach an additional sheet of paper if more space is needed.

Payment Information - Monthly Automatic Payment Plan

Premium payments for this policy will be made through USAA Life's Automatic Payment Plan (APP). Complete the following:

I authorize USAA Life Insurance Company to make electronic withdrawals and deposits to my account listed below until I notify USAA Life that I terminate authorization and USAA Life has reasonable time to act. I acknowledge that the origination of Automated Clearing House (ACH) transactions to my account must comply with U.S. law.

Specify a day between the 1st and 28th of the month for payment. _____ Day

- Checking
- Savings

Name of Financial Institution _____ Name(s) of Account Holder _____ Type of Account _____

Transit Routing Number (the nine-digit number in the lower-left corner of check or deposit slip) _____ Account Number _____

^x _____
Signature of Account Holder _____ Date (mm/dd/yyyy) _____

Additional Information

Provide any additional information or details you want considered below.

Medical Information(This section must be completed to acquire life insurance.)

Complete this section for the Insured individual. (In the following questions, "You" refers to the Insured.)

Have you consulted a physician or other physical or mental health advisor for any reason within the last five years?

Yes No

If "Yes," provide the date, name and address of physician(s) consulted, reason for visit, type of treatment and any medication prescribed.

Attach an additional sheet of paper if more space is needed.

Personal Profile (This section must be completed to acquire life insurance.)

Complete this section for the Insured individual. Provide details for any "Yes" answer in the Personal Profile Details section (In the following questions, "You" refers to the Insured).

1. Have you participated in any of the following activities in the past three years or do you plan to do so in the next year? (Indicate activity, frequency and details, i.e., speeds attained, depths/heights reached, in the Personal Profile Details section.)

- | | | | |
|-----------------------------|--|------------------------|--|
| Automobile Racing | <input type="checkbox"/> Yes <input type="checkbox"/> No | Powerboat Racing | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Aviation (not as passenger) | <input type="checkbox"/> Yes <input type="checkbox"/> No | Rock/Mountain Climbing | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Ballooning | <input type="checkbox"/> Yes <input type="checkbox"/> No | Scuba Diving | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Hang-Gliding | <input type="checkbox"/> Yes <input type="checkbox"/> No | Skydiving/Parachuting | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Motorcycle Racing | <input type="checkbox"/> Yes <input type="checkbox"/> No | Ultralight Flying | <input type="checkbox"/> Yes <input type="checkbox"/> No |

2. Do you plan to travel to or reside in a foreign country within the next 12 months? Yes No
(Indicate country's name, purpose of visit and length of stay in the Personal Profile Details section.)

3. Have you ever been convicted of Driving While Intoxicated or Driving Under the Influence or ever had a driver's license suspended or revoked or had any moving violations within the last three years? Yes No

Personal Profile Details

Provide details below for any "Yes" answer in the Personal Profile. Include the question number and details.

Attach an additional sheet of paper if more space is needed.

Read and Sign

Effective Date of Coverage: I agree that, except as provided in the company's Temporary Insurance Agreement, no insurance coverage will take effect prior to delivery of the policy to the Owner and then only if all of the following conditions have been met:

- (1) the health and insurability of each person is as stated in this application and in additional parts (if applicable), and the company is immediately notified in writing of any changes; and
- (2) the company has received the first full premium payment while each person is alive.

If the above conditions have been met, coverage under the policy will be effective on the date the policy is delivered to the Owner; provided however, that if a later effective date has been requested, coverage under the policy will be effective on that later date. I understand that any insurance coverage issued will be subject to the suicide and incontestability provisions of the policy. These provisions begin on the effective date.

Insurance Fraud Warning

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

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 or a denial of insurance benefits.

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.

Kentucky, 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.

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.

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.



EXAMINER'S REPORT

THIS FORM MUST BE COMPLETED AND SIGNED BY THE EXAMINER AND RETURNED TO USAA LIFE INSURANCE COMPANY.

Name of Proposed Insured

USAA Number

Contract Number

INSTRUCTIONS TO EXAMINER

1. Have applicant provide or verify answers to all questions in the Personal Profile and Medical Questions Section, sign and date form in your presence.
2. Complete Examiner's Report.
3. **USAA LIFE INSURANCE COMPANY will not reimburse the cost of lab tests not specifically requested by USAA LIFE INSURANCE COMPANY.**
4. **If this examination is performed by a party not currently under contract with us, contact us to discuss negotiated reimbursement.**
5. Only disinterested parties may complete the examination. Exams may not be completed by blood relatives, business associates of the same clinic, or any person with beneficiary or ownership rights to the Life Insurance proceeds.

Personal Profile (This section must be completed to acquire life insurance.)

Complete this section for all Insured individuals, including any person to be covered by the Child Protection Plan.

	Insured	Insured Children (If Child Protection Plan is selected)
1. Have you ever used any form of tobacco or nicotine substitute?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Not Applicable
Form of Tobacco or Nicotine Substitute Date of Last Use How Often Used		
2. Has any Insured flown as a pilot, crew member or student pilot in the past two years or does any Insured plan to do so in the next year?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
DESCRIPTION	TYPE(S) OF AIRCRAFT	HOURS FLOWN
MILITARY		NEXT 12 MOS LAST 12 MOS 13-24 MOS AGO
COMMERCIAL		
CIVILIAN/PLEASURE		
TOTAL PILOT-IN-COMMAND HOURS: _____ MILITARY _____ CIVILIAN/PLEASURE		
3. Has any Insured participated in any of the following activities in the past three years or does any Insured plan to do so in the next year?	Automobile Racing	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No
	Ballooning	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No
	Hang-Gliding	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No
	Motorcycle Racing	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No
	Powerboat Racing	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No
	Rock/Mountain Climbing	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No
	Scuba Diving	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No
	Skydiving/Parachuting	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No
Ultralight Flying	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No	
Activity Last Activity Date Frequency Details (speeds attained, depths/heights reached, etc.)		
4. Does any Insured plan to travel to or reside in a foreign country within the next 12 months?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Country's Name	Purpose of Visit	Length of Stay
5. Has any Insured ever been convicted of Driving While Intoxicated or Driving Under the Influence or ever had a driver's license suspended or revoked or had any moving violations within the last three years?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Violation Type Date Details (speeds, length of suspension/revocation, etc.)		

Attach an additional sheet of paper if more space is needed.

Medical Information (This section must be completed to acquire life insurance.)

A. Medical Questionnaire

Complete this section for all Insured individuals, including any person to be covered by the Child Protection Plan. Provide details for any "Yes" answer in the Medical Details section.

		Insured	Insured Children (If Child Protection Plan is selected)
1. What is your current height and weight? ____ Feet ____ Inches ____ Lbs.			
2. Has there been any change in weight during the last 12 months for any Insured? If yes, indicate gain or loss. Gain ____ Lbs. Loss ____ Lbs.		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
3. Is any Insured currently receiving regular medical consultation?		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
4. Has any Insured consulted with a health care provider for a routine physical in the last 12 months?		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
5. Has any Insured ever consulted with a health care provider for:			
a.	seizures, paralysis, stroke, depression, anxiety or other mental or nervous system disorder?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
b.	asthma, emphysema, pneumonia or other respiratory system disorder?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
c.	chest pain, high blood pressure, murmur, heart attack or other heart or blood vessel disorder?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
d.	disorder of the throat, esophagus, stomach, intestines, rectum, liver or pancreas?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
e.	abnormal urine test or other disorder of the kidney, ureter or bladder?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
f.	diabetes or other endocrine or thyroid disorder?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
g.	arthritis, collagen vascular disease or disorder of the muscles, bones or skin?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
h.	any cancer or tumor?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
i.	disorder of the prostate or reproductive system?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
j.	hepatitis, anemia, disorder of the blood or lymph glands?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
6. Is any Insured currently taking prescription medication not previously disclosed?		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
7. Has any Insured been diagnosed for Human Immunodeficiency Virus (HIV) Infection, Acquired Immune Deficiency Syndrome (AIDS), AIDS-related complex (ARC), AIDS-related condition, or a sexually transmitted disease?		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
8. Has any Insured, within the past five years:			
a.	had an electrocardiogram, X-ray or any other diagnostic test or procedure that was not previously disclosed?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
b.	been advised to have any diagnostic test, hospitalization or surgery which was not completed?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
9. Has any Insured had an application for life or health insurance declined, postponed, modified or rated?		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
10. Has any Insured ever used an illegal drug or used a controlled substance without a physician's approval?		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
11. Has any Insured been diagnosed or treated for alcohol or drug abuse or been advised by a health care professional to discontinue the use of alcohol or to seek treatment for drug or alcohol dependency?		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
12. Has any Insured consulted a health care provider for any reason not previously disclosed?		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
13. Did your biological mother or father die before the age of 60 from cardiovascular disease or cancer?		<input type="checkbox"/> Yes <input type="checkbox"/> No	Not Applicable

MEDICAL DETAILS

Identify the question, name of Insured, date of visit, reason for visit, name and address or phone number of physician, type of treatment, and any medication prescribed. (ATTACH A SEPARATE SHEET IF MORE SPACE IS REQUIRED.)

[Empty box for medical details]

I have read the above statements and answers and represent that they are true and complete and correctly recorded. I agree that such statements and answers shall be part of the application and are made with the expectation that USAA LIFE INSURANCE COMPANY will consider the information when determining whether to issue the policy or contract for which I have applied.

Dated at _____ on _____, _____.
(City) (State) (Month) (Day) (Year)

X

Signature of Proposed Insured

Witness: _____
Signature of Medical Examiner

X

Signature of Custodial Parent of Child (if Child Protection Plan selected)

MEDICAL EXAMINER'S REPORT

This examination should be made in private. If 3rd person present, give details.

Name	USAA #	Details of "Yes" answers. (Identify item.)
D.O.B. Mo. Day Yr.	Contract #	

Identification: Driver's License Other _____

1. HEIGHT (IN SHOES)	WEIGHT (CLOTHED)	ABDOMEN AT UMBILICUS RELAXED
FT. IN.	LBS.	IN.

Did you weigh? Yes No Did you measure? Yes No
 Weight change in past year? _____ lbs. Gain Loss

2. Blood Pressure (Record all readings)	INITIAL READING	FOLLOW UP READING IF NEEDED	If initial BP Reading exceeds 129 Systolic, or 79 Diastolic. Complete 1 Additional BP Reading.
Systolic	_____	_____	
Diastolic	_____	_____	

3. Resting Pulse:
 Rate _____
 Irregularities Per Min. _____

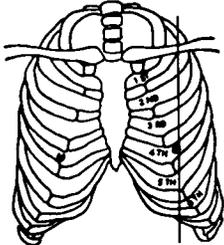
4. Heart:
 a. Are there physical findings of cyanosis, dyspnea, edema, arteriosclerosis,
 peripheral vascular or other cardiovascular disorder? Yes No
 b. Is murmur present? Yes No (If yes, complete 4c)

c. Murmur is: Systolic Apical Soft (Gr. 1-2)
 Constant Transmitted Presystolic Basal Mod. (Gr. 3-4)
 Inconstant Localized Diastolic Sternal Loud (Gr. 5-6)

After exercise: Unchanged Increased Other
 Decreased Absent

Show Location Of:
 Apex by _____
 Area of murmur by _____
 Point of greatest intensity by _____
 Transmission by _____
 Your impression? _____

XOOI ↓



5. Is there on examination any abnormality of the following:
 (Check applicable items and give details.)

	YES	NO
a. Eyes, ears, nose, mouth, pharynx?	<input type="checkbox"/>	<input type="checkbox"/>
(If vision or hearing markedly impaired, indicate degree and correction.)		
b. Skin (incl. scars); lymph nodes; blood vessels?	<input type="checkbox"/>	<input type="checkbox"/>
c. Nervous system (include reflexes, gait)?	<input type="checkbox"/>	<input type="checkbox"/>
d. Respiratory system?	<input type="checkbox"/>	<input type="checkbox"/>
e. Abdomen?	<input type="checkbox"/>	<input type="checkbox"/>
f. Genitourinary system (include prostate)?	<input type="checkbox"/>	<input type="checkbox"/>
g. Endocrine system (include thyroid and breasts)?	<input type="checkbox"/>	<input type="checkbox"/>
h. Musculoskeletal system (include spine, joints, amputations, deformities)?	<input type="checkbox"/>	<input type="checkbox"/>

6. Are there any hernias? YES NO

7. Have you any pertinent information not brought out above? YES NO

8. Urinalysis: SPECIFIC GRAVITY	ALBUMIN	SUGAR	To which lab was this specimen sent?
---------------------------------	---------	-------	--------------------------------------

I certify that I made this examination on the _____ day of _____ Year _____

Examiner's signature: _____ Address _____
 Examiner's name (print) _____ City _____
 State _____ Zip Code _____

Policy Change-Cont. (Some features and coverages are not available for all products in all states.)

C. Add Optional Coverages

- Disability Waiver of Premium (Not available for Universal Life or Variable Universal Life.)
- Waiver of Monthly Deduction (Available only for Universal Life and Variable Universal Life.)
- Increasing Coverage Benefit (ICB) (Available only for Annual Renewable Term [ART].)
- Accidental Death Benefit: \$ _____
- Child Protection Plan (Not available for Seven-Year Term): \$ _____
(Also, complete Child Protection Plan, Medical Information and Personal Profile sections.)

D. Change Options

- Universal Life Option to B (instead of Option A.)
- Variable Universal Life Option to B (instead of Option A.)

E. Other

- Premium Review
- Policy Exclusion Review
- Periodic Payment change to \$ _____
(Available only for Universal Life or Variable Universal Life.)
- _____

Child Protection Plan (Available only for those age 17 or younger. Not available in Hawaii.)

C. Child Protection Plan \$ _____
(age 17 or younger) Amount of Child Rider Insurance

Child's Name	Social Security Number	Date of Birth (mm/dd/yyyy)
--------------	------------------------	----------------------------

What is this child's total amount of life insurance protection, current and pending, excluding this application? \$ _____

Is this application for insurance intended to replace, discontinue or change any life insurance or annuities? Yes No If yes, list details. (Attach an additional sheet of paper if more space is needed.)

- Annuity
- Life Insurance \$ _____

Company Name	Amount	Policy/Contract Number
--------------	--------	------------------------

Child's Name	Social Security Number	Date of Birth (mm/dd/yyyy)
--------------	------------------------	----------------------------

What is this child's total amount of life insurance protection, current and pending, excluding this application? \$ _____

Is this application for insurance intended to replace, discontinue or change any life insurance or annuities? Yes No If yes, list details. (Attach an additional sheet of paper if more space is needed.)

- Annuity
- Life Insurance \$ _____

Company Name	Amount	Policy/Contract Number
--------------	--------	------------------------

Child's Name	Social Security Number	Date of Birth (mm/dd/yyyy)
--------------	------------------------	----------------------------

What is this child's total amount of life insurance protection, current and pending, excluding this application? \$ _____

Is this application for insurance intended to replace, discontinue or change any life insurance or annuities? Yes No If yes, list details. (Attach an additional sheet of paper if more space is needed.)

- Annuity
- Life Insurance \$ _____

Company Name	Amount	Policy/Contract Number
--------------	--------	------------------------

Attach an additional sheet of paper if more than three children.

Medical Information (This section must be completed to acquire life insurance.)

A. Medical Questionnaire

Complete this section for all Insured individuals, including any person to be covered by the Child Protection Plan. Provide details for any "Yes" answer in the Medical Details section.

		Insured	Insured Children (If Child Protection Plan is selected)
1. What is your current height and weight? _____ Feet _____ Inches _____ Lbs.			
2. Has there been any change in weight during the last 12 months for any Insured? If yes, indicate gain or loss. Gain _____ Lbs. Loss _____ Lbs.		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
3. Is any Insured currently receiving regular medical consultation?		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
4. Has any Insured consulted with a health care provider for a routine physical in the last 12 months?		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
5. Has any Insured ever consulted with a health care provider for:			
a.	seizures, paralysis, stroke, depression, anxiety or other mental or nervous system disorder?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
b.	asthma, emphysema, pneumonia or other respiratory system disorder?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
c.	chest pain, high blood pressure, murmur, heart attack or other heart or blood vessel disorder?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
d.	disorder of the throat, esophagus, stomach, intestines, rectum, liver or pancreas?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
e.	abnormal urine test or other disorder of the kidney, ureter or bladder?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
f.	diabetes or other endocrine or thyroid disorder?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
g.	arthritis, collagen vascular disease or disorder of the muscles, bones or skin?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
h.	any cancer or tumor?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
i.	disorder of the prostate or reproductive system?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
j.	hepatitis, anemia, disorder of the blood or lymph glands?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
6. Is any Insured currently taking prescription medication not previously disclosed?		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
7. Has any Insured been diagnosed for Human Immunodeficiency Virus (HIV) Infection, Acquired Immune Deficiency Syndrome (AIDS), AIDS-related complex (ARC), AIDS-related condition, or a sexually transmitted disease?		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
8. Has any Insured, within the past five years:			
a.	had an electrocardiogram, X-ray or any other diagnostic test or procedure that was not previously disclosed?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
b.	been advised to have any diagnostic test, hospitalization or surgery which was not completed?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
9. Has any Insured had an application for life or health insurance declined, postponed, modified or rated?		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
10. Has any Insured ever used an illegal drug or used a controlled substance without a physician's approval?		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
11. Has any Insured been diagnosed or treated for alcohol or drug abuse or been advised by a health care professional to discontinue the use of alcohol or to seek treatment for drug or alcohol dependency?		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
12. Has any Insured consulted a health care provider for any reason not previously disclosed?		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
13. Did your biological mother or father die before the age of 60 from cardiovascular disease or cancer?		<input type="checkbox"/> Yes <input type="checkbox"/> No	Not Applicable

B. Medical Details - Attach an additional sheet of paper if more space is needed.

Question Insured's name / / Date of Visit Physician's Name

Physician's Address

Reason For Visit

Type of Treatment Medication Prescribed (if any)

B. Medical Details - Attach an additional sheet of paper if more space is needed.

Question Insured's name

Personal Profile (This section must be completed to acquire life insurance.)

Complete this section for all Insured individuals, including any person to be covered by the Child Protection Plan.

	Insured	Insured Children (If Child Protection Plan is selected)
1. Have you ever used any form of tobacco or nicotine substitute?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Not Applicable
Form of Tobacco or Nicotine Substitute Date of Last Use How Often Used		
2. Has any Insured flown as a pilot, crew member or student pilot in the past two years or does any Insured plan to do so in the next year?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
DESCRIPTION	TYPE(S) OF AIRCRAFT	HOURS FLOWN
MILITARY		NEXT 12 MOS LAST 12 MOS 13-24 MOS AGO
COMMERCIAL		
CIVILIAN/PLEASURE		
TOTAL PILOT-IN-COMMAND HOURS: MILITARY CIVILIAN/PLEASURE		
3. Has any Insured participated in any of the following activities in the past three years or does any Insured plan to do so in the next year?	Automobile Racing	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No
	Ballooning	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No
	Hang-Gliding	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No
	Motorcycle Racing	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No
	Powerboat Racing	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No
	Rock/Mountain Climbing	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No
	Scuba Diving	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No
	Skydiving/Parachuting	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No
Ultralight Flying	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No	
Activity	Last Activity Date	Frequency Details (speeds attained, depths/heights reached, etc.)
4. Does any Insured plan to travel to or reside in a foreign country within the next 12 months?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Country's Name	Purpose of Visit	Length of Stay
5. Has any Insured ever been convicted of Driving While Intoxicated or Driving Under the Influence or ever had a driver's license suspended or revoked or had any moving violations within the last three years?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Violation Type	Date	Details (speeds, length of suspension/revocation, etc.)

Attach an additional sheet of paper if more space is needed.

Read and Sign

Effective Date of Coverage: I agree that no requested change in coverage will take effect prior to approval by the Company and notification to the Owner and then only if the health and insurability of each person is as stated in this application and in additional parts (if applicable), and the company is immediately notified in writing of any changes.

If the above conditions have been met, the revised coverage under the policy will be effective on the date the Company notifies the initial Owner of approval. I understand that any additional coverage will be subject to the suicide and incontestability provisions of the policy.

Insurance Fraud Warning

Arkansas, Louisiana, New Mexico, Ohio, West Virginia:

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

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 or a denial of insurance benefits.

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.

Kentucky, 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.

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.

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.



LIFE INSURANCE
PERSONAL FINANCIAL STATEMENT

Proposed Insured _____

USAA No. _____

I. PERSONAL INSURANCE DATA

- A. Amount of Life Insurance in force with all companies (exclude Employer Group) \$ _____
B. Amount of Accidental Death Coverage in force with all companies (exclude Travel Accidental Death Coverage) \$ _____
C. What is the purpose of the Life Insurance purchased with USAA Life Insurance Company?
[] Estate Protection [] Family Income Protection [] Debt Repayment

OTHER: _____

D. Do you have a Life Insurance application pending with any other company? [] YES [] NO
If YES, please give name of company, amount of coverage, and purpose of insurance.

E. In what field, industry, profession or vocation are you currently employed? _____

F. What is your job title/occupation? _____

II. PERSONAL INCOME STATEMENT For year ended _____

- A. Annual Earned Income B. Annual Unearned Income C. If Self-Employed
1. Salary/wages: \$ _____ 1. Dividends: \$ _____ 1. Gross Income: \$ _____
2. Bonus or Commission: \$ _____ 2. Interest: \$ _____ 2. Expenses: \$ _____
3. Other (Describe): \$ _____ 3. Rentals: \$ _____
4. Other: \$ _____
Total Earned Income: \$ _____ Total Unearned Income: \$ _____ Adjusted Gross Income: \$ _____
Total Income (Add Earned, Unearned and Adjusted Gross Income): \$ _____
D. Spouse's Earned Income: \$ _____

III. PERSONAL ASSET/LIABILITY STATEMENT

Assets (Current Market Value)

- Business Equity: \$ _____
Personal Assets: \$ _____
Real Estate: \$ _____
Stocks: \$ _____
Bonds: \$ _____
Cash, CDs, and Savings: \$ _____
Money Market Accounts: \$ _____
Accounts Receivable: \$ _____
Automobile(s): \$ _____
IRA & Keogh: \$ _____
Retirement Plan (401k, 403b, etc.) \$ _____
Other: \$ _____
Total Assets: \$ _____

Liabilities

- Mortgage(s): \$ _____
Interest Owed: \$ _____
Home Equity Loans: \$ _____
Auto Loans: \$ _____
Personal Loans: \$ _____
Charge Accounts: \$ _____
Credit Cards: \$ _____
Accounts Payable: \$ _____
Taxes Owed: \$ _____
Liens: \$ _____
Other: \$ _____
Total Liabilities: \$ _____

LESS Total Assets: \$ _____
EQUALS Total Liabilities: \$ _____
Net Worth: \$ _____

I understand that USAA Life Insurance Company will rely on the above statements in determining the need and justification for the insurance applied for, and I represent that all answers are true and accurate. A reproduction of this statement may be attached to and made part of any insurance policy issued.

Signature of Proposed Insured _____ Date _____

Signature of Owner (if other than Proposed Insured) _____ Date _____



FOREIGN TRAVEL QUESTIONNAIRE

Propose Insured's Name _____

USAA Number _____

Contract Number _____

You indicated you plan to travel or reside in a foreign country within the next 12 months.

1. To which proposed insured do the travel or foreign residence details apply?

2. What countries do you plan to reside in, or travel to? _____

3. Within those countries, which cities will you stay in? _____

4. How long do you plan to remain in each country being traveled to? _____

5. How frequently do you plan to travel to any of the above named countries? _____

6. What is the purpose of the travel (Business, Military Duty, Missionary Travel, Vacation, etc)?

7. If the purpose for travel is business, please provide the name of your employer and details of your day-to-day job duties. _____

I understand that USAA Life Insurance Company will rely on the above statements in determining the need and justification for the insurance applied for, and I represent that all answers are true and accurate. A reproduction of this statement may be attached to and made part of any insurance policy issued.

Signed at _____ this _____ day of _____, _____
City State Year

Signature of Proposed Insured

Transmittal Header

SERT-6GPLF7346/00-00/00-00/00
 Created by Tim Stoner on 09/29/2005
 Assigned To: Linda Bird, [Receiver]
 Company List: USAA Life Insurance Company
 publicAccess
 No value

Sent: 09/29/2005 02:05:04 PM
 Other Authors: None
 TOI: Life/Annuity-Individual
 SubTOI: Life-Whole

Filing Information:

Filing Action:	Initial	Filing Date:	09/29/2005
State:	Arkansas	State Instance:	None
State Domain:	None	Identifier:	
Type of Insurance:	Life/Annuity-Individual	Filing Type:	Form
Product Name:	Simplified Life Application	Sub TOI:	Life-Whole
Implementation Date Requested:	None	Effective Date Requested:	None
Project Name:	Simplified Life Application	Project #:	TKS08272005
Fee Required:	No	Fee Amount:	
Reference Filing:	No	Reference Org:	None
Reference #:	None	Advisory Org Circular #:	None

Components sent originally with filing:

SERT-6GPLF7346/00-01/00-00/00
 SERT-6GPLF7346/00-02/00-00/00
 SERT- 6GPLF7346/00-03/00-00/00
 SERT-6GPLF7346/00-04/00-00/00
 SERT-6GPLF7346/00-0 5/00-00/00

Company Contact:

Lead Company: USAA

Filing Company Info	Contact Info
USAA Life Insurance Company 9800 Fredericksburg Road, San Antonio, TX 78288 USA Phone: 800-531-8000 FAX: 210-498-0083 CoCode: 69663 Group Code: 200 FEIN: 74-1472662 State of Domicile: Texas State ID Number: None.	Timothy Stoner Compliance Analyst USAA 9800 Fredericksburg Road, B-1-E, Operations Compliance 47195, San Antonio, TX 78288 Phone: 800-531-8000 ext. 84612 FAX: 210-498-0083 Email: timothy.stoner@usaa.com

Submission Requirements:

Status	Requirement
Satisfied	Cover letter
Satisfied	L/font>
Bypassed	Lont>
Bypassed	L Justification

Tracking Information:

Transmittal Header SERT-6GPLF7346/00-00/00-00/00

Company Tracking #:	None	State Tracking #:	30737
Company Status:	None	State Status:	None
Date Company Status Changed:	None	Date State Status Changed:	None
SERFF Tracking #:	SERT-6GPLF7346/00	Delivery Date:	09/29/2005 02:11:36 PM
SERFF Status:	Closed - Approved	Disposition Date:	10/03/2005
Date SERFF Status Changed:	10/03/2005	Implementation Date:	None
Deemer Date:	None	Effective Date:	None
Reviewers:	Linda Bird, [Receiver]		

Additional State Tracking Numbers

USAA Life Insurance Company 30737

State-Specific Fields:

No State-Specific Fields present for this State.

Filing Description: None

File Attachments: None

Disposition Report

Report Type: Disposition Report

Filing Originally Sent: 09/29/2005 02:05:04 PM

Created by Linda Bird on 10/03/2005

Sent: 10/03/2005 03:03:37 PM

State: Arkansas
SERFF Tracking No.: SERT-6GPLF7346/00-00/00-01/00

Response To: TransmittalHeader
Response To No.: SERT-6GPLF7346/00-00/00-00/00
SERFF Tracking No.:

Lead Company: USAA
Product Name: Simplified Life Application
Filing Date: 09/29/2005 02:05:04 PM

Company: USAA Life Insurance Company
Project Name: Simplified Life Application
Project No.: TKS08272005

State Tracking No.: 30737

Company Tracking No.: None

TOI: Life/Annuity-Individual
Disposition: Approved
Reviewer Phone No.: None

Sub TOI: Life-Whole
SERFF Status: None

No disposition descriptions.

Disposition: Approved
Disposition Date: 10/03/2005
Effective Date: None
Type:
Effective Date: None
Implementation Date: None
Date:
Deemer Date: None
Comments: None

Applies to Components

CH 01/00 --- Cover letter
CH 02/00 --- LBR>CH 03/00 --- L>CH 04/00 --- LJustification
CH 05/00 --- Life Insurance Applications an

File Attachments: None

Component Header

Component 01 – Rev 00
Created by Tim Stoner on 09/29/2005
Assigned To: Linda Bird, [Receiver]
Company List: USAA Life Insurance Company

Sent: 09/29/2005 02:05:04 PM
Other Authors: None
TOI: Life/Annuity-Individual
SubTOI: Life-Whole

Tracking Information:

State: Arkansas
State Tracking #: 30737
Component Status (State): Approved
Disposition Date: None
Implementation Date: None
Deemer Date: None
Effective Date: None
Requirement Status: None

SERFF Tracking #: SERT-6GPLF7346/00-01/00-00/00
Component Status (SERFF): Closed – Approved
Delivery Date: 09/29/2005 02:11:37 PM
Reviewer: Linda Bird, [Receiver]
Reviewer Phone: None
Reviewer Fax: None
Primary Reviewer: None

Component Information:

Component Type: Supporting Documentation
Lead Form Number: LAP50570ST 06-05
Requirement Satisfied: Cover letter
Brief Description: Cover Letter
Filer's Notes: None
Document(s): None

Component Action: Initial
State Specific Code: 200-69663

Company Contact:

Lead Company: USAA

Company Information

USAA Life Insurance Company

Contact

Stoner, Timothy

File Attachments: Cvr Ltr.AR.pdf



9800 Fredericksburg Road
San Antonio, Texas 78288

September 29, 2005

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

USAA Life Insurance Company
NAIC No. 200-69663
FEIN 74-1472662

RE: Form No. LAP50570ST 06-05, *et al.* Life Insurance Application

Sir:

Enclosed please find the above referenced application forms submitted for approval. This is a new application intended for use with existing life policies previously approved by your department, as well as forms that will be used with the application in the underwriting process. We also plan to make this application available on life policies that would be submitted for approval in the future. We are filing the application in 50 other jurisdictions and will modify only to meet respective state requirements:

Form No.	Description	Status
LAP50570ST 06-05, LAP50571ST 06-05	Term Life Insurance Application	New
LAP50580ST 06-05, LAP50581ST 06-05	Whole Life Insurance Application	New
LAP50584ST 06-05, LAP50585ST 06-05	Simplified Whole Life Insurance Application	New
LAP50588ST 06-05, LAP50589ST 06-05	Universal Life Insurance Application	New
LAP50592ST 06-05	7 Year Term Life Insurance Application	New
MUF50593ST 06-05	Examiner's Report	New

LAP50594ST 06-05	Application for Life Insurance Policy Change	New
LUF18294ST 08-05	Foreign Travel Questionnaire	New
LUF07562ST 12-93	Personal Financial Statement	Revised

Notes to Aid in Your Review

The application consists of fixed-text forms that vary only by product, as shown above, and by an additional two pages of underwriting questions. In most cases the insured will receive the shorter form which will be pre-filled based on a telephone conversation with one of our licensed representatives. The insured must sign and return the application. Underwriting information would be obtained at a later date by means of a physical examination (paramed) using form number MUF50593ST 06-05, which would be considered as part of the application and the issued policy. For those insured that are unable to schedule an exam owing to a military deployment or other exigency, we will send the longer version of the application that contains two pages of underwriting questions. The underwriting evaluation will be based on that application without a physical exam.

The application forms will be used for the following life policies previously approved by your department:

Form numbers LAP50570ST 06-05 and LAP50571ST 06-05 will be used to apply for Level Term Life Insurance policy LLT30653AR 10-97, approved May 12, 1998.

Form numbers LAP50580ST 06-05 and LAP50581ST 06-05 will be used to apply for Whole Life Insurance policy LWL42068AR 08-02, approved January 4, 2003.

Form numbers LAP50584ST 06-05 and LAP50585ST 06-05 will be used to apply for Simplified Whole Life Insurance policy LWL39088AR 07-01, approved August 2, 2001.

Form numbers LAP50588ST 06-05 and LAP50589ST 06-05 will be used to apply for Universal Life Insurance policy UL594-0825 6-87, approved December 11, 2001.

Form number LAP50592ST 06-05 will be used to apply for 7 Year Term Insurance policy SY594-0102 2-83, approved September 25, 2003.

The information to complete the application is based on our representative's telephone conversation with the proposed insured. This does not constitute taking an application over the phone. It is taking the information for the application so that when the form arrives in the mail it will have been completed as fully as possible for the convenience of the applicant. In most cases all that will be required is for the proposed insured to review and sign the application. The application will be delivered by regular mail or by email, and may be submitted with an e-signature using existing procedures for the delivery of our applications by email.

The Medical Examiner's Report (MUF50593ST 06-05) is a separate part of the application used to gather detailed information for underwriting, as described above. It will be used when the "short" form of the application is sent.

The Application for Policy Change (LAP50594ST 06-05) is used for changes to the policy after issue.

Both the Foreign Travel Questionnaire (LUF18294ST 08-05) and the Personal Financial Statement (LUF07562ST 12-93) will be used only when additional information is needed by underwriting; these forms will be sent out as needed and will not accompany every application.

In all cases the application will meet the readability requirements of our state.

We may modify the application for use with other products in the future, in which case we would notify you by informational filing.

Should you have any questions or concerns, please contact Timothy Stoner toll free at 1-800-531-8000, extension 84612. You may also dial direct at (210) 498-4612. Fax is available at (210) 498-0083, and Tim's email account is Timothy.Stoner@usaa.com.

Sincerely,

A handwritten signature in black ink that reads "Kristi Matus". The signature is written in a cursive style with a large initial 'K' and 'M'.

Kristi Matus
President
USAA Life Insurance Company

Component Header

Component 02 – Rev 00
Created by Tim Stoner on 09/29/2005
Assigned To: Linda Bird, [Receiver]
Company List: USAA Life Insurance Company

Sent: 09/29/2005 02:05:04 PM
Other Authors: None
TOI: Life/Annuity-Individual
SubTOI: Life-Whole

Tracking Information:

State: Arkansas
State Tracking #: 30737
Component Status (State): Approved
Disposition Date: None
Implementation Date: None
Deemer Date: None
Effective Date: None
Requirement Status: None

SERFF Tracking #: SERT-6GPLF7346/00-02/00-00/00
Component Status (SERFF): Closed – Approved
Delivery Date: 09/29/2005 02:11:37 PM
Reviewer: Linda Bird, [Receiver]
Reviewer Phone: None
Reviewer Fax: None
Primary Reviewer: None

Component Information:

Component Type: Supporting Documentation
Component Action: Initial
Lead Form Number: LAP50570ST 06-05
Requirement Satisfied: L/FONT>
State Specific Code: 200-69663
Brief Description: Certification of Compliance with Reg 19 and Certification of Readability
Filer's Notes: None
Document(s): None

Company Contact:

Lead Company: USAA

Company Information

USAA Life Insurance Company

Contact

Stoner, Timothy

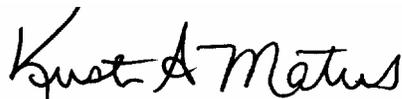
File Attachments: Certif of Compliance with Rule 19.pdf, Certificate of Readability.AR.pdf

Certificate of Compliance with Arkansas Rule and Regulation 19

Insurer: USAA Life Insurance Company

Form Number(s): LAP50570ST 06-05, LAP50571ST 06-05, LAP50580ST 06-05, LAP50581ST 06-05,
LAP50584ST 06-05, LAP50585ST 06-05, LAP50588ST 06-05, LAP50589ST 06-05,
LAP50592ST 06-05, MUF50593ST 06-05, LAP50594ST 06-05,
LUF18294ST 08-05, LUF07562ST 12-93

I hereby certify that the filing above meets all applicable Arkansas requirements including the requirements of Rule and Regulation 19.



Signature of Company Officer

Kristi A. Matus

Name

President

Title

September 29, 2005

Date

CERTIFICATE OF READABILITY

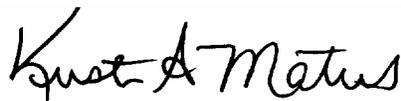
September 29, 2005

Form #	Description	Flesch Score
LAP50570ST 06-05	Term Life Insurance Application	41
LAP50571ST 06-05	Term Life Insurance Application	44
LAP50580ST 06-05	Whole Life Insurance Application	41
LAP50581ST 06-05	Whole Life Insurance Application	45
LAP50584ST 06-05	Simplified Whole Life Insurance Application	40
LAP50585ST 06-05	Simplified Whole Life Insurance Application	44
LAP50588ST 06-05	Universal Life Insurance Application	40
LAP50589ST 06-05	Universal Life Insurance Application	43
LAP50592ST 06-05	7 Year Term Life Insurance Application	42
MUF50593ST 06-05	Examiner's Report	51
LAP50594ST 06-05	Application for Life Insurance Policy Change	42
LUF18294ST 08-05	Foreign Travel Questionnaire	53
LUF07562ST 12-93	Personal Financial Statement	46

The print is ten point type, one point leaded.

The text was Flesch scored by computer.

I certify that to the best of my knowledge and belief, the above referenced forms meet or exceed the readability, legibility, and format requirements of any applicable laws and regulations of the state of Arkansas.



Kristi A. Matus
President
USAA Life Insurance Company

Component Header

Component 03 – Rev 00
Created by Tim Stoner on 09/29/2005
Assigned To: Linda Bird, [Receiver]
Company List: USAA Life Insurance Company

Sent: 09/29/2005 02:05:04 PM
Other Authors: None
TOI: Life/Annuity-Individual
SubTOI: Life-Whole

Tracking Information:

State: Arkansas
State Tracking #: 30737
Component Status (State): Approved
Disposition Date: None
Implementation Date: None
Deemer Date: None
Effective Date: None
Requirement Status: Bypassed
Reason: Please see Component 5 for all forms.

SERFF Tracking #: SERT-6GPLF7346/00-03/00-00/00
Component Status (SERFF): Closed – Approved
Delivery Date: 09/29/2005 02:11:36 PM
Reviewer: Linda Bird, [Receiver]
Reviewer Phone: None
Reviewer Fax: None
Primary Reviewer: None

Component Information:

Component Type: Form
Lead Form Number: LAP50570ST 06-05
Form Title: Term Life Insurance Application
Readability Score: None
Requirement Satisfied: LONT>
Brief Description: None
Filer's Notes: None
Document(s): None

Component Action: Initial
State Specific Code: 200-69663
Company Form Number: None
Replaces Form Number: None

Company Contact:

Lead Company: USAA

Company Information

USAA Life Insurance Company

Contact

Stoner, Timothy

File Attachments: None

Component Header

Component 04 – Rev 00
Created by Tim Stoner on 09/29/2005
Assigned To: Linda Bird, [Receiver]
Company List: USAA Life Insurance Company

Sent: 09/29/2005 02:05:04 PM
Other Authors: None
TOI: Life/Annuity-Individual
SubTOI: Life-Whole

Tracking Information:

State: Arkansas
State Tracking #: 30737
Component Status (State): Approved
Disposition Date: None
Implementation Date: None
Deemer Date: None
Effective Date: None
Requirement Status: Bypassed
Reason: Not required. This is application only, not policy.

SERFF Tracking #: SERT-6GPLF7346/00-04/00-00/00
Component Status (SERFF): Closed – Approved
Delivery Date: 09/29/2005 02:11:38 PM
Reviewer: Linda Bird, [Receiver]
Reviewer Phone: None
Reviewer Fax: None
Primary Reviewer: None

Component Information:

Component Type: Form
Lead Form Number: LAP50570ST 06-05
Form Title: Term Life Insurance Application
Readability Score: None
Requirement Satisfied: L Justification
Brief Description: None
Filer's Notes: None
Document(s): None

Component Action: Initial
State Specific Code: 200-69663
Company Form Number: None
Replaces Form Number: None

Company Contact:

Lead Company: USAA

Company Information

USAA Life Insurance Company

Contact

Stoner, Timothy

File Attachments: None

Component Header

Component 05 – Rev 00
Created by Tim Stoner on 09/29/2005
Assigned To: Linda Bird, [Receiver]
Company List: USAA Life Insurance Company

Sent: 09/29/2005 02:05:04 PM
Other Authors: None
TOI: Life/Annuity-Individual
SubTOI: Life-Whole

Tracking Information:

State: Arkansas
State Tracking #: 30737
Component Status (State): Approved
Disposition Date: None
Implementation Date: None
Deemer Date: None
Effective Date: None
Requirement Status: None

SERFF Tracking #: SERT-6GPLF7346/00-05/00-00/00
Component Status (SERFF): Closed – Approved
Delivery Date: 09/29/2005 02:11:38 PM
Reviewer: Linda Bird, [Receiver]
Reviewer Phone: None
Reviewer Fax: None
Primary Reviewer: None

Component Information:

Component Type: Form
Lead Form Number: LAP50570ST 06-05
Form Title: Term Life Insurance Application
Readability Score: None
Requirement Satisfied: N/A
Brief Description: Life Insurance Applications and associated forms
Filer's Notes: None
Document(s): None

Component Action: Initial
State Specific Code: 200-69663
Company Form Number: None
Replaces Form Number: None

Company Contact:

Lead Company: USAA

Company Information

USAA Life Insurance Company

Contact

Stoner, Timothy

File Attachments:

LAP50570ST 06-05.PDF, LAP50571ST 06-05.PDF, LAP50580ST 06-05.PDF, LAP50581ST 06-05.PDF, LAP50584ST 06-05.PDF, LAP50585ST 06-05.PDF, LAP50588ST 06-05.PDF, LAP50589ST 06-05.PDF, LAP50592ST 06-05.PDF, MUF50593ST 06-05.pdf, LAP50594ST 06-05.pdf, LUF07652ST 12-93.pdf, LUF18294ST 08-05.pdf



9800 Fredericksburg Road
San Antonio, Texas 78288

Term Life Insurance Application

Step 1. Verify and complete the following information. Make changes to incorrect information directly on this application. Initial each change.

Step 2. Return completed and signed application to USAA Life.

IMPORTANT INFORMATION. Federal law requires us to obtain, verify and record your name, address, date of birth and other information that will allow us to identify you when you open an account and in certain other circumstances.

Personal Information

A. Insured

USAA Number _____ Social Security Number _____ / / _____
Date of Birth (mm/dd/yyyy)

Name _____

Mailing Address _____

Physical/Residence Address _____

Residence Phone Number (include area code) _____ E-mail Address _____

Occupation _____ \$
Annual Income _____

Branch of Service _____ Rank _____ Military Status _____

Female Male

Gender _____ State of Birth _____ Driver's License Number _____ State of Issue _____

Are you a U.S. citizen? Yes No

What is your total amount of life insurance protection, current and pending, excluding this application? _____

Is this application for insurance intended to replace, discontinue or change any life insurance or annuities?

Yes No If yes, list details. (Attach an additional sheet of paper if more space is needed.)

Annuity

Life Insurance \$

Company Name _____ Amount _____ Policy/ Contract Number _____

Annuity

Life Insurance \$

Company Name _____ Amount _____ Policy/ Contract Number _____

B. Owner

USAA Number _____ Social Security Number _____ / / _____
(or Tax ID Number) (If trust, provide date of inception.)

Name (If trust, provide name of trust and trustee.) _____ Relationship to Insured _____

Mailing Address _____

Physical/Residence Address _____

Residence Phone Number (include area code) _____ E-mail Address _____

Are you a U.S. citizen? Yes No

USAA Life Insurance Company ▪ (888) 275-5330 ▪ Fax (877) 435-7099 ▪ usaa.com

C. Payor

USAA Number _____ Social Security Number _____ Date of Birth (mm/dd/yyyy) _____
(or Tax ID Number) (If trust, provide date of inception.)

Name (If trust, provide name of trust and trustee.) _____

Mailing Address _____

Physical/Residence Address _____

Residence Phone Number (include area code) _____

E-mail Address _____

Are you a U.S. citizen? Yes No

Product and Optional Coverages

A. Product

Insurance Product Name _____ \$ Insurance Amount _____

B. Optional Coverage

Disability Waiver of Premium (age 55 or younger) Accidental Death Benefit (ADB) \$ _____ Amount
(age 60 or younger)

C. Child Protection Plan \$ _____ Amount of Child Rider Insurance
(age 17 or younger)

Child's Name _____ Social Security Number _____ Date of Birth (mm/dd/yyyy) _____

What is this child's total amount of life insurance protection, current and pending, excluding this application? \$ _____

Is this application for insurance intended to replace, discontinue or change any life insurance or annuities? Yes No If yes, list details. (Attach an additional sheet of paper if more space is needed.)

Annuity
 Life Insurance \$ _____

Company Name _____ Amount _____ Policy/ Contract Number _____

Child's Name _____ Social Security Number _____ Date of Birth (mm/dd/yyyy) _____

What is this child's total amount of life insurance protection, current and pending, excluding this application? \$ _____

Is this application for insurance intended to replace, discontinue or change any life insurance or annuities? Yes No If yes, list details. (Attach an additional sheet of paper if more space is needed.)

Annuity
 Life Insurance \$ _____

Company Name _____ Amount _____ Policy/ Contract Number _____

Attach an additional sheet of paper if more than two children.

Beneficiary Information

Primary Beneficiary Name (If trust, provide name of trust.) Social Security Number (or Tax ID Number) Date of Birth (mm/dd/yyyy) Relationship to Insured (If trust, provide date of inception.)

Contingent Beneficiary Name (If trust, provide name of trust.) Social Security Number (or Tax ID Number) Date of Birth (mm/dd/yyyy) Relationship to Insured (If trust, provide date of inception.)

Attach an additional sheet of paper if more space is needed.

Payment Information

A. Method

Automatic Payment Plan (APP): \$ (For APP, complete section C. Financial Information) Direct Billing: \$ Monthly Government Allotment : \$

B. Frequency of Payment

Monthly (not available with Direct Billing) Quarterly Semi-Annually Annually

C. Financial Information (Complete only if APP is selected.)

I authorize USAA Life Insurance Company to make electronic withdrawals and deposits to my account listed below until I notify USAA Life that I terminate authorization and USAA Life has reasonable time to act. I acknowledge that the origination of Automated Clearing House (ACH) transactions to my account must comply with U.S. law.

Specify a day between the 1st and 28th of the month for payment. Day

Checking Savings

Name of Financial Institution Name(s) of Account Holder Type of Account

Transit Routing Number (the nine-digit number in the lower-left corner of check or deposit slip) Account Number

X Signature of Account Holder Date (mm/dd/yyyy)

Additional Information

Provide any additional information or details you want considered below.

Four horizontal lines for providing additional information.

Read and Sign

Effective Date of Coverage: I agree that, except as provided in the company's Temporary Insurance Agreement, no insurance coverage will take effect prior to delivery of the policy to the Owner and then only if all of the following conditions have been met:

- (1) the health and insurability of each person is as stated in this application and in additional parts (if applicable), and the company is immediately notified in writing of any changes; and
- (2) the company has received the first full premium payment while each person is alive.

If the above conditions have been met, coverage under the policy will be effective on the date the policy is delivered to the Owner; provided however, that if a later effective date has been requested, coverage under the policy will be effective on that later date. I understand that any insurance coverage issued will be subject to the suicide and incontestability provisions of the policy. These provisions begin on the effective date.

Insurance Fraud Warning

Arkansas, Louisiana, New Mexico, Ohio, West Virginia:

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

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 or a denial of insurance benefits.

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.

Kentucky, 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.

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.

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.

Authorization: I understand the information obtained by use of this Authorization will be used by USAA Life to determine my eligibility for life insurance. I understand that information released pursuant to this Authorization may no longer be protected by federal privacy regulations and could be subject to redisclosure. I understand that although this authorization is voluntary, USAA Life reserves the right to decline to issue the insurance applied for if I refuse to grant this authorization.

I authorize the following persons and organizations to provide information to USAA Life Insurance Company ("USAA Life"): (a) any licensed physician; (b) any medical practitioner; (c) any hospital; (d) any insurance company; (e) any clinic, Veteran's Administration clinic, or medically-related facility; (f) Medical Information Bureau (MIB); (g) any psychiatrist or psychologist; (h) any health facility; (i) any consumer reporting agency.

For purposes of this Authorization, "information" means any records or knowledge concerning any insured's health or mental condition, general character and driving record.

This includes the release of the entire medical record of any Insured including all information about AIDS, HIV, drugs, alcoholism, or mental illness. This Authorization overrides any existing agreement to restrict information pursuant to 45 CFR 164.522.

I further authorize a consumer reporting agency to make an investigative report on me if it is requested by USAA Life and expect to be interviewed if a report is prepared.

I authorize the above listed sources to provide records or knowledge to any agency employed by USAA Life to collect and transmit such information. A reproduction of this Authorization shall be as valid as the original. I agree this Authorization shall be valid for twenty-four (24) months from the date signed, and upon request I or my authorized representative can receive a copy of this Authorization. I understand that I may revoke this Authorization by sending a written request to USAA Life. A revocation does not affect any action taken by USAA Life in reliance on the authorization prior to the revocation, nor does it have any effect on any right of contestability under the policy.

I have read and understand this authorization. I have received, read and understand the enclosed Notice of Privacy and Disclosure Practices.

Acknowledgment: I have read the questions and answers in this application. I represent that all statements and answers provided in this application and as part of the application process are true, complete and correctly recorded and will be relied upon by USAA Life Insurance Company to form the basis of any policy which may be issued. I agree that a copy of this application, if approved, will be a part of any policy issued. I understand I may not receive an illustration until the policy is issued.

Printed Name of Insured

X
Signature of Insured _____ Date (mm/dd/yyyy) _____ City _____ State _____

X
Signature of Owner (if different than Insured) _____ Date (mm/dd/yyyy) _____

X
Signature of Custodial Parent of Child (if Child Protection Plan selected) _____ Date (mm/dd/yyyy) _____



9800 Fredericksburg Road
San Antonio, Texas 78288

Term Life Insurance Application

Step 1. Verify and complete the following information. Make changes to incorrect information directly on this application. Initial each change.

Step 2. Return completed and signed application to USAA Life.

IMPORTANT INFORMATION. Federal law requires us to obtain, verify and record your name, address, date of birth and other information that will allow us to identify you when you open an account and in certain other circumstances.

Personal Information

A. Insured

USAA Number _____ Social Security Number _____ Date of Birth (mm/dd/yyyy) _____ / _____ / _____

Name _____

Mailing Address _____

Physical/Residence Address _____

Residence Phone Number (include area code) _____ E-mail Address _____

Occupation _____ Annual Income \$ _____

Branch of Service _____ Rank _____ Military Status _____

Female Male

Gender _____ State of Birth _____ Driver's License Number _____ State of Issue _____

Are you a U.S. citizen? Yes No

What is your total amount of life insurance protection, current and pending, excluding this application? _____

Is this application for insurance intended to replace, discontinue or change any life insurance or annuities?

Yes No If yes, list details. (Attach an additional sheet of paper if more space is needed.)

Annuity

Life Insurance \$ _____

Company Name _____ Amount _____ Policy/ Contract Number _____

Annuity

Life Insurance \$ _____

Company Name _____ Amount _____ Policy/ Contract Number _____

B. Owner

USAA Number _____ Social Security Number (or Tax ID Number) _____ Date of Birth (mm/dd/yyyy) (If trust, provide date of inception.) _____ / _____ / _____

Name (If trust, provide name of trust and trustee.) _____ Relationship to Insured _____

Mailing Address _____

Physical/Residence Address _____

Residence Phone Number (include area code) _____ E-mail Address _____

Are you a U.S. citizen? Yes No

USAA Life Insurance Company ▪ (888) 275-5330 ▪ Fax (877) 435-7099 ▪ usaa.com

C. Payor

USAA Number _____ Social Security Number (or Tax ID Number) _____ Date of Birth (mm/dd/yyyy) (If trust, provide date of inception.) _____ / /

Name (If trust, provide name of trust and trustee.) _____

Mailing Address _____

Physical/Residence Address _____

Residence Phone Number (include area code) _____

E-mail Address _____

Are you a U.S. citizen? Yes No

Product and Optional Coverages

A. Product

Insurance Product Name _____ \$ Insurance Amount _____

B. Optional Coverage

Disability Waiver of Premium (age 55 or younger) Accidental Death Benefit (ADB) \$ _____ (age 60 or younger) Amount _____

C. Child Protection Plan \$ _____ (age 17 or younger) Amount of Child Rider Insurance _____

Child's Name _____ Social Security Number _____ Date of Birth (mm/dd/yyyy) _____ / /

What is this child's total amount of life insurance protection, current and pending, excluding this application? \$ _____

Is this application for insurance intended to replace, discontinue or change any life insurance or annuities? Yes No If yes, list details. (Attach an additional sheet of paper if more space is needed.)

Annuity Life Insurance \$ _____

Company Name _____ Amount _____ Policy/ Contract Number _____

Child's Name _____ Social Security Number _____ Date of Birth (mm/dd/yyyy) _____ / /

What is this child's total amount of life insurance protection, current and pending, excluding this application? \$ _____

Is this application for insurance intended to replace, discontinue or change any life insurance or annuities? Yes No If yes, list details. (Attach an additional sheet of paper if more space is needed.)

Annuity Life Insurance \$ _____

Company Name _____ Amount _____ Policy/ Contract Number _____

Attach an additional sheet of paper if more than two children.

Beneficiary Information

Primary Beneficiary Name (If trust, provide name of trust.) Social Security Number (or Tax ID Number) Date of Birth (mm/dd/yyyy) Relationship to Insured (If trust, provide date of inception.)

Contingent Beneficiary Name (If trust, provide name of trust.) Social Security Number (or Tax ID Number) Date of Birth (mm/dd/yyyy) Relationship to Insured (If trust, provide date of inception.)

Attach an additional sheet of paper if more space is needed.

Payment Information

A. Method

Automatic Payment Plan (APP): \$ Direct Billing: \$
Monthly Government Allotment : \$

B. Frequency of Payment

Monthly (not available with Direct Billing) Quarterly Semi-Annually Annually

C. Financial Information (Complete only if APP is selected.)

I authorize USAA Life Insurance Company to make electronic withdrawals and deposits to my account listed below until I notify USAA Life that I terminate authorization and USAA Life has reasonable time to act. I acknowledge that the origination of Automated Clearing House (ACH) transactions to my account must comply with U.S. law.

Specify a day between the 1st and 28th of the month for payment. Day

Checking Savings

Name of Financial Institution Name(s) of Account Holder Type of Account

Transit Routing Number (the nine-digit number in the lower-left corner of check or deposit slip) Account Number

X Signature of Account Holder Date (mm/dd/yyyy)

Additional Information

Provide any additional information or details you want considered below.

Blank lines for additional information.

Medical Information (This section must be completed to acquire life insurance.)

A. Medical Questionnaire

Complete this section for all Insured individuals, including any person to be covered by the Child Protection Plan. Provide details for any "Yes" answer in the Medical Details section.

		Insured	Insured Children (If Child Protection Plan is selected)
1. What is your current height and weight? _____ Feet _____ Inches _____ Lbs.			
2. Has there been any change in weight during the last 12 months for any Insured? If yes, indicate gain or loss. Gain _____ Lbs. Loss _____ Lbs.		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
3. Is any Insured currently receiving regular medical consultation?		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
4. Has any Insured consulted with a health care provider for a routine physical in the last 12 months?		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
5. Has any Insured ever consulted with a health care provider for:			
a.	seizures, paralysis, stroke, depression, anxiety or other mental or nervous system disorder?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
b.	asthma, emphysema, pneumonia or other respiratory system disorder?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
c.	chest pain, high blood pressure, murmur, heart attack or other heart or blood vessel disorder?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
d.	disorder of the throat, esophagus, stomach, intestines, rectum, liver or pancreas?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
e.	abnormal urine test or other disorder of the kidney, ureter or bladder?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
f.	diabetes or other endocrine or thyroid disorder?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
g.	arthritis, collagen vascular disease or disorder of the muscles, bones or skin?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
h.	any cancer or tumor?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
i.	disorder of the prostate or reproductive system?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
j.	hepatitis, anemia, disorder of the blood or lymph glands?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
6. Is any Insured currently taking prescription medication not previously disclosed?		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
7. Has any Insured been diagnosed for Human Immunodeficiency Virus (HIV) Infection, Acquired Immune Deficiency Syndrome (AIDS), AIDS-related complex (ARC), AIDS-related condition, or a sexually transmitted disease?		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
8. Has any Insured, within the past five years:			
a.	had an electrocardiogram, X-ray or any other diagnostic test or procedure that was not previously disclosed?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
b.	been advised to have any diagnostic test, hospitalization or surgery which was not completed?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
9. Has any Insured had an application for life or health insurance declined, postponed, modified or rated?		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
10. Has any Insured ever used an illegal drug or used a controlled substance without a physician's approval?		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
11. Has any Insured been diagnosed or treated for alcohol or drug abuse or been advised by a health care professional to discontinue the use of alcohol or to seek treatment for drug or alcohol dependency?		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
12. Has any Insured consulted a health care provider for any reason not previously disclosed?		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
13. Did your biological mother or father die before the age of 60 from cardiovascular disease or cancer?		<input type="checkbox"/> Yes <input type="checkbox"/> No	Not Applicable

B. Medical Details - Attach an additional sheet of paper if more space is needed.

Question Insured's name Date of Visit Physician's Name

Physician's Address

Reason For Visit

Type of Treatment Medication Prescribed (if any)

B. Medical Details - Attach an additional sheet of paper if more space is needed.

Question Insured's name

Personal Profile (This section must be completed to acquire life insurance.)

Complete this section for all Insured individuals, including any person to be covered by the Child Protection Plan.

	Insured	Insured Children (If Child Protection Plan is selected)
1. Have you ever used any form of tobacco or nicotine substitute?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Not Applicable
Form of Tobacco or Nicotine Substitute Date of Last Use How Often Used		
2. Has any Insured flown as a pilot, crew member or student pilot in the past two years or does any Insured plan to do so in the next year?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
DESCRIPTION	TYPE(S) OF AIRCRAFT	HOURS FLOWN
MILITARY		NEXT 12 MOS LAST 12 MOS 13-24 MOS AGO
COMMERCIAL		
CIVILIAN/PLEASURE		
TOTAL PILOT-IN-COMMAND HOURS: _____ MILITARY _____ CIVILIAN/PLEASURE		
3. Has any Insured participated in any of the following activities in the past three years or does any Insured plan to do so in the next year?	Automobile Racing	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No
	Ballooning	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No
	Hang-Gliding	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No
	Motorcycle Racing	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No
	Powerboat Racing	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No
	Rock/Mountain Climbing	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No
	Scuba Diving	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No
	Skydiving/Parachuting	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No
Ultralight Flying	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No	
Activity	Last Activity Date	Frequency Details (speeds attained, depths/heights reached, etc.)
4. Does any Insured plan to travel to or reside in a foreign country within the next 12 months?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Country's Name	Purpose of Visit	Length of Stay
5. Has any Insured ever been convicted of Driving While Intoxicated or Driving Under the Influence or ever had a driver's license suspended or revoked or had any moving violations within the last three years?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Violation Type	Date	Details (speeds, length of suspension/revocation, etc.)

Attach an additional sheet of paper if more space is needed.

Read and Sign

Effective Date of Coverage: I agree that, except as provided in the company's Temporary Insurance Agreement, no insurance coverage will take effect prior to delivery of the policy to the Owner and then only if all of the following conditions have been met:

- (1) the health and insurability of each person is as stated in this application and in additional parts (if applicable), and the company is immediately notified in writing of any changes; and
- (2) the company has received the first full premium payment while each person is alive.

If the above conditions have been met, coverage under the policy will be effective on the date the policy is delivered to the Owner; provided however, that if a later effective date has been requested, coverage under the policy will be effective on that later date. I understand that any insurance coverage issued will be subject to the suicide and incontestability provisions of the policy. These provisions begin on the effective date.

Insurance Fraud Warning

Arkansas, Louisiana, New Mexico, Ohio, West Virginia:

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

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 or a denial of insurance benefits.

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.

Kentucky, 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.

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.

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.

Authorization: I understand the information obtained by use of this Authorization will be used by USAA Life to determine my eligibility for life insurance. I understand that information released pursuant to this Authorization may no longer be protected by federal privacy regulations and could be subject to redisclosure. I understand that although this authorization is voluntary, USAA Life reserves the right to decline to issue the insurance applied for if I refuse to grant this authorization.

I authorize the following persons and organizations to provide information to USAA Life Insurance Company ("USAA Life"): (a) any licensed physician; (b) any medical practitioner; (c) any hospital; (d) any insurance company; (e) any clinic, Veteran's Administration clinic, or medically-related facility; (f) Medical Information Bureau (MIB); (g) any psychiatrist or psychologist; (h) any health facility; (i) any consumer reporting agency.

For purposes of this Authorization, "information" means any records or knowledge concerning any insured's health or mental condition, general character and driving record.

This includes the release of the entire medical record of any Insured including all information about AIDS, HIV, drugs, alcoholism, or mental illness. This Authorization overrides any existing agreement to restrict information pursuant to 45 CFR 164.522.

I further authorize a consumer reporting agency to make an investigative report on me if it is requested by USAA Life and expect to be interviewed if a report is prepared.

I authorize the above listed sources to provide records or knowledge to any agency employed by USAA Life to collect and transmit such information. A reproduction of this Authorization shall be as valid as the original. I agree this Authorization shall be valid for twenty-four (24) months from the date signed, and upon request I or my authorized representative can receive a copy of this Authorization. I understand that I may revoke this Authorization by sending a written request to USAA Life. A revocation does not affect any action taken by USAA Life in reliance on the authorization prior to the revocation, nor does it have any effect on any right of contestability under the policy.

I have read and understand this authorization. I have received, read and understand the enclosed Notice of Privacy and Disclosure Practices.

Acknowledgment: I have read the questions and answers in this application. I represent that all statements and answers provided in this application and as part of the application process are true, complete and correctly recorded and will be relied upon by USAA Life Insurance Company to form the basis of any policy which may be issued. I agree that a copy of this application, if approved, will be a part of any policy issued. I understand I may not receive an illustration until the policy is issued.

Printed Name of Insured

X
Signature of Insured _____ Date (mm/dd/yyyy) _____ City _____ State _____

X
Signature of Owner (if different than Insured) _____ Date (mm/dd/yyyy) _____

X
Signature of Custodial Parent of Child (if Child Protection Plan selected) _____ Date (mm/dd/yyyy) _____



9800 Fredericksburg Road
San Antonio, Texas 78288

Competitive Whole Life Insurance Application

Step 1. Verify and complete the following information. Make changes to incorrect information directly on this application. Initial each change.

Step 2. Return completed and signed application to USAA Life.

IMPORTANT INFORMATION. Federal law requires us to obtain, verify and record your name, address, date of birth and other information that will allow us to identify you when you open an account and in certain other circumstances.

Personal Information

A. Insured

USAA Number _____ Social Security Number _____ Date of Birth (mm/dd/yyyy) _____ / _____ / _____

Name _____

Mailing Address _____

Physical/Residence Address _____

Residence Phone Number (include area code) _____ E-mail Address _____

Occupation _____ Annual Income \$ _____

Branch of Service _____ Rank _____ Military Status _____

Female Male

Gender _____ State of Birth _____ Driver's License Number _____ State of Issue _____

Are you a U.S. citizen? Yes No

What is your total amount of life insurance protection, current and pending, excluding this application? _____

Is this application for insurance intended to replace, discontinue or change any life insurance or annuities?

Yes No If yes, list details. (Attach an additional sheet of paper if more space is needed.)

Annuity

Life Insurance \$ _____

Company Name _____ Amount _____ Policy/ Contract Number _____

Annuity

Life Insurance \$ _____

Company Name _____ Amount _____ Policy/ Contract Number _____

B. Owner

USAA Number _____ Social Security Number (or Tax ID Number) _____ Date of Birth (mm/dd/yyyy) (If trust, provide date of inception.) _____ / _____ / _____

Name (If trust, provide name of trust and trustee.) _____ Relationship to Insured _____

Mailing Address _____

Physical/Residence Address _____

Residence Phone Number (include area code) _____ E-mail Address _____

Are you a U.S. citizen? Yes No

USAA Life Insurance Company ▪ (888) 275-5330 ▪ Fax (877) 435-7099 ▪ usaa.com

C. Payor

USAA Number _____ Social Security Number (or Tax ID Number) _____ Date of Birth (mm/dd/yyyy) (If trust, provide date of inception.) _____ / _____ / _____

Name (If trust, provide name of trust and trustee.) _____

Mailing Address _____

Physical/Residence Address _____

Residence Phone Number (include area code) _____

E-mail Address _____

Are you a U.S. citizen? Yes No

Product and Optional Coverages

A. Product

Insurance Product Name _____ Insurance Amount \$ _____

Applied to Purchase Paid up Additions Applied to Reduce Premiums Paid in Cash Left to Accumulate at Interest Applied to Purchase 1 Year Term Additions

Dividend Option _____

B. Optional Coverage

Disability Waiver of Premium (age 55 or younger) Accidental Death Benefit (ADB) (age 60 or younger) \$ _____ Amount Paid-Up Additions Rider (PUAR)

C. Child Protection Plan \$ _____ Amount of Child Rider Insurance (age 17 or younger)

Child's Name _____ Social Security Number _____ Date of Birth (mm/dd/yyyy) _____ / _____ / _____

What is this child's total amount of life insurance protection, current and pending, excluding this application? \$ _____

Is this application for insurance intended to replace, discontinue or change any life insurance or annuities? Yes No If yes, list details. (Attach an additional sheet of paper if more space is needed.)

Annuity Life Insurance \$ _____

Company Name _____ Amount _____ Policy/ Contract Number _____

Child's Name _____ Social Security Number _____ Date of Birth (mm/dd/yyyy) _____ / _____ / _____

What is this child's total amount of life insurance protection, current and pending, excluding this application? \$ _____

Is this application for insurance intended to replace, discontinue or change any life insurance or annuities? Yes No If yes, list details. (Attach an additional sheet of paper if more space is needed.)

Annuity Life Insurance \$ _____

Company Name _____ Amount _____ Policy/ Contract Number _____

Attach an additional sheet of paper if more than two children.

Beneficiary Information

Primary Beneficiary Name (If trust, provide name of trust.)	Social Security Number (or Tax ID Number)	Date of Birth (mm/dd/yyyy) (If trust, provide date of inception.)	Relationship to Insured
Contingent Beneficiary Name (If trust, provide name of trust.)	Social Security Number (or Tax ID Number)	Date of Birth (mm/dd/yyyy) (If trust, provide date of inception.)	Relationship to Insured

Attach an additional sheet of paper if more space is needed.

Payment Information

A. Method

Automatic Payment Plan (APP): \$ _____
(For APP, complete section D. Financial Information)

Direct Billing: \$ _____

Monthly Government Allotment : \$ _____

B. Frequency of Payment

Monthly (not available with Direct Billing) Quarterly Semi-Annually Annually

C. Paid Up Additions Rider (PUAR) Payment Method (If Paid Up Additions Rider was selected.)

PUAR Payment: \$ _____ Initial Lump Sum: \$ _____

1035 Exchange: \$ _____

D. Financial Information (Complete only if APP is selected.)

I authorize USAA Life Insurance Company to make electronic withdrawals and deposits to my account listed below until I notify USAA Life that I terminate authorization and USAA Life has reasonable time to act. I acknowledge that the origination of Automated Clearing House (ACH) transactions to my account must comply with U.S. law.

Specify a day between the 1st and 28th of the month for payment. _____ Day

Name of Financial Institution	Name(s) of Account Holder	Type of Account
		<input type="checkbox"/> Checking <input type="checkbox"/> Savings

Transit Routing Number (the nine-digit number in the lower-left corner of check or deposit slip) Account Number

X
Signature of Account Holder Date (mm/dd/yyyy)

E. Automatic Premium Loan

If you check "Yes" below for Automatic Premium Loan, USAA Life is authorized to make a policy loan against any cash value to pay any overdue premiums. If you do not select an option, "Yes" is selected for you.

Is Automatic Premium Loan to be authorized? Yes No

Additional Information

Provide any additional information or details you want considered below.

Read and Sign

Effective Date of Coverage: I agree that, except as provided in the company's Temporary Insurance Agreement, no insurance coverage will take effect prior to delivery of the policy to the Owner and then only if all of the following conditions have been met:

- (1) the health and insurability of each person is as stated in this application and in additional parts (if applicable), and the company is immediately notified in writing of any changes; and
- (2) the company has received the first full premium payment while each person is alive.

If the above conditions have been met, coverage under the policy will be effective on the date the policy is delivered to the Owner; provided however, that if a later effective date has been requested, coverage under the policy will be effective on that later date. I understand that any insurance coverage issued will be subject to the suicide and incontestability provisions of the policy. These provisions begin on the effective date.

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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.

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Authorization: I understand the information obtained by use of this Authorization will be used by USAA Life to determine my eligibility for life insurance. I understand that information released pursuant to this Authorization may no longer be protected by federal privacy regulations and could be subject to redisclosure. I understand that although this authorization is voluntary, USAA Life reserves the right to decline to issue the insurance applied for if I refuse to grant this authorization.

I authorize the following persons and organizations to provide information to USAA Life Insurance Company ("USAA Life"): (a) any licensed physician; (b) any medical practitioner; (c) any hospital; (d) any insurance company; (e) any clinic, Veteran's Administration clinic, or medically-related facility; (f) Medical Information Bureau (MIB); (g) any psychiatrist or psychologist; (h) any health facility; (i) any consumer reporting agency.

For purposes of this Authorization, "information" means any records or knowledge concerning any insured's health or mental condition, general character and driving record.

This includes the release of the entire medical record of any Insured including all information about AIDS, HIV, drugs, alcoholism, or mental illness. This Authorization overrides any existing agreement to restrict information pursuant to 45 CFR 164.522.

I further authorize a consumer reporting agency to make an investigative report on me if it is requested by USAA Life and expect to be interviewed if a report is prepared.

I authorize the above listed sources to provide records or knowledge to any agency employed by USAA Life to collect and transmit such information. A reproduction of this Authorization shall be as valid as the original. I agree this Authorization shall be valid for twenty-four (24) months from the date signed, and upon request I or my authorized representative can receive a copy of this Authorization. I understand that I may revoke this Authorization by sending a written request to USAA Life. A revocation does not affect any action taken by USAA Life in reliance on the authorization prior to the revocation, nor does it have any effect on any right of contestability under the policy.

I have read and understand this authorization. I have received, read and understand the enclosed Notice of Privacy and Disclosure Practices.

Internal Revenue Service Certification For Policyowner

The following certification is required by the Internal Revenue Service (IRS) and does not affect your insurability. Under penalties of perjury, I certify that:

1. The number shown on this form is my correct taxpayer identification number (or I am waiting for a number to be issued to me), and
2. I am not subject to backup withholding either because I have not been notified by the IRS that I am subject to backup withholding as a result of failure to report all interest or dividends, or the IRS has notified me that I am no longer subject to backup withholding (does not apply to real estate transactions, mortgage interest paid, the acquisition or abandonment of secured property, contributions to an Individual Retirement Arrangement (IRA), and payments other than interest and dividends).

Instructions - You must cross out item (2) above if you have been notified by IRS that you are currently subject to backup withholding because of underreporting interest or dividends on your tax return. The IRS does not require your consent to any provision of this document other than the certifications required to avoid backup withholding.

Acknowledgment: I have read the questions and answers in this application. I represent that all statements and answers provided in this application and as part of the application process are true, complete and correctly recorded and will be relied upon by USAA Life Insurance Company to form the basis of any policy which may be issued. I agree that a copy of this application, if approved, will be a part of any policy issued. I understand I may not receive an illustration until the policy is issued.

Printed Name of Insured

X
Signature of Insured _____ Date (mm/dd/yyyy) _____ City _____ State _____

X
Signature of Owner (if different than Insured) _____ Date (mm/dd/yyyy) _____

X
Signature of Custodial Parent of Child (if Child Protection Plan selected) _____ Date (mm/dd/yyyy) _____



9800 Fredericksburg Road
San Antonio, Texas 78288

Competitive Whole Life Insurance Application

Step 1. Verify and complete the following information. Make changes to incorrect information directly on this application. Initial each change.

Step 2. Return completed and signed application to USAA Life.

IMPORTANT INFORMATION. Federal law requires us to obtain, verify and record your name, address, date of birth and other information that will allow us to identify you when you open an account and in certain other circumstances.

Personal Information

A. Insured

USAA Number _____ Social Security Number _____ Date of Birth (mm/dd/yyyy) _____ / _____ / _____

Name _____

Mailing Address _____

Physical/Residence Address _____

Residence Phone Number (include area code) _____ E-mail Address _____

Occupation _____ Annual Income \$ _____

Branch of Service _____ Rank _____ Military Status _____

Female Male

Gender _____ State of Birth _____ Driver's License Number _____ State of Issue _____

Are you a U.S. citizen? Yes No

What is your total amount of life insurance protection, current and pending, excluding this application? _____

Is this application for insurance intended to replace, discontinue or change any life insurance or annuities?

Yes No If yes, list details. (Attach an additional sheet of paper if more space is needed.)

Annuity

Life Insurance \$ _____

Company Name _____ Amount _____ Policy/ Contract Number _____

Annuity

Life Insurance \$ _____

Company Name _____ Amount _____ Policy/ Contract Number _____

B. Owner

USAA Number _____ Social Security Number (or Tax ID Number) _____ Date of Birth (mm/dd/yyyy) (If trust, provide date of inception.) _____ / _____ / _____

Name (If trust, provide name of trust and trustee.) _____ Relationship to Insured _____

Mailing Address _____

Physical/Residence Address _____

Residence Phone Number (include area code) _____ E-mail Address _____

Are you a U.S. citizen? Yes No

USAA Life Insurance Company ▪ (888) 275-5330 ▪ Fax (877) 435-7099 ▪ usaa.com

C. Payor

USAA Number _____ Social Security Number (or Tax ID Number) _____ Date of Birth (mm/dd/yyyy) (If trust, provide date of inception.) _____ / _____ / _____

Name (If trust, provide name of trust and trustee.) _____

Mailing Address _____

Physical/Residence Address _____

Residence Phone Number (include area code) _____ E-mail Address _____

Are you a U.S. citizen? Yes No

Product and Optional Coverages

A. Product

Insurance Product Name _____ Insurance Amount \$ _____
 Applied to Purchase Applied to Paid in Left to Accumulate Applied to Purchase
 Paid up Additions Reduce Premiums Cash at Interest 1 Year Term Additions

Dividend Option _____

B. Optional Coverage

Disability Waiver of Premium (age 55 or younger) Accidental Death Benefit (ADB) (age 60 or younger) \$ _____ Amount Paid-Up Additions Rider (PUAR)

C. Child Protection Plan \$ _____ Amount of Child Rider Insurance
(age 17 or younger)

Child's Name _____ Social Security Number _____ Date of Birth (mm/dd/yyyy) _____ / _____ / _____

What is this child's total amount of life insurance protection, current and pending, excluding this application? \$ _____

Is this application for insurance intended to replace, discontinue or change any life insurance or annuities? Yes No If yes, list details. (Attach an additional sheet of paper if more space is needed.)

Annuity
 Life Insurance \$ _____

Company Name _____ Amount _____ Policy/ Contract Number _____

Child's Name _____ Social Security Number _____ Date of Birth (mm/dd/yyyy) _____ / _____ / _____

What is this child's total amount of life insurance protection, current and pending, excluding this application? \$ _____

Is this application for insurance intended to replace, discontinue or change any life insurance or annuities? Yes No If yes, list details. (Attach an additional sheet of paper if more space is needed.)

Annuity
 Life Insurance \$ _____

Company Name _____ Amount _____ Policy/ Contract Number _____

Attach an additional sheet of paper if more than two children.

Beneficiary Information

Primary Beneficiary Name (If trust, provide name of trust.)	Social Security Number (or Tax ID Number)	Date of Birth (mm/dd/yyyy) (If trust, provide date of inception.)	Relationship to Insured
Contingent Beneficiary Name (If trust, provide name of trust.)	Social Security Number (or Tax ID Number)	Date of Birth (mm/dd/yyyy) (If trust, provide date of inception.)	Relationship to Insured

Attach an additional sheet of paper if more space is needed.

Payment Information

A. Method

Automatic Payment Plan (APP): \$ _____
(For APP, complete section D. Financial Information)

Direct Billing: \$ _____

Monthly Government Allotment : \$ _____

B. Frequency of Payment

Monthly (not available with Direct Billing) Quarterly Semi-Annually Annually

C. Paid Up Additions Rider (PUAR) Payment Method (If Paid Up Additions Rider was selected.)

PUAR Payment: \$ _____ Initial Lump Sum: \$ _____

1035 Exchange: \$ _____

D. Financial Information (Complete only if APP is selected.)

I authorize USAA Life Insurance Company to make electronic withdrawals and deposits to my account listed below until I notify USAA Life that I terminate authorization and USAA Life has reasonable time to act. I acknowledge that the origination of Automated Clearing House (ACH) transactions to my account must comply with U.S. law.

Specify a day between the 1st and 28th of the month for payment. _____ Day

Name of Financial Institution	Name(s) of Account Holder	Type of Account
		<input type="checkbox"/> Checking <input type="checkbox"/> Savings

Transit Routing Number (the nine-digit number in the lower-left corner of check or deposit slip) Account Number

X
Signature of Account Holder Date (mm/dd/yyyy)

E. Automatic Premium Loan

If you check "Yes" below for Automatic Premium Loan, USAA Life is authorized to make a policy loan against any cash value to pay any overdue premiums. If you do not select an option, "Yes" is selected for you.

Is Automatic Premium Loan to be authorized? Yes No

Additional Information

Provide any additional information or details you want considered below.

Medical Information (This section must be completed to acquire life insurance.)

A. Medical Questionnaire

Complete this section for all Insured individuals, including any person to be covered by the Child Protection Plan. Provide details for any "Yes" answer in the Medical Details section.

		Insured	Insured Children (If Child Protection Plan is selected)
1. What is your current height and weight? _____ Feet _____ Inches _____ Lbs.			
2. Has there been any change in weight during the last 12 months for any Insured? If yes, indicate gain or loss. Gain _____ Lbs. Loss _____ Lbs.		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
3. Is any Insured currently receiving regular medical consultation?		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
4. Has any Insured consulted with a health care provider for a routine physical in the last 12 months?		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
5. Has any Insured ever consulted with a health care provider for:			
a.	seizures, paralysis, stroke, depression, anxiety or other mental or nervous system disorder?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
b.	asthma, emphysema, pneumonia or other respiratory system disorder?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
c.	chest pain, high blood pressure, murmur, heart attack or other heart or blood vessel disorder?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
d.	disorder of the throat, esophagus, stomach, intestines, rectum, liver or pancreas?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
e.	abnormal urine test or other disorder of the kidney, ureter or bladder?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
f.	diabetes or other endocrine or thyroid disorder?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
g.	arthritis, collagen vascular disease or disorder of the muscles, bones or skin?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
h.	any cancer or tumor?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
i.	disorder of the prostate or reproductive system?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
j.	hepatitis, anemia, disorder of the blood or lymph glands?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
6. Is any Insured currently taking prescription medication not previously disclosed?		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
7. Has any Insured been diagnosed for Human Immunodeficiency Virus (HIV) Infection, Acquired Immune Deficiency Syndrome (AIDS), AIDS-related complex (ARC), AIDS-related condition, or a sexually transmitted disease?		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
8. Has any Insured, within the past five years:			
a.	had an electrocardiogram, X-ray or any other diagnostic test or procedure that was not previously disclosed?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
b.	been advised to have any diagnostic test, hospitalization or surgery which was not completed?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
9. Has any Insured had an application for life or health insurance declined, postponed, modified or rated?		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
10. Has any Insured ever used an illegal drug or used a controlled substance without a physician's approval?		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
11. Has any Insured been diagnosed or treated for alcohol or drug abuse or been advised by a health care professional to discontinue the use of alcohol or to seek treatment for drug or alcohol dependency?		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
12. Has any Insured consulted a health care provider for any reason not previously disclosed?		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
13. Did your biological mother or father die before the age of 60 from cardiovascular disease or cancer?		<input type="checkbox"/> Yes <input type="checkbox"/> No	Not Applicable

B. Medical Details - Attach an additional sheet of paper if more space is needed.

Question Insured's name / / Date of Visit Physician's Name

Physician's Address

Reason For Visit

Type of Treatment Medication Prescribed (if any)

B. Medical Details - Attach an additional sheet of paper if more space is needed.

Question	Insured's name

Personal Profile (This section must be completed to acquire life insurance.)

Complete this section for all Insured individuals, including any person to be covered by the Child Protection Plan.

	Insured	Insured Children (If Child Protection Plan is selected)
1. Have you ever used any form of tobacco or nicotine substitute?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Not Applicable
Form of Tobacco or Nicotine Substitute	Date of Last Use	How Often Used
2. Has any Insured flown as a pilot, crew member or student pilot in the past two years or does any Insured plan to do so in the next year?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
DESCRIPTION	TYPE(S) OF AIRCRAFT	HOURS FLOWN
MILITARY		NEXT 12 MOS LAST 12 MOS 13-24 MOS AGO
COMMERCIAL		
CIVILIAN/PLEASURE		
TOTAL PILOT-IN-COMMAND HOURS:	_____ MILITARY	_____ CIVILIAN/PLEASURE
3. Has any Insured participated in any of the following activities in the past three years or does any Insured plan to do so in the next year?	Automobile Racing	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No
	Ballooning	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No
	Hang-Gliding	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No
	Motorcycle Racing	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No
	Powerboat Racing	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No
	Rock/Mountain Climbing	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No
	Scuba Diving	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No
	Skydiving/Parachuting	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No
	Ultralight Flying	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No
Activity	Last Activity Date	Frequency Details (speeds attained, depths/heights reached, etc.)
4. Does any Insured plan to travel to or reside in a foreign country within the next 12 months?		<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No
Country's Name	Purpose of Visit	Length of Stay
5. Has any Insured ever been convicted of Driving While Intoxicated or Driving Under the Influence or ever had a driver's license suspended or revoked or had any moving violations within the last three years?		<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No
Violation Type	Date	Details (speeds, length of suspension/revocation, etc.)

Attach an additional sheet of paper if more space is needed.

Read and Sign

Effective Date of Coverage: I agree that, except as provided in the company's Temporary Insurance Agreement, no insurance coverage will take effect prior to delivery of the policy to the Owner and then only if all of the following conditions have been met:

- (1) the health and insurability of each person is as stated in this application and in additional parts (if applicable), and the company is immediately notified in writing of any changes; and
- (2) the company has received the first full premium payment while each person is alive.

If the above conditions have been met, coverage under the policy will be effective on the date the policy is delivered to the Owner; provided however, that if a later effective date has been requested, coverage under the policy will be effective on that later date. I understand that any insurance coverage issued will be subject to the suicide and incontestability provisions of the policy. These provisions begin on the effective date.

Insurance Fraud Warning

Arkansas, Louisiana, New Mexico, Ohio, West Virginia:

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

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 or a denial of insurance benefits.

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.

Kentucky, 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.

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.

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.

Authorization: I understand the information obtained by use of this Authorization will be used by USAA Life to determine my eligibility for life insurance. I understand that information released pursuant to this Authorization may no longer be protected by federal privacy regulations and could be subject to redisclosure. I understand that although this authorization is voluntary, USAA Life reserves the right to decline to issue the insurance applied for if I refuse to grant this authorization.

I authorize the following persons and organizations to provide information to USAA Life Insurance Company ("USAA Life"): (a) any licensed physician; (b) any medical practitioner; (c) any hospital; (d) any insurance company; (e) any clinic, Veteran's Administration clinic, or medically-related facility; (f) Medical Information Bureau (MIB); (g) any psychiatrist or psychologist; (h) any health facility; (i) any consumer reporting agency.

For purposes of this Authorization, "information" means any records or knowledge concerning any insured's health or mental condition, general character and driving record.

This includes the release of the entire medical record of any Insured including all information about AIDS, HIV, drugs, alcoholism, or mental illness. This Authorization overrides any existing agreement to restrict information pursuant to 45 CFR 164.522.

I further authorize a consumer reporting agency to make an investigative report on me if it is requested by USAA Life and expect to be interviewed if a report is prepared.

I authorize the above listed sources to provide records or knowledge to any agency employed by USAA Life to collect and transmit such information. A reproduction of this Authorization shall be as valid as the original. I agree this Authorization shall be valid for twenty-four (24) months from the date signed, and upon request I or my authorized representative can receive a copy of this Authorization. I understand that I may revoke this Authorization by sending a written request to USAA Life. A revocation does not affect any action taken by USAA Life in reliance on the authorization prior to the revocation, nor does it have any effect on any right of contestability under the policy.

I have read and understand this authorization. I have received, read and understand the enclosed Notice of Privacy and Disclosure Practices.

Internal Revenue Service Certification For Policyowner

The following certification is required by the Internal Revenue Service (IRS) and does not affect your insurability. Under penalties of perjury, I certify that:

1. The number shown on this form is my correct taxpayer identification number (or I am waiting for a number to be issued to me), and
2. I am not subject to backup withholding either because I have not been notified by the IRS that I am subject to backup withholding as a result of failure to report all interest or dividends, or the IRS has notified me that I am no longer subject to backup withholding (does not apply to real estate transactions, mortgage interest paid, the acquisition or abandonment of secured property, contributions to an Individual Retirement Arrangement (IRA), and payments other than interest and dividends).

Instructions - You must cross out item (2) above if you have been notified by IRS that you are currently subject to backup withholding because of underreporting interest or dividends on your tax return. The IRS does not require your consent to any provision of this document other than the certifications required to avoid backup withholding.

Acknowledgment: I have read the questions and answers in this application. I represent that all statements and answers provided in this application and as part of the application process are true, complete and correctly recorded and will be relied upon by USAA Life Insurance Company to form the basis of any policy which may be issued. I agree that a copy of this application, if approved, will be a part of any policy issued. I understand I may not receive an illustration until the policy is issued.

Printed Name of Insured

X
Signature of Insured _____ Date (mm/dd/yyyy) _____ City _____ State _____

X
Signature of Owner (if different than Insured) _____ Date (mm/dd/yyyy) _____

X
Signature of Custodial Parent of Child (if Child Protection Plan selected) _____ Date (mm/dd/yyyy) _____



9800 Fredericksburg Road
San Antonio, Texas 78288

Simplified Whole Life Insurance Application

Step 1. Verify and complete the following information. Make changes to incorrect information directly on this application. Initial each change.

Step 2. Return completed and signed application to USAA Life.

IMPORTANT INFORMATION. Federal law requires us to obtain, verify and record your name, address, date of birth and other information that will allow us to identify you when you open an account and in certain other circumstances.

Personal Information

A. Insured

USAA Number _____ Social Security Number _____ Date of Birth (mm/dd/yyyy) _____ / _____ / _____

Name _____

Mailing Address _____

Physical/Residence Address _____

Residence Phone Number (include area code) _____ E-mail Address _____

Occupation _____ Annual Income \$ _____

Branch of Service _____ Rank _____ Military Status _____

Female Male

Gender _____ State of Birth _____ Driver's License Number _____ State of Issue _____

Are you a U.S. citizen? Yes No

What is your total amount of life insurance protection, current and pending, excluding this application? _____

Is this application for insurance intended to replace, discontinue or change any life insurance or annuities?

Yes No If yes, list details. (Attach an additional sheet of paper if more space is needed.)

Annuity

Life Insurance \$ _____

Company Name _____ Amount _____ Policy/ Contract Number _____

Annuity

Life Insurance \$ _____

Company Name _____ Amount _____ Policy/ Contract Number _____

B. Owner

USAA Number _____ Social Security Number (or Tax ID Number) _____ Date of Birth (mm/dd/yyyy) (If trust, provide date of inception.) _____ / _____ / _____

Name (If trust, provide name of trust and trustee.) _____ Relationship to Insured _____

Mailing Address _____

Physical/Residence Address _____

Residence Phone Number (include area code) _____ E-mail Address _____

Are you a U.S. citizen? Yes No

USAA Life Insurance Company • (888) 275-5330 • Fax (877) 435-7099 • usaa.com

C. Payor

USAA Number _____ Social Security Number (or Tax ID Number) _____ / / Date of Birth (mm/dd/yyyy) (If trust, provide date of inception.) _____

Name (If trust, provide name of trust and trustee.) _____

Mailing Address _____

Physical/Residence Address _____

Residence Phone Number (include area code) _____

E-mail Address _____

Are you a U.S. citizen? Yes No

Product and Optional Coverages

A. Product

Insurance Product Name _____ \$ Insurance Amount _____

B. Optional Coverage

Disability Waiver of Premium (age 55 or younger) Accidental Death Benefit (ADB) \$ _____ Amount _____ (age 60 or younger)

C. Child Protection Plan \$ _____ Amount of Child Rider Insurance _____ (age 17 or younger)

Child's Name _____ Social Security Number _____ / / Date of Birth (mm/dd/yyyy) _____

What is this child's total amount of life insurance protection, current and pending, excluding this application? \$ _____

Is this application for insurance intended to replace, discontinue or change any life insurance or annuities? Yes No If yes, list details. (Attach an additional sheet of paper if more space is needed.)

Annuity
 Life Insurance \$ _____

Company Name _____ Amount _____ Policy/ Contract Number _____

Child's Name _____ Social Security Number _____ / / Date of Birth (mm/dd/yyyy) _____

What is this child's total amount of life insurance protection, current and pending, excluding this application? \$ _____

Is this application for insurance intended to replace, discontinue or change any life insurance or annuities? Yes No If yes, list details. (Attach an additional sheet of paper if more space is needed.)

Annuity
 Life Insurance \$ _____

Company Name _____ Amount _____ Policy/ Contract Number _____

Attach an additional sheet of paper if more than two children.

Beneficiary Information

Primary Beneficiary Name (If trust, provide name of trust.)	Social Security Number (or Tax ID Number)	Date of Birth (mm/dd/yyyy) (If trust, provide date of inception.)	Relationship to Insured
Contingent Beneficiary Name (If trust, provide name of trust.)	Social Security Number (or Tax ID Number)	Date of Birth (mm/dd/yyyy) (If trust, provide date of inception.)	Relationship to Insured

Attach an additional sheet of paper if more space is needed.

Payment Information

A. Method

Automatic Payment Plan (APP): \$ _____
(For APP, complete section C. Financial Information)

Direct Billing: \$ _____

Monthly Government Allotment: \$ _____

Single Premium: \$ _____

1035 Exchange: \$ _____

B. Frequency of Payment

Monthly (not available with Direct Billing) Quarterly Semi-Annually Annually

C. Financial Information (Complete only if APP is selected.)

I authorize USAA Life Insurance Company to make electronic withdrawals and deposits to my account listed below until I notify USAA Life that I terminate authorization and USAA Life has reasonable time to act. I acknowledge that the origination of Automated Clearing House (ACH) transactions to my account must comply with U.S. law.

Specify a day between the 1st and 28th of the month for payment. _____
Day

- Checking
- Savings

Name of Financial Institution	Name(s) of Account Holder	Type of Account
-------------------------------	---------------------------	-----------------

Transit Routing Number (the nine-digit number in the lower-left corner of check or deposit slip) Account Number

 X
Signature of Account Holder Date (mm/dd/yyyy)

D. Automatic Premium Loan

If you check "Yes" below for Automatic Premium Loan, USAA Life is authorized to make a policy loan against any cash value to pay any overdue premiums. If you do not select an option, "Yes" is selected for you.

Is Automatic Premium Loan to be authorized? Yes No

Additional Information

Provide any additional information or details you want considered below.

Read and Sign

Effective Date of Coverage: I agree that, except as provided in the company's Temporary Insurance Agreement, no insurance coverage will take effect prior to delivery of the policy to the Owner and then only if all of the following conditions have been met:

- (1) the health and insurability of each person is as stated in this application and in additional parts (if applicable), and the company is immediately notified in writing of any changes; and
- (2) the company has received the first full premium payment while each person is alive.

If the above conditions have been met, coverage under the policy will be effective on the date the policy is delivered to the Owner; provided however, that if a later effective date has been requested, coverage under the policy will be effective on that later date. I understand that any insurance coverage issued will be subject to the suicide and incontestability provisions of the policy. These provisions begin on the effective date.

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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.

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Kentucky, 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.

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Oklahoma:

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9800 Fredericksburg Road
San Antonio, Texas 78288

Simplified Whole Life Insurance Application

Step 1. Verify and complete the following information. Make changes to incorrect information directly on this application. Initial each change.

Step 2. Return completed and signed application to USAA Life.

IMPORTANT INFORMATION. Federal law requires us to obtain, verify and record your name, address, date of birth and other information that will allow us to identify you when you open an account and in certain other circumstances.

Personal Information

A. Insured

USAA Number _____ Social Security Number _____ Date of Birth (mm/dd/yyyy) _____ / _____ / _____

Name _____

Mailing Address _____

Physical/Residence Address _____

Residence Phone Number (include area code) _____ E-mail Address _____

Occupation _____ Annual Income \$ _____

Branch of Service _____ Rank _____ Military Status _____

Female Male

Gender _____ State of Birth _____ Driver's License Number _____ State of Issue _____

Are you a U.S. citizen? Yes No

What is your total amount of life insurance protection, current and pending, excluding this application? _____

Is this application for insurance intended to replace, discontinue or change any life insurance or annuities?

Yes No If yes, list details. (Attach an additional sheet of paper if more space is needed.)

Annuity

Life Insurance \$ _____

Company Name _____ Amount _____ Policy/ Contract Number _____

Annuity

Life Insurance \$ _____

Company Name _____ Amount _____ Policy/ Contract Number _____

B. Owner

USAA Number _____ Social Security Number (or Tax ID Number) _____ Date of Birth (mm/dd/yyyy) (If trust, provide date of inception.) _____ / _____ / _____

Name (If trust, provide name of trust and trustee.) _____ Relationship to Insured _____

Mailing Address _____

Physical/Residence Address _____

Residence Phone Number (include area code) _____ E-mail Address _____

Are you a U.S. citizen? Yes No

USAA Life Insurance Company • (888) 275-5330 • Fax (877) 435-7099 • usaa.com

C. Payor

USAA Number _____ Social Security Number (or Tax ID Number) _____ / / Date of Birth (mm/dd/yyyy) (If trust, provide date of inception.) _____

Name (If trust, provide name of trust and trustee.) _____

Mailing Address _____

Physical/Residence Address _____

Residence Phone Number (include area code) _____

E-mail Address _____

Are you a U.S. citizen? Yes No

Product and Optional Coverages

A. Product

Insurance Product Name _____ \$ Insurance Amount _____

B. Optional Coverage

Disability Waiver of Premium (age 55 or younger) Accidental Death Benefit (ADB) \$ _____ Amount _____ (age 60 or younger)

C. Child Protection Plan \$ _____ Amount of Child Rider Insurance _____ (age 17 or younger)

Child's Name _____ Social Security Number _____ / / Date of Birth (mm/dd/yyyy) _____

What is this child's total amount of life insurance protection, current and pending, excluding this application? \$ _____

Is this application for insurance intended to replace, discontinue or change any life insurance or annuities? Yes No If yes, list details. (Attach an additional sheet of paper if more space is needed.)

Annuity
 Life Insurance \$ _____

Company Name _____ Amount _____ Policy/ Contract Number _____

Child's Name _____ Social Security Number _____ / / Date of Birth (mm/dd/yyyy) _____

What is this child's total amount of life insurance protection, current and pending, excluding this application? \$ _____

Is this application for insurance intended to replace, discontinue or change any life insurance or annuities? Yes No If yes, list details. (Attach an additional sheet of paper if more space is needed.)

Annuity
 Life Insurance \$ _____

Company Name _____ Amount _____ Policy/ Contract Number _____

Attach an additional sheet of paper if more than two children.

Beneficiary Information

Primary Beneficiary Name (If trust, provide name of trust.) Social Security Number (or Tax ID Number) Date of Birth (mm/dd/yyyy) (If trust, provide date of inception.) Relationship to Insured

Contingent Beneficiary Name (If trust, provide name of trust.) Social Security Number (or Tax ID Number) Date of Birth (mm/dd/yyyy) (If trust, provide date of inception.) Relationship to Insured

Attach an additional sheet of paper if more space is needed.

Payment Information

A. Method

- Automatic Payment Plan (APP): \$ (For APP, complete section C. Financial Information)
Monthly Government Allotment: \$
Single Premium: \$
Direct Billing: \$
1035 Exchange: \$

B. Frequency of Payment

- Monthly (not available with Direct Billing)
Quarterly
Semi-Annually
Annually

C. Financial Information (Complete only if APP is selected.)

I authorize USAA Life Insurance Company to make electronic withdrawals and deposits to my account listed below until I notify USAA Life that I terminate authorization and USAA Life has reasonable time to act. I acknowledge that the origination of Automated Clearing House (ACH) transactions to my account must comply with U.S. law.

Specify a day between the 1st and 28th of the month for payment. Day

- Checking
Savings

Name of Financial Institution Name(s) of Account Holder Type of Account

Transit Routing Number (the nine-digit number in the lower-left corner of check or deposit slip) Account Number

x Signature of Account Holder Date (mm/dd/yyyy)

D. Automatic Premium Loan

If you check "Yes" below for Automatic Premium Loan, USAA Life is authorized to make a policy loan against any cash value to pay any overdue premiums. If you do not select an option, "Yes" is selected for you.

Is Automatic Premium Loan to be authorized? Yes No

Additional Information

Provide any additional information or details you want considered below.

Blank lines for providing additional information.

Medical Information (This section must be completed to acquire life insurance.)

A. Medical Questionnaire

Complete this section for all Insured individuals, including any person to be covered by the Child Protection Plan. Provide details for any "Yes" answer in the Medical Details section.

		Insured	Insured Children (If Child Protection Plan is selected)
1. What is your current height and weight? ____ Feet ____ Inches ____ Lbs.			
2. Has there been any change in weight during the last 12 months for any Insured? If yes, indicate gain or loss. Gain ____ Lbs. Loss ____ Lbs.		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
3. Is any Insured currently receiving regular medical consultation?		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
4. Has any Insured consulted with a health care provider for a routine physical in the last 12 months?		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
5. Has any Insured ever consulted with a health care provider for:			
a.	seizures, paralysis, stroke, depression, anxiety or other mental or nervous system disorder?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
b.	asthma, emphysema, pneumonia or other respiratory system disorder?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
c.	chest pain, high blood pressure, murmur, heart attack or other heart or blood vessel disorder?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
d.	disorder of the throat, esophagus, stomach, intestines, rectum, liver or pancreas?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
e.	abnormal urine test or other disorder of the kidney, ureter or bladder?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
f.	diabetes or other endocrine or thyroid disorder?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
g.	arthritis, collagen vascular disease or disorder of the muscles, bones or skin?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
h.	any cancer or tumor?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
i.	disorder of the prostate or reproductive system?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
j.	hepatitis, anemia, disorder of the blood or lymph glands?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
6. Is any Insured currently taking prescription medication not previously disclosed?		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
7. Has any Insured been diagnosed for Human Immunodeficiency Virus (HIV) Infection, Acquired Immune Deficiency Syndrome (AIDS), AIDS-related complex (ARC), AIDS-related condition, or a sexually transmitted disease?		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
8. Has any Insured, within the past five years:			
a.	had an electrocardiogram, X-ray or any other diagnostic test or procedure that was not previously disclosed?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
b.	been advised to have any diagnostic test, hospitalization or surgery which was not completed?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
9. Has any Insured had an application for life or health insurance declined, postponed, modified or rated?		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
10. Has any Insured ever used an illegal drug or used a controlled substance without a physician's approval?		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
11. Has any Insured been diagnosed or treated for alcohol or drug abuse or been advised by a health care professional to discontinue the use of alcohol or to seek treatment for drug or alcohol dependency?		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
12. Has any Insured consulted a health care provider for any reason not previously disclosed?		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
13. Did your biological mother or father die before the age of 60 from cardiovascular disease or cancer?		<input type="checkbox"/> Yes <input type="checkbox"/> No	Not Applicable

B. Medical Details- Attach an additional sheet of paper if more space is needed.

Question Insured's name Date of Visit Physician's Name

Physician's Address

Reason For Visit

Type of Treatment Medication Prescribed (if any)
 LAP50585ST 06-05 50585-0805
 Page 4 of 7 LAP145ST

B. Medical Details - Attach an additional sheet of paper if more space is needed.

Question Insured's name

Personal Profile (This section must be completed to acquire life insurance.)

Complete this section for all Insured individuals, including any person to be covered by the Child Protection Plan.

		Insured	Insured Children (If Child Protection Plan is selected)	
1. Have you ever used any form of tobacco or nicotine substitute?		<input type="checkbox"/> Yes <input type="checkbox"/> No	Not Applicable	
Form of Tobacco or Nicotine Substitute Date of Last Use How Often Used				
2. Has any Insured flown as a pilot, crew member or student pilot in the past two years or does any Insured plan to do so in the next year?		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
DESCRIPTION	TYPE(S) OF AIRCRAFT	HOURS FLOWN		
		NEXT 12 MOS	LAST 12 MOS	13-24 MOS AGO
MILITARY				
COMMERCIAL				
CIVILIAN/PLEASURE				
TOTAL PILOT-IN-COMMAND HOURS: _____ MILITARY _____ CIVILIAN/PLEASURE				
3. Has any Insured participated in any of the following activities in the past three years or does any Insured plan to do so in the next year?		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Automobile Racing		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Ballooning		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Hang-Gliding		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Motorcycle Racing		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Powerboat Racing		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Rock/Mountain Climbing		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Scuba Diving		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Skydiving/Parachuting		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Ultralight Flying		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Activity	Last Activity Date	Frequency	Details (speeds attained, depths/heights reached, etc.)	
4. Does any Insured plan to travel to or reside in a foreign country within the next 12 months?		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Country's Name	Purpose of Visit		Length of Stay	
5. Has any Insured ever been convicted of Driving While Intoxicated or Driving Under the Influence or ever had a driver's license suspended or revoked or had any moving violations within the last three years?		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Violation Type	Date	Details (speeds, length of suspension/revocation, etc.)		

Attach an additional sheet of paper if more space is needed.

Read and Sign

Effective Date of Coverage: I agree that, except as provided in the company's Temporary Insurance Agreement, no insurance coverage will take effect prior to delivery of the policy to the Owner and then only if all of the following conditions have been met:

- (1) the health and insurability of each person is as stated in this application and in additional parts (if applicable), and the company is immediately notified in writing of any changes; and
- (2) the company has received the first full premium payment while each person is alive.

If the above conditions have been met, coverage under the policy will be effective on the date the policy is delivered to the Owner; provided however, that if a later effective date has been requested, coverage under the policy will be effective on that later date. I understand that any insurance coverage issued will be subject to the suicide and incontestability provisions of the policy. These provisions begin on the effective date.

Insurance Fraud Warning

Arkansas, Louisiana, New Mexico, Ohio, West Virginia:

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

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 or a denial of insurance benefits.

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.

Kentucky, 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.

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.

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.

Authorization: I understand the information obtained by use of this Authorization will be used by USAA Life to determine my eligibility for life insurance. I understand that information released pursuant to this Authorization may no longer be protected by federal privacy regulations and could be subject to redisclosure. I understand that although this authorization is voluntary, USAA Life reserves the right to decline to issue the insurance applied for if I refuse to grant this authorization.

I authorize the following persons and organizations to provide information to USAA Life Insurance Company ("USAA Life"): (a) any licensed physician; (b) any medical practitioner; (c) any hospital; (d) any insurance company; (e) any clinic, Veteran's Administration clinic, or medically-related facility; (f) Medical Information Bureau (MIB); (g) any psychiatrist or psychologist; (h) any health facility; (i) any consumer reporting agency.

For purposes of this Authorization, "information" means any records or knowledge concerning any insured's health or mental condition, general character and driving record.

This includes the release of the entire medical record of any Insured including all information about AIDS, HIV, drugs, alcoholism, or mental illness. This Authorization overrides any existing agreement to restrict information pursuant to 45 CFR 164.522.

I further authorize a consumer reporting agency to make an investigative report on me if it is requested by USAA Life and expect to be interviewed if a report is prepared.

I authorize the above listed sources to provide records or knowledge to any agency employed by USAA Life to collect and transmit such information. A reproduction of this Authorization shall be as valid as the original. I agree this Authorization shall be valid for twenty-four (24) months from the date signed, and upon request I or my authorized representative can receive a copy of this Authorization. I understand that I may revoke this Authorization by sending a written request to USAA Life. A revocation does not affect any action taken by USAA Life in reliance on the authorization prior to the revocation, nor does it have any effect on any right of contestability under the policy.

I have read and understand this authorization. I have received, read and understand the enclosed Notice of Privacy and Disclosure Practices.

Internal Revenue Service Certification For Policyowner

The following certification is required by the Internal Revenue Service (IRS) and does not affect your insurability. Under penalties of perjury, I certify that:

1. The number shown on this form is my correct taxpayer identification number (or I am waiting for a number to be issued to me), and
2. I am not subject to backup withholding either because I have not been notified by the IRS that I am subject to backup withholding as a result of failure to report all interest or dividends, or the IRS has notified me that I am no longer subject to backup withholding (does not apply to real estate transactions, mortgage interest paid, the acquisition or abandonment of secured property, contributions to an Individual Retirement Arrangement (IRA), and payments other than interest and dividends).

Instructions - You must cross out item (2) above if you have been notified by IRS that you are currently subject to backup withholding because of underreporting interest or dividends on your tax return. The IRS does not require your consent to any provision of this document other than the certifications required to avoid backup withholding.

Acknowledgment: I have read the questions and answers in this application. I represent that all statements and answers provided in this application and as part of the application process are true, complete and correctly recorded and will be relied upon by USAA Life Insurance Company to form the basis of any policy which may be issued. I agree that a copy of this application, if approved, will be a part of any policy issued. I understand I may not receive an illustration until the policy is issued.

Printed Name of Insured

X
Signature of Insured Date (mm/dd/yyyy) City State

X
Signature of Owner (if different than Insured) Date (mm/dd/yyyy)

X
Signature of Custodial Parent of Child (if Child Protection Plan selected) Date (mm/dd/yyyy)



9800 Fredericksburg Road
San Antonio, Texas 78288

Universal Life Insurance Application

Step 1. Verify and complete the following information. Make changes to incorrect information directly on this application. Initial each change.

Step 2. Return completed and signed application to USAA Life.

IMPORTANT INFORMATION. Federal law requires us to obtain, verify and record your name, address, date of birth and other information that will allow us to identify you when you open an account and in certain other circumstances.

Personal Information

A. Insured

USAA Number _____ Social Security Number _____ Date of Birth (mm/dd/yyyy) _____ / _____ / _____

Name _____

Mailing Address _____

Physical/Residence Address _____

Residence Phone Number (include area code) _____ E-mail Address _____

Occupation _____ Annual Income \$ _____

Branch of Service _____ Rank _____ Military Status _____

Female Male

Gender _____ State of Birth _____ Driver's License Number _____ State of Issue _____

Are you a U.S. citizen? Yes No

What is your total amount of life insurance protection, current and pending, excluding this application? _____

Is this application for insurance intended to replace, discontinue or change any life insurance or annuities?

Yes No If yes, list details. (Attach an additional sheet of paper if more space is needed.)

Annuity

Life Insurance \$ _____

Company Name _____ Amount _____ Policy/ Contract Number _____

Annuity

Life Insurance \$ _____

Company Name _____ Amount _____ Policy/ Contract Number _____

B. Owner

USAA Number _____ Social Security Number (or Tax ID Number) _____ Date of Birth (mm/dd/yyyy) _____ (If trust, provide date of inception.) _____ / _____ / _____

Name (If trust, provide name of trust and trustee.) _____ Relationship to Insured _____

Mailing Address _____

Physical/Residence Address _____

Residence Phone Number (include area code) _____ E-mail Address _____

Are you a U.S. citizen? Yes No

USAA Life Insurance Company ▪ (888) 275-5330 ▪ Fax (877) 435-7099 ▪ usaa.com

C. Payor

USAA Number _____ Social Security Number (or Tax ID Number) _____ Date of Birth (mm/dd/yyyy) (If trust, provide date of inception.) _____ / /

Name (If trust, provide name of trust and trustee.) _____

Mailing Address _____

Physical/Residence Address _____

Residence Phone Number (include area code) _____ E-mail Address _____

Are you a U.S. citizen? Yes No

Product and Optional Coverages

A. Product

Insurance Product Name _____ \$ Insurance Amount _____

- Option A: Provides fixed insurance protection.
- Option B: Provides increasing insurance protection.

B. Optional Coverage

Waiver of Monthly Deduction (age 55 or younger) Accidental Death Benefit (ADB) \$ _____ (age 60 or younger) Amount _____

C. Child Protection Plan \$ _____ (age 17 or younger) Amount of Child Rider Insurance _____

Child's Name _____ Social Security Number _____ Date of Birth (mm/dd/yyyy) _____ / /

What is this child's total amount of life insurance protection, current and pending, excluding this application? \$ _____

Is this application for insurance intended to replace, discontinue or change any life insurance or annuities? Yes No If yes, list details. (Attach an additional sheet of paper if more space is needed.)

- Annuity
- Life Insurance \$ _____

Company Name _____ Amount _____ Policy/ Contract Number _____

Child's Name _____ Social Security Number _____ Date of Birth (mm/dd/yyyy) _____ / /

What is this child's total amount of life insurance protection, current and pending, excluding this application? \$ _____

Is this application for insurance intended to replace, discontinue or change any life insurance or annuities? Yes No If yes, list details. (Attach an additional sheet of paper if more space is needed.)

- Annuity
- Life Insurance \$ _____

Company Name _____ Amount _____ Policy/ Contract Number _____

Attach an additional sheet of paper if more than two children.

Beneficiary Information

Primary Beneficiary Name (If trust, provide name of trust.) Social Security Number (or Tax ID Number) Date of Birth (mm/dd/yyyy) (If trust, provide date of inception.) Relationship to Insured

Contingent Beneficiary Name (If trust, provide name of trust.) Social Security Number (or Tax ID Number) Date of Birth (mm/dd/yyyy) (If trust, provide date of inception.) Relationship to Insured

Attach an additional sheet of paper if more space is needed.

Payment Information

A. Method

- Automatic Payment Plan (APP): \$ _____ (For APP, complete section C. Financial Information) Direct Billing: \$ _____
- Monthly Government Allotment: \$ _____
- Initial Lump Sum: \$ _____ 1035 Exchange: \$ _____

B. Frequency of Payment

- Monthly (not available with Direct Billing) Quarterly Semi-Annually Annually

C. Financial Information (Complete only if APP is selected.)

I authorize USAA Life Insurance Company to make electronic withdrawals and deposits to my account listed below until I notify USAA Life that I terminate authorization and USAA Life has reasonable time to act. I acknowledge that the origination of Automated Clearing House (ACH) transactions to my account must comply with U.S. law.

Specify a day between the 1st and 28th of the month for payment. _____
Day

- Checking
- Savings

Name of Financial Institution Name(s) of Account Holder Type of Account

Transit Routing Number (the nine-digit number in the lower-left corner of check or deposit slip) Account Number

^x
Signature of Account Holder Date (mm/dd/yyyy)

Additional Information

Provide any additional information or details you want considered below.

Read and Sign

Effective Date of Coverage: I agree that, except as provided in the company's Temporary Insurance Agreement, no insurance coverage will take effect prior to delivery of the policy to the Owner and then only if all of the following conditions have been met:

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Authorization: I understand the information obtained by use of this Authorization will be used by USAA Life to determine my eligibility for life insurance. I understand that information released pursuant to this Authorization may no longer be protected by federal privacy regulations and could be subject to redisclosure. I understand that although this authorization is voluntary, USAA Life reserves the right to decline to issue the insurance applied for if I refuse to grant this authorization.

I authorize the following persons and organizations to provide information to USAA Life Insurance Company ("USAA Life"): (a) any licensed physician; (b) any medical practitioner; (c) any hospital; (d) any insurance company; (e) any clinic, Veteran's Administration clinic, or medically-related facility; (f) Medical Information Bureau (MIB); (g) any psychiatrist or psychologist; (h) any health facility; (i) any consumer reporting agency.

For purposes of this Authorization, "information" means any records or knowledge concerning any insured's health or mental condition, general character and driving record.

This includes the release of the entire medical record of any Insured including all information about AIDS, HIV, drugs, alcoholism, or mental illness. This Authorization overrides any existing agreement to restrict information pursuant to 45 CFR 164.522.

I further authorize a consumer reporting agency to make an investigative report on me if it is requested by USAA Life and expect to be interviewed if a report is prepared.

I authorize the above listed sources to provide records or knowledge to any agency employed by USAA Life to collect and transmit such information. A reproduction of this Authorization shall be as valid as the original. I agree this Authorization shall be valid for twenty-four (24) months from the date signed, and upon request I or my authorized representative can receive a copy of this Authorization. I understand that I may revoke this Authorization by sending a written request to USAA Life. A revocation does not affect any action taken by USAA Life in reliance on the authorization prior to the revocation, nor does it have any effect on any right of contestability under the policy.

I have read and understand this authorization. I have received, read and understand the enclosed Notice of Privacy and Disclosure Practices.

Internal Revenue Service Certification For Policyowner

The following certification is required by the Internal Revenue Service (IRS) and does not affect your insurability. Under penalties of perjury, I certify that:

1. The number shown on this form is my correct taxpayer identification number (or I am waiting for a number to be issued to me), and
2. I am not subject to backup withholding either because I have not been notified by the IRS that I am subject to backup withholding as a result of failure to report all interest or dividends, or the IRS has notified me that I am no longer subject to backup withholding (does not apply to real estate transactions, mortgage interest paid, the acquisition or abandonment of secured property, contributions to an Individual Retirement Arrangement (IRA), and payments other than interest and dividends).

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Acknowledgment: I have read the questions and answers in this application. I represent that all statements and answers provided in this application and as part of the application process are true, complete and correctly recorded and will be relied upon by USAA Life Insurance Company to form the basis of any policy which may be issued. I agree that a copy of this application, if approved, will be a part of any policy issued. I understand I may not receive an illustration until the policy is issued.

Printed Name of Insured

X

Signature of Insured

Date (mm/dd/yyyy)

City

State

X

Signature of Owner (if different than Insured)

Date (mm/dd/yyyy)

X

Signature of Custodial Parent of Child (if Child Protection Plan selected)

Date (mm/dd/yyyy)



9800 Fredericksburg Road
San Antonio, Texas 78288

Universal Life Insurance Application

Step 1. Verify and complete the following information. Make changes to incorrect information directly on this application. Initial each change.

Step 2. Return completed and signed application to USAA Life.

IMPORTANT INFORMATION. Federal law requires us to obtain, verify and record your name, address, date of birth and other information that will allow us to identify you when you open an account and in certain other circumstances.

Personal Information

A. Insured

/ /

USAA Number Social Security Number Date of Birth (mm/dd/yyyy)

Name

Mailing Address

Physical/Residence Address

Residence Phone Number (include area code) E-mail Address

Occupation Annual Income \$

Branch of Service Rank Military Status

Female Male

Gender State of Birth Driver's License Number State of Issue

Are you a U.S. citizen? Yes No

What is your total amount of life insurance protection, current and pending, excluding this application? _____

Is this application for insurance intended to replace, discontinue or change any life insurance or annuities?

Yes No If yes, list details. (Attach an additional sheet of paper if more space is needed.)

Annuity

Life Insurance \$

Company Name Amount Policy/ Contract Number

Annuity

Life Insurance \$

Company Name Amount Policy/ Contract Number

B. Owner

/ /

USAA Number Social Security Number (or Tax ID Number) Date of Birth (mm/dd/yyyy) (If trust, provide date of inception.)

Name (If trust, provide name of trust and trustee.) Relationship to Insured

Mailing Address

Physical/Residence Address

Residence Phone Number (include area code) E-mail Address

Are you a U.S. citizen? Yes No

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C. Payor

USAA Number _____ Social Security Number (or Tax ID Number) _____ Date of Birth (mm/dd/yyyy) (If trust, provide date of inception.) _____ / /

Name (If trust, provide name of trust and trustee.) _____

Mailing Address _____

Physical/Residence Address _____

Residence Phone Number (include area code) _____ E-mail Address _____

Are you a U.S. citizen? Yes No

Product and Optional Coverages

A. Product

Insurance Product Name _____ \$ Insurance Amount _____

- Option A: Provides fixed insurance protection.
- Option B: Provides increasing insurance protection.

B. Optional Coverage

Waiver of Monthly Deduction (age 55 or younger) Accidental Death Benefit (ADB) \$ _____ (age 60 or younger) Amount _____

C. Child Protection Plan \$ _____ (age 17 or younger) Amount of Child Rider Insurance _____

Child's Name _____ Social Security Number _____ Date of Birth (mm/dd/yyyy) _____ / /

What is this child's total amount of life insurance protection, current and pending, excluding this application? \$ _____

Is this application for insurance intended to replace, discontinue or change any life insurance or annuities? Yes No If yes, list details. (Attach an additional sheet of paper if more space is needed.)

- Annuity
- Life Insurance \$ _____

Company Name _____ Amount _____ Policy/ Contract Number _____

Child's Name _____ Social Security Number _____ Date of Birth (mm/dd/yyyy) _____ / /

What is this child's total amount of life insurance protection, current and pending, excluding this application? \$ _____

Is this application for insurance intended to replace, discontinue or change any life insurance or annuities? Yes No If yes, list details. (Attach an additional sheet of paper if more space is needed.)

- Annuity
- Life Insurance \$ _____

Company Name _____ Amount _____ Policy/ Contract Number _____

Attach an additional sheet of paper if more than two children.

Beneficiary Information

Primary Beneficiary Name (If trust, provide name of trust.)	Social Security Number (or Tax ID Number)	Date of Birth (mm/dd/yyyy) (If trust, provide date of inception.)	Relationship to Insured
Contingent Beneficiary Name (If trust, provide name of trust.)	Social Security Number (or Tax ID Number)	Date of Birth (mm/dd/yyyy) (If trust, provide date of inception.)	Relationship to Insured

Attach an additional sheet of paper if more space is needed.

