

SERFF Tracking Number: AHLL-125794313 State: Arkansas
 Filing Company: The American Home Life Insurance Company State Tracking Number: 40099
 Company Tracking Number:
 TOI: L04I Individual Life - Term Sub-TOI: L04I.313 Decreasing - Single Life - Fixed/Indeterminate Premium
 Product Name: Term Life Insurance to Age 100
 Project Name/Number: /

Filing at a Glance

Company: The American Home Life Insurance Company

Product Name: Term Life Insurance to Age 100 SERFF Tr Num: AHLL-125794313 State: ArkansasLH

TOI: L04I Individual Life - Term SERFF Status: Closed State Tr Num: 40099

Sub-TOI: L04I.313 Decreasing - Single Life - Co Tr Num: State Status: Approved-Closed
 Fixed/Indeterminate Premium

Filing Type: Form Co Status: Reviewer(s): Linda Bird

Author: Juell Nebergall Disposition Date: 09/08/2008

Date Submitted: 08/27/2008 Disposition Status: Approved

Implementation Date Requested: On Approval Implementation Date:

State Filing Description:

General Information

Project Name: Status of Filing in Domicile: Authorized

Project Number: Date Approved in Domicile: 08/26/2008

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: 09/08/2008

State Status Changed: 09/08/2008 Deemer Date:

Corresponding Filing Tracking Number:

Filing Description:

American Home Life is introducing a new policy, Term Life Insurance to Age 100. This term insurance policy, FORM 08 LPDT-AR, provides a level death benefit for a period of years, then it becomes a decreasing death benefit policy. The premiums are level throughout the life of the policy. It is a participating life insurance plan eligible for dividends. The premiums used within the policy are not final. This policy will be used with our previously approved Traditional Applicatoin, AHL-U-07-ALT-AR.

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Company and Contact

Filing Contact Information

Juell Nebergall, Legal Correspondent jnebergall@amhomelife.com
 400 S Kansas Ave (785) 235-6276 [Phone]
 Topeka, KS 66601 (785) 235-1037[FAX]

Filing Company Information

The American Home Life Insurance Company CoCode: 60542 State of Domicile: Kansas
 400 S Kansas Ave Group Code: Company Type: Life Insurance & Annuities
 P.O. Box 1497
 Topeka, KS 66601 Group Name: State ID Number:
 (785) 235-6276 ext. [Phone] FEIN Number: 48-0119710

Filing Fees

Fee Required? Yes
 Fee Amount: \$50.00
 Retaliatory? No
 Fee Explanation: 1 policy @ \$50 ea.
 Per Company: No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
The American Home Life Insurance Company	\$50.00	08/27/2008	22168535

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Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved	Linda Bird	09/08/2008	09/08/2008

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	09/04/2008	09/04/2008	Juell Nebergall	09/04/2008	09/04/2008

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Disposition

Disposition Date: 09/08/2008

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	Application		Yes
Supporting Document	Life & Annuity - Acturial Memo		No
Form	Term Life Insurance to Age 100		Yes

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Objection Letter

Objection Letter Status Pending Industry Response
Objection Letter Date 09/04/2008
Submitted Date 09/04/2008

Respond By Date

Dear Juell Nebergall,

This will acknowledge receipt of the captioned filing.

Objection 1

- Term Life Insurance to Age 100 (Form)

Comment: We did not find a provision in the contract that provide for the payment of interest on delayed claim payments as described in Ark. Code Ann. 23-81-118.

Please feel free to contact me if you have questions.

Sincerely,

Linda Bird

Response Letter

Response Letter Status Submitted to State
Response Letter Date 09/04/2008
Submitted Date 09/04/2008

Dear Linda Bird,

Comments:

Response 1

Comments: The Death Benefit provision on page 5 of FORM 08 LPDT-AR contains the following language:

This policy pays death benefits to the beneficiary. The amount payable is the total of the following amounts determined on the date of the Insured's death:

The Guaranteed Death Benefit of this policy as shown in the Table of Benefits,

PLUS Any one year term insurance purchased by dividend;

PLUS Interest from date of death to date of payment at the rate then used by the Company, which in no event shall be

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less than the rate required by state law;
PLUS Any dividends due but unpaid;
PLUS Any additional insurance on the Insured's life provided by rider;
PLUS Any part of a premium which pays beyond the date of death will be returned;
MINUS Any part of any unpaid premium to the date of death if death occurs during the grace period.

It is our belief that the Death Benefits provision is in accordance with Ark. Code Ann. 23-81-118 and that it does provide for payment of interest on delayed claim payments. I hope that this answers your objection. Please let us know if additional information is needed.

Thank you,

Juell Nebergall

Related Objection 1

Applies To:

- Term Life Insurance to Age 100 (Form)

Comment:

We did not find a provision in the contract that provide for the payment of interest on delayed claim payments as described in Ark. Code Ann. 23-81-118.

Changed Items:

No Supporting Documents changed.

No Form Schedule items changed.

No Rate/Rule Schedule items changed.

Sincerely,
Juell Nebergall

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Form Schedule

Lead Form Number: FORM 08 LPDT-AR

Review Status	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
	FORM 08 LPDT-AR	Policy/Cont ract/Fratern al Certificate	Term Life Insurance to Age 100	Initial		46	Form 08 LPDT-AR.pdf

THE AMERICAN HOME LIFE INSURANCE COMPANY OF KANSAS

400 Kansas Avenue, P.O. Box 1497
Topeka, Kansas 66601

A Mutual Company

Term Life Insurance to Age 100
This is a Legal Contract – Please read it carefully

The American Home Life Insurance Company of Kansas agrees to pay the death benefit to the Beneficiary, subject to the conditions and provisions of this policy. Payment will be made when proof of the Insured's death is received at the Company's Home Office in **Topeka, Kansas**. This policy may have to be returned.

The policy is issued in consideration of the application and the payment of premium.
This policy terminates on the Expiry Date.

**NOTICE OF 30 DAY RIGHT TO EXAMINE
RIGHT TO CANCEL**

This policy may be cancelled by delivering or sending a written notice to The American Home Life Insurance Company of Kansas, P.O. Box 1497, Topeka, Kansas 66601 or to the insurance agent through whom it was effected, and by returning the policy before midnight of the thirtieth day after the date the policy is delivered. Notice given by mail and return of the policy by mail are effective on being postmarked, properly addressed and postage prepaid. The Company must return all payments made for this policy within thirty days after it receives notice of cancellation and the returned policy.

COMPLAINT NOTICE

To obtain information or to make further inquiries regarding this policy, you may call the Company's toll-free number 1-800-876-0199. You may write to the Company at its Home Office address: The American Home Life Insurance Company of Kansas, Attention: Policyowners Service, P.O. Box 1497, Topeka, Kansas 66601. If you are unable to contact the Company and/or unable to resolve your complaint, you may contact the Arkansas Insurance Department, Consumer Services Divisions, 1200 West Third Street, Little Rock, Arkansas 72201 or by telephone at (800) 852-5494.

Signed for the Company at Topeka, Kansas on the issue date.


Secretary


President

TERM LIFE INSURANCE TO AGE 100
Death Benefit Level for a Period Then Decreasing
Insurance Payable at Death Prior to Expiry Date
Participating
Level Premiums Payable to Expiry Date or Until Prior Death
Convertible as Provided Herein

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SCHEDULE OF BENEