

SERFF Tracking Number: AEGB-125695572 State: Arkansas
Filing Company: Western Reserve Life Assurance Co. of Ohio State Tracking Number: 39483
Company Tracking Number: U000313
TOI: L06I Individual Life - Variable Sub-TOI: L06I.002 Single Life - Flexible Premium
Product Name: Individual Life Application
Project Name/Number: Individual Life Application/U000313

Filing at a Glance

Company: Western Reserve Life Assurance Co. of Ohio

Product Name: Individual Life Application SERFF Tr Num: AEGB-125695572 State: ArkansasLH
TOI: L06I Individual Life - Variable SERFF Status: Closed State Tr Num: 39483
Sub-TOI: L06I.002 Single Life - Flexible Co Tr Num: U000313 State Status: Approved-Closed
Premium
Filing Type: Form Co Status: Reviewer(s): Linda Bird
Author: Suzanne Voight Disposition Date: 07/03/2008
Date Submitted: 06/30/2008 Disposition Status: Approved
Implementation Date Requested: On Approval Implementation Date:

State Filing Description:

General Information

Project Name: Individual Life Application Status of Filing in Domicile: Authorized
Project Number: U000313 Date Approved in Domicile: 06/26/2008
Requested Filing Mode: Review & Approval Domicile Status Comments:
Explanation for Combination/Other: Market Type: Individual
Submission Type: New Submission Group Market Size:
Overall Rate Impact: Group Market Type:
Filing Status Changed: 07/03/2008
State Status Changed: 07/03/2008 Deemer Date:
Corresponding Filing Tracking Number: U000313
Filing Description:
Re: Western Reserve Life Assurance Company of Ohio
NAIC #0468-91413
FEIN #43-1162657
Form: U000313 Individual Life Application

Dear Sir/Madam:

SERFF Tracking Number: AEGB-125695572 State: Arkansas
 Filing Company: Western Reserve Life Assurance Co. of Ohio State Tracking Number: 39483
 Company Tracking Number: U000313
 TOI: L06I Individual Life - Variable Sub-TOI: L06I.002 Single Life - Flexible Premium
 Product Name: Individual Life Application
 Project Name/Number: Individual Life Application/U000313

Filing Contact Information

Suzanne Voight, Policy Analyst I svoight@aegonusa.com
 4333 Edgewood Road NE (319) 398-7860 [Phone]
 Cedar Rapids, IA 52449 (319) 369-2501[FAX]

Filing Company Information

Western Reserve Life Assurance Co. of Ohio	CoCode: 91413	State of Domicile: Ohio
4333 Edgewood Road NE	Group Code: 468	Company Type:
Cedar Rapids, IA 52499	Group Name:	State ID Number:
(319) 398-7888 ext. [Phone]	FEIN Number: 43-1162657	

Filing Fees

Fee Required? Yes
 Fee Amount: \$50.00
 Retaliatory? No
 Fee Explanation: WRL retaliatory fee of \$50.00 is greater than \$20.00 fee for forms filed separately from policies, and the higher amount is required per DOI
 Per Company: No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Western Reserve Life Assurance Co. of Ohio	\$50.00	06/30/2008	21148344

SERFF Tracking Number: *AEGB-125695572* *State:* *Arkansas*
Filing Company: *Western Reserve Life Assurance Co. of Ohio* *State Tracking Number:* *39483*
Company Tracking Number: *U000313*
TOI: *L06I Individual Life - Variable* *Sub-TOI:* *L06I.002 Single Life - Flexible Premium*
Product Name: *Individual Life Application*
Project Name/Number: *Individual Life Application/U000313*

Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved	Linda Bird	07/03/2008	07/03/2008

SERFF Tracking Number: AEGB-125695572 *State:* Arkansas
Filing Company: Western Reserve Life Assurance Co. of Ohio *State Tracking Number:* 39483
Company Tracking Number: U000313
TOI: L06I Individual Life - Variable *Sub-TOI:* L06I.002 Single Life - Flexible Premium
Product Name: Individual Life Application
Project Name/Number: Individual Life Application/U000313

Disposition

Disposition Date: 07/03/2008

Implementation Date:

Status: Approved

Comment:

Rate data does NOT apply to filing.

SERFF Tracking Number: AEGB-125695572 *State:* Arkansas
Filing Company: Western Reserve Life Assurance Co. of Ohio *State Tracking Number:* 39483
Company Tracking Number: U000313
TOI: L061 Individual Life - Variable *Sub-TOI:* L061.002 Single Life - Flexible Premium
Product Name: Individual Life Application
Project Name/Number: Individual Life Application/U000313

Form Schedule

Lead Form Number: U000313

Review Status	Form Number	Form Type Form Name	Action	Action Specific Data	Readability	Attachment
	U000313	Application/ Individual Life Enrollment Application Form	Initial		50	U000313.pdf

[WRL Freedom Elite Builder II]

WRL – WESTERN RESERVE LIFE ASSURANCE CO. OF OHIO Individual Life Insurance Application

Mailing Address: [4333 Edgewood Road NE, Cedar Rapids, IA 52499] Administrative Office: [P.O. Box 5068, Clearwater, FL 33758-5068]

SECTION 1. PROPOSED PRIMARY INSURED/OWNER SPECIFIED AMOUNT \$ _____
If proposed Contingent Owner is named, please use Additional Information Supplement.