Payment Information

A. Method

Automatic Payment Plan (APP): \$ _____ (For APP, complete section C. Financial Information) Direct Billing: \$ _____

Monthly Government Allotment: \$ _____

Initial Lump Sum: \$ _____ 1035 Exchange: \$ _____

B. Frequency of Payment

Monthly (not available with Direct Billing) Quarterly Semi-Annually Annually

C. Financial Information (Complete only if APP is selected.)

I authorize USAA Life Insurance Company to make electronic withdrawals and deposits to my account listed below until I notify USAA Life that I terminate authorization and USAA Life has reasonable time to act. I acknowledge that the origination of Automated Clearing House (ACH) transactions to my account must comply with U.S. law.

Specify a day between the 1st and 28th of the month for payment. _____ Day

Name of Financial Institution	Name(s) of Account Holder	Type of Account
		<input type="checkbox"/> Checking <input type="checkbox"/> Savings

Transit Routing Number (the nine-digit number in the lower-left corner of check or deposit slip) Account Number

^x
Signature of Account Holder _____ Date (mm/dd/yyyy) _____

Additional Information

Provide any additional information or details you want considered below.

Medical Information (This section must be completed to acquire life insurance.)

A. Medical Questionnaire

Complete this section for all Insured individuals, including any person to be covered by the Child Protection Plan. Provide details for any "Yes" answer in the Medical Details section.

		Insured	Insured Children (If Child Protection Plan is selected)
1. What is your current height and weight? ___ Feet ___ Inches ___ Lbs.			
2. Has there been any change in weight during the last 12 months for any Insured? If yes, indicate gain or loss. Gain ___ Lbs. Loss ___ Lbs.		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
3. Is any Insured currently receiving regular medical consultation?		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
4. Has any Insured consulted with a health care provider for a routine physical in the last 12 months?		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
5. Has any Insured ever consulted with a health care provider for:			
a.	seizures, paralysis, stroke, depression, anxiety or other mental or nervous system disorder?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
b.	asthma, emphysema, pneumonia or other respiratory system disorder?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
c.	chest pain, high blood pressure, murmur, heart attack or other heart or blood vessel disorder?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
d.	disorder of the throat, esophagus, stomach, intestines, rectum, liver or pancreas?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
e.	abnormal urine test or other disorder of the kidney, ureter or bladder?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
f.	diabetes or other endocrine or thyroid disorder?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
g.	arthritis, collagen vascular disease or disorder of the muscles, bones or skin?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
h.	any cancer or tumor?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
i.	disorder of the prostate or reproductive system?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
j.	hepatitis, anemia, disorder of the blood or lymph glands?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
6. Is any Insured currently taking prescription medication not previously disclosed?		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
7. Has any Insured been diagnosed for Human Immunodeficiency Virus (HIV) Infection, Acquired Immune Deficiency Syndrome (AIDS), AIDS-related complex (ARC), AIDS-related condition, or a sexually transmitted disease?		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
8. Has any Insured, within the past five years:			
a.	had an electrocardiogram, X-ray or any other diagnostic test or procedure that was not previously disclosed?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
b.	been advised to have any diagnostic test, hospitalization or surgery which was not completed?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
9. Has any Insured had an application for life or health insurance declined, postponed, modified or rated?		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
10. Has any Insured ever used an illegal drug or used a controlled substance without a physician's approval?		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
11. Has any Insured been diagnosed or treated for alcohol or drug abuse or been advised by a health care professional to discontinue the use of alcohol or to seek treatment for drug or alcohol dependency?		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
12. Has any Insured consulted a health care provider for any reason not previously disclosed?		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
13. Did your biological mother or father die before the age of 60 from cardiovascular disease or cancer?		<input type="checkbox"/> Yes <input type="checkbox"/> No	Not Applicable

B. Medical Details - Attach an additional sheet of paper if more space is needed.

/ /

Question Insured's name Date of Visit Physician's Name

Physician's Address

Reason For Visit

Type of Treatment Medication Prescribed (if any)

B. Medical Details - Attach an additional sheet of paper if more space is needed.

Question	Insured's name

Personal Profile (This section must be completed to acquire life insurance.)

Complete this section for all Insured individuals, including any person to be covered by the Child Protection Plan.

	Insured	Insured Children (If Child Protection Plan is selected)
1. Have you ever used any form of tobacco or nicotine substitute?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Not Applicable
Form of Tobacco or Nicotine Substitute Date of Last Use How Often Used		
2. Has any Insured flown as a pilot, crew member or student pilot in the past two years or does any Insured plan to do so in the next year?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
DESCRIPTION	TYPE(S) OF AIRCRAFT	HOURS FLOWN
MILITARY		NEXT 12 MOS LAST 12 MOS 13-24 MOS AGO
COMMERCIAL		
CIVILIAN/PLEASURE		
TOTAL PILOT-IN-COMMAND HOURS: _____ MILITARY _____ CIVILIAN/PLEASURE		
3. Has any Insured participated in any of the following activities in the past three years or does any Insured plan to do so in the next year?	Automobile Racing	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No
	Ballooning	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No
	Hang-Gliding	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No
	Motorcycle Racing	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No
	Powerboat Racing	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No
	Rock/Mountain Climbing	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No
	Scuba Diving	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No
	Skydiving/Parachuting	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No
	Ultralight Flying	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No
Activity	Last Activity Date	Frequency Details (speeds attained, depths/heights reached, etc.)
4. Does any Insured plan to travel to or reside in a foreign country within the next 12 months?		<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No
Country's Name	Purpose of Visit	Length of Stay
5. Has any Insured ever been convicted of Driving While Intoxicated or Driving Under the Influence or ever had a driver's license suspended or revoked or had any moving violations within the last three years?		<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No
Violation Type	Date	Details (speeds, length of suspension/revocation, etc.)

Attach an additional sheet of paper if more space is needed.

Read and Sign

Effective Date of Coverage: I agree that, except as provided in the company's Temporary Insurance Agreement, no insurance coverage will take effect prior to delivery of the policy to the Owner and then only if all of the following conditions have been met:

- (1) the health and insurability of each person is as stated in this application and in additional parts (if applicable), and the company is immediately notified in writing of any changes; and
- (2) the company has received the first full premium payment while each person is alive.

If the above conditions have been met, coverage under the policy will be effective on the date the policy is delivered to the Owner; provided however, that if a later effective date has been requested, coverage under the policy will be effective on that later date. I understand that any insurance coverage issued will be subject to the suicide and incontestability provisions of the policy. These provisions begin on the effective date.

Insurance Fraud Warning

Arkansas, Louisiana, New Mexico, Ohio, West Virginia:

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

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 or a denial of insurance benefits.

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.

Kentucky, 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.

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.

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.

Authorization: I understand the information obtained by use of this Authorization will be used by USAA Life to determine my eligibility for life insurance. I understand that information released pursuant to this Authorization may no longer be protected by federal privacy regulations and could be subject to redisclosure. I understand that although this authorization is voluntary, USAA Life reserves the right to decline to issue the insurance applied for if I refuse to grant this authorization.

I authorize the following persons and organizations to provide information to USAA Life Insurance Company ("USAA Life"): (a) any licensed physician; (b) any medical practitioner; (c) any hospital; (d) any insurance company; (e) any clinic, Veteran's Administration clinic, or medically-related facility; (f) Medical Information Bureau (MIB); (g) any psychiatrist or psychologist; (h) any health facility; (i) any consumer reporting agency.

For purposes of this Authorization, "information" means any records or knowledge concerning any insured's health or mental condition, general character and driving record.

This includes the release of the entire medical record of any Insured including all information about AIDS, HIV, drugs, alcoholism, or mental illness. This Authorization overrides any existing agreement to restrict information pursuant to 45 CFR 164.522.

I further authorize a consumer reporting agency to make an investigative report on me if it is requested by USAA Life and expect to be interviewed if a report is prepared.

I authorize the above listed sources to provide records or knowledge to any agency employed by USAA Life to collect and transmit such information. A reproduction of this Authorization shall be as valid as the original. I agree this Authorization shall be valid for twenty-four (24) months from the date signed, and upon request I or my authorized representative can receive a copy of this Authorization. I understand that I may revoke this Authorization by sending a written request to USAA Life. A revocation does not affect any action taken by USAA Life in reliance on the authorization prior to the revocation, nor does it have any effect on any right of contestability under the policy.

I have read and understand this authorization. I have received, read and understand the enclosed Notice of Privacy and Disclosure Practices.

Internal Revenue Service Certification For Policyowner

The following certification is required by the Internal Revenue Service (IRS) and does not affect your insurability. Under penalties of perjury, I certify that:

1. The number shown on this form is my correct taxpayer identification number (or I am waiting for a number to be issued to me), and
2. I am not subject to backup withholding either because I have not been notified by the IRS that I am subject to backup withholding as a result of failure to report all interest or dividends, or the IRS has notified me that I am no longer subject to backup withholding (does not apply to real estate transactions, mortgage interest paid, the acquisition or abandonment of secured property, contributions to an Individual Retirement Arrangement (IRA), and payments other than interest and dividends).

Instructions - You must cross out item (2) above if you have been notified by IRS that you are currently subject to backup withholding because of underreporting interest or dividends on your tax return. The IRS does not require your consent to any provision of this document other than the certifications required to avoid backup withholding.

Acknowledgment: I have read the questions and answers in this application. I represent that all statements and answers provided in this application and as part of the application process are true, complete and correctly recorded and will be relied upon by USAA Life Insurance Company to form the basis of any policy which may be issued. I agree that a copy of this application, if approved, will be a part of any policy issued. I understand I may not receive an illustration until the policy is issued.

Printed Name of Insured

X
Signature of Insured _____ Date (mm/dd/yyyy) _____ City _____ State _____

X
Signature of Owner (if different than Insured) _____ Date (mm/dd/yyyy) _____

X
Signature of Custodial Parent of Child (if Child Protection Plan selected) _____ Date (mm/dd/yyyy) _____



9800 Fredericksburg Road
San Antonio, Texas 78288

7-Year Term Life Insurance Application

Step 1. Verify and complete the following information. Make changes to incorrect information directly on this application. Initial each change.

Step 2. Return completed and signed application to USAA Life.

IMPORTANT INFORMATION. Federal law requires us to obtain, verify and record your name, address, date of birth and other information that will allow us to identify you when you open an account and in certain other circumstances.

Personal Information

A. Insured

USAA Number _____ Social Security Number _____ Date of Birth (mm/dd/yyyy) _____ / _____ / _____

Name _____

Mailing Address _____

Physical/Residence Address _____

Residence Phone Number (include area code) _____ E-mail Address _____

Occupation _____ Annual Income \$ _____

Branch of Service _____ Rank _____ Military Status _____

Female Male

Gender _____ State of Birth _____ Driver's License Number _____ State of Issue _____

Are you a U.S. citizen? Yes No

What is your total amount of life insurance protection, current and pending, excluding this application? _____

Is this application for insurance intended to replace, discontinue or change any life insurance or annuities?

Yes No If yes, list details. (Attach an additional sheet of paper if more space is needed.)

Annuity

Life Insurance \$ _____

Company Name _____ Amount _____ Policy/Contract Number _____

Annuity

Life Insurance \$ _____

Company Name _____ Amount _____ Policy/Contract Number _____

B. Owner

USAA Number _____ Social Security Number (or Tax ID Number) _____ Date of Birth (mm/dd/yyyy) (If trust, provide date of inception.) _____ / _____ / _____

Name (If trust, provide name of trust and trustee) _____ Relationship to Insured _____

Mailing Address _____

Physical/Residence Address _____

Residence Phone Number (include area code) _____ E-mail Address _____

Are you a U.S. citizen? Yes No

USAA Life Insurance Company ▪ (888) 275-5330 ▪ Fax (877) 435-7099 ▪ usaa.com

C. Payor

USAA Number _____ Social Security Number (or Tax ID Number) _____ Date of Birth (mm/dd/yyyy) (If trust, provide date of inception.) _____ / /

Name (If trust, provide name of trust and trustee.) _____

Mailing Address _____

Physical/Residence Address _____

Residence Phone Number (include area code) _____ E-mail Address _____

Are you a U.S. citizen? Yes No

Product

Insurance Product Name _____ \$ Insurance Amount _____

Beneficiary Information

Primary Beneficiary Name (If trust, provide name of trust.) _____ Social Security Number (or Tax ID Number) _____ Date of Birth (mm/dd/yyyy) (If trust, provide date of inception.) _____ Relationship to Insured _____ / /

Contingent Beneficiary Name (If trust, provide name of trust.) _____ Social Security Number (or Tax ID Number) _____ Date of Birth (mm/dd/yyyy) (If trust, provide date of inception.) _____ Relationship to Insured _____ / /

Attach an additional sheet of paper if more space is needed.

Payment Information - Monthly Automatic Payment Plan

Premium payments for this policy will be made through USAA Life's Automatic Payment Plan (APP). Complete the following:

I authorize USAA Life Insurance Company to make electronic withdrawals and deposits to my account listed below until I notify USAA Life that I terminate authorization and USAA Life has reasonable time to act. I acknowledge that the origination of Automated Clearing House (ACH) transactions to my account must comply with U.S. law.

Specify a day between the 1st and 28th of the month for payment. _____ Day

- Checking
- Savings

Name of Financial Institution _____ Name(s) of Account Holder _____ Type of Account _____

Transit Routing Number (the nine-digit number in the lower-left corner of check or deposit slip) _____ Account Number _____

^x Signature of Account Holder _____ Date (mm/dd/yyyy) _____

Additional Information

Provide any additional information or details you want considered below.

Medical Information(This section must be completed to acquire life insurance.)

Complete this section for the Insured individual. (In the following questions, "You" refers to the Insured.)

Have you consulted a physician or other physical or mental health advisor for any reason within the last five years?

Yes No

If "Yes," provide the date, name and address of physician(s) consulted, reason for visit, type of treatment and any medication prescribed.

Attach an additional sheet of paper if more space is needed.

Personal Profile (This section must be completed to acquire life insurance.)

Complete this section for the Insured individual. Provide details for any "Yes" answer in the Personal Profile Details section (In the following questions, "You" refers to the Insured).

1. Have you participated in any of the following activities in the past three years or do you plan to do so in the next year? (Indicate activity, frequency and details, i.e., speeds attained, depths/heights reached, in the Personal Profile Details section.)

- | | | | |
|-----------------------------|--|------------------------|--|
| Automobile Racing | <input type="checkbox"/> Yes <input type="checkbox"/> No | Powerboat Racing | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Aviation (not as passenger) | <input type="checkbox"/> Yes <input type="checkbox"/> No | Rock/Mountain Climbing | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Ballooning | <input type="checkbox"/> Yes <input type="checkbox"/> No | Scuba Diving | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Hang-Gliding | <input type="checkbox"/> Yes <input type="checkbox"/> No | Skydiving/Parachuting | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Motorcycle Racing | <input type="checkbox"/> Yes <input type="checkbox"/> No | Ultralight Flying | <input type="checkbox"/> Yes <input type="checkbox"/> No |

2. Do you plan to travel to or reside in a foreign country within the next 12 months? Yes No
(Indicate country's name, purpose of visit and length of stay in the Personal Profile Details section.)

3. Have you ever been convicted of Driving While Intoxicated or Driving Under the Influence or ever had a driver's license suspended or revoked or had any moving violations within the last three years? Yes No

Personal Profile Details

Provide details below for any "Yes" answer in the Personal Profile. Include the question number and details.

Attach an additional sheet of paper if more space is needed.

Read and Sign

Effective Date of Coverage: I agree that, except as provided in the company's Temporary Insurance Agreement, no insurance coverage will take effect prior to delivery of the policy to the Owner and then only if all of the following conditions have been met:

- (1) the health and insurability of each person is as stated in this application and in additional parts (if applicable), and the company is immediately notified in writing of any changes; and
- (2) the company has received the first full premium payment while each person is alive.

If the above conditions have been met, coverage under the policy will be effective on the date the policy is delivered to the Owner; provided however, that if a later effective date has been requested, coverage under the policy will be effective on that later date. I understand that any insurance coverage issued will be subject to the suicide and incontestability provisions of the policy. These provisions begin on the effective date.

Insurance Fraud Warning

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

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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.

Kentucky, 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.

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.

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.



EXAMINER'S REPORT

THIS FORM MUST BE COMPLETED AND SIGNED BY THE EXAMINER AND RETURNED TO USAA LIFE INSURANCE COMPANY.

Name of Proposed Insured

USAA Number

Contract Number

INSTRUCTIONS TO EXAMINER

1. Have applicant provide or verify answers to all questions in the Personal Profile and Medical Questions Section, sign and date form in your presence.
2. Complete Examiner's Report.
3. **USAA LIFE INSURANCE COMPANY will not reimburse the cost of lab tests not specifically requested by USAA LIFE INSURANCE COMPANY.**
4. **If this examination is performed by a party not currently under contract with us, contact us to discuss negotiated reimbursement.**
5. Only disinterested parties may complete the examination. Exams may not be completed by blood relatives, business associates of the same clinic, or any person with beneficiary or ownership rights to the Life Insurance proceeds.

Personal Profile (This section must be completed to acquire life insurance.)

Complete this section for all Insured individuals, including any person to be covered by the Child Protection Plan.

		Insured	Insured Children (If Child Protection Plan is selected)	
1. Have you ever used any form of tobacco or nicotine substitute?		<input type="checkbox"/> Yes <input type="checkbox"/> No		Not Applicable
Form of Tobacco or Nicotine Substitute Date of Last Use How Often Used				
2. Has any Insured flown as a pilot, crew member or student pilot in the past two years or does any Insured plan to do so in the next year?		<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No
DESCRIPTION	TYPE(S) OF AIRCRAFT	HOURS FLOWN		
MILITARY		NEXT 12 MOS	LAST 12 MOS	13-24 MOS AGO
COMMERCIAL				
CIVILIAN/PLEASURE				
TOTAL PILOT-IN-COMMAND HOURS: _____ MILITARY _____ CIVILIAN/PLEASURE				
3. Has any Insured participated in any of the following activities in the past three years or does any Insured plan to do so in the next year?		Automobile Racing		<input type="checkbox"/> Yes <input type="checkbox"/> No
		Ballooning		<input type="checkbox"/> Yes <input type="checkbox"/> No
		Hang-Gliding		<input type="checkbox"/> Yes <input type="checkbox"/> No
		Motorcycle Racing		<input type="checkbox"/> Yes <input type="checkbox"/> No
		Powerboat Racing		<input type="checkbox"/> Yes <input type="checkbox"/> No
		Rock/Mountain Climbing		<input type="checkbox"/> Yes <input type="checkbox"/> No
		Scuba Diving		<input type="checkbox"/> Yes <input type="checkbox"/> No
		Skydiving/Parachuting		<input type="checkbox"/> Yes <input type="checkbox"/> No
		Ultralight Flying		<input type="checkbox"/> Yes <input type="checkbox"/> No
Activity Last Activity Date Frequency Details (speeds attained, depths/heights reached, etc.)				
4. Does any Insured plan to travel to or reside in a foreign country within the next 12 months?		<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No
Country's Name		Purpose of Visit		Length of Stay
5. Has any Insured ever been convicted of Driving While Intoxicated or Driving Under the Influence or ever had a driver's license suspended or revoked or had any moving violations within the last three years?		<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No
Violation Type		Date		Details (speeds, length of suspension/revocation, etc.)

Attach an additional sheet of paper if more space is needed.

Medical Information (This section must be completed to acquire life insurance.)

A. Medical Questionnaire

Complete this section for all Insured individuals, including any person to be covered by the Child Protection Plan. Provide details for any "Yes" answer in the Medical Details section.

		Insured	Insured Children (If Child Protection Plan is selected)
1. What is your current height and weight? ____ Feet ____ Inches ____ Lbs.			
2. Has there been any change in weight during the last 12 months for any Insured? If yes, indicate gain or loss. Gain ____ Lbs. Loss ____ Lbs.		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
3. Is any Insured currently receiving regular medical consultation?		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
4. Has any Insured consulted with a health care provider for a routine physical in the last 12 months?		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
5. Has any Insured ever consulted with a health care provider for:			
	a. seizures, paralysis, stroke, depression, anxiety or other mental or nervous system disorder?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
	b. asthma, emphysema, pneumonia or other respiratory system disorder?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
	c. chest pain, high blood pressure, murmur, heart attack or other heart or blood vessel disorder?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
	d. disorder of the throat, esophagus, stomach, intestines, rectum, liver or pancreas?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
	e. abnormal urine test or other disorder of the kidney, ureter or bladder?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
	f. diabetes or other endocrine or thyroid disorder?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
	g. arthritis, collagen vascular disease or disorder of the muscles, bones or skin?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
	h. any cancer or tumor?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
	i. disorder of the prostate or reproductive system?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
	j. hepatitis, anemia, disorder of the blood or lymph glands?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
6. Is any Insured currently taking prescription medication not previously disclosed?		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
7. Has any Insured been diagnosed for Human Immunodeficiency Virus (HIV) Infection, Acquired Immune Deficiency Syndrome (AIDS), AIDS-related complex (ARC), AIDS-related condition, or a sexually transmitted disease?		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
8. Has any Insured, within the past five years:			
	a. had an electrocardiogram, X-ray or any other diagnostic test or procedure that was not previously disclosed?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
	b. been advised to have any diagnostic test, hospitalization or surgery which was not completed?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
9. Has any Insured had an application for life or health insurance declined, postponed, modified or rated?		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
10. Has any Insured ever used an illegal drug or used a controlled substance without a physician's approval?		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
11. Has any Insured been diagnosed or treated for alcohol or drug abuse or been advised by a health care professional to discontinue the use of alcohol or to seek treatment for drug or alcohol dependency?		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
12. Has any Insured consulted a health care provider for any reason not previously disclosed?		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
13. Did your biological mother or father die before the age of 60 from cardiovascular disease or cancer?		<input type="checkbox"/> Yes <input type="checkbox"/> No	Not Applicable

MEDICAL DETAILS

Identify the question, name of Insured, date of visit, reason for visit, name and address or phone number of physician, type of treatment, and any medication prescribed. (ATTACH A SEPARATE SHEET IF MORE SPACE IS REQUIRED.)

[Empty box for medical details]

I have read the above statements and answers and represent that they are true and complete and correctly recorded. I agree that such statements and answers shall be part of the application and are made with the expectation that USAA LIFE INSURANCE COMPANY will consider the information when determining whether to issue the policy or contract for which I have applied.

Dated at _____ on _____, _____.
(City) (State) (Month) (Day) (Year)

X _____
Signature of Proposed Insured

Witness: _____
Signature of Medical Examiner

X _____
Signature of Custodial Parent of Child (if Child Protection Plan selected)

MEDICAL EXAMINER'S REPORT

This examination should be made in private. If 3rd person present, give details.

Name _____	USAA # _____	Details of "Yes" answers. (Identify item.)
D.O.B. Mo. Day Yr. _____	Contract # _____	

Identification: Driver's License Other _____

1. HEIGHT (IN SHOES)	WEIGHT (CLOTHED)	ABDOMEN AT UMBILICUS RELAXED
FT. IN.	LBS.	IN.

Did you weigh? Yes No Did you measure? Yes No
 Weight change in past year? _____ lbs. Gain Loss

2. Blood Pressure (Record all readings)	INITIAL READING	FOLLOW UP READING IF NEEDED	If initial BP Reading exceeds 129 Systolic, or 79 Diastolic. Complete 1 Additional BP Reading.
Systolic	_____	_____	
Diastolic	_____	_____	

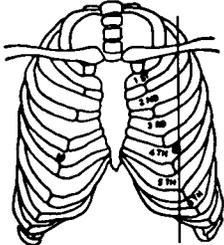
3. Resting Pulse:
 Rate _____
 Irregularities Per Min. _____

4. Heart:
 a. Are there physical findings of cyanosis, dyspnea, edema, arteriosclerosis,
 peripheral vascular or other cardiovascular disorder? Yes No
 b. Is murmur present? Yes No (If yes, complete 4c)

c. Murmur is: Systolic Apical Soft (Gr. 1-2)
 Constant Transmitted Presystolic Basal Mod. (Gr. 3-4)
 Inconstant Localized Diastolic Sternal Loud (Gr. 5-6)
 After exercise: Unchanged Increased Other
 Decreased Absent

Show Location Of:
 Apex by _____
 Area of murmur by _____
 Point of greatest intensity by _____
 Transmission by _____
 Your impression? _____

XOOI ↓



5. Is there on examination any abnormality of the following:
 (Check applicable items and give details.)

	YES	NO
a. Eyes, ears, nose, mouth, pharynx?	<input type="checkbox"/>	<input type="checkbox"/>
(If vision or hearing markedly impaired, indicate degree and correction.)		
b. Skin (incl. scars); lymph nodes; blood vessels?	<input type="checkbox"/>	<input type="checkbox"/>
c. Nervous system (include reflexes, gait)?	<input type="checkbox"/>	<input type="checkbox"/>
d. Respiratory system?	<input type="checkbox"/>	<input type="checkbox"/>
e. Abdomen?	<input type="checkbox"/>	<input type="checkbox"/>
f. Genitourinary system (include prostate)?	<input type="checkbox"/>	<input type="checkbox"/>
g. Endocrine system (include thyroid and breasts)?	<input type="checkbox"/>	<input type="checkbox"/>
h. Musculoskeletal system (include spine, joints, amputations, deformities)?	<input type="checkbox"/>	<input type="checkbox"/>

6. Are there any hernias? YES NO

7. Have you any pertinent information not brought out above? YES NO

8. Urinalysis: SPECIFIC GRAVITY	ALBUMIN	SUGAR	To which lab was this specimen sent?
---------------------------------	---------	-------	--------------------------------------

I certify that I made this examination on the _____ day of _____ Year _____

Examiner's signature: _____ Address _____
 Examiner's name (print) _____ City _____
 State _____ Zip Code _____

Policy Change-Cont. (Some features and coverages are not available for all products in all states.)

C. Add Optional Coverages

- Disability Waiver of Premium (Not available for Universal Life or Variable Universal Life.)
- Waiver of Monthly Deduction (Available only for Universal Life and Variable Universal Life.)
- Increasing Coverage Benefit (ICB) (Available only for Annual Renewable Term [ART].)
- Accidental Death Benefit: \$ _____
- Child Protection Plan (Not available for Seven-Year Term): \$ _____
(Also, complete Child Protection Plan, Medical Information and Personal Profile sections.)

D. Change Options

- Universal Life Option to B (instead of Option A.)
- Variable Universal Life Option to B (instead of Option A.)

E. Other

- Premium Review
- Policy Exclusion Review
- Periodic Payment change to \$ _____
(Available only for Universal Life or Variable Universal Life.)
- _____

Child Protection Plan (Available only for those age 17 or younger. Not available in Hawaii.)

C. Child Protection Plan \$ _____
(age 17 or younger) Amount of Child Rider Insurance

Child's Name	Social Security Number	Date of Birth (mm/dd/yyyy)
--------------	------------------------	----------------------------

What is this child's total amount of life insurance protection, current and pending, excluding this application? \$ _____

Is this application for insurance intended to replace, discontinue or change any life insurance or annuities? Yes No If yes, list details. (Attach an additional sheet of paper if more space is needed.)

- Annuity
- Life Insurance \$ _____

Company Name	Amount	Policy/Contract Number
--------------	--------	------------------------

Child's Name	Social Security Number	Date of Birth (mm/dd/yyyy)
--------------	------------------------	----------------------------

What is this child's total amount of life insurance protection, current and pending, excluding this application? \$ _____

Is this application for insurance intended to replace, discontinue or change any life insurance or annuities? Yes No If yes, list details. (Attach an additional sheet of paper if more space is needed.)

- Annuity
- Life Insurance \$ _____

Company Name	Amount	Policy/Contract Number
--------------	--------	------------------------

Child's Name	Social Security Number	Date of Birth (mm/dd/yyyy)
--------------	------------------------	----------------------------

What is this child's total amount of life insurance protection, current and pending, excluding this application? \$ _____

Is this application for insurance intended to replace, discontinue or change any life insurance or annuities? Yes No If yes, list details. (Attach an additional sheet of paper if more space is needed.)

- Annuity
- Life Insurance \$ _____

Company Name	Amount	Policy/Contract Number
--------------	--------	------------------------

Attach an additional sheet of paper if more than three children.

Medical Information (This section must be completed to acquire life insurance.)

A. Medical Questionnaire

Complete this section for all Insured individuals, including any person to be covered by the Child Protection Plan. Provide details for any "Yes" answer in the Medical Details section.

		Insured	Insured Children (If Child Protection Plan is selected)
1. What is your current height and weight? _____ Feet _____ Inches _____ Lbs.			
2. Has there been any change in weight during the last 12 months for any Insured? If yes, indicate gain or loss. Gain _____ Lbs. Loss _____ Lbs.		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
3. Is any Insured currently receiving regular medical consultation?		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
4. Has any Insured consulted with a health care provider for a routine physical in the last 12 months?		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
5. Has any Insured ever consulted with a health care provider for:			
a.	seizures, paralysis, stroke, depression, anxiety or other mental or nervous system disorder?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
b.	asthma, emphysema, pneumonia or other respiratory system disorder?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
c.	chest pain, high blood pressure, murmur, heart attack or other heart or blood vessel disorder?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
d.	disorder of the throat, esophagus, stomach, intestines, rectum, liver or pancreas?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
e.	abnormal urine test or other disorder of the kidney, ureter or bladder?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
f.	diabetes or other endocrine or thyroid disorder?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
g.	arthritis, collagen vascular disease or disorder of the muscles, bones or skin?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
h.	any cancer or tumor?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
i.	disorder of the prostate or reproductive system?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
j.	hepatitis, anemia, disorder of the blood or lymph glands?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
6. Is any Insured currently taking prescription medication not previously disclosed?		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
7. Has any Insured been diagnosed for Human Immunodeficiency Virus (HIV) Infection, Acquired Immune Deficiency Syndrome (AIDS), AIDS-related complex (ARC), AIDS-related condition, or a sexually transmitted disease?		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
8. Has any Insured, within the past five years:			
a.	had an electrocardiogram, X-ray or any other diagnostic test or procedure that was not previously disclosed?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
b.	been advised to have any diagnostic test, hospitalization or surgery which was not completed?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
9. Has any Insured had an application for life or health insurance declined, postponed, modified or rated?		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
10. Has any Insured ever used an illegal drug or used a controlled substance without a physician's approval?		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
11. Has any Insured been diagnosed or treated for alcohol or drug abuse or been advised by a health care professional to discontinue the use of alcohol or to seek treatment for drug or alcohol dependency?		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
12. Has any Insured consulted a health care provider for any reason not previously disclosed?		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
13. Did your biological mother or father die before the age of 60 from cardiovascular disease or cancer?		<input type="checkbox"/> Yes <input type="checkbox"/> No	Not Applicable

B. Medical Details - Attach an additional sheet of paper if more space is needed.

Question Insured's name / / Date of Visit Physician's Name

Physician's Address

Reason For Visit

Type of Treatment Medication Prescribed (if any)

B. Medical Details - Attach an additional sheet of paper if more space is needed.

Question Insured's name

Personal Profile (This section must be completed to acquire life insurance.)

Complete this section for all Insured individuals, including any person to be covered by the Child Protection Plan.

		Insured	Insured Children (If Child Protection Plan is selected)	
1. Have you ever used any form of tobacco or nicotine substitute?		<input type="checkbox"/> Yes <input type="checkbox"/> No	Not Applicable	
Form of Tobacco or Nicotine Substitute		Date of Last Use	How Often Used	
2. Has any Insured flown as a pilot, crew member or student pilot in the past two years or does any Insured plan to do so in the next year?		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
DESCRIPTION	TYPE(S) OF AIRCRAFT	HOURS FLOWN		
MILITARY		NEXT 12 MOS	LAST 12 MOS	13-24 MOS AGO
COMMERCIAL				
CIVILIAN/PLEASURE				
TOTAL PILOT-IN-COMMAND HOURS:		MILITARY		CIVILIAN/PLEASURE
3. Has any Insured participated in any of the following activities in the past three years or does any Insured plan to do so in the next year?	Automobile Racing	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
	Ballooning	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
	Hang-Gliding	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
	Motorcycle Racing	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
	Powerboat Racing	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
	Rock/Mountain Climbing	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
	Scuba Diving	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
	Skydiving/Parachuting	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Ultralight Flying	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Activity	Last Activity Date	Frequency	Details (speeds attained, depths/heights reached, etc.)	
4. Does any Insured plan to travel to or reside in a foreign country within the next 12 months?		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Country's Name	Purpose of Visit		Length of Stay	
5. Has any Insured ever been convicted of Driving While Intoxicated or Driving Under the Influence or ever had a driver's license suspended or revoked or had any moving violations within the last three years?		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Violation Type	Date	Details (speeds, length of suspension/revocation, etc.)		

Attach an additional sheet of paper if more space is needed.

Read and Sign

Effective Date of Coverage: I agree that no requested change in coverage will take effect prior to approval by the Company and notification to the Owner and then only if the health and insurability of each person is as stated in this application and in additional parts (if applicable), and the company is immediately notified in writing of any changes.

If the above conditions have been met, the revised coverage under the policy will be effective on the date the Company notifies the initial Owner of approval. I understand that any additional coverage will be subject to the suicide and incontestability provisions of the policy.

Insurance Fraud Warning

Arkansas, Louisiana, New Mexico, Ohio, West Virginia:

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

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 or a denial of insurance benefits.

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.

Kentucky, 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.

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.

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.



LIFE INSURANCE
PERSONAL FINANCIAL STATEMENT

Proposed Insured _____

USAA No. _____

I. PERSONAL INSURANCE DATA

- A. Amount of Life Insurance in force with all companies (exclude Employer Group) \$ _____
B. Amount of Accidental Death Coverage in force with all companies (exclude Travel Accidental Death Coverage) \$ _____
C. What is the purpose of the Life Insurance purchased with USAA Life Insurance Company?
[] Estate Protection [] Family Income Protection [] Debt Repayment

OTHER: _____

D. Do you have a Life Insurance application pending with any other company? [] YES [] NO
If YES, please give name of company, amount of coverage, and purpose of insurance.

E. In what field, industry, profession or vocation are you currently employed? _____

F. What is your job title/occupation? _____

II. PERSONAL INCOME STATEMENT For year ended _____

- A. Annual Earned Income B. Annual Unearned Income C. If Self-Employed
1. Salary/wages: \$ _____ 1. Dividends: \$ _____ 1. Gross Income: \$ _____
2. Bonus or Commission: \$ _____ 2. Interest: \$ _____ 2. Expenses: \$ _____
3. Other (Describe): \$ _____ 3. Rentals: \$ _____
4. Other: \$ _____
Total Earned Income: \$ _____ Total Unearned Income: \$ _____ Adjusted Gross Income: \$ _____
Total Income (Add Earned, Unearned and Adjusted Gross Income): \$ _____
D. Spouse's Earned Income: \$ _____

III. PERSONAL ASSET/LIABILITY STATEMENT

Assets (Current Market Value)

- Business Equity: \$ _____
Personal Assets: \$ _____
Real Estate: \$ _____
Stocks: \$ _____
Bonds: \$ _____
Cash, CDs, and Savings: \$ _____
Money Market Accounts: \$ _____
Accounts Receivable: \$ _____
Automobile(s): \$ _____
IRA & Keogh: \$ _____
Retirement Plan (401k, 403b, etc.) \$ _____
Other: \$ _____
Total Assets: \$ _____

Liabilities

- Mortgage(s): \$ _____
Interest Owed: \$ _____
Home Equity Loans: \$ _____
Auto Loans: \$ _____
Personal Loans: \$ _____
Charge Accounts: \$ _____
Credit Cards: \$ _____
Accounts Payable: \$ _____
Taxes Owed: \$ _____
Liens: \$ _____
Other: \$ _____
Total Liabilities: \$ _____

LESS Total Assets: \$ _____
EQUALS Total Liabilities: \$ _____
Net Worth: \$ _____

I understand that USAA Life Insurance Company will rely on the above statements in determining the need and justification for the insurance applied for, and I represent that all answers are true and accurate. A reproduction of this statement may be attached to and made part of any insurance policy issued.

Signature of Proposed Insured _____ Date _____

Signature of Owner (if other than Proposed Insured) _____ Date _____



FOREIGN TRAVEL QUESTIONNAIRE

Propose Insured's Name _____

USAA Number _____

Contract Number _____

You indicated you plan to travel or reside in a foreign country within the next 12 months.

1. To which proposed insured do the travel or foreign residence details apply?

2. What countries do you plan to reside in, or travel to? _____

3. Within those countries, which cities will you stay in? _____

4. How long do you plan to remain in each country being traveled to? _____

5. How frequently do you plan to travel to any of the above named countries? _____

6. What is the purpose of the travel (Business, Military Duty, Missionary Travel, Vacation, etc)?

7. If the purpose for travel is business, please provide the name of your employer and details of your day-to-day job duties. _____

I understand that USAA Life Insurance Company will rely on the above statements in determining the need and justification for the insurance applied for, and I represent that all answers are true and accurate. A reproduction of this statement may be attached to and made part of any insurance policy issued.

Signed at _____ this _____ day of _____, _____
City State Year

Signature of Proposed Insured

ACTUARIAL DESCRIPTION OF UNIVERSAL LIFE

Policy Form Number: LUL88326AR 05-08

I. DESCRIPTION OF POLICY CHARACTERISTICS

This policy provides flexible premium universal life insurance coverage until the policy matures on the anniversary following the insured's age 120th birthday.

A. Death Benefits

Insurance on the life of the insured is integrated with the cash value of the policy under one of two options:

Option A -- the total death benefit is level and composed of the cash value plus a varying net amount at risk.

Option B -- the total death benefit is defined as the cash value plus a level net amount at risk.

For both Options A and B the minimum death benefit is determined such that it satisfies the cash value corridor requirement. This is the minimum death benefit required by the Internal Revenue Code to qualify the policy as life insurance so that the death benefit may be excluded from the beneficiary's gross income. It is calculated by multiplying the policy's cash value by a specified percentage, which is based on the insured's attained age. The percentages utilized are those that are specified in the Internal Revenue Code Section 7702 (d)(2) and it is assumed that the percentages above age 95 will be 100%.

B. Cash Values

The policy's cash value is an accumulation at interest of 97% of the gross premiums less specified monthly charges. The charges are \$12.50 per month for the first year for a first year expense charge, \$7.50 per month in all years for monthly maintenance, and monthly cost of insurance charges based on the net amount at risk in effect at that time.

The cash value will vary to reflect the amount and frequency of premium payments, the effect of any partial surrenders, the effect of any loans and the charges and deductions connected with the policy. There are no secondary guarantees associated with this policy.

Partial surrenders under death benefit option A will reduce the face amount by the amount of the partial withdrawal, including any partial surrender charge. Partial surrenders under death benefit option B will not impact the face amount. Partial surrenders are allowed after the first policy year but before the maturity date. Partial surrenders are subject to the terms, conditions and limitations found in the Policy Information section of the UL contract.

C. Paid-up Nonforfeiture Benefits

If the policyholder ceases paying premiums, the policy will be treated as paid-up term insurance. The rates for calculating the cost of paid-up insurance will be the same as those used while on premium paying status. The paid-up term period will run for as long as the cash value will purchase term insurance protection or until the maturity date, whichever is sooner.

D. Maturity Benefit

The policy matures on the policy anniversary following the insured's 120th birthday, at which time the cash value becomes payable.

E. Flexibility

At issue, the owner selects both a premium amount and the amount of insurance, subject to our minimum insurance amounts. A continuation of the original combination of premium and amount of insurance will result in a coverage period that could range from a very short term of coverage to coverage to the maturity date, depending upon the relationship of the selected values.

At any time, while the policy is in force, the owner may change the premium amount and/or the amount of insurance. Decreases may not lower the amount of insurance below the minimum amount. Evidence of insurability is required for any increase in amount of insurance.

II. BASIS OF VALUES

A. Interest

The guaranteed minimum interest rate applicable in the calculation of cash values is 3%. The company may credit a higher rate of interest in the calculation of cash values. The credited rate may vary depending on when the premiums are received. The current rate of interest is applied to the amount of cash value in excess of any loan indebtedness outstanding on the policy. The amount of loan indebtedness will be credited a rate equal to the minimum guaranteed interest rate.

The amount of interest credited to the account will be affected by the following items:

1. The timing and amount of premiums
2. The monthly COI deduction
3. The monthly expense load
4. Partial surrender and partial surrender service charge
5. Policy Change Service Fees
6. Information Report Fee

Because of the retrospective approach used for the calculation of cash values, the use of an increased rate of interest will produce increased cash values. Therefore, such use is not in conflict with the maximum interest rate defined in the Standard Nonforfeiture Law (SNFL).

B. Cost of Insurance

The guaranteed maximum cost of insurance rates utilized in the calculation of cash values under this policy, are based on the 2001 Commissioners' Standard Ordinary Smoker/Nonsmoker Mortality Tables. The company may use modified cost of insurance rates which produce a lower cost of insurance, thus producing higher cash values than those generated by the guaranteed maximum rates.

C. Expense Charges

The expense charges are \$12.50 per month for the first year for a first year expense charge, \$7.50 per month in all years for monthly maintenance. A percent of premium charge of 3% of each premium will be applied to each premium payment as it is processed. The company reserves the right to change the expense charges. The company guarantees that any changes in the expense charges would be

in compliance with the Standard Nonforfeiture Law.

III. DEMONSTRATION OF COMPLIANCE WITH THE STANDARD NONFORFEITURE LAW

For Universal Life (UL), the ultimate plan of insurance at any point in time prior to the maturity date is unknown due to the following:

1. Flexibility of premium payments and death benefits.
2. Interest credited to the cash value at a rate in excess of the minimum guaranteed interest rate.
3. Monthly cost of insurance rates less than the maximum permitted.

The UL Insurance Model Regulation defines minimum cash values using a retrospective formula. The method of calculating these policy cash values is designed in such a way that it is consistent with the retrospective method described in the UL Model Regulation Nonforfeiture Section 6. The following section will demonstrate that the UL cash values are consistent with the method of calculating cash values required by the UL Model Regulation:

- (1) It will be shown that the UL cash value formula is consistent with the retrospective formula defined in the UL Model Regulation.
- (2) Minimum cash surrender values will be generated by using the guaranteed minimum interest rate of 3% and maximum cost of insurance rates as previously described. Excess interest and/or lower cost of insurance rates will result in cash values greater than those based on the guaranteed maximum cost of insurance rates and guaranteed minimum interest.

- (3) It will be shown that the initial acquisition expense charge is less than or equal to the initial expense allowance provided by the Standard Nonforfeiture Law.
- (4) The surrender charge in all years is zero, which is always less than the unamortized unused initial and additional expense allowance.
- (5) The combination of items (1), (2), (3), and (4) above demonstrates that the UL cash values are consistent with the UL Model Regulation calculation method and will result in cash values at least as great as those required by the UL Model Regulation.

The minimum cash value available on any valuation date t , as provided by the Universal Life Model Regulation, is equal to:

$$\sum_{n=0}^t (1+i)^{t-n} P_n$$

$$- \sum_{n=0}^t (1+i)^{t-n} (BC_n + AAEC_n + AAC_n + IAEC_n)$$

– Unamortized unused initial and additional expense allowance

Where,

i is the interest rate credited to premiums consistent with the manner in which interest is credited in determining the policy value.

P_n is the gross premium paid at time n .

BC_n is the benefit charge (i.e., mortality and rider charge) assessed at time n .

$AAEC_n$ is the averaged administrative expense charges for the first policy year and any insurance-increase years.

AAC_n is the actual administrative expense charges for other years.

$IAEC_n$ are initial and additional acquisition expense charges not exceeding the initial or additional expense allowances.

This policy calculates account values and cash surrender values using a retrospective fund

formula which is consistent with the minimum cash value formula as follows:

$$AV_t = \sum_{n=0}^t (1+i)^{t-n} P_n$$

$$- \sum_{n=0}^t (1+i)^{t-n} (COI_n + PPC_n + PL_n)$$

and $CSV_t = AV_t$

Where,

i is the interest rate credited to cash value

P_n is the gross premium paid at time n.

COI_n is the mortality charge for time n

PPC_n are policy charges (\$12.50 per month in year 1, \$7.50 per month in years 2+)

PL_n are percent of premium loads (3.0% of premium in all years)

The AAEC for this policy is $[19 \times (12 \times \$7.50) + 19 \times 0.03 P_1] / 19 = \$90.00 + 0.03 P_1$

The initial acquisition expense charge, as defined by the UL Model Regulation is the First year expense charge less the AAEC.

The first year expense charge, $12 \times \$12.50 + .03 P_1$, less the AAEC is

$\$150.00 + .03 P_1 - (\$90.00 + .03 P_1) = \$60.00$.

This initial acquisition expense charge must be less than or equal to the initial expense allowance provided by the Standard Nonforfeiture Law. This initial expense allowance is:

$$(0.01 \times AAI) + 1.25 \times \text{the lesser of } [0.04 \times AAI, NLP]$$

where AAI = the average amount of insurance for the first 10 years, and

NLP = Nonforfeiture net level premium

The worst-case scenario for the comparison of the initial acquisition expense charge compared to the initial expense allowance provided by the Standard Nonforfeiture Law

occurs for the minimum face amount that will be issued, which is \$25,000. By looking at just the first term, $.01 \times \text{AAI}$, the initial expense allowance must be greater than \$250 ($0.01 \times \$25,000$). In all cases the initial acquisition expense of \$60.00 will be less than the initial expense allowance. See Appendix B-1.

The above demonstrations refer to Option A where the cash value does not exceed the face amount less the corridor. When the cash value multiplied by the appropriate corridor factor exceeds the face amount, the face amount is adjusted so that the face amount equals the cash value plus the corridor amount. This phase of Option A is actually an Option B situation where the face amount equals the cash value plus a level net amount at risk. The above comparisons are also valid for these situations. That can be shown by simply substituting the proper Option B face amount for the AAI term in the above formulas.

Since there are no surrender charges associated with this policy for a full surrender, they will always be less than the unused initial expense allowance. See Appendix B-2.

In summary, it has been shown that:

- The UL cash values are consistent with the cash value calculation method required by the UL Model regulation;
- The first-year expense charge never exceeds the maximum first-year expense allowable under the SNFL, and
- The surrender charges are less than the unused initial expense allowance

Together, these points demonstrate compliance with guidelines for Universal Life policies.

The policy form does not contain a table of cash values, since future cash values after the issue date will vary due to:

- (1) The flexibility of future premium payments and death benefits.

- (2) Interest credited in excess of the 3% minimum.
- (3) Cost of insurance rates less than the guaranteed maximum.

The method of calculating cash values is described in the policy form; annually, the Company will furnish the insured a statement showing the current cash values.

IV. DEMONSTRATION OF COMPLIANCE WITH THE STANDARD VALUATION LAW

The Standard Valuation Law (SVL) defines the Commissioners' Reserve Valuation Method (CRVM) provided in the NAIC's UL Model Regulation as the minimum reserve requirements.

A. Base Plan Reserves

The basic reserve for this policy will be the greater of:

- 1) The minimum reserve floor – a discounted continuous interpolated \bar{c}_x based on 2001 CSO Mortality (Age Last Birthday, ultimate, sex and smoker/non-smoker distinct), and an interest rate equal to the lesser of:
 - 3.00% (the contractual guaranteed minimum interest rate), or
 - The maximum valuation rate permitted for life insurance with a guaranteed duration of 20 or more years (the long life rate)

- 2) The amount $((A) - (B)) \times r - r \times [\{ ((a) - (b)) \bar{a}_{x+t} \} / \bar{a}_x]$, where:

(A) is equal to the present value of future benefits on the valuation date. The present value of future benefits is calculated by projecting the larger of the actual account value or the Guarantee Maturity Fund (GMF) on the valuation date. The projection assumes (1) payment of future Guaranteed Maturity Premiums (GMPs), (2) a 3.00% rate of return, and (3) deductions of guaranteed maximum charges specified in the contract. The GMF is the account value generated by payment of GMPs and guaranteed expense loads, guaranteed mortality, and 3% interest.

(B) is equal to $PVFB \times \bar{a}_{x+t} / \bar{a}_x$, where PVFB is the present value of future benefits at issue assuming GMPs are paid from issue. The GMP is defined as

the level gross premium paid from issue which matures the policy at age 120 for the initial specified amount based upon guaranteed maximum mortality charges, guaranteed maximum expense loads, and 3% interest.

The value of r is equal to the lesser of :

- 1.0, and
- $\frac{\text{Account Value}}{\text{GMF}}$

$((a) - (b))$ is the expense allowance at issue (as described in the Standard Valuation Law) based upon a plan of insurance defined by the payment of GMPs, guaranteed maximum charges, and a 3% rate of return.

The expense allowance equals $\bar{P}_{x-1} - \bar{c}_x$, where \bar{P}_x , \bar{c}_x are standard actuarial values.

Values of (A), (B), \bar{a}_x , \bar{P}_x , and \bar{c}_x are all based upon present values calculated using 2001 CSO Mortality (Age Last Birthday, ultimate, sex and smoker/non-smoker distinct, and an interest rate equal to the lesser of:

- 3.00% (the contractual guaranteed minimum interest rate), or
- The maximum valuation rate permitted for life insurance with a guaranteed duration of 20 or more years (the long life rate).

Deficiency Reserves

Deficiency reserves may result if the GMP is less than the valuation net premium, where the valuation net premium is calculated using:

- The valuation method actually used in calculating the reserve
- The minimum standards of mortality and interest.

The Company will hold a minimum reserve equal to the greater of :

- (1) The reserve calculated according to the method, mortality table, and rate of

interest actually used, or

- (2) The reserve calculated according to the method actually used but using the minimum valuation standards of mortality and rate of interest and replacing the valuation net premium by the Guarantee Maturity Premium in each policy year for which the valuation net premium exceeds the Guaranteed Maturity Premium.

B. NAIC Regulation XXX (if applicable)

As defined by NAIC Regulation XXX, a UL policy without guarantees will be exempt from this regulation. This policy does not provide any secondary guarantees.

A handwritten signature in black ink that reads "Phillip N. Beyer". The signature is written in a cursive style with a long, sweeping underline.

Phillip N. Beyer, FSA, MAAA
USAA Life Insurance Company

Date: February 1, 2008

INDIVIDUAL LIFE POLICY DEMONSTRATION FORMAT

Appendix B-1

USAA Life Insurance Company
 Universal Life Insurance Policy Form Number LUL69700ST 01-08

Gender: Male

Specified Amount Assumption:

25,000

Rating class: Preferred, Preferred Plus, Preferred Ultra

Table of Per \$1,000 Maximum First year Excess Expense Allowances

Issue Age	SNFL Max Excess 1st Yr Expense Allowance	Gross Premium	Actual Excess 1st Year Expenses	Unamortized Excess 1st Yr Expense Allowance	Unamortized Excess First Year Expense Allowance End of Year*									
					1	2	3	4	5	6	7	8	9	10
0	14.7254	n/a	2.4000	12.3254	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
1	14.8564	n/a	2.4000	12.4564	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
2	15.0032	n/a	2.4000	12.6032	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
3	15.1609	n/a	2.4000	12.7609	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
4	15.3284	n/a	2.4000	12.9284	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
5	15.5036	n/a	2.4000	13.1036	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
6	15.6857	n/a	2.4000	13.2857	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
7	15.8746	n/a	2.4000	13.4746	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
8	16.0709	n/a	2.4000	13.6709	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
9	16.2750	n/a	2.4000	13.8750	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
10	16.4870	n/a	2.4000	14.0870	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
11	16.7072	n/a	2.4000	14.3072	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
12	16.9347	n/a	2.4000	14.5347	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
13	17.1689	n/a	2.4000	14.7689	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
14	17.4103	n/a	2.4000	15.0103	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
15	17.6566	n/a	2.4000	15.2566	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
16	17.9071	n/a	2.4000	15.5071	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
17	18.1634	n/a	2.4000	15.7634	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
18	18.4262	n/a	2.4000	16.0262	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
19	18.6981	n/a	2.4000	16.2981	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
20	18.9810	n/a	2.4000	16.5810	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
21	19.2760	n/a	2.4000	16.8760	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
22	19.5841	n/a	2.4000	17.1841	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
23	19.9062	n/a	2.4000	17.5062	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
24	20.2425	n/a	2.4000	17.8425	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
25	20.5940	n/a	2.4000	18.1940	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
26	20.9605	n/a	2.4000	18.5605	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
27	21.3425	n/a	2.4000	18.9425	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
28	21.7419	n/a	2.4000	19.3419	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
29	22.1617	n/a	2.4000	19.7617	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
30	22.6028	n/a	2.4000	20.2028	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
31	23.0666	n/a	2.4000	20.6666	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
32	23.5546	n/a	2.4000	21.1546	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
33	24.0674	n/a	2.4000	21.6674	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
34	24.6057	n/a	2.4000	22.2057	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
35	25.1719	n/a	2.4000	22.7719	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
36	25.7664	n/a	2.4000	23.3664	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
37	26.3913	n/a	2.4000	23.9913	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
38	27.0478	n/a	2.4000	24.6478	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
39	27.7373	n/a	2.4000	25.3373	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
40	28.4629	n/a	2.4000	26.0629	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
41	29.2259	n/a	2.4000	26.8259	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
42	30.0282	n/a	2.4000	27.6282	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
43	30.8713	n/a	2.4000	28.4713	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
44	31.7571	n/a	2.4000	29.3571	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a

* Values will be shown for all policy years for which the surrender charge at the end of the year is greater than zero.

There are no surrender charges for this contract.

INDIVIDUAL LIFE POLICY DEMONSTRATION FORMAT

Appendix B-1

USAA Life Insurance Company
 Universal Life Insurance Policy Form Number LUL69700ST 01-08

Gender: Male

Specified Amount Assumption:

25,000

Rating class: Preferred, Preferred Plus, Preferred Ultra

Table of Per \$1,000 Maximum First year Excess Expense Allowances

Issue Age	SNFL Max Excess 1st Yr Expense Allowance	Gross Premium	Actual Excess 1st Year Expenses	Unamortized Excess 1st Yr Expense Allowance	Unamortized Excess First Year Expense Allowance End of Year*									
					1	2	3	4	5	6	7	8	9	10
45	32.6880	n/a	2.4000	30.2880	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
46	33.6669	n/a	2.4000	31.2669	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
47	34.6981	n/a	2.4000	32.2981	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
48	35.7892	n/a	2.4000	33.3892	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
49	36.9483	n/a	2.4000	34.5483	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
50	38.1797	n/a	2.4000	35.7797	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
51	39.4870	n/a	2.4000	37.0870	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
52	40.8733	n/a	2.4000	38.4733	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
53	42.3424	n/a	2.4000	39.9424	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
54	43.8991	n/a	2.4000	41.4991	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
55	45.5448	n/a	2.4000	43.1448	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
56	47.2844	n/a	2.4000	44.8844	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
57	49.1275	n/a	2.4000	46.7275	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
58	51.0882	n/a	2.4000	48.6882	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
59	53.1815	n/a	2.4000	50.7815	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
60	55.4156	n/a	2.4000	53.0156	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
61	57.7959	n/a	2.4000	55.3959	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
62	60.0000	n/a	2.4000	57.6000	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
63	60.0000	n/a	2.4000	57.6000	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
64	60.0000	n/a	2.4000	57.6000	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
65	60.0000	n/a	2.4000	57.6000	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
66	60.0000	n/a	2.4000	57.6000	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
67	60.0000	n/a	2.4000	57.6000	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
68	60.0000	n/a	2.4000	57.6000	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
69	60.0000	n/a	2.4000	57.6000	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
70	60.0000	n/a	2.4000	57.6000	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
71	60.0000	n/a	2.4000	57.6000	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
72	60.0000	n/a	2.4000	57.6000	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
73	60.0000	n/a	2.4000	57.6000	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
74	60.0000	n/a	2.4000	57.6000	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
75	60.0000	n/a	2.4000	57.6000	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
76	60.0000	n/a	2.4000	57.6000	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
77	60.0000	n/a	2.4000	57.6000	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
78	60.0000	n/a	2.4000	57.6000	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
79	60.0000	n/a	2.4000	57.6000	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
80	60.0000	n/a	2.4000	57.6000	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
81	60.0000	n/a	2.4000	57.6000	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
82	60.0000	n/a	2.4000	57.6000	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
83	60.0000	n/a	2.4000	57.6000	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
84	60.0000	n/a	2.4000	57.6000	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
85	60.0000	n/a	2.4000	57.6000	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
86	60.0000	n/a	2.4000	57.6000	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
87	60.0000	n/a	2.4000	57.6000	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
88	60.0000	n/a	2.4000	57.6000	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
89	60.0000	n/a	2.4000	57.6000	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
90	60.0000	n/a	2.4000	57.6000	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a

* Values will be shown for all policy years for which the surrender charge at the end of the year is greater than zero.
 There are no surrender charges for this contract.

INDIVIDUAL LIFE POLICY DEMONSTRATION FORMAT

Appendix B-1

USAA Life Insurance Company
 Universal Life Insurance Policy Form Number LUL69700ST 01-08

Gender: Female

Specified Amount Assumption:

25,000

Rating class: Preferred, Preferred Plus, Preferred Ultra

Table of Per \$1,000 Maximum First year Excess Expense Allowances

Issue Age	SNFL Max Excess 1st Yr Expense Allowance	Gross Premium	Actual Excess 1st Year Expenses	Unamortized Excess 1st Yr Expense Allowance	Unamortized Excess First Year Expense Allowance End of Year*									
					1	2	3	4	5	6	7	8	9	10
0	14.1229	n/a	2.4000	11.7229	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
1	14.2439	n/a	2.4000	11.8439	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
2	14.3740	n/a	2.4000	11.9740	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
3	14.5121	n/a	2.4000	12.1121	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
4	14.6565	n/a	2.4000	12.2565	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
5	14.8069	n/a	2.4000	12.4069	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
6	14.9633	n/a	2.4000	12.5633	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
7	15.1253	n/a	2.4000	12.7253	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
8	15.2927	n/a	2.4000	12.8927	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
9	15.4666	n/a	2.4000	13.0666	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
10	15.6472	n/a	2.4000	13.2472	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
11	15.8345	n/a	2.4000	13.4345	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
12	16.0280	n/a	2.4000	13.6280	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
13	16.2283	n/a	2.4000	13.8283	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
14	16.4350	n/a	2.4000	14.0350	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
15	16.6487	n/a	2.4000	14.2487	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
16	16.8703	n/a	2.4000	14.4703	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
17	17.0997	n/a	2.4000	14.6997	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
18	17.3378	n/a	2.4000	14.9378	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
19	17.5850	n/a	2.4000	15.1850	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
20	17.8418	n/a	2.4000	15.4418	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
21	18.1095	n/a	2.4000	15.7095	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
22	18.3879	n/a	2.4000	15.9879	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
23	18.6780	n/a	2.4000	16.2780	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
24	18.9810	n/a	2.4000	16.5810	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
25	19.2965	n/a	2.4000	16.8965	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
26	19.6258	n/a	2.4000	17.2258	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
27	19.9683	n/a	2.4000	17.5683	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
28	20.3258	n/a	2.4000	17.9258	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
29	20.6985	n/a	2.4000	18.2985	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
30	21.0875	n/a	2.4000	18.6875	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
31	21.4938	n/a	2.4000	19.0938	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
32	21.9180	n/a	2.4000	19.5180	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
33	22.3612	n/a	2.4000	19.9612	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
34	22.8241	n/a	2.4000	20.4241	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
35	23.3076	n/a	2.4000	20.9076	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
36	23.8125	n/a	2.4000	21.4125	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
37	24.3404	n/a	2.4000	21.9404	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
38	24.8933	n/a	2.4000	22.4933	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
39	25.4736	n/a	2.4000	23.0736	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
40	26.0827	n/a	2.4000	23.6827	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
41	26.7222	n/a	2.4000	24.3222	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
42	27.3939	n/a	2.4000	24.9939	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
43	28.0998	n/a	2.4000	25.6998	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
44	28.8415	n/a	2.4000	26.4415	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a

* Values will be shown for all policy years for which the surrender charge at the end of the year is greater than zero.

