

SERFF Tracking Number: AEGF-125727248 State: Arkansas
Filing Company: Monumental Life Insurance Company- State Tracking Number: 39571
Company Tracking Number: A08100 ET AL
TOI: L08 Life - Other Sub-TOI: L08.000 Life - Other
Product Name: E-smartapp
Project Name/Number: /

Filing at a Glance

Company: Monumental Life Insurance Company-

Product Name: E-smartapp

TOI: L08 Life - Other

Sub-TOI: L08.000 Life - Other

Filing Type: Form

SERFF Tr Num: AEGF-125727248 State: ArkansasLH

SERFF Status: Closed

Co Tr Num: A08100 ET AL

Co Status: Approved

Author: Neil Tomas

Date Submitted: 07/09/2008

State Tr Num: 39571

State Status: Approved-Closed

Reviewer(s): Linda Bird

Disposition Date: 07/15/2008

Disposition Status: Approved

Implementation Date:

Implementation Date Requested: On Approval

State Filing Description:

General Information

Project Name:

Project Number:

Requested Filing Mode: Review & Approval

Explanation for Combination/Other:

Submission Type: New Submission

Overall Rate Impact:

Filing Status Changed: 07/15/2008

State Status Changed: 07/15/2008

Corresponding Filing Tracking Number:

Filing Description:

Re: Monumental Life Insurance Company - NAIC #468-66281 - FEIN #52-0419790

Status of Filing in Domicile: Authorized

Date Approved in Domicile: 06/30/2008

Domicile Status Comments:

Market Type: Individual

Group Market Size:

Group Market Type:

Deemer Date:

Form - Description - Replaces Form - Approved

A08100 - Life & Health Application - Part 1 - A95100 - 2/23/1998

A08101 - Life & Health Application - Part 2 - A95101 - 2/23/1998

A08102 - Cancer Application - Part 2 - A97101 - 8/20/1998

A08103 - Accident Application - Part 2 - A95103 - 2/23/1998

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Previously approved forms to be used in conjunction with the above forms:

A95110 - Agreement/Authorization - Part 3 – Approved 2/23/1998

A0310R - Conditional Receipt – Approved 7/18/2003

To Whom It May Concern:

We respectfully request that the above captioned forms be considered for approval. These are new forms that replace the previously approved forms indicated above.

Monumental Life has an electronic submission process for life and health insurance applications. Under this process, the application questions appear on a laptop screen. The application is taken in-person with both the agent and the applicant present. The agent records the applicant's answers by typing them into the laptop. When all of the information needed for the application has been entered, the agent "locks-in" the application, has the applicant digitally sign the application, and then transmit it to our Administrative Office.

The laptop assigns a distinct "lock-in" number to the application. This number is recorded on the agreement form before the applicant digitally signs the agreement. The "lock-in" procedure was designed to freeze the applicant's answers at the point of sale. This prohibits anyone from tampering with the applicant's answers once he or she has reviewed the completed application on the laptop screen.

Each application is made up of a series of records stored in a file on the agent's laptop. The "lock-in" of these records on the laptop is final. No modifications can be made to an application after the "lock-in" has been processed. After the application has been locked, the applicant will be able to digitally sign the application through the use of an electronic pen and signature pad that is connected to the laptop. The applicant will see their signature appear the laptop screen as they inscribe it. When the contract is issued, the application will be printed by the computer and attached to the policy. The forms are being submitted in final printed form in which they will be printed in the final policy print given to the owner. The forms are subject to only minor modifications in paper size and stock, ink border, Company Logo, Company address and adaptation to computer printing.

Each applicant will always complete a Part 1, Part 2 and Part 3. Our Part 1 Form A08100 will be used for all life and health products. The Part 2 Form will depend on the type of product being applied for. Part 2 Form A08102 will be used for our Cancer product, and Part 2 Form A08103 will be used for our Accident Only product. Finally, Part 2 Form

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A08101 will be used with all other products.

The previously approved Conditional Receipt Form A0330R will be used whenever an initial premium is paid. The applicant must sign the previously approved Agreement/Authorization Part 3 Form A95110 at the point of sale. In the event that an applicants' response to an application question would exclude the applicant from being issued a policy, the electronic application will automatically fill in the rest of the questions with "Not Asked" and cease. These forms are marketed by Career Agents on an individual basis. These forms will not be available on the Internet.

Your prompt attention to this filing will be greatly appreciated. Please contact me if you have any questions.