1. Last Name		First Name		M.I.	
2. Address (Cannot be a P.O. Box)			Apt#	City	
State	Zip Code	3. Years at Address	4. Home Phone ()	5. Driver License Number	State
6. Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	7. Date of Birth MM-DD-YYYY	8. Age	9. Place of Birth – State/Country	10. Social Security Number	
11. Height (ft. in.)	12. Weight (lbs.)	13. Marital Status	14. Employer	#Years	
15. Employer’s Address and Phone Number					
16. Occupation & Duties					
17. Have you used TOBACCO or any other product containing NICOTINE in the last 5 years? <input type="checkbox"/> No <input type="checkbox"/> Yes Date last used _____					
18. Rate Class Quoted: <input type="checkbox"/> Preferred Elite <input type="checkbox"/> Preferred Plus <input type="checkbox"/> Preferred <input type="checkbox"/> Non-Tobacco <input type="checkbox"/> Preferred Tobacco <input type="checkbox"/> Tobacco <input type="checkbox"/> Juvenile					

SECTION 2. PROPOSED OTHER INSURED SPECIFIED AMOUNT \$ _____
If more than one Other Insured, please use Additional Information Supplement.
We will allow the OIR death benefit recipient to be a choice of: Owner Primary Insured Same Beneficiary as the base policy
 Other _____

1. Last Name		First Name		M.I.	
2. Address (Cannot be a P.O. Box)			Apt#	City	
State	Zip Code	3. Years at Address	4. Home Phone ()	5. Driver License Number	State
6. Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	7. Date of Birth MM-DD-YYYY	8. Age	9. Place of Birth – State/Country	10. Social Security Number	
11. Height (ft. in.)	12. Weight (lbs.)	13. Marital Status	14. Relationship to proposed Primary Insured		
15. Employer					#Years
16. Employer’s Address and Phone Number					
17. Occupation & Duties					
18. Have you used TOBACCO or any other product containing NICOTINE in the last 5 years? <input type="checkbox"/> No <input type="checkbox"/> Yes Date last used _____					
19. Rate Class Quoted: <input type="checkbox"/> Preferred Elite <input type="checkbox"/> Preferred Plus <input type="checkbox"/> Preferred <input type="checkbox"/> Non-Tobacco <input type="checkbox"/> Preferred Tobacco <input type="checkbox"/> Tobacco <input type="checkbox"/> Juvenile					

SECTION 3. APPLICANT/OWNER IF OTHER THAN THE PROPOSED PRIMARY INSURED If ownership is corporation, partnership or institutional body, please complete the Entity Certification of Authority form. If ownership is a trust, please complete the Trustee Certification Trust form. Attach a copy of the first page and the signature page of the Trust.

1. Last Name		First Name		M.I.	
2. Address (Cannot be a P.O. Box)			Apt#	City	
State	Zip Code	3. Home Phone ()		4. Social Security Number / Tax ID #	
5. Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	6. Date of Birth/Trust Date MM-DD-YYYY	7. Relationship to proposed Primary Insured			
8. Are you a citizen of <input type="checkbox"/> USA <input type="checkbox"/> Other Country _____ Type of VISA _____					

SECTION 4. CHILDREN'S BENEFIT RIDER **SPECIFIED AMOUNT \$** _____

Name	Relationship	Date of Birth (mmddyyyy)	Height (ft. in.)	Weight (lbs.)

Are all children listed? Yes No Are children living with proposed Primary Insured? Yes No
 If not, explain why: _____

SECTION 5. PRIMARY BENEFICIARY – If percentage shares are not listed below, they will be divided equally among the beneficiaries. If ownership or beneficiary is a corporation, partnership or institutional body, please complete the Entity Certification of Authority form. If ownership or beneficiary is a trust, please complete the Trustee Certification Trust form. Attach a copy of the first page and the signature page of the Trust.

Name	Percent	Relationship	Social Security Number/Tax ID#
Total	100		

SECTION 6. CONTINGENT BENEFICIARY – If percentage shares are not listed below, they will be divided equally among the beneficiaries.

Name	Percent	Relationship	Social Security Number/Tax ID#
Total	100		

SECTION 7. DEATH BENEFIT OPTION

A) Level Benefit B) Increasing Benefit C) Option B to Age 70 then grade to Option A

SECTION 8. LIFE INSURANCE COMPLIANCE TEST (Only choose one)

Guideline Premium Test Cash Value Accumulation Test (CVAT)]

SECTION 9. ADDITIONAL BENEFITS – PRIMARY INSURED ONLY

<input type="checkbox"/> Disability Waiver of Monthly Deductions Rider	<input type="checkbox"/> Disability Waiver of Premium Rider
<input type="checkbox"/> Primary Insured Rider Plus \$ _____	<input type="checkbox"/> Inflation Fighter Rider (Level Premium)
<input type="checkbox"/> Accidental Death Benefit Rider \$ _____ (\$150,000 maximum)	

SECTION 10. PREMIUMS PAYABLE

Initial Planned Premium \$ _____ Electronic (bank draft) _____ Draft Date (1st through 28th)

Direct Bill Single Premium Annually Semiannually Quarterly Monthly Other _____

Premium Payor (If other than Owner) Applicant may specify a payor other than Owner and a Secondary Addressee who may be named to receive copies of notices and letters regarding possible lapses in coverage.

1. Payor's Last Name _____ First Name _____ M.I. _____

2. Address (Cannot be a P.O. Box) _____ Apt# _____ City _____

State _____ Zip Code _____ 3. Home Phone _____ 4. Social Security Number/Tax ID # _____ 5. Relationship to proposed Primary Insured _____

Secondary Addressee

1. Last Name _____ First Name _____ M.I. _____

2. Address (Cannot be a P.O. Box) _____ City _____ State _____ Zip Code _____

SECTION 11. PREMIUM ALLOCATION OPTIONS

I have completed and signed the allocation form. Please allocate funds accordingly.

SECTION 12. OTHER INSURANCE IN FORCE FOR ALL PROPOSED INSURED

A) Has any proposed Insured ever had life, disability or health insurance declined, rated, modified, issued with an exclusion rider, canceled, or not renewed? If yes, please explain. _____ Yes No

B) Is there an application for life, accident or sickness insurance now pending or contemplated on any proposed Insured in this or any other company? If yes, give details in Agent's Report. Yes No

C) Will the insurance applied for on any proposed Insured discontinue, replace or change any existing life or annuity policy? If yes, complete replacement forms, if appropriate. Yes No

D) Does any proposed Insured have existing life insurance policies or annuity contracts? Yes No

Proposed Insured Name	Company	Amount of Insurance	Year Issued	Replacement?
				<input type="checkbox"/> Yes <input type="checkbox"/> No
				<input type="checkbox"/> Yes <input type="checkbox"/> No
				<input type="checkbox"/> Yes <input type="checkbox"/> No

IS THIS INTENDED TO BE A 1035 EXCHANGE? Yes No

Anticipated Cash Value Transfer \$ _____

SECTION 13. PERSONAL FINANCIAL STATEMENT FOR PROPOSED PRIMARY INSURED

All financial information on non-juvenile business must be that of the proposed Primary Insured, not the Owner.

A) Gross Income Current Year \$ _____

B) Gross Income Previous Year \$ _____

C) Source of Funds Employment Retirement Inheritance 1035 Exchange Other _____

D) Current Net Worth \$ _____

For over \$1,000,000.00 applied coverage complete a separate Financial Questionnaire.

SECTION 14. BUSINESS FINANCIAL STATEMENT FOR PROPOSED PRIMARY INSURED

A) Current Estimated Market Value \$ _____

B) Assets *Liquid* \$ _____

Nonliquid \$ _____

C) Liabilities \$ _____

D) Net Worth \$ _____

SECTION 15. MEDICAL QUESTIONS – Each question must be individually asked and answered for each proposed Insured.

Give the details to a “No” answer for medical question 15A and “Yes” answers to questions 15B-E below:

- A) For the last 180 days has the proposed Primary Insured been actively at work, on a full time basis, at their usual place of business or employment? Yes No
- B) To the best of your knowledge and belief, has any proposed Insured within the last 10 years been diagnosed, treated or been given medical advice by a member of the medical profession for:
- 1) Heart murmur, high blood pressure, chest pain, heart attack, stroke, or other disorder of the heart, blood vessels or circulatory system? Yes No
 - 2) Asthma, emphysema, chronic bronchitis, tuberculosis, or any other respiratory disorder; colitis, ulcer or any other gastrointestinal disorder; jaundice, hepatitis, liver or kidney disorder? Yes No
 - 3) Cancer, tumor, polyp, breast, prostate or any other reproductive disorder; or any thyroid or endocrine disorder? Yes No
 - 4) Brain, nervous system, seizure or mental disorder, anxiety, depression, suicide attempt or any paralysis? Yes No
 - 5) Diabetes, anemia, or any disorder of the blood; sugar, protein, or blood in the urine? Yes No
- C) To the best of your knowledge and belief, has any proposed Insured within the last 10 years:
- 1) Used amphetamines, heroin, cocaine, marijuana, or any other illegal or controlled substance except as prescribed by a physician? Yes No
 - 2) Received treatment or counseling for or been advised by a member of the medical profession to limit or discontinue the use of alcohol or prescribed or non-prescribed drugs, or been a member of any self help group such as Alcoholics Anonymous or Narcotics Anonymous? Yes No
 - 3) Been on or are now on prescribed medication or prescribed diet? Yes No
 - 4) Had or been advised to have any hospitalization, surgery, or any diagnostic test including, but not limited to, electrocardiograms, blood studies, scans, MRI's or other test? Yes No
 - 5) Had an examination, treatment or consultation with a doctor or health care provider other than above? Yes No
- D) Within the last 10 years, has any proposed Insured been told by a member of the medical profession that he or she had a diagnosis of AIDS (Acquired Immune Deficiency Syndrome), ARC (AIDS Related Complex), or the HIV (Human Immunodeficiency Virus) infection? Yes No
- E) Has any proposed Insured had a parent, brother, or sister who had any occurrence of or death from coronary artery disease, cardiovascular disease, internal cancer or melanoma prior to age 60? Yes No

SECTION 16. DETAILS TO ANSWERS FOR MEDICAL QUESTIONS Identify question number; state diagnosis, dates, duration, treatment, medications and results of each illness or injury. List the name, full address, phone number, and dates of each health care provider consulted.

Question #	Proposed Insured's Name	Diagnosis, Dates, Durations, Treatments, Medications and Results	Name, Address and Phone # of Attending Doctor and Hospital

SECTION 17. PERSONAL PHYSICIAN (if none, so state)

Proposed Insured's Name	Date Last Seen, Reason and Results	Name, Address and Phone # of Attending Doctor and Hospital

SECTION 18. RESIDENCY AND FOREIGN TRAVEL Each question must be individually asked and answered for each proposed Insured.

- A) Is every proposed Insured a citizen of USA Other Country _____ Type of VISA _____
- B) How many years has the proposed Insured resided in the USA? _____
- C) Has any proposed Insured resided outside the USA during the past 2 years or intends to live outside the USA during the next 2 years? Yes No If yes, provide details: include name of proposed Insured and location.

- D) Does any proposed Insured intend to travel outside the USA during the next 2 years? Yes No
If yes, provide details: include name of proposed Insured, destination, number of trips, duration and purpose of each trip.

SECTION 19. DRIVING AND PUBLIC RECORDS Each question must be individually asked and answered for each proposed Insured.

- A) Has any proposed Insured had their driver's license suspended, restricted, revoked, or been cited for a moving violation in the last 5 years? Yes No If yes, give description of the Department of Motor Vehicles' action, plea, conviction or accident; the number of times the various occurrence(s) have taken place, the date and state of each occurrence:

- B) Has any proposed Insured in the last 10 years pled guilty to or been convicted of a felony or misdemeanor or do they have any charges currently against them (other than a minor traffic violation)? Yes No If yes, give reason:

SECTION 20. SPECIAL ACTIVITIES Each question must be individually asked and answered for each proposed Insured.

- A) Except as a passenger on a regularly scheduled flight, has any proposed Insured flown within the past 2 years, or does the proposed Insured have plans to fly in the next 2 years? If yes, complete the Avocation & Aviation Questionnaire. Yes No
- B) In the past 2 years has any proposed Insured participated in or intends within the next 2 years to engage in organized racing (automobile, truck, motorcycle, or boat), underwater or sky diving, hang gliding, canyoneering, mountain or rock climbing? If yes, complete the Avocation & Aviation Questionnaire. Yes No

SECTION 21. SUITABILITY FOR VARIABLE LIFE INSURANCE POLICY

- A) Have you, the proposed Primary Insured, and Applicant/Owner, if other than the proposed Primary Insured, received the current Prospectus for the policy? Yes No
- B) **Do you understand that the Death Benefit may be variable or fixed under specified conditions?** Yes No
- C) **DO YOU UNDERSTAND THAT UNDER THE POLICY APPLIED FOR (EXCLUSIVE OF ANY OPTIONAL BENEFITS), THE ENTIRE AMOUNT OF THE POLICY CASH VALUE MAY INCREASE OR DECREASE DEPENDING UPON THE INVESTMENT EXPERIENCE?** Yes No
- D) With this in mind, is the policy in accordance with your insurance objectives and your anticipated financial needs? Yes No

SECTION 22. TRANSFER AUTHORIZATION – TO BE COMPLETED BY APPLICANT/OWNER

(See Prospectus for transfer procedures.)

Your policy applied for, if issued, will automatically receive transfer privileges described in the applicable prospectus. These privileges allow the Owner and the registered representative of record to make transfers and to change the allocation of future payments unless declined below.

Western Reserve Life Assurance Co. of Ohio will not be liable for complying with transfer instructions it reasonably believes to be authentic, nor for any loss, damage, costs or expense in acting on such instructions, and Policy Owners will bear the risk of any such loss. Western Reserve Life Assurance Co. of Ohio will employ reasonable procedures to confirm that transfer instructions are genuine. If Western Reserve Life Assurance Co. of Ohio does not employ such procedures, it may be liable for losses due to unauthorized or fraudulent instructions. These procedures include but are not limited to requiring forms of personal identification prior to acting upon such transfer instruction, providing written confirmation of such transactions to the Owner and/or tape recording of telephone transfer request instructions received.

- The registered representative does **not** have authority to make transfers or change payment allocations on my behalf.

FRAUD WARNING

The following state(s) and U.S. territories require that insurance applicants acknowledge a fraud warning statement. Please refer to the fraud warning statement for your state or U.S. territory as indicated below.

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

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

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

MAINE: 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.

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

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

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

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

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

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

PUERTO RICO: Any person who knowingly, and with the intention to defraud, includes false information in an application for insurance or files, assists or abets in the filing of a fraudulent claim to obtain payment of a loss or other benefit, or files more than one claim for the same loss or damage, commits a felony, and if found guilty, shall be punished for each violation with a fine of no less than five thousand dollars (\$5000), not to exceed ten thousand dollars (\$10,000); or imprisoned for a fixed term of three (3) years, or both. If aggravating circumstances exist, the fixed jail term may be increased to a maximum of five (5) years; and if mitigating circumstances are present, the jail term may be reduced to a minimum of two (2) years.

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

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

SECTION 23. AUTHORIZATION TO OBTAIN AND DISCLOSE INFORMATION

Each of the undersigned hereby certifies and represents as follows: The statements and answers given on this application are true and complete to the best of my knowledge and belief. I acknowledge and agree (A) that this application and any amendments shall be the basis for any insurance issued; (B) that the registered representative does not have the authority to waive any question on this application, to decide if insurance will be issued, or to modify any term or provision of any insurance which may be issued based on this application, only a writing signed by an officer of the Company can change the terms of this application or the terms of any insurance issued by the Company; (C) except as provided in the Conditional Receipt, if issued with the same proposed Insured(s) as on this application, no policy applied for shall take effect until after all of the following conditions have been met: 1) the minimum initial premium must be received by the Company; 2) the proposed Owner must have personally received and accepted the policy during the lifetime of each proposed Insured and there must have been no change in the insurability of any proposed Insured; and 3) on the date of the later of either 1) or 2) above, all of the statements and answers given in this application must be true and complete. Unless otherwise stated the undersigned applicant is the premium payor and Owner of the policy applied for.

I authorize MIB Group, Inc. and its members or affiliates, my employer or former employer, any consumer reporting agency or governmental agency, medical provider, or any insurer or reinsurer to provide medical or personal information about me that is reasonably required for the purposes stated in this authorization to Western Reserve Life Assurance Co. of Ohio, its administrators, representatives or its reinsurers. I understand the information obtained by use of the authorization will be used by Western Reserve Life Assurance Co. of Ohio to determine eligibility for insurance, and eligibility for benefits under an existing policy. Any information obtained will not be released by Western Reserve Life Assurance Co. of Ohio to any person or organization except to reinsurers, MIB Group, Inc. and its members or affiliates, or other persons or organizations performing business or legal services in connection with my application, claim or as may be otherwise lawfully required or as I may authorize. This authorization will expire 30 months from the date signed. A copy of this authorization shall be as valid as the original. Either my authorized representative or I may receive a copy of this authorization upon request.

The Company shall have 60 days from the date hereof within which to consider and act on this application and if within such period a policy has not been received by the applicant or if notice of approval or rejection has not been given, then this application shall be deemed to have been declined by the Company.

I acknowledge receipt of the (1) Notice to Persons Applying for Insurance Regarding Investigative Report, (2) MIB Group, Inc. Pre-Notification, and (3) Notice of Insurance Information Practices.

I understand that any omissions or misstatements in this application could cause an otherwise valid claim to be denied under any insurance issued from this application.

Signed at _____ (city) _____ (state) on _____ (month/day/year)

Signature of proposed Primary Insured/Owner
(Child over age 15 must sign)

Print Registered Rep. Name

Signature of Applicant/Owner if other than the proposed Primary Insured (If business insurance, show title of officer and name of firm. If trust, show trustee's name)

Registered Rep. Number

Signature of proposed Other Insured

Signature of Registered Rep.

Signature of Parent or Legal Guardian of Children age 15 and under

Signature of Registered Rep. (Split)

SECTION 24. TAXPAYER IDENTIFICATION CERTIFICATION

Under current federal tax laws, the Company is required to obtain your Taxpayer Identification Number (e.g., a social security or employer identification number, or "TIN") and certification that you are not subject to backup withholding. Please review the following certification and sign accordingly.

Under penalties of perjury, I certify that (1) the TIN listed in this application is my correct TIN; (2) I have not been notified that I am subject to backup withholding or I am not subject to backup withholding because I am an exempt recipient; and (3) I am a U.S. Person (U.S. citizen/legal resident). If not a U.S. Person, I have completed the appropriate Form W-8BEN. The IRS does not require your consent to any provision of this form other than this certification.