There are no surrender charges for this contract.

INDIVIDUAL LIFE POLICY DEMONSTRATION FORMAT

Appendix B-1

USAA Life Insurance Company
 Universal Life Insurance Policy Form Number LUL69700ST 01-08

Gender: Female
 Rating class: Preferred, Preferred Plus, Preferred Ultra

Specified Amount Assumption: 25,000

Table of Per \$1,000 Maximum First year Excess Expense Allowances

Issue Age	SNFL Max Excess 1st Yr Expense Allowance	Gross Premium	Actual Excess 1st Year Expenses	Unamortized Excess 1st Yr Expense Allowance	Unamortized Excess First Year Expense Allowance End of Year*									
					1	2	3	4	5	6	7	8	9	10
45	29.6208	n/a	2.4000	27.2208	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
46	30.4396	n/a	2.4000	28.0396	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
47	31.2995	n/a	2.4000	28.8995	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
48	32.2023	n/a	2.4000	29.8023	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
49	33.1507	n/a	2.4000	30.7507	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
50	34.1468	n/a	2.4000	31.7468	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
51	35.1933	n/a	2.4000	32.7933	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
52	36.2922	n/a	2.4000	33.8922	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
53	37.4461	n/a	2.4000	35.0461	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
54	38.6590	n/a	2.4000	36.2590	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
55	39.9355	n/a	2.4000	37.5355	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
56	41.2780	n/a	2.4000	38.8780	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
57	42.6907	n/a	2.4000	40.2907	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
58	44.1789	n/a	2.4000	41.7789	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
59	45.7495	n/a	2.4000	43.3495	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
60	47.4110	n/a	2.4000	45.0110	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
61	49.1717	n/a	2.4000	46.7717	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
62	51.0388	n/a	2.4000	48.6388	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
63	53.0224	n/a	2.4000	50.6224	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
64	55.1339	n/a	2.4000	52.7339	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
65	57.3842	n/a	2.4000	54.9842	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
66	59.7842	n/a	2.4000	57.3842	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
67	60.0000	n/a	2.4000	57.6000	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
68	60.0000	n/a	2.4000	57.6000	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
69	60.0000	n/a	2.4000	57.6000	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
70	60.0000	n/a	2.4000	57.6000	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
71	60.0000	n/a	2.4000	57.6000	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
72	60.0000	n/a	2.4000	57.6000	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
73	60.0000	n/a	2.4000	57.6000	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
74	60.0000	n/a	2.4000	57.6000	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
75	60.0000	n/a	2.4000	57.6000	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
76	60.0000	n/a	2.4000	57.6000	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
77	60.0000	n/a	2.4000	57.6000	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
78	60.0000	n/a	2.4000	57.6000	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
79	60.0000	n/a	2.4000	57.6000	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
80	60.0000	n/a	2.4000	57.6000	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
81	60.0000	n/a	2.4000	57.6000	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
82	60.0000	n/a	2.4000	57.6000	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
83	60.0000	n/a	2.4000	57.6000	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
84	60.0000	n/a	2.4000	57.6000	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
85	60.0000	n/a	2.4000	57.6000	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
86	60.0000	n/a	2.4000	57.6000	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
87	60.0000	n/a	2.4000	57.6000	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
88	60.0000	n/a	2.4000	57.6000	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
89	60.0000	n/a	2.4000	57.6000	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
90	60.0000	n/a	2.4000	57.6000	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a

* Values will be shown for all policy years for which the surrender charge at the end of the year is greater than zero.
 There are no surrender charges for this contract.

INDIVIDUAL LIFE POLICY DEMONSTRATION FORMAT

Appendix B-1

USAA Life Insurance Company
 Universal Life Insurance Policy Form Number LUL69700ST 01-08

Gender: Male

Specified Amount Assumption:

25,000

Rating class: Standard, Standard Plus

Table of Per \$1,000 Maximum First year Excess Expense Allowances

Issue Age	SNFL Max Excess 1st Yr Expense Allowance	Gross Premium	Actual Excess 1st Year Expenses	Unamortized Excess 1st Yr Expense Allowance	Unamortized Excess First Year Expense Allowance End of Year*									
					1	2	3	4	5	6	7	8	9	10
0	15.6510	n/a	2.4000	13.2510	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
1	15.8174	n/a	2.4000	13.4174	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
2	16.0012	n/a	2.4000	13.6012	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
3	16.1979	n/a	2.4000	13.7979	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
4	16.4063	n/a	2.4000	14.0063	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
5	16.6245	n/a	2.4000	14.2245	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
6	16.8516	n/a	2.4000	14.4516	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
7	17.0877	n/a	2.4000	14.6877	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
8	17.3335	n/a	2.4000	14.9335	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
9	17.5898	n/a	2.4000	15.1898	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
10	17.8565	n/a	2.4000	15.4565	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
11	18.1342	n/a	2.4000	15.7342	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
12	18.4222	n/a	2.4000	16.0222	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
13	18.7202	n/a	2.4000	16.3202	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
14	19.0286	n/a	2.4000	16.6286	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
15	19.3454	n/a	2.4000	16.9454	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
16	19.6700	n/a	2.4000	17.2700	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
17	20.0002	n/a	2.4000	17.6002	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
18	20.3375	n/a	2.4000	17.9375	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
19	20.6854	n/a	2.4000	18.2854	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
20	21.0453	n/a	2.4000	18.6453	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
21	21.4189	n/a	2.4000	19.0189	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
22	21.8075	n/a	2.4000	19.4075	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
23	22.2116	n/a	2.4000	19.8116	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
24	22.6321	n/a	2.4000	20.2321	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
25	23.0696	n/a	2.4000	20.6696	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
26	23.5248	n/a	2.4000	21.1248	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
27	23.9986	n/a	2.4000	21.5986	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
28	24.4945	n/a	2.4000	22.0945	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
29	25.0161	n/a	2.4000	22.6161	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
30	25.5661	n/a	2.4000	23.1661	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
31	26.1466	n/a	2.4000	23.7466	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
32	26.7589	n/a	2.4000	24.3589	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
33	27.4041	n/a	2.4000	25.0041	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
34	28.0834	n/a	2.4000	25.6834	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
35	28.7986	n/a	2.4000	26.3986	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
36	29.5523	n/a	2.4000	27.1523	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
37	30.3452	n/a	2.4000	27.9452	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
38	31.1795	n/a	2.4000	28.7795	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
39	32.0570	n/a	2.4000	29.6570	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
40	32.9803	n/a	2.4000	30.5803	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
41	33.9510	n/a	2.4000	31.5510	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
42	34.9704	n/a	2.4000	32.5704	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
43	36.0399	n/a	2.4000	33.6399	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
44	37.1603	n/a	2.4000	34.7603	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a

* Values will be shown for all policy years for which the surrender charge at the end of the year is greater than zero.

There are no surrender charges for this contract.

INDIVIDUAL LIFE POLICY DEMONSTRATION FORMAT

Appendix B-1

USAA Life Insurance Company
 Universal Life Insurance Policy Form Number LUL69700ST 01-08

Gender: Male

Specified Amount Assumption:

25,000

Rating class: Standard, Standard Plus

Table of Per \$1,000 Maximum First year Excess Expense Allowances

Issue Age	SNFL Max Excess 1st Yr Expense Allowance	Gross Premium	Actual Excess 1st Year Expenses	Unamortized Excess 1st Yr Expense Allowance	Unamortized Excess First Year Expense Allowance End of Year*									
					1	2	3	4	5	6	7	8	9	10
45	38.3333	n/a	2.4000	35.9333	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
46	39.5641	n/a	2.4000	37.1641	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
47	40.8583	n/a	2.4000	38.4583	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
48	42.2275	n/a	2.4000	39.8275	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
49	43.6860	n/a	2.4000	41.2860	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
50	45.2380	n/a	2.4000	42.8380	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
51	46.8862	n/a	2.4000	44.4862	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
52	48.6312	n/a	2.4000	46.2312	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
53	50.4744	n/a	2.4000	48.0744	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
54	52.4159	n/a	2.4000	50.0159	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
55	54.4539	n/a	2.4000	52.0539	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
56	56.5942	n/a	2.4000	54.1942	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
57	58.8465	n/a	2.4000	56.4465	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
58	60.0000	n/a	2.4000	57.6000	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
59	60.0000	n/a	2.4000	57.6000	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
60	60.0000	n/a	2.4000	57.6000	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
61	60.0000	n/a	2.4000	57.6000	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
62	60.0000	n/a	2.4000	57.6000	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
63	60.0000	n/a	2.4000	57.6000	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
64	60.0000	n/a	2.4000	57.6000	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
65	60.0000	n/a	2.4000	57.6000	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
66	60.0000	n/a	2.4000	57.6000	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
67	60.0000	n/a	2.4000	57.6000	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
68	60.0000	n/a	2.4000	57.6000	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
69	60.0000	n/a	2.4000	57.6000	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
70	60.0000	n/a	2.4000	57.6000	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
71	60.0000	n/a	2.4000	57.6000	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
72	60.0000	n/a	2.4000	57.6000	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
73	60.0000	n/a	2.4000	57.6000	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
74	60.0000	n/a	2.4000	57.6000	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
75	60.0000	n/a	2.4000	57.6000	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
76	60.0000	n/a	2.4000	57.6000	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
77	60.0000	n/a	2.4000	57.6000	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
78	60.0000	n/a	2.4000	57.6000	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
79	60.0000	n/a	2.4000	57.6000	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
80	60.0000	n/a	2.4000	57.6000	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
81	60.0000	n/a	2.4000	57.6000	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
82	60.0000	n/a	2.4000	57.6000	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
83	60.0000	n/a	2.4000	57.6000	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
84	60.0000	n/a	2.4000	57.6000	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
85	60.0000	n/a	2.4000	57.6000	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
86	60.0000	n/a	2.4000	57.6000	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
87	60.0000	n/a	2.4000	57.6000	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
88	60.0000	n/a	2.4000	57.6000	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
89	60.0000	n/a	2.4000	57.6000	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
90	60.0000	n/a	2.4000	57.6000	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a

* Values will be shown for all policy years for which the surrender charge at the end of the year is greater than zero.

There are no surrender charges for this contract.

INDIVIDUAL LIFE POLICY DEMONSTRATION FORMAT

Appendix B-1

USAA Life Insurance Company
 Universal Life Insurance Policy Form Number LUL69700ST 01-08

Gender: Female

Specified Amount Assumption:

25,000

Rating class: Standard, Standard Plus

Table of Per \$1,000 Maximum First year Excess Expense Allowances

Issue Age	SNFL Max Excess 1st Yr Expense Allowance	Gross Premium	Actual Excess 1st Year Expenses	Unamortized Excess 1st Yr Expense Allowance	Unamortized Excess First Year Expense Allowance End of Year*									
					1	2	3	4	5	6	7	8	9	10
0	14.9830	n/a	2.4000	12.5830	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
1	15.1362	n/a	2.4000	12.7362	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
2	15.2998	n/a	2.4000	12.8998	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
3	15.4732	n/a	2.4000	13.0732	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
4	15.6545	n/a	2.4000	13.2545	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
5	15.8433	n/a	2.4000	13.4433	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
6	16.0401	n/a	2.4000	13.6401	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
7	16.2443	n/a	2.4000	13.8443	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
8	16.4559	n/a	2.4000	14.0559	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
9	16.6761	n/a	2.4000	14.2761	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
10	16.9053	n/a	2.4000	14.5053	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
11	17.1436	n/a	2.4000	14.7436	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
12	17.3905	n/a	2.4000	14.9905	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
13	17.6470	n/a	2.4000	15.2470	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
14	17.9126	n/a	2.4000	15.5126	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
15	18.1883	n/a	2.4000	15.7883	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
16	18.4751	n/a	2.4000	16.0751	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
17	18.7713	n/a	2.4000	16.3713	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
18	19.0788	n/a	2.4000	16.6788	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
19	19.3983	n/a	2.4000	16.9983	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
20	19.7299	n/a	2.4000	17.3299	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
21	20.0754	n/a	2.4000	17.6754	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
22	20.4350	n/a	2.4000	18.0350	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
23	20.8101	n/a	2.4000	18.4101	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
24	21.2016	n/a	2.4000	18.8016	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
25	21.6100	n/a	2.4000	19.2100	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
26	22.0355	n/a	2.4000	19.6355	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
27	22.4797	n/a	2.4000	20.0797	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
28	22.9437	n/a	2.4000	20.5437	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
29	23.4283	n/a	2.4000	21.0283	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
30	23.9350	n/a	2.4000	21.5350	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
31	24.4653	n/a	2.4000	22.0653	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
32	25.0198	n/a	2.4000	22.6198	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
33	25.6002	n/a	2.4000	23.2002	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
34	26.2074	n/a	2.4000	23.8074	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
35	26.8417	n/a	2.4000	24.4417	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
36	27.5052	n/a	2.4000	25.1052	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
37	28.2002	n/a	2.4000	25.8002	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
38	28.9301	n/a	2.4000	26.5301	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
39	29.6979	n/a	2.4000	27.2979	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
40	30.5061	n/a	2.4000	28.1061	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
41	31.3575	n/a	2.4000	28.9575	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
42	32.2548	n/a	2.4000	29.8548	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
43	33.1994	n/a	2.4000	30.7994	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
44	34.1946	n/a	2.4000	31.7946	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a

* Values will be shown for all policy years for which the surrender charge at the end of the year is greater than zero.

There are no surrender charges for this contract.

INDIVIDUAL LIFE POLICY DEMONSTRATION FORMAT

Appendix B-1

USAA Life Insurance Company
 Universal Life Insurance Policy Form Number LUL69700ST 01-08

Gender: Female

Specified Amount Assumption:

25,000

Rating class: Standard, Standard Plus

Table of Per \$1,000 Maximum First year Excess Expense Allowances

Issue Age	SNFL Max Excess 1st Yr Expense Allowance	Gross Premium	Actual Excess 1st Year Expenses	Unamortized Excess 1st Yr Expense Allowance	Unamortized Excess First Year Expense Allowance End of Year*									
					1	2	3	4	5	6	7	8	9	10
45	35.2425	n/a	2.4000	32.8425	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
46	36.3455	n/a	2.4000	33.9455	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
47	37.5058	n/a	2.4000	35.1058	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
48	38.7238	n/a	2.4000	36.3238	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
49	39.9999	n/a	2.4000	37.5999	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
50	41.3358	n/a	2.4000	38.9358	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
51	42.7350	n/a	2.4000	40.3350	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
52	44.1998	n/a	2.4000	41.7998	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
53	45.7335	n/a	2.4000	43.3335	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
54	47.3394	n/a	2.4000	44.9394	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
55	49.0215	n/a	2.4000	46.6215	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
56	50.7847	n/a	2.4000	48.3847	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
57	52.6336	n/a	2.4000	50.2336	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
58	54.5775	n/a	2.4000	52.1775	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
59	56.6249	n/a	2.4000	54.2249	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
60	58.7827	n/a	2.4000	56.3827	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
61	60.0000	n/a	2.4000	57.6000	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
62	60.0000	n/a	2.4000	57.6000	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
63	60.0000	n/a	2.4000	57.6000	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
64	60.0000	n/a	2.4000	57.6000	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
65	60.0000	n/a	2.4000	57.6000	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
66	60.0000	n/a	2.4000	57.6000	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
67	60.0000	n/a	2.4000	57.6000	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
68	60.0000	n/a	2.4000	57.6000	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
69	60.0000	n/a	2.4000	57.6000	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
70	60.0000	n/a	2.4000	57.6000	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
71	60.0000	n/a	2.4000	57.6000	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
72	60.0000	n/a	2.4000	57.6000	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
73	60.0000	n/a	2.4000	57.6000	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
74	60.0000	n/a	2.4000	57.6000	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
75	60.0000	n/a	2.4000	57.6000	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
76	60.0000	n/a	2.4000	57.6000	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
77	60.0000	n/a	2.4000	57.6000	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
78	60.0000	n/a	2.4000	57.6000	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
79	60.0000	n/a	2.4000	57.6000	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
80	60.0000	n/a	2.4000	57.6000	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
81	60.0000	n/a	2.4000	57.6000	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
82	60.0000	n/a	2.4000	57.6000	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
83	60.0000	n/a	2.4000	57.6000	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
84	60.0000	n/a	2.4000	57.6000	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
85	60.0000	n/a	2.4000	57.6000	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
86	60.0000	n/a	2.4000	57.6000	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
87	60.0000	n/a	2.4000	57.6000	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
88	60.0000	n/a	2.4000	57.6000	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
89	60.0000	n/a	2.4000	57.6000	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
90	60.0000	n/a	2.4000	57.6000	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a

* Values will be shown for all policy years for which the surrender charge at the end of the year is greater than zero.

There are no surrender charges for this contract.

INDIVIDUAL LIFE POLICY DEMONSTRATION FORMAT

Appendix B-2

USAA Life Insurance Company
 Universal Life Insurance Policy Form Number LUL69700ST 01-08

Gender: Male Specified Amount Assumption: 25,000
 Rating class: Preferred, Preferred Plus, Preferred Ultra

Table of Per \$1,000 Surrender Charges

Issue Age	Initial Surrender Charge	Surrender Charge at End of Year: *									
		1	2	3	4	5	6	7	8	9	10
0	0	0	0	0	0	0	0	0	0	0	0
1	0	0	0	0	0	0	0	0	0	0	0
2	0	0	0	0	0	0	0	0	0	0	0
3	0	0	0	0	0	0	0	0	0	0	0
4	0	0	0	0	0	0	0	0	0	0	0
5	0	0	0	0	0	0	0	0	0	0	0
6	0	0	0	0	0	0	0	0	0	0	0
7	0	0	0	0	0	0	0	0	0	0	0
8	0	0	0	0	0	0	0	0	0	0	0
9	0	0	0	0	0	0	0	0	0	0	0
10	0	0	0	0	0	0	0	0	0	0	0
11	0	0	0	0	0	0	0	0	0	0	0
12	0	0	0	0	0	0	0	0	0	0	0
13	0	0	0	0	0	0	0	0	0	0	0
14	0	0	0	0	0	0	0	0	0	0	0
15	0	0	0	0	0	0	0	0	0	0	0
16	0	0	0	0	0	0	0	0	0	0	0
17	0	0	0	0	0	0	0	0	0	0	0
18	0	0	0	0	0	0	0	0	0	0	0
19	0	0	0	0	0	0	0	0	0	0	0
20	0	0	0	0	0	0	0	0	0	0	0
21	0	0	0	0	0	0	0	0	0	0	0
22	0	0	0	0	0	0	0	0	0	0	0
23	0	0	0	0	0	0	0	0	0	0	0
24	0	0	0	0	0	0	0	0	0	0	0
25	0	0	0	0	0	0	0	0	0	0	0
26	0	0	0	0	0	0	0	0	0	0	0
27	0	0	0	0	0	0	0	0	0	0	0
28	0	0	0	0	0	0	0	0	0	0	0
29	0	0	0	0	0	0	0	0	0	0	0
30	0	0	0	0	0	0	0	0	0	0	0
31	0	0	0	0	0	0	0	0	0	0	0
32	0	0	0	0	0	0	0	0	0	0	0
33	0	0	0	0	0	0	0	0	0	0	0
34	0	0	0	0	0	0	0	0	0	0	0
35	0	0	0	0	0	0	0	0	0	0	0
36	0	0	0	0	0	0	0	0	0	0	0
37	0	0	0	0	0	0	0	0	0	0	0
38	0	0	0	0	0	0	0	0	0	0	0
39	0	0	0	0	0	0	0	0	0	0	0
40	0	0	0	0	0	0	0	0	0	0	0
41	0	0	0	0	0	0	0	0	0	0	0
42	0	0	0	0	0	0	0	0	0	0	0
43	0	0	0	0	0	0	0	0	0	0	0
44	0	0	0	0	0	0	0	0	0	0	0

* Values will be shown for all policy years for which the surrender charge is greater than zero.
 There are no surrender charges for this contract.

INDIVIDUAL LIFE POLICY DEMONSTRATION FORMAT

Appendix B-2

USAA Life Insurance Company
 Universal Life Insurance Policy Form Number LUL69700ST 01-08

Gender: Male

Specified Amount Assumption:

25,000

Rating class: Preferred, Preferred Plus, Preferred Ultra

Table of Per \$1,000 Surrender Charges

Issue Age	Initial Surrender Charge	Surrender Charge at End of Year: *									
		1	2	3	4	5	6	7	8	9	10
45	0	0	0	0	0	0	0	0	0	0	0
46	0	0	0	0	0	0	0	0	0	0	0
47	0	0	0	0	0	0	0	0	0	0	0
48	0	0	0	0	0	0	0	0	0	0	0
49	0	0	0	0	0	0	0	0	0	0	0
50	0	0	0	0	0	0	0	0	0	0	0
51	0	0	0	0	0	0	0	0	0	0	0
52	0	0	0	0	0	0	0	0	0	0	0
53	0	0	0	0	0	0	0	0	0	0	0
54	0	0	0	0	0	0	0	0	0	0	0
55	0	0	0	0	0	0	0	0	0	0	0
56	0	0	0	0	0	0	0	0	0	0	0
57	0	0	0	0	0	0	0	0	0	0	0
58	0	0	0	0	0	0	0	0	0	0	0
59	0	0	0	0	0	0	0	0	0	0	0
60	0	0	0	0	0	0	0	0	0	0	0
61	0	0	0	0	0	0	0	0	0	0	0
62	0	0	0	0	0	0	0	0	0	0	0
63	0	0	0	0	0	0	0	0	0	0	0
64	0	0	0	0	0	0	0	0	0	0	0
65	0	0	0	0	0	0	0	0	0	0	0
66	0	0	0	0	0	0	0	0	0	0	0
67	0	0	0	0	0	0	0	0	0	0	0
68	0	0	0	0	0	0	0	0	0	0	0
69	0	0	0	0	0	0	0	0	0	0	0
70	0	0	0	0	0	0	0	0	0	0	0
71	0	0	0	0	0	0	0	0	0	0	0
72	0	0	0	0	0	0	0	0	0	0	0
73	0	0	0	0	0	0	0	0	0	0	0
74	0	0	0	0	0	0	0	0	0	0	0
75	0	0	0	0	0	0	0	0	0	0	0
76	0	0	0	0	0	0	0	0	0	0	0
77	0	0	0	0	0	0	0	0	0	0	0
78	0	0	0	0	0	0	0	0	0	0	0
79	0	0	0	0	0	0	0	0	0	0	0
80	0	0	0	0	0	0	0	0	0	0	0
81	0	0	0	0	0	0	0	0	0	0	0
82	0	0	0	0	0	0	0	0	0	0	0
83	0	0	0	0	0	0	0	0	0	0	0
84	0	0	0	0	0	0	0	0	0	0	0
85	0	0	0	0	0	0	0	0	0	0	0
86	0	0	0	0	0	0	0	0	0	0	0
87	0	0	0	0	0	0	0	0	0	0	0
88	0	0	0	0	0	0	0	0	0	0	0
89	0	0	0	0	0	0	0	0	0	0	0
90	0	0	0	0	0	0	0	0	0	0	0

* Values will be shown for all policy years for which the surrender charge is greater than zero.
 There are no surrender charges for this contract.

INDIVIDUAL LIFE POLICY DEMONSTRATION FORMAT

Appendix B-2

USAA Life Insurance Company
 Universal Life Insurance Policy Form Number LUL69700ST 01-08

Gender: Female

Specified Amount Assumption:

25,000

Rating class: Preferred, Preferred Plus, Preferred Ultra

Table of Per \$1,000 Surrender Charges

Issue Age	Initial Surrender Charge	Surrender Charge at End of Year: *									
		1	2	3	4	5	6	7	8	9	10
0	0	0	0	0	0	0	0	0	0	0	0
1	0	0	0	0	0	0	0	0	0	0	0
2	0	0	0	0	0	0	0	0	0	0	0
3	0	0	0	0	0	0	0	0	0	0	0
4	0	0	0	0	0	0	0	0	0	0	0
5	0	0	0	0	0	0	0	0	0	0	0
6	0	0	0	0	0	0	0	0	0	0	0
7	0	0	0	0	0	0	0	0	0	0	0
8	0	0	0	0	0	0	0	0	0	0	0
9	0	0	0	0	0	0	0	0	0	0	0
10	0	0	0	0	0	0	0	0	0	0	0
11	0	0	0	0	0	0	0	0	0	0	0
12	0	0	0	0	0	0	0	0	0	0	0
13	0	0	0	0	0	0	0	0	0	0	0
14	0	0	0	0	0	0	0	0	0	0	0
15	0	0	0	0	0	0	0	0	0	0	0
16	0	0	0	0	0	0	0	0	0	0	0
17	0	0	0	0	0	0	0	0	0	0	0
18	0	0	0	0	0	0	0	0	0	0	0
19	0	0	0	0	0	0	0	0	0	0	0
20	0	0	0	0	0	0	0	0	0	0	0
21	0	0	0	0	0	0	0	0	0	0	0
22	0	0	0	0	0	0	0	0	0	0	0
23	0	0	0	0	0	0	0	0	0	0	0
24	0	0	0	0	0	0	0	0	0	0	0
25	0	0	0	0	0	0	0	0	0	0	0
26	0	0	0	0	0	0	0	0	0	0	0
27	0	0	0	0	0	0	0	0	0	0	0
28	0	0	0	0	0	0	0	0	0	0	0
29	0	0	0	0	0	0	0	0	0	0	0
30	0	0	0	0	0	0	0	0	0	0	0
31	0	0	0	0	0	0	0	0	0	0	0
32	0	0	0	0	0	0	0	0	0	0	0
33	0	0	0	0	0	0	0	0	0	0	0
34	0	0	0	0	0	0	0	0	0	0	0
35	0	0	0	0	0	0	0	0	0	0	0
36	0	0	0	0	0	0	0	0	0	0	0
37	0	0	0	0	0	0	0	0	0	0	0
38	0	0	0	0	0	0	0	0	0	0	0
39	0	0	0	0	0	0	0	0	0	0	0
40	0	0	0	0	0	0	0	0	0	0	0
41	0	0	0	0	0	0	0	0	0	0	0
42	0	0	0	0	0	0	0	0	0	0	0
43	0	0	0	0	0	0	0	0	0	0	0
44	0	0	0	0	0	0	0	0	0	0	0

* Values will be shown for all policy years for which the surrender charge is greater than zero.
 There are no surrender charges for this contract.

INDIVIDUAL LIFE POLICY DEMONSTRATION FORMAT

Appendix B-2

USAA Life Insurance Company
 Universal Life Insurance Policy Form Number LUL69700ST 01-08

Gender: Female

Specified Amount Assumption:

25,000

Rating class: Preferred, Preferred Plus, Preferred Ultra

Table of Per \$1,000 Surrender Charges

Issue Age	Initial Surrender Charge	Surrender Charge at End of Year: *									
		1	2	3	4	5	6	7	8	9	10
45	0	0	0	0	0	0	0	0	0	0	0
46	0	0	0	0	0	0	0	0	0	0	0
47	0	0	0	0	0	0	0	0	0	0	0
48	0	0	0	0	0	0	0	0	0	0	0
49	0	0	0	0	0	0	0	0	0	0	0
50	0	0	0	0	0	0	0	0	0	0	0
51	0	0	0	0	0	0	0	0	0	0	0
52	0	0	0	0	0	0	0	0	0	0	0
53	0	0	0	0	0	0	0	0	0	0	0
54	0	0	0	0	0	0	0	0	0	0	0
55	0	0	0	0	0	0	0	0	0	0	0
56	0	0	0	0	0	0	0	0	0	0	0
57	0	0	0	0	0	0	0	0	0	0	0
58	0	0	0	0	0	0	0	0	0	0	0
59	0	0	0	0	0	0	0	0	0	0	0
60	0	0	0	0	0	0	0	0	0	0	0
61	0	0	0	0	0	0	0	0	0	0	0
62	0	0	0	0	0	0	0	0	0	0	0
63	0	0	0	0	0	0	0	0	0	0	0
64	0	0	0	0	0	0	0	0	0	0	0
65	0	0	0	0	0	0	0	0	0	0	0
66	0	0	0	0	0	0	0	0	0	0	0
67	0	0	0	0	0	0	0	0	0	0	0
68	0	0	0	0	0	0	0	0	0	0	0
69	0	0	0	0	0	0	0	0	0	0	0
70	0	0	0	0	0	0	0	0	0	0	0
71	0	0	0	0	0	0	0	0	0	0	0
72	0	0	0	0	0	0	0	0	0	0	0
73	0	0	0	0	0	0	0	0	0	0	0
74	0	0	0	0	0	0	0	0	0	0	0
75	0	0	0	0	0	0	0	0	0	0	0
76	0	0	0	0	0	0	0	0	0	0	0
77	0	0	0	0	0	0	0	0	0	0	0
78	0	0	0	0	0	0	0	0	0	0	0
79	0	0	0	0	0	0	0	0	0	0	0
80	0	0	0	0	0	0	0	0	0	0	0
81	0	0	0	0	0	0	0	0	0	0	0
82	0	0	0	0	0	0	0	0	0	0	0
83	0	0	0	0	0	0	0	0	0	0	0
84	0	0	0	0	0	0	0	0	0	0	0
85	0	0	0	0	0	0	0	0	0	0	0
86	0	0	0	0	0	0	0	0	0	0	0
87	0	0	0	0	0	0	0	0	0	0	0
88	0	0	0	0	0	0	0	0	0	0	0
89	0	0	0	0	0	0	0	0	0	0	0
90	0	0	0	0	0	0	0	0	0	0	0

* Values will be shown for all policy years for which the surrender charge is greater than zero. There are no surrender charges for this contract.