Sincerely,

Neil Tomas
Compliance Analyst
Phone: 410-685-2900, ext. 2034
Fax: 410-576-4554
NTomas@monlife.com

Company and Contact

Filing Contact Information

Neil Tomas, Compliance Analyst
2 E Chase Street
Baltimore, MD 21202

NTomas@monlife.com
(410) 685-2900 [Phone]
(410) 576-4554[FAX]

Filing Company Information

Monumental Life Insurance Company-
4333 Edgewood Rd NE
Cedar Rapids, IA 52499
(410) 685-2900 ext. [Phone]

CoCode: 66281
Group Code: 468
Group Name:
FEIN Number: 52-0419790

State of Domicile: Iowa
Company Type: Life & Health
State ID Number:

Filing Fees

SERFF Tracking Number: AEGF-125727248 State: Arkansas
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TOI: L08 Life - Other Sub-TOI: L08.000 Life - Other
Product Name: E-smartapp
Project Name/Number: /

Fee Required? Yes
Fee Amount: \$80.00
Retaliatory? No
Fee Explanation: 20 x Amount of Applications = Total

20 x 4 = 80

Per Company: No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Monumental Life Insurance Company-	\$80.00	07/09/2008	21320637

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Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved	Linda Bird	07/15/2008	07/15/2008

Objection Letters and Response Letters

Objection Letters				Response Letters		
Status	Created By	Created On	Date Submitted	Responded By	Created On	Date Submitted
Pending	Linda Bird	07/10/2008	07/10/2008	Neil Tomas	07/15/2008	07/15/2008
Industry Response						

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Product Name: E-smartapp
Project Name/Number: /

Disposition

Disposition Date: 07/15/2008

Implementation Date:

Status: Approved

Comment:

Rate data does NOT apply to filing.

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Item Type	Item Name	Item Status	Public Access
Supporting Document	Certification/Notice		Yes
Supporting Document (revised)	Application		Yes
Supporting Document	Application	Withdrawn	Yes
Form	Life & Health Application - Part 1		Yes
Form	Life & Health Application - Part 2		Yes
Form	Cancer Application - Part 2		Yes
Form	Accident Application - Part 2		Yes

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Project Name/Number: /

Objection Letter

Objection Letter Status Pending Industry Response

Objection Letter Date 07/10/2008

Submitted Date 07/10/2008

Respond By Date

Dear Neil Tomas,

This will acknowledge receipt of the captioned filing.

Objection 1

- Life & Health Application - Part 1 (Form)
- Life & Health Application - Part 2 (Form)
- Cancer Application - Part 2 (Form)
- Accident Application - Part 2 (Form)

Comment: Ark. Code Ann. 23-66-503(a) requires a statement in an application substantially the same as that included in the statute.

Please feel free to contact me if you have questions.

Sincerely,

Linda Bird

Response Letter

Response Letter Status Submitted to State

Response Letter Date 07/15/2008

Submitted Date 07/15/2008

Dear Linda Bird,

Comments:

Response 1

Comments: Dear Ms. Bird,

We received your problem report dated July 10th, 2008 and can now respond as follows:

1. Form A95110 was incorrectly listed in the Filing Description and attached under the Supporting Documentation. The

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correct form that should have been listed and attached is A95110AR, which contains a fraud warning that is compliant with Ark. Code. Ann. 23-66-503(a). A stamped approval of form A95110AR has been attached and we apologize for any confusion that this may have caused.

Your continued review of this filing is greatly appreciated. If you have any questions or comments please feel free to contact me.

Sincerely,

Neil Tomas

Related Objection 1

Applies To:

- Life & Health Application - Part 1 (Form)
- Life & Health Application - Part 2 (Form)
- Cancer Application - Part 2 (Form)
- Accident Application - Part 2 (Form)

Comment:

Ark. Code Ann. 23-66-503(a) requires a statement in an application substantially the same as that included in the statute.

Changed Items:

Supporting Document Schedule Item Changes

Satisfied -Name: Application

Comment: Attached are the two previously approved application forms to be used in conjunction with the four applications filed for approval under the Form Schedule tab. Please see the Filing Description for further details.

No Form Schedule items changed.

No Rate/Rule Schedule items changed.

Sincerely,
Neil Tomas

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 Product Name: E-smartapp
 Project Name/Number: /

Form Schedule

Lead Form Number: A08100

Review Status	Form Number	Form Type Form Name	Action	Action Specific Data	Readability	Attachment
	A08100	Application/Life & Health Enrollment Application - Part 1 Form	Initial		52	A08100.pdf
	A08101	Application/Life & Health Enrollment Application - Part 2 Form	Initial		50	A08101.pdf
	A08102	Application/Cancer Application - Enrollment Part 2 Form	Initial		59	A08102.pdf
	A08103	Application/Accident Application Enrollment - Part 2 Form	Initial		50	A08103.pdf

ISSUE DATE:

APPLICATION FOR LIFE/HEALTH INSURANCE

POLICY NO.