Signature of Owner _____ Date _____

SECTION 25. OTHER INSURANCE – TO BE COMPLETED BY THE REGISTERED REPRESENTATIVE

- A) Will the policy applied for discontinue, replace or change any existing life insurance policy or annuity? Yes No
- B) If replacement of existing insurance is involved, have you complied with all state requirements, including any Disclosure and Comparison Statements? Yes No N/A
If No, explain _____
- C) Did you present and leave the Applicant/Owner approved sales material? Yes No

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left blank**

CONDITIONAL RECEIPT

(Detach and leave with applicant only if money is submitted with application. **If within the past 12 months the proposed Insured has been diagnosed, treated or been given medical advice by a member of the medical profession for heart trouble, stroke or cancer, no payment may be accepted with the application.** Do not accept money unless all required signatures below are obtained.)

PLEASE READ THIS CAREFULLY

No coverage will become effective prior to the delivery of the policy applied for unless and until all conditions of this receipt have been fulfilled exactly. No registered representative is authorized to waive or modify any of the provisions of the conditional receipt.

Make all checks payable to the Company. Do not make checks payable to the registered representative or leave the payee blank or you may jeopardize the insurance for which you have applied.

Received from _____, the sum of \$_____ for the insurance application dated _____, with _____ as the proposed Insured. The policy you applied for will not become effective unless and until a policy contract is delivered to you and all other conditions of coverage are met. However, subject to the conditions and limitations of this Receipt, conditional insurance under the terms of the policy applied for may become effective as of the later of (1) the date of application and (2) the date of the last medical examination, tests, and other screenings required by the Company, if any (the "Effective Date"). Such conditional insurance will take effect as of the Effective Date, so long as all of the following requirements are met:

1. Each person proposed to be insured is found to have been insurable as of the Effective Date, exactly as applied for in accordance with the Company's underwriting rules and standards, without any modifications as to plan, amount, or premium rate;
2. As of the Effective Date, all statements and answers given in the application must be true and complete to the best of my knowledge and belief.
3. The payment made with the application must not be less than the full initial premium for the mode of payment chosen in the application and must be received at our Administrative Office within the lifetime of the proposed Insured to whom the conditional insurance would apply and, if in the form of check or draft, must be honored for payment;
4. All medical examinations, tests, and other screenings required of the proposed Insured by the Company are completed and the results received at our Administrative Office within 60 days of the date the application was completed; and
5. All parts of the application, any supplemental application, questionnaires, addendum and/or amendment to the application are signed and received at our Administrative Office.

Any conditional insurance provided by this Receipt will terminate on the earliest of: (a) 60 days from the date the application was signed; (b) the date the Company either mails notice to the applicant of the rejection of the application and/or mails a refund of any amounts paid with the application; (c) when the insurance applied for goes into effect under the terms of the policy applied for; or (d) the date the Company offers to provide insurance on terms that differ from the insurance for which you have applied.

If one or more of this Receipt's conditions have not been met exactly, or if the proposed Insured dies by suicide, the Company will not be liable except to return any payment made with the application.

If the Company does not approve and accept the application for insurance within 60 days of the date you signed the application, the application will be deemed to be rejected by the Company and there will be no conditional insurance. In that case, the Company's liability will be limited to returning any payment(s) you have made upon return of this Receipt to the Company.

The aggregate amount of conditional insurance provided under this Receipt, if any, and any other conditional receipt issued by the Company shall be limited to the lesser of the amount(s) applied for or \$500,000 of life insurance. There is no conditional insurance for any riders, additional benefits, proposed Other Insured(s) or proposed insured child(ren) if any, for which you have applied.

Authorization (Signatures Required)

I certify that I have read and reviewed the Conditional Receipt and the Authorization to Obtain and Disclose Information in the application. The terms and conditions of the Conditional Receipt have been explained to me fully by the registered representative and I understand them.

Dated at _____ on _____
City, State Date Signature of Registered or Authorized Company Rep.

Signature of proposed Primary Insured Signature of Applicant (if other than proposed Primary Insured)

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NOTICES

DETACH AND LEAVE THIS PAGE WITH APPLICANT

NOTICE TO PERSONS APPLYING FOR INSURANCE REGARDING INVESTIGATIVE REPORT

To proposed Insured: In connection with this application, an investigative consumer report may be prepared about you. Such reports are part of the process of evaluating risks for life and health insurance. Typically, this report will contain information about your character, general reputation, personal characteristics and mode of living. The information in the report may be obtained by talking with you or members of your family, business associates, financial sources, neighbors, and others you know. You may ask to be interviewed in connection with the preparation of any such report. Also, we may have the report updated if you apply for more coverage.

Upon your written request, we will let you know whether a report was prepared and we will give you the name, address, and telephone number of the agency preparing the report. By contacting that agency and providing proper identification, you may obtain a copy of the report.

MIB GROUP, INC. (MIB) PRE-NOTIFICATION

To proposed Insured and other persons proposed to be insured, if any. Information regarding your insurability will be treated as confidential. We or our reinsurer(s) may, however, make a brief report on this information to MIB Group, Inc., a non-profit membership organization of insurance companies that operates an information exchange on behalf of its members. If you apply to another MIB member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, MIB may, upon request, supply such company with the information in its file.

Upon receipt of a request from you, MIB will arrange disclosure of any information it may have in your file. If you question the accuracy of information in MIB's file, you may contact MIB and seek a correction in accordance with the procedures set forth in the federal Fair Credit Reporting Act. The address of MIB's information office is: Post Office Box 105, Essex Station, Boston, Massachusetts 02122; and telephone number is 866-692-6901 (TTY 866-346-3642 for hearing impaired).

NOTICE OF INSURANCE INFORMATION PRACTICES

To proposed Insured: Personal information may be collected from persons other than the individual(s) proposed for coverage. Such information as well as other personal or privileged information subsequently collected by us or our registered representative may in certain circumstances be disclosed to third parties without authorization. Upon request, you have the right to access your personal information and ask for corrections. You may obtain a complete description of our Information Practices by writing to Western Reserve Life Assurance Co. of Ohio, Attn: Director of Underwriting, [4333 Edgewood Road NE, Cedar Rapids, Iowa 52499].

**PLEASE PROVIDE A COPY OF THIS NOTICE TO THE PROPOSED INSURED
IF NOT A HOUSEHOLD MEMBER.**

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Additional Information Supplement

SECTION 1. PROPOSED CONTINGENT OWNER If ownership is corporation, partnership or institutional body, please complete the Entity Certification of Authority form. If ownership is a trust, please complete the Trustee Certification Trust form. Attach a copy of the first page and the signature page of the Trust.

1. Last Name		First Name		M.I.
2. Address (Cannot be a P.O. Box)			Apt#	City
State	Zip Code	3. Home Phone ()	4. Social Security Number / Tax ID #	
5. Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	6. Date of Birth/Trust Date MM-DD-YYYY	7. Relationship to proposed Primary Insured		
8. Are you a citizen of <input type="checkbox"/> USA <input type="checkbox"/> Other Country _____ Type of VISA _____				

SECTION 2. PROPOSED OTHER INSURED **SPECIFIED AMOUNT \$** _____
 We will allow the OIR death benefit recipient to be a choice of: Owner Primary Insured Same Beneficiary as the base policy
 Other _____

1. Last Name		First Name		M.I.
2. Address (Cannot be a P.O. Box)			Apt#	City
State	Zip Code	3. Years at Address	4. Home Phone ()	5. Driver License Number
6. Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	7. Date of Birth MM-DD-YYYY	8. Age	9. Place of Birth – State/Country	10. Social Security Number
11. Height (ft. in.)	12. Weight (lbs.)	13. Marital Status	14. Relationship to proposed Primary Insured	
15. Employer				#Years
16. Employer's Address and Phone Number				
17. Occupation & Duties				
18. Have you used TOBACCO or any other product containing NICOTINE in the last 5 years? <input type="checkbox"/> No <input type="checkbox"/> Yes Date last used _____				
19. Rate Class Quoted: <input type="checkbox"/> Preferred Elite <input type="checkbox"/> Preferred Plus <input type="checkbox"/> Preferred <input type="checkbox"/> Non-Tobacco <input type="checkbox"/> Preferred Tobacco <input type="checkbox"/> Tobacco <input type="checkbox"/> Juvenile				

SECTION 3. PROPOSED OTHER INSURED **SPECIFIED AMOUNT \$** _____
 We will allow the OIR death benefit recipient to be a choice of: Owner Primary Insured Same Beneficiary as the base policy
 Other _____

1. Last Name		First Name		M.I.
2. Address (Cannot be a P.O. Box)			Apt#	City
State	Zip Code	3. Years at Address	4. Home Phone ()	5. Driver License Number
6. Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	7. Date of Birth MM-DD-YYYY	8. Age	9. Place of Birth – State/Country	10. Social Security Number
11. Height (ft. in.)	12. Weight (lbs.)	13. Marital Status	14. Relationship to proposed Primary Insured	
15. Employer				#Years
16. Employer's Address and Phone Number				
17. Occupation & Duties				
18. Have you used TOBACCO or any other product containing NICOTINE in the last 5 years? <input type="checkbox"/> No <input type="checkbox"/> Yes Date last used _____				
19. Rate Class Quoted: <input type="checkbox"/> Preferred Elite <input type="checkbox"/> Preferred Plus <input type="checkbox"/> Preferred <input type="checkbox"/> Non-Tobacco <input type="checkbox"/> Preferred Tobacco <input type="checkbox"/> Tobacco <input type="checkbox"/> Juvenile				

SECTION 4. PROPOSED OTHER INSURED				SPECIFIED AMOUNT \$			
We will allow the OIR death benefit recipient to be a choice of: <input type="checkbox"/> Owner <input type="checkbox"/> Primary Insured <input type="checkbox"/> Same Beneficiary as the base policy <input type="checkbox"/> Other _____							
1. Last Name _____				First Name _____			M.I. _____
2. Address (Cannot be a P.O. Box) _____				Apt# _____	City _____		
State _____	Zip Code _____	3. Years at Address _____	4. Home Phone _____ ()		5. Driver License Number _____		State _____
6. Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	7. Date of Birth _____ MM-DD-YYYY	8. Age _____	9. Place of Birth – State/Country _____		10. Social Security Number _____		
11. Height (ft. in.) _____	12. Weight (lbs.) _____	13. Marital Status _____	14. Relationship to proposed Primary Insured _____				
15. Employer and Employer's Phone Number _____						#Years _____	
16. Employer's Address _____				17. Occupation & Duties _____			
18. Have you used TOBACCO or any other product containing NICOTINE in the last 5 years? <input type="checkbox"/> No <input type="checkbox"/> Yes Date last used _____							
19. Rate Class Quoted: <input type="checkbox"/> Preferred Elite <input type="checkbox"/> Preferred Plus <input type="checkbox"/> Preferred <input type="checkbox"/> Non-Tobacco <input type="checkbox"/> Preferred Tobacco <input type="checkbox"/> Tobacco <input type="checkbox"/> Juvenile							

SECTION 5. PROPOSED OTHER INSURED				SPECIFIED AMOUNT \$			
We will allow the OIR death benefit recipient to be a choice of: <input type="checkbox"/> Owner <input type="checkbox"/> Primary Insured <input type="checkbox"/> Same Beneficiary as the base policy <input type="checkbox"/> Other _____							
1. Last Name _____				First Name _____			M.I. _____
2. Address (Cannot be a P.O. Box) _____				Apt# _____	City _____		
State _____	Zip Code _____	3. Years at Address _____	4. Home Phone _____ ()		5. Driver License Number _____		State _____
6. Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	7. Date of Birth _____ MM-DD-YYYY	8. Age _____	9. Place of Birth – State/Country _____		10. Social Security Number _____		
11. Height (ft. in.) _____	12. Weight (lbs.) _____	13. Marital Status _____	14. Relationship to proposed Primary Insured _____				
15. Employer and Employer's Phone Number _____						#Years _____	
16. Employer's Address _____				17. Occupation & Duties _____			
18. Have you used TOBACCO or any other product containing NICOTINE in the last 5 years? <input type="checkbox"/> No <input type="checkbox"/> Yes Date last used _____							
19. Rate Class Quoted: <input type="checkbox"/> Preferred Elite <input type="checkbox"/> Preferred Plus <input type="checkbox"/> Preferred <input type="checkbox"/> Non-Tobacco <input type="checkbox"/> Preferred Tobacco <input type="checkbox"/> Tobacco <input type="checkbox"/> Juvenile							

SECTION 6. DECLARATIONS	
I (We) represent that all statements and answers made in this supplement are full, complete and true to the best of my (our) knowledge and belief. It is agreed that this statement shall be made part of the application, and is subject to all terms and conditions contained in the application.	
Signed at _____ (city) _____ on _____ (state) _____ (month/day/year)	
sec. 2 _____ Signature of proposed Other Insured (Child over age 15 must sign)	sec. 4 _____ Signature of proposed Other Insured (Child over age 15 must sign)
sec. 3 _____ Signature of proposed Other Insured (Child over age 15 must sign)	sec. 5 _____ Signature of proposed Other Insured (Child over age 15 must sign)
_____ Signature of Parent or Legal Guardian for Insured(s) age 15 and under	_____ Signature of Applicant/Owner, if other than the proposed Primary Insured (If business insurance, show title of officer and name of firm. If trust, show trustee's name)
_____ Witness (Registered Representative)	

SERFF Tracking Number: *AEGB-125695572* *State:* *Arkansas*
Filing Company: *Western Reserve Life Assurance Co. of Ohio* *State Tracking Number:* *39483*
Company Tracking Number: *U000313*
TOI: *L06I Individual Life - Variable* *Sub-TOI:* *L06I.002 Single Life - Flexible Premium*
Product Name: *Individual Life Application*
Project Name/Number: *Individual Life Application/U000313*

Rate Information

Rate data does NOT apply to filing.

SERFF Tracking Number: AEGB-125695572 State: Arkansas
Filing Company: Western Reserve Life Assurance Co. of Ohio State Tracking Number: 39483
Company Tracking Number: U000313
TOI: L06I Individual Life - Variable Sub-TOI: L06I.002 Single Life - Flexible Premium
Product Name: Individual Life Application
Project Name/Number: Individual Life Application/U000313

Supporting Document Schedules

Review Status:

Satisfied -Name: Certification/Notice

06/13/2008

Comments:

Only the Flesch certification is required for application filings

Attachment:

U000313 - Flesch Score.pdf

**WESTERN RESERVE LIFE ASSURANCE CO. OF OHIO
FLESCH READABILITY CERTIFICATION**

Form Number (may vary by state)

Flesch Score

U000313

50.5

I certify that the machine scored Flesch Readability score(s) for the above mentioned form(s) is/are accurate.

Cheryl Bock, Assistant Vice President of Contract Development