INDIVIDUAL LIFE POLICY DEMONSTRATION FORMAT

Appendix B-2

USAA Life Insurance Company
 Universal Life Insurance Policy Form Number LUL69700ST 01-08

Gender: Male

Specified Amount Assumption:

25,000

Rating class: Standard, Standard Plus

Table of Per \$1,000 Surrender Charges

Issue Age	Initial Surrender Charge	Surrender Charge at End of Year: *									
		1	2	3	4	5	6	7	8	9	10
0	0	0	0	0	0	0	0	0	0	0	0
1	0	0	0	0	0	0	0	0	0	0	0
2	0	0	0	0	0	0	0	0	0	0	0
3	0	0	0	0	0	0	0	0	0	0	0
4	0	0	0	0	0	0	0	0	0	0	0
5	0	0	0	0	0	0	0	0	0	0	0
6	0	0	0	0	0	0	0	0	0	0	0
7	0	0	0	0	0	0	0	0	0	0	0
8	0	0	0	0	0	0	0	0	0	0	0
9	0	0	0	0	0	0	0	0	0	0	0
10	0	0	0	0	0	0	0	0	0	0	0
11	0	0	0	0	0	0	0	0	0	0	0
12	0	0	0	0	0	0	0	0	0	0	0
13	0	0	0	0	0	0	0	0	0	0	0
14	0	0	0	0	0	0	0	0	0	0	0
15	0	0	0	0	0	0	0	0	0	0	0
16	0	0	0	0	0	0	0	0	0	0	0
17	0	0	0	0	0	0	0	0	0	0	0
18	0	0	0	0	0	0	0	0	0	0	0
19	0	0	0	0	0	0	0	0	0	0	0
20	0	0	0	0	0	0	0	0	0	0	0
21	0	0	0	0	0	0	0	0	0	0	0
22	0	0	0	0	0	0	0	0	0	0	0
23	0	0	0	0	0	0	0	0	0	0	0
24	0	0	0	0	0	0	0	0	0	0	0
25	0	0	0	0	0	0	0	0	0	0	0
26	0	0	0	0	0	0	0	0	0	0	0
27	0	0	0	0	0	0	0	0	0	0	0
28	0	0	0	0	0	0	0	0	0	0	0
29	0	0	0	0	0	0	0	0	0	0	0
30	0	0	0	0	0	0	0	0	0	0	0
31	0	0	0	0	0	0	0	0	0	0	0
32	0	0	0	0	0	0	0	0	0	0	0
33	0	0	0	0	0	0	0	0	0	0	0
34	0	0	0	0	0	0	0	0	0	0	0
35	0	0	0	0	0	0	0	0	0	0	0
36	0	0	0	0	0	0	0	0	0	0	0
37	0	0	0	0	0	0	0	0	0	0	0
38	0	0	0	0	0	0	0	0	0	0	0
39	0	0	0	0	0	0	0	0	0	0	0
40	0	0	0	0	0	0	0	0	0	0	0
41	0	0	0	0	0	0	0	0	0	0	0
42	0	0	0	0	0	0	0	0	0	0	0
43	0	0	0	0	0	0	0	0	0	0	0
44	0	0	0	0	0	0	0	0	0	0	0

* Values will be shown for all policy years for which the surrender charge is greater than zero.
 There are no surrender charges for this contract.

INDIVIDUAL LIFE POLICY DEMONSTRATION FORMAT

Appendix B-2

USAA Life Insurance Company
 Universal Life Insurance Policy Form Number LUL69700ST 01-08

Gender: Male

Specified Amount Assumption:

25,000

Rating class: Standard, Standard Plus

Table of Per \$1,000 Surrender Charges

Issue Age	Initial Surrender Charge	Surrender Charge at End of Year: *									
		1	2	3	4	5	6	7	8	9	10
45	0	0	0	0	0	0	0	0	0	0	0
46	0	0	0	0	0	0	0	0	0	0	0
47	0	0	0	0	0	0	0	0	0	0	0
48	0	0	0	0	0	0	0	0	0	0	0
49	0	0	0	0	0	0	0	0	0	0	0
50	0	0	0	0	0	0	0	0	0	0	0
51	0	0	0	0	0	0	0	0	0	0	0
52	0	0	0	0	0	0	0	0	0	0	0
53	0	0	0	0	0	0	0	0	0	0	0
54	0	0	0	0	0	0	0	0	0	0	0
55	0	0	0	0	0	0	0	0	0	0	0
56	0	0	0	0	0	0	0	0	0	0	0
57	0	0	0	0	0	0	0	0	0	0	0
58	0	0	0	0	0	0	0	0	0	0	0
59	0	0	0	0	0	0	0	0	0	0	0
60	0	0	0	0	0	0	0	0	0	0	0
61	0	0	0	0	0	0	0	0	0	0	0
62	0	0	0	0	0	0	0	0	0	0	0
63	0	0	0	0	0	0	0	0	0	0	0
64	0	0	0	0	0	0	0	0	0	0	0
65	0	0	0	0	0	0	0	0	0	0	0
66	0	0	0	0	0	0	0	0	0	0	0
67	0	0	0	0	0	0	0	0	0	0	0
68	0	0	0	0	0	0	0	0	0	0	0
69	0	0	0	0	0	0	0	0	0	0	0
70	0	0	0	0	0	0	0	0	0	0	0
71	0	0	0	0	0	0	0	0	0	0	0
72	0	0	0	0	0	0	0	0	0	0	0
73	0	0	0	0	0	0	0	0	0	0	0
74	0	0	0	0	0	0	0	0	0	0	0
75	0	0	0	0	0	0	0	0	0	0	0
76	0	0	0	0	0	0	0	0	0	0	0
77	0	0	0	0	0	0	0	0	0	0	0
78	0	0	0	0	0	0	0	0	0	0	0
79	0	0	0	0	0	0	0	0	0	0	0
80	0	0	0	0	0	0	0	0	0	0	0
81	0	0	0	0	0	0	0	0	0	0	0
82	0	0	0	0	0	0	0	0	0	0	0
83	0	0	0	0	0	0	0	0	0	0	0
84	0	0	0	0	0	0	0	0	0	0	0
85	0	0	0	0	0	0	0	0	0	0	0
86	0	0	0	0	0	0	0	0	0	0	0
87	0	0	0	0	0	0	0	0	0	0	0
88	0	0	0	0	0	0	0	0	0	0	0
89	0	0	0	0	0	0	0	0	0	0	0
90	0	0	0	0	0	0	0	0	0	0	0

* Values will be shown for all policy years for which the surrender charge is greater than zero. There are no surrender charges for this contract.

INDIVIDUAL LIFE POLICY DEMONSTRATION FORMAT

Appendix B-2

USAA Life Insurance Company
 Universal Life Insurance Policy Form Number LUL69700ST 01-08

Gender: Female

Specified Amount Assumption:

25,000

Rating class: Standard, Standard Plus

Table of Per \$1,000 Surrender Charges

Issue Age	Initial Surrender Charge	Surrender Charge at End of Year: *									
		1	2	3	4	5	6	7	8	9	10
0	0	0	0	0	0	0	0	0	0	0	0
1	0	0	0	0	0	0	0	0	0	0	0
2	0	0	0	0	0	0	0	0	0	0	0
3	0	0	0	0	0	0	0	0	0	0	0
4	0	0	0	0	0	0	0	0	0	0	0
5	0	0	0	0	0	0	0	0	0	0	0
6	0	0	0	0	0	0	0	0	0	0	0
7	0	0	0	0	0	0	0	0	0	0	0
8	0	0	0	0	0	0	0	0	0	0	0
9	0	0	0	0	0	0	0	0	0	0	0
10	0	0	0	0	0	0	0	0	0	0	0
11	0	0	0	0	0	0	0	0	0	0	0
12	0	0	0	0	0	0	0	0	0	0	0
13	0	0	0	0	0	0	0	0	0	0	0
14	0	0	0	0	0	0	0	0	0	0	0
15	0	0	0	0	0	0	0	0	0	0	0
16	0	0	0	0	0	0	0	0	0	0	0
17	0	0	0	0	0	0	0	0	0	0	0
18	0	0	0	0	0	0	0	0	0	0	0
19	0	0	0	0	0	0	0	0	0	0	0
20	0	0	0	0	0	0	0	0	0	0	0
21	0	0	0	0	0	0	0	0	0	0	0
22	0	0	0	0	0	0	0	0	0	0	0
23	0	0	0	0	0	0	0	0	0	0	0
24	0	0	0	0	0	0	0	0	0	0	0
25	0	0	0	0	0	0	0	0	0	0	0
26	0	0	0	0	0	0	0	0	0	0	0
27	0	0	0	0	0	0	0	0	0	0	0
28	0	0	0	0	0	0	0	0	0	0	0
29	0	0	0	0	0	0	0	0	0	0	0
30	0	0	0	0	0	0	0	0	0	0	0
31	0	0	0	0	0	0	0	0	0	0	0
32	0	0	0	0	0	0	0	0	0	0	0
33	0	0	0	0	0	0	0	0	0	0	0
34	0	0	0	0	0	0	0	0	0	0	0
35	0	0	0	0	0	0	0	0	0	0	0
36	0	0	0	0	0	0	0	0	0	0	0
37	0	0	0	0	0	0	0	0	0	0	0
38	0	0	0	0	0	0	0	0	0	0	0
39	0	0	0	0	0	0	0	0	0	0	0
40	0	0	0	0	0	0	0	0	0	0	0
41	0	0	0	0	0	0	0	0	0	0	0
42	0	0	0	0	0	0	0	0	0	0	0
43	0	0	0	0	0	0	0	0	0	0	0
44	0	0	0	0	0	0	0	0	0	0	0

* Values will be shown for all policy years for which the surrender charge is greater than zero.
 There are no surrender charges for this contract.

INDIVIDUAL LIFE POLICY DEMONSTRATION FORMAT

Appendix B-2

USAA Life Insurance Company
 Universal Life Insurance Policy Form Number LUL69700ST 01-08

Gender: Female
 Rating class: Standard, Standard Plus

Specified Amount Assumption: 25,000

Table of Per \$1,000 Surrender Charges

Issue Age	Initial Surrender Charge	Surrender Charge at End of Year: *									
		1	2	3	4	5	6	7	8	9	10
45	0	0	0	0	0	0	0	0	0	0	0
46	0	0	0	0	0	0	0	0	0	0	0
47	0	0	0	0	0	0	0	0	0	0	0
48	0	0	0	0	0	0	0	0	0	0	0
49	0	0	0	0	0	0	0	0	0	0	0
50	0	0	0	0	0	0	0	0	0	0	0
51	0	0	0	0	0	0	0	0	0	0	0
52	0	0	0	0	0	0	0	0	0	0	0
53	0	0	0	0	0	0	0	0	0	0	0
54	0	0	0	0	0	0	0	0	0	0	0
55	0	0	0	0	0	0	0	0	0	0	0
56	0	0	0	0	0	0	0	0	0	0	0
57	0	0	0	0	0	0	0	0	0	0	0
58	0	0	0	0	0	0	0	0	0	0	0
59	0	0	0	0	0	0	0	0	0	0	0
60	0	0	0	0	0	0	0	0	0	0	0
61	0	0	0	0	0	0	0	0	0	0	0
62	0	0	0	0	0	0	0	0	0	0	0
63	0	0	0	0	0	0	0	0	0	0	0
64	0	0	0	0	0	0	0	0	0	0	0
65	0	0	0	0	0	0	0	0	0	0	0
66	0	0	0	0	0	0	0	0	0	0	0
67	0	0	0	0	0	0	0	0	0	0	0
68	0	0	0	0	0	0	0	0	0	0	0
69	0	0	0	0	0	0	0	0	0	0	0
70	0	0	0	0	0	0	0	0	0	0	0
71	0	0	0	0	0	0	0	0	0	0	0
72	0	0	0	0	0	0	0	0	0	0	0
73	0	0	0	0	0	0	0	0	0	0	0
74	0	0	0	0	0	0	0	0	0	0	0
75	0	0	0	0	0	0	0	0	0	0	0
76	0	0	0	0	0	0	0	0	0	0	0
77	0	0	0	0	0	0	0	0	0	0	0
78	0	0	0	0	0	0	0	0	0	0	0
79	0	0	0	0	0	0	0	0	0	0	0
80	0	0	0	0	0	0	0	0	0	0	0
81	0	0	0	0	0	0	0	0	0	0	0
82	0	0	0	0	0	0	0	0	0	0	0
83	0	0	0	0	0	0	0	0	0	0	0
84	0	0	0	0	0	0	0	0	0	0	0
85	0	0	0	0	0	0	0	0	0	0	0
86	0	0	0	0	0	0	0	0	0	0	0
87	0	0	0	0	0	0	0	0	0	0	0
88	0	0	0	0	0	0	0	0	0	0	0
89	0	0	0	0	0	0	0	0	0	0	0
90	0	0	0	0	0	0	0	0	0	0	0

* Values will be shown for all policy years for which the surrender charge is greater than zero. There are no surrender charges for this contract.

**USAA LIFE INSURANCE COMPANY
Universal Life Insurance Policy
Memorandum of Variable Material**

Form Number: LUL88326AR 05-08

Variability Ranges for Policy Information Section of Universal Life

INITIAL FACE AMOUNT [\$25,000]

The initial face amount cannot be less than the MINIMUM FACE AMOUNT.

DEATH BENEFIT OPTION [A OR B]

The policyholder has a choice of either specified amount or specified amount plus fund value.

MINIMUM FACE AMOUNT [\$2,500]

The range for the bracketed text is \$1,000 to \$100,000.

MINIMUM DECREASE AMOUNT [\$5,000]

The range for the bracketed text is \$2,500 to \$25,000.

MINIMUM INCREASE AMOUNT [\$25,000]

The range for the bracketed text is \$10,000 to \$100,000.

MINIMUM ADDITIONAL PREMIUM AMOUNT [\$25]

The range for the bracketed text is \$10 to \$100.

MINIMUM GUARANTEED ACCOUNT VALUE INTEREST [3%]

The range for the bracketed text is 1% to 10%

ADDITIONAL ACCOUNT VALUE INTEREST [[1%] CREDITED AFTER [20TH]YEAR][[0%]

The range for the first bracketed interest rate ([1%]) is 0% to 10%.

The range for the number of years is 10th to 30th year.

The range for the second bracketed interest rate ([0%]) is 0% to 10%.

MINIMUM ANNUAL LOAN INTEREST [4%] [[4.0%] for Policy Years [1] through [20]
[[3.0%] for Policy Years [21] [and after]]

The range for the bracketed interest rates is 3% to 10%.

The range for the Policy Years is 1 to 30

MAXIMUM INFORMATION REPORT FEE [\$25.00]

The range for the bracketed text is \$0 to \$100.

MAXIMUM PREMIUM EXPENSE CHARGE [8%] of each premium payment received

The range for the bracketed text is 3% to 8%.

CURRENT PREMIUM EXPENSE CHARGE [3%] of each premium payment received

The range for the bracketed text is 0% to 8%

MAXIMUM MONTHLY EXPENSE CHARGE [\$25.00] per [MONTH]

The range for the bracketed dollar amount is \$10 to \$25

The range for the bracketed time period can be monthly, quarterly, semi annually or annually.

CURRENT MONTHLY EXPENSE CHARGE [\$7.50] per [MONTH]

The range for the bracketed dollar amount is \$0 to \$25

The range for the bracketed time period can be monthly, quarterly, semi annually or annually.

MAXIMUM ADMINISTRATIVE CHARGE [\$100] PER [MONTH] [(first year only)]

The range for the bracketed dollar amount is \$5 to \$100

The range for the bracketed time period can be monthly, quarterly, semi annually or annually.

The bracketed phrase "first year only" indicates that the administrative charge should occur in the first year only. By bracketing the "first year only" phrase, this indicates that an administrative charge could occur in any year of the policy.

CURRENT ADMINISTRATIVE CHARGE [\$5] PER [MONTH] [(first year only)]

The range for the bracketed dollar amount is \$0 to \$100

The range for the bracketed time period can be monthly, quarterly, semi annually or annually.

The bracketed phrase "first year only" indicates that the administrative charge should occur in the first year only. By bracketing the "first year only" phrase, this indicates that an administrative charge could occur in any year of the policy.

POLICY CHANGE SERVICE CHARGE [\$25.00]

The range for the bracketed text is from \$0 to \$100.

PARTIAL SURRENDER SERVICE CHARGE [\$25.00]

The range for the bracketed text is from \$0 to \$100.

MINIMUM PARTIAL SURRENDER AMOUNT [\$500]

The range for the bracketed text is from \$500 to \$5,000.

MINIMUM ACCOUNT VALUE AFTER PARTIAL SURRENDER [\$1,000]

The range for the bracketed text is from \$1,000 to \$25,000.

MAXIMUM PARTIAL SURRENDERS ALLOWED PER YEAR [5]

The range for the bracketed text is from 3 to 12.

UNDER THE METHODS OF SETTLEMENT SECTION

Guaranteed Monthly Payments are based on a [2.5%] effective annual interest rate and the [2000 NAIC Individual Annuity Mortality Table].

The bracketed interest rate has a range of 0.5% and 10%.

The bracketed mortality table may be revised if the NAIC adopts a revised annuity annuity mortality table.



Phillip N Beyer, FSA, MAAA
AVP, Product Solutions
USAA Direct Life Insurance Company

February 26, 2008

Date

Table of Guaranteed Maximum Monthly Cost of Insurance Rates Per \$1,000				
Based on the 2001 Commissioners Standard Ordinary Smoker and Nonsmoker Ultimate Mortality Tables				
Attained Age	Male	Female	Male	Female
	Nonsmoker	Nonsmoker	Smoker	Smoker
0	0.0600	0.0350	0.0600	0.0350
1	0.0383	0.0258	0.0383	0.0258
2	0.0275	0.0192	0.0275	0.0192
3	0.0200	0.0167	0.0200	0.0167
4	0.0175	0.0158	0.0175	0.0158
5	0.0175	0.0150	0.0175	0.0150
6	0.0183	0.0158	0.0183	0.0158
7	0.0183	0.0175	0.0183	0.0175
8	0.0183	0.0175	0.0183	0.0175
9	0.0192	0.0175	0.0192	0.0175
10	0.0200	0.0183	0.0200	0.0183
11	0.0233	0.0208	0.0233	0.0208
12	0.0283	0.0225	0.0283	0.0225
13	0.0333	0.0258	0.0333	0.0258
14	0.0433	0.0283	0.0433	0.0283
15	0.0550	0.0300	0.0550	0.0300
16	0.0642	0.0325	0.0717	0.0358
17	0.0725	0.0342	0.0858	0.0392
18	0.0767	0.0358	0.0950	0.0425
19	0.0783	0.0375	0.1025	0.0467
20	0.0792	0.0375	0.1083	0.0492
21	0.0792	0.0392	0.1133	0.0525
22	0.0792	0.0400	0.1192	0.0550
23	0.0800	0.0400	0.1250	0.0575
24	0.0808	0.0417	0.1317	0.0608
25	0.0833	0.0425	0.1392	0.0658
26	0.0867	0.0458	0.1467	0.0700
27	0.0883	0.0475	0.1508	0.0742
28	0.0867	0.0500	0.1517	0.0792
29	0.0858	0.0525	0.1508	0.0842
30	0.0850	0.0550	0.1500	0.0892
31	0.0842	0.0583	0.1508	0.0958
32	0.0850	0.0617	0.1533	0.1025
33	0.0875	0.0658	0.1583	0.1108
34	0.0892	0.0708	0.1642	0.1217
35	0.0933	0.0767	0.1708	0.1325

Table of Guaranteed Maximum Monthly Cost of Insurance Rates Per \$1,000				
Based on the 2001 Commissioners Standard Ordinary Smoker and Nonsmoker Ultimate Mortality Tables				
Attained Age	Male	Female	Male	Female
	Nonsmoker	Nonsmoker	Smoker	Smoker
36	0.0975	0.0825	0.1808	0.1433
37	0.1033	0.0875	0.1925	0.1525
38	0.1108	0.0917	0.2067	0.1617
39	0.1175	0.0967	0.2225	0.1717
40	0.1267	0.1025	0.2417	0.1825
41	0.1375	0.1092	0.2650	0.1950
42	0.1508	0.1167	0.2925	0.2108
43	0.1667	0.1258	0.3250	0.2283
44	0.1842	0.1367	0.3617	0.2492
45	0.2033	0.1492	0.3983	0.2733
46	0.2225	0.1642	0.4350	0.3017
47	0.2383	0.1817	0.4658	0.3367
48	0.2508	0.2008	0.4892	0.3783
49	0.2667	0.2225	0.5192	0.4250
50	0.2875	0.2467	0.5583	0.4750
51	0.3142	0.2742	0.6092	0.5300
52	0.3467	0.3050	0.6708	0.5892
53	0.3842	0.3375	0.7450	0.6533
54	0.4317	0.3717	0.8333	0.7217
55	0.4850	0.4108	0.9275	0.7942
56	0.5400	0.4533	1.0250	0.8717
57	0.5933	0.4983	1.1150	0.9500
58	0.6467	0.5450	1.2008	1.0317
59	0.7092	0.5925	1.3017	1.1192
60	0.7850	0.6425	1.4258	1.2100
61	0.8775	0.6975	1.5775	1.3083
62	0.9850	0.7558	1.7517	1.4125
63	1.1025	0.8175	1.9383	1.5192
64	1.2250	0.8850	2.1250	1.6342
65	1.3525	0.9600	2.3075	1.7583
66	1.4817	1.0417	2.4842	1.8933
67	1.6167	1.1325	2.6625	2.0433
68	1.7592	1.2333	2.8450	2.2075
69	1.9192	1.3433	3.0458	2.3883
70	2.1058	1.4675	3.2758	2.5925
71	2.3325	1.6092	3.5583	2.8208

Table of Guaranteed Maximum Monthly Cost of Insurance Rates Per \$1,000				
Based on the 2001 Commissioners Standard Ordinary Smoker and Nonsmoker Ultimate Mortality Tables				
Attained Age	Male	Female	Male	Female
	Nonsmoker	Nonsmoker	Smoker	Smoker
72	2.5975	1.7642	3.8867	3.0692
73	2.8767	1.9333	4.2175	3.3400
74	3.1767	2.1208	4.5758	3.6233
75	3.5033	2.3267	4.9742	3.9208
76	3.8717	2.5525	5.4158	4.2425
77	4.3000	2.8025	5.9267	4.5892
78	4.7975	3.0750	6.5125	4.9633
79	5.3550	3.3742	7.1575	5.3658
80	5.9767	3.7458	7.8625	5.8675
81	6.6525	4.2025	8.6117	6.4808
82	7.3683	4.6858	9.3825	7.1125
83	8.1500	5.1933	10.2042	7.7575
84	9.0192	5.7592	11.1333	8.4292
85	9.9858	6.3325	12.1867	9.0500
86	11.0492	7.0100	13.3292	9.7675
87	12.1983	7.8467	14.5433	10.6575
88	13.4200	8.7292	15.8092	11.5483
89	14.7017	9.6075	17.1108	12.3633
90	15.9783	10.2542	18.3683	12.8267
91	17.2350	10.8725	19.5650	13.2067
92	18.5517	11.8975	20.7933	14.0275
93	19.9400	13.2867	22.0633	15.1892
94	21.4025	15.0167	23.4183	16.8083
95	22.8508	16.8992	24.7825	18.7183
96	24.2650	18.7533	26.0775	20.5375
97	25.7717	19.9567	27.4425	21.6167
98	27.3783	20.6100	28.8833	22.0492
99	29.0925	21.9658	30.4042	23.2142
100	30.7300	23.7283	31.8267	24.7900
101	32.1825	25.6433	33.0425	26.4933
102	33.7275	27.7533	34.3208	28.3442
103	35.3700	30.0583	35.6633	30.3367
104	37.1058	32.5708	37.1942	32.6358
105	38.9342	35.2258	39.0167	35.2867
106	40.8750	37.9433	40.9517	37.9992
107	42.9342	40.7058	43.0058	40.7583

Table of Guaranteed Maximum Monthly Cost of Insurance Rates Per \$1,000				
Based on the 2001 Commissioners Standard Ordinary Smoker and Nonsmoker Ultimate Mortality Tables				
Attained Age	Male	Female	Male	Female
	Nonsmoker	Nonsmoker	Smoker	Smoker
108	45.1192	43.5158	45.1842	43.5642
109	47.4350	46.4192	47.4950	46.4633
110	49.8875	49.3292	49.9417	49.3692
111	52.4858	52.1342	52.5342	52.1708
112	55.2358	54.8133	55.2792	54.8458
113	58.1458	57.5650	58.1825	57.5933
114	61.2208	61.0042	61.2525	61.0283
115	64.4692	64.2783	64.4958	64.2992
116	67.8967	67.6958	67.9183	67.7117
117	71.5108	71.3250	71.5267	71.3367
118	75.3167	74.7150	75.3267	74.7233
119	79.3058	78.2550	79.3117	78.2592
120	83.3333	83.3333	83.3333	83.3333



9800 Fredericksburg Road
San Antonio, Texas 78288

March 10, 2008

Re: United Services Automobile Association (USAA), NAIC CoCode: 25941
USAA Casualty Insurance Company (USAA-CIC), NAIC CoCode: 25968
USAA General Indemnity Company (USAA-GIC), NAIC CoCode: 18600
Garrison Property & Casualty Insurance Company (GAR), NAIC CoCode: 21253
USAA County Mutual Insurance Company, NAIC CoCode: 10078
USAA Texas Lloyds Company, NAIC CoCode: 11120
USAA Life Insurance Company of New York, NAIC CoCode: 60228
USAA Direct Life Insurance Company, NAIC CoCode: 72613
USAA Life Insurance Company, NAIC CoCode 69663

To Whom It May Concern:

Perr&Knight, Inc. is hereby authorized to submit rates, rule, and form filings on behalf of the above listed companies. This authorization includes providing additional information and responding to questions regarding the filing on our behalf as necessary. This authorization is deemed to be in effect until rescinded in writing.

Please direct all correspondences and inquires related to this filing to Perr&Knight, Inc. at the following address:

State Filings Department
Perr&Knight, Inc.
881 Alma Real Drive, Suite 205
Pacific Palisades, CA 90272
Phone: (310) 230-9339
Fax: (310) 230-8529

Please contact me if you have any questions regarding this authorization.

Sincerely,

A handwritten signature in cursive script that reads "Layne C. Roetzel".

Layne C Roetzel, Assistant Vice President
USAA
9800 Fredericksburg Road
San Antonio, TX 78288
Phone: (210) 498-6729
Fax: (210) 498-0083
Email: layne.roetzel@usaa.com

FLESCH SCORE INFO FOR LUL88326AR 05-08

Flesch Score 58

of sentences 397

of paragraphs 342

of words 5,683

USAA LIFE INSURANCE COMPANY

CERTIFICATION

DATE: June 10, 2008

This is to certify that the attached Form Number LUL88326AR 05-08, to the best of our knowledge, complies with the Arkansas Rule and Regulation 19 – Unfair Sex Discrimination in the sale of insurance.

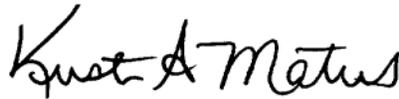
A handwritten signature in black ink that reads "Kristi Matus". The signature is written in a cursive style with a large initial 'K' and 'M'.

Kristi Matus
President
USAA LIFE INSURANCE COMPANY

CONSENT TO SUBMIT RATES AND/OR
COST BASES FOR APPROVAL

The USAA Life Insurance Company of San Antonio, Texas does hereby consent and agree that all premium rates and/or cost bases both “maximum” and “current or projected,” used in relation to policy form number LUL88326AR 05-08 must be filed with the Insurance Commissioner for the State of Arkansas (“Commissioner”) at least sixty (60) days prior to their proposed effective. Such rates and/or cost bases shall be deemed effective after they are filed with the Commissioner, unless the Commissioner shall approve or disapprove such rates and/or cost bases prior to the expiration of sixty (60) days.

USAA Life Insurance Company

A handwritten signature in black ink that reads "Kristi A. Matus". The signature is written in a cursive style with a large initial 'K' and 'M'.

Kristi A Matus
President, USAA Life Insurance Company