MONUMENTAL LIFE INSURANCE COMPANY

[HOME OFFICE: CEDAR RAPIDS, IA]

[ADMINISTRATIVE OFFICE: 2 E. CHASE ST. / BALTIMORE, MARYLAND 21202]

PART 1

1. Name of Proposed Insured: _____ 2. Phone No.: _____

3. Address: _____

4. Social Security No.: _____ 5. Birth Date: _____ Age: _____

6. Sex: _____ 7. Birth Place: _____ 8. Height: _____ Weight: _____

9. Employer: _____ Phone No.: _____

Employer Address: _____

Industry: _____

Occupation: _____

10. Plan of Insurance: _____ 11. Amount of Insurance: _____

12. Supplemental Riders and/or Benefits Requested: _____

13. Premiums Payable: _____ Payment Mode: _____

14. Full Names of All others Proposed for Coverage:

<u>Name</u>	<u>Birth Place</u>	<u>Birth Date</u>	<u>Age</u>	<u>Sex</u>	<u>Height</u>	<u>Weight</u>	<u>Pending & Present Insurance</u>	<u>Relationship</u>

15. Additional Insured: _____

Employer: _____ Phone No.: _____

Employer Address: _____

Industry: _____

Occupation: _____

16. Payor (if other than insured):

Name: _____ Phone No.: _____

Address: _____

17. Primary Beneficiaries:

<u>Name</u>	<u>Relationship</u>	<u>Address</u>	<u>SSN</u>	<u>%</u>

18. Contingent Beneficiaries (automatically becomes beneficiary upon death of the Primary):

<u>Name</u>	<u>Relationship</u>	<u>Address</u>	<u>SSN</u>	<u>%</u>

PART 1 - (con't)

19. Owner(s):
Name: _____ Relationship: _____
Soc Sec No/Tax ID: _____ Phone No: _____
Address: _____

Name: _____ Relationship: _____
Soc Sec No/Tax ID: _____ Phone No: _____
Address: _____

20. Contingent owner (automatically becomes owner upon death of the Primary):
Name: _____ Relationship: _____
Soc Sec No/Tax ID: _____ Phone No: _____
Address: _____

21. Does proposed insured now have life or health insurance with this or any other company?
Life: YES [] NO [] Not Asked [] Health: Yes [] No [] Not Asked []
If yes, give details:

Company	Policy Number	Life/Health	Year Issued	Amount	Accidental Death?	Waiver?	Pending?
-----	-----	-----	-----	-----	-----	-----	-----

22. Are all owners citizens of the United States?
If no, provide details at the end of Part 1 Yes [] No [] Not Asked []

23. Are all proposed insureds citizens of the United States?
If no, provide details at the end of Part 1 Yes [] No [] Not Asked []

EXPLAIN ALL YES RESPONSES AT THE END OF PART 1

24. Has any proposed insured in the past 2 years traveled or resided, or does any proposed insured intend to travel or reside, outside of the continental United States for more than 3 consecutive weeks? Yes [] No [] Not Asked []

25. Provide all proposed insureds Drivers License Number(s):
Name: _____ License number: _____ State: _____
Name: _____ License number: _____ State: _____
Name: _____ License number: _____ State: _____

26. Within the past 5 years, has any proposed insured had his/her driver's license suspended or revoked, had two or more moving violations or accidents or been convicted of, pled guilty or no contest to, driving under the influence of alcohol or drugs?
Yes [] No [] Not Asked []

27. Within the past 3 years has any proposed insured participated in or within the next 12 months does any proposed insured intend to participate in flying as a pilot, racing a motor vehicle, underwater diving or any other similar sport, activity or avocation?
Yes [] No [] Not Asked []

28. Is any proposed insured currently on probation, parole, or awaiting trial for an illegal activity or within the past 10 years, has a proposed insured been convicted of a felony? Within the past 5 years, has any proposed insured been convicted of a misdemeanor?
Yes [] No [] Not Asked []

29. Will any existing life (including paid-up additions), health or annuity contracts be lapsed, surrendered, or borrowed against, reissued or converted (in order to reduce amount, premium, or period of coverage including surrender options) if the proposed policy is issued? Yes [] No [] Not Asked []

30. Has any person to be covered applied for life or accident & health insurance without receiving the amount and plan applied for at the standard premium?
Yes [] No [] Not Asked []

31. Special Request:

Details of YES answers (Identify question number, indicate applicable items).

PART 2 - Life/Health

-
1. Is any proposed insured currently hospitalized, residing in a nursing home, long term care facility, convalescent home, receiving hospice, home healthcare or waiting for an organ transplant (except corneal)? Yes [] No [] Not Asked []
 2. Has any proposed insured been diagnosed with, been treated for, or advised to receive treatment for Alzheimer's disease or dementia? Yes [] No [] Not Asked []
 3. Has any proposed insured been medically diagnosed, been treated for Acquired Immune Deficiency Syndrome (AIDS), any disease or disorder of the immune system or tested positive for antibodies to the AIDS (HIV Virus)? Yes [] No [] Not Asked []

4. a. Name(s) of primary health care provider: _____
Phone No: _____
Address: _____

b. Date(s) last consulted: _____

Yes answers explained in detail at the end of part 2 questions

5. Is any proposed insured taking any medication or been prescribed a medication that has not been filled? Yes [] No [] Not Asked []
6. Within the past 12 months, has any proposed insured used a tobacco or nicotine product? Yes [] No [] Not Asked []
7. Within the past 12 months, has any proposed insured lost 25 or more pounds? Yes [] No [] Not Asked []
8. Within the past 7 years, has any proposed insured been told that he/she has been diagnosed or treated by a licensed health care provider or taken medication for:
 - a. Allergies, asthma, bronchitis, chronic obstructive pulmonary disease (COPD), emphysema, pneumonia, shortness of breath, sinusitis, sleep apnea, tuberculosis (TB) or other disease or disorder of the lung or respiratory system? Yes [] No [] Not Asked []
 - b. Anemia, aneurysm, blood clot, phlebitis, coronary artery disease (CAD), chest pain, angina, cholesterol, congestive heart failure, edema, heart attack, heart murmur, high blood pressure, irregular heartbeat, palpitations, stroke, transient ischemic attack (TIA) or any other disease or disorder of the heart, circulatory system, or arteries? Yes [] No [] Not Asked []
 - c. Cirrhosis, crohn's, ulcerative colitis, diverticulitis, fatty liver, gastritis, gastroesophageal reflux, hepatitis, hernia, pancreatitis, stomach bypass, stomach banding, stomach stapling, ulcer or other disease or disorder of the stomach, liver, colon, rectum, intestines? Yes [] No [] Not Asked []
 - d. Attention deficit disorder (ADD/ADHD), anxiety, autism, depression, dizziness, vertigo, down's syndrome, fainting, schizophrenia, seizures, epilepsy, convulsions, or other disease or disorder of the brain or nervous system, or mental or nervous disorder, or consulted a psychiatrist or psychologist? Yes [] No [] Not Asked []
 - e. Amputation, arthritis, rheumatoid arthritis, osteoarthritis, cerebral palsy, concussion, fibromyalgia, fracture, herniated disc, multiple sclerosis, osteoporosis, paralysis, Parkinson's, or other disease or disorder of the muscles, bones, joints, or connective tissue? Yes [] No [] Not Asked []
 - f. Dialysis, infection, kidney stones, menstrual irregularity, nephritis, or other disease or disorder of the kidney, bladder, prostate, breast, or reproductive organs, urine abnormality or sexually transmitted disease? Yes [] No [] Not Asked []
 - g. Diabetes or other disease or disorder of the thyroid, pituitary, adrenal glands? Yes [] No [] Not Asked []

PART 2 - Life/Health Con't

h. Cancer, cysts, growths, Hodgkin's, leukemia, lupus, lymphoma, melanoma, polyps, tumors or other disease or disorder of the skin or malignant disorders? Yes [] No [] Not Asked []

9. Within the past 10 years, has any proposed insured received advice or sought advice or counseling by a licensed health care provider for the use of drugs or alcohol or has any proposed insured used amphetamines, barbiturates, cocaine, heroin, opium, LSD, PCP, hallucinogens, marijuana, narcotics or any other controlled substance except that taken in doses as prescribed by a physician? Yes [] No [] Not Asked []
10. Within the past 5 years, has any proposed insured consulted, been treated or examined by a licensed health care provider for reasons not stated in the application?
Yes [] No [] Not Asked []

(Ask only if Premium Waiver or Multiple Coverage is applied for)

11. Within the past 7 years, has any proposed insured ever requested or received a benefit, discharge or rejection, payment or pension because of a disability, impaired condition, injury, or sickness? Yes [] No [] Not Asked []
12. Within the past 12 months, excluding pregnancy, has any proposed insured had an illness or condition that prevented them from working at their job for more than 5 consecutive business days? Yes [] No [] Not Asked []

(Ask only if combined amount applied for is \$100,000 or greater and adult base or rider is less than age 60.)

13. Family History:

Father:
Age if living:
Age at death:
Cause:

Mother:
Age if living:
Age at death:
Cause:

Had a brother, or sister who was diagnosed and/or died from cancer, diabetes, stroke, heart or kidney disease or suicide? Yes [] No [] Not Asked []

(Ask only if a proposed insured is less than 1 year old)

14. Birth weight: _____

Details of YES answers (Identify question number, indicate applicable items).

PART 2 - CANCER

1. Does any proposed insured now have health insurance with this or any other company? Yes [] No [] Not Asked []

If yes, give details:

Company	Policy Number	Year Issued	Amount	Accidental Death?	Waiver?	Pending?
-----	-----	-----	-----	-----	-----	-----

2. Is any person proposed for coverage also covered by:

- a. Medicaid? Yes [] No [] Not Asked []
- b. Medicare? Yes [] No [] Not Asked []

(If yes to Medicare, I received the "Important Notice to Persons on Medicare Form.")
Yes [] No [] Not Asked []

3. a. Names(s) of primary health care provider: _____ Phone No: _____
Address: _____

b. Dates(s) last consulted: _____
Reasons(s) for consultation: _____
(if more than one, enter in "Details". For additional insureds primary health care provider information enter in "Details").

4. Within the past 10 years, has any proposed insured been medically diagnosed as having or been treated for Acquired Immune Deficiency Syndrome (AIDS), any disease or disorder of the immune system, or tested positive for antibodies to the AIDS (HIV) virus? Yes [] No [] Not Asked []

5. Within the past 10 years, has any proposed insured been diagnosed as having, been treated for, or had any indications of:

- a. Any benign or malignant tumor, polyp, cyst, growth, tissue enlargement or lesion? Yes [] No [] Not Asked []
- b. Cancer, leukemia, Hodgkin's disease or any cancerous or pre-cancerous disorder of the skin or blood? Yes [] No [] Not Asked []
- c. Fibrocystic breast disease, ovarian cyst, or an abnormal PAP smear that was not subsequently followed by a normal PAP smear? Yes [] No [] Not Asked []

6. Within the past 12 months, has any proposed insured had treatment for, any indications of, been advised of, or seen a physician for:

- a. Any sores that have not healed? Yes [] No [] Not Asked []
- b. Any changes in the size, shape, or appearance of a wart, mole or birthmark? Yes [] No [] Not Asked []
- c. Any unexplained weight loss? Yes [] No [] Not Asked []
- d. Any abnormal PAP smear that was not subsequently followed by a normal PAP smear, mammogram, X-ray, Prostate Specific Antigen (PSA), CAT scan, or MRI? Yes [] No [] Not Asked []
- e. Crohn's disease, regional enteritis, ileitis, or ulcerative colitis? Yes [] No [] Not Asked []
- f. Unexplained weakness, fatigue, anemia, diarrhea, enlargement of a lymph node, lump or growth? Yes [] No [] Not Asked []
- g. Any abnormal or excessive bleeding, gastric ulcer, Barrett's Esophagus, or chronic hepatitis? Yes [] No [] Not Asked []
- h. Any persistent hoarseness, cough, blood in urine or stool, breast lump or discharge? Yes [] No [] Not Asked []
- i. Any recommended test or treatment not yet completed? Yes [] No [] Not Asked []

Details of "YES" answers. (IDENTIFY QUESTION NUMBER, INDICATE APPLICABLE ITEMS:
Include diagnoses, dates, duration and name and address of all attending physicians and
medical facilities. INDICATE TO WHICH APPLICANT EACH EXPLANATION PERTAINS.)

PART 2 - ACCIDENT

1. Does any proposed insured now have accident insurance with this or any other company? YES [] NO [] Not Asked []

If yes, give details:

Company	Policy Number	Year Issued	Amount	Accidental Death?	Waiver?	Pending?
-----	-----	-----	-----	-----	-----	-----

2. Within the past 7 years, has any proposed insured been told that he/she has been diagnosed or treated by a licensed health care provider or taken medication for:

- a. Diabetes or other disease or disorder of the thyroid, pituitary, adrenal glands? Yes [] No [] Not Asked []
- b. Anemia, aneurysm, blood clot, phlebitis, coronary artery disease (CAD), chest Pain, angina, cholesterol, congestive heart failure, edema, heart attack, heart Murmur, high blood pressure, irregular heartbeat, palpitations, stroke, transient ischemic attack (TIA) or any other disease or disorder of the heart, circulatory system, or arteries? Yes [] No [] Not Asked []
- c. Attention deficit disorder (ADD/ADHD), anxiety, autism, depression, dizziness, Vertigo, down's syndrome, fainting, schizophrenia, seizures, epilepsy, convulsions, or other disease or disorder of the brain or nervous system, or mental or nervous disorder or consulted a psychiatrist or psychologist? Yes [] No [] Not Asked []
- d. Amputation, arthritis, rheumatoid arthritis, osteoarthritis, cerebral palsy, concussion, fibromyalgia, fracture, herniated disc, multiple sclerosis, osteoporosis, paralysis, Parkinson's, or other disease or disorder of the muscles, bones, joints, or connective tissue? Yes [] No [] Not Asked []

3. Within the past 10 years, has any proposed insured received advice or sought advice or counseling by a licensed health care provider for the use of drugs or alcohol or has any proposed insured used amphetamines, barbiturates, cocaine, heroin, opium, LSD, PCP, hallucinogens, marijuana, narcotics or any other controlled substance except that taken in doses as prescribed by a physician? Yes [] No [] Not Asked []

Details of "YES" answers. (IDENTIFY QUESTION NUMBER, INDICATE APPLICABLE ITEMS: Include diagnoses, dates, duration and name and address of all attending physicians and medical facilities. INDICATE TO WHICH APPLICANT EACH EXPLANATION PERTAINS.)

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Rate Information

Rate data does NOT apply to filing.

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Supporting Document Schedules

Review Status:

Satisfied -Name: Certification/Notice 07/09/2008

Comments:

Attachment:

Readability Certification.pdf

Review Status:

Satisfied -Name: Application 07/15/2008

Comments:

Attached are the two previously approved application forms to be used in conjunction with the four applications filed for approval under the Form Schedule tab. Please see the Filing Description for further details.

Attachments:

A0310R.pdf

A95110AR.pdf

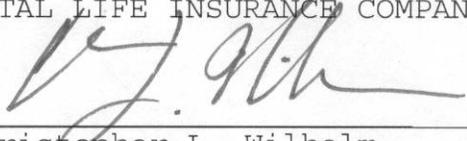
CERTIFICATION

THIS IS TO CERTIFY, that the forms listed below achieved the following Flesch Reading Ease Scores and are in compliance with the requirements of Arkansas Insurance Code ACA 23-80-206.

<u>Form</u>	<u>Flesch Score</u>
A08100	51.6
A08101	50.0
A08102	58.9
A08103	50.4

MONUMENTAL LIFE INSURANCE COMPANY

Date: 08/9/2008

By: 

Christopher L. Wilhelm
Assistant General Counsel &
Assistant Vice President

CRTARR.DOC

CONDITIONAL RECEIPT

MONUMENTAL LIFE INSURANCE COMPANY

Home Office: Cedar Rapids, Iowa
Administrative Office: 2 East Chase Street, Baltimore, MD 21202

IMPORTANT NOTICE TO PROPOSED INSURED AND OWNER

Please Read This Receipt Carefully. No insurance will become effective prior to delivery of the policy and/or rider applied for unless and until all the conditions of this receipt are met. No agent, producer and/or broker is authorized to alter or waive any conditions of this receipt. Under no circumstances can a claim be made both under this receipt and under the policy and/or rider applied for should the policy and/or rider applied for be issued.

CONDITIONS WHICH MUST BE MET BEFORE INSURANCE MAY BECOME EFFECTIVE PRIOR TO DELIVERY OF THE POLICY AND/OR RIDER:

1. On the Effective Date indicated below, the state of health and all factors affecting insurability of each person proposed for coverage must be as stated in applications required by the Company; and
2. On the Effective Date indicated below, an amount equal to the initial premium indicated by the mode of payment selected on the application must be submitted; the amount must be annual, semi-annual, quarterly or monthly; and
3. Any check or money order given in payment must be honored when first presented; and
4. All medical examinations, tests, x-rays and electrocardiograms initially required by the Company's written rules with regard to age and amount requested must be completed within sixty (60) days from the date of this receipt; and
5. On the Effective Date indicated below, any person proposed for coverage must be a risk acceptable for insurance exactly as applied for on a standard premium basis according to the Company's underwriting rules and standards.

EFFECTIVE DATE

If all the conditions above are met, insurance in the amount set forth below or the amount applied for, whichever is lower, subject to all the terms and conditions of the policy and/or rider applied for and as if the policy and/or rider applied for had been issued and delivered, will become effective on the LATER of: a) the date of the application or, b) the date of completion of all underwriting requirements stated in (4) above.

MAXIMUM AMOUNT

The liability of the Company prior to delivery of the policy and/or rider and under the receipt and application for life insurance and/or accidental death benefits will not exceed one hundred and fifty thousand dollars (\$150,000.00).

LIABILITY NOT ASSUMED

Each person proposed for insurance must meet the qualifications set forth in this receipt individually. If the Company determines, after completion of all underwriting requirements stated in (4) above, that any person proposed for coverage is not at least a standard risk according to the Company's underwriting rules and standards for the plan and amount of insurance applied for in the application or if any person proposed for coverage dies before completion of all the underwriting requirements stated in (4) above, then the Company assumes NO liability under the receipt and application for life insurance with respect to that person.

RETURN OF MONEY

If any of the above stated conditions are not met, the liability of the Company shall be limited to the return of the amount remitted with this receipt. All returns shall be made without interest to or for the benefit of the owner. Any delay in returning the amount paid shall not be construed as approval of the application.

AGREEMENT

I understand and agree that: (1) any coverage provided under this receipt will be void if the application or this receipt contains any material misrepresentation or if the Proposed Insured dies by suicide; (2) any coverage of insurance available under this receipt will not begin unless all the CONDITIONS listed above are first met exactly; and (3) any coverage which takes effect through this receipt will terminate on the **EARLIEST** of the following: a) sixty (60) days after the date of this receipt; b) the date the policy and/or rider is delivered to the owner; c) the Effective Date of the policy and/or rider; d) the date the entire amount remitted with this receipt is returned; or e) the date the Company determines that the person proposed for coverage is not entitled to insurance as a standard risk on the plan and amount of insurance applied for under the Company's underwriting rules and standards.

If, after termination of coverage under this receipt pursuant to section (e) above, the Company is willing to issue a policy and/or rider on terms other than those applied for (rated policy and/or rider), no such rated policy and/or rider shall become effective until during the lifetime of the person proposed for insurance, the policy and/or rider is delivered to the Owner, the first full monthly premium on the rated policy and/or rider is delivered to the agent, and an acknowledgement referring to the rated policy and/or rider is signed by the Owner, and then only if there has been no change in the health of the person proposed for insurance since the date of this receipt. The decision to issue a rated policy and/or rider shall not create any liability on the part of the Company on a conditional receipt basis for any reason.

Signature of Proposed Insured

Date of this Receipt

Signature of Owner if Other than Proposed Insured

Payment of \$ _____ has been received toward the premium for life insurance with Monumental Life Insurance Company in the application having the same name and date of this receipt. I know of no reason why any person to be covered may not be eligible for insurance. I accurately represented the terms and conditions of this receipt to the Proposed Insured(s) and Owner(s).

Signature of Agent

PART 3 - AGREEMENT/AUTHORIZATION

Application Lock-In Number: _____

AGREEMENT

I have reviewed all of the questions shown on the computer screen. I have also reviewed all of the answers and statements given in response to these questions. They are the answers and statements I provided, and they are true and complete to the best of my knowledge and belief. I understand that these answers and statements, once locked into the computer, cannot be changed. Any subsequent changes to this Application must be made on separate forms supplied by Monumental and signed by me. The answers and statements have been locked in with an assigned Application Lock-In Number. I understand that this Lock-In Number is unique. I have confirmed that the Application Lock-In Number shown at the top of this Agreement is the same as shown on the computer screen.

I understand that the Application consists of this Agreement together with all lock-in questions, answers and statements. Unless stated in this Application, no information given about any proposed insured will be considered to have been given to Monumental. I also understand that Monumental will rely upon the Application in the issuance of any policy. The Application will be attached to and made a part of that policy.

No agent has the authority to: (a) waive a complete answer to any question; or (b) change or waive any of the terms of an application receipt, or policy; or (c) waive any other rights or requirements of the Company.

If the first full premium due is paid when the Application is signed, the terms and limitations of the Conditional Receipt will apply. If insurance has not become effective under the terms of the Conditional Receipt, Monumental will not have any liability until: (a) the policy is delivered to and accepted by the owner; and (b) the first full premium is paid while all proposed insureds are living; and (c) at the time of payment and delivery, the health and insurability of all proposed insureds remains as stated in the Application.

I have received the M.I.B. Disclosure Notification and the Notice to Persons Applying for Insurance. I have paid \$ _____ and hold a Receipt, corresponding with this Application, for that amount.

INSURANCE FRAUD WARNING: 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.

The owner certifies, under penalty of perjury, that the owner's Social Security or Tax ID. number is correct and the owner is not subject to back-up withholding.

Signed at _____
City State Proposed Insured

Date _____
Spouse/Additional Insured

Applicant/Owner
(if other than proposed insured)

APPROVED

To the best of your knowledge and belief, does this application involve the replacement of any existing insurance or annuities? YES [] NO []

FEB 23 1998

Witnessed by _____
Writing Agent

INSURANCE COMMISSIONER
STATE OF ARKANSAS

District/Agency/Account

AUTHORIZATION TO OBTAIN INFORMATION

I authorize any physician, medical practitioner, hospital, clinic, other medical or medically related facility, insurance, or reinsuring company, the Medical Information Bureau Inc., Consumer Reporting Agency, or employer, having information as to diagnosis, treatment, and/or prognosis with respect to any physical or mental condition of any proposed insured, and any other non-medical information of any proposed insured, to give to the Monumental Life Insurance Company, or its legal representative or reinsurers, any and all such information.

I understand the information obtained by use of the Authorization will be used by the Monumental Life Insurance Company to determine eligibility for insurance and eligibility for benefits under an existing policy. Any information obtained will not be released by the Monumental Life Insurance Company to any person or organization EXCEPT to reinsuring companies, the Medical Information Bureau, Inc., 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 further authorize.

I know that I may request a copy of this Authorization. This Authorization will be valid for twenty-six months from the date shown below. A photocopy or facsimile of this Authorization will be as valid as the original.

Date

Proposed Insured

(if proposed insured is a minor, Signature of Parent, Guardian, or Person liable for child's support)

Spouse/Additional Insured

Names of Minor Children

APPROVED

FEB 23 1990

INSURANCE COMMISSIONER
STATE OF ARKANSAS

SERFF Tracking Number: AEGF-125727248 State: Arkansas
 Filing Company: Monumental Life Insurance Company- State Tracking Number: 39571
 Company Tracking Number: A08100 ET AL
 TOI: L08 Life - Other Sub-TOI: L08.000 Life - Other
 Product Name: E-smartapp
 Project Name/Number: /

Superseded Attachments

Please note that all items on the following pages are items, which have been replaced by a newer version. The newest version is located with the appropriate schedule on previous pages. These items are in date order with most recent first.

Original Date:	Schedule	Document Name	Replaced Date	Attach Document
No original date	Supporting Document	Application	07/09/2008	A0310R.pdf A95110.pdf

CONDITIONAL RECEIPT

MONUMENTAL LIFE INSURANCE COMPANY

Home Office: Cedar Rapids, Iowa
Administrative Office: 2 East Chase Street, Baltimore, MD 21202

IMPORTANT NOTICE TO PROPOSED INSURED AND OWNER

Please Read This Receipt Carefully. No insurance will become effective prior to delivery of the policy and/or rider applied for unless and until all the conditions of this receipt are met. No agent, producer and/or broker is authorized to alter or waive any conditions of this receipt. Under no circumstances can a claim be made both under this receipt and under the policy and/or rider applied for should the policy and/or rider applied for be issued.

CONDITIONS WHICH MUST BE MET BEFORE INSURANCE MAY BECOME EFFECTIVE PRIOR TO DELIVERY OF THE POLICY AND/OR RIDER:

1. On the Effective Date indicated below, the state of health and all factors affecting insurability of each person proposed for coverage must be as stated in applications required by the Company; and
2. On the Effective Date indicated below, an amount equal to the initial premium indicated by the mode of payment selected on the application must be submitted; the amount must be annual, semi-annual, quarterly or monthly; and
3. Any check or money order given in payment must be honored when first presented; and
4. All medical examinations, tests, x-rays and electrocardiograms initially required by the Company's written rules with regard to age and amount requested must be completed within sixty (60) days from the date of this receipt; and
5. On the Effective Date indicated below, any person proposed for coverage must be a risk acceptable for insurance exactly as applied for on a standard premium basis according to the Company's underwriting rules and standards.

EFFECTIVE DATE

If all the conditions above are met, insurance in the amount set forth below or the amount applied for, whichever is lower, subject to all the terms and conditions of the policy and/or rider applied for and as if the policy and/or rider applied for had been issued and delivered, will become effective on the LATER of: a) the date of the application or, b) the date of completion of all underwriting requirements stated in (4) above.

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Signature of Proposed Insured

Date of this Receipt

Signature of Owner if Other than Proposed Insured

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Signature of Agent

MONUMENTAL LIFE INSURANCE COMPANY
ADMINISTRATIVE OFFICE: BALTIMORE, MD 21202

PART 3 - AGREEMENT/AUTHORIZATION

Application Lock-In Number: _____

AGREEMENT

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The owner certifies, under penalty of perjury, that the owner's Social Security or Tax ID. number is correct and the owner is not subject to back-up withholding.

Signed at _____
City State Proposed Insured

Date _____
Spouse/Additional Insured

Applicant/Owner
(if other than proposed insured)

To the best of your knowledge and belief, does this application involve the replacement of any existing insurance or annuities? YES [] NO []

Witnessed by _____
Writing Agent District/Agency/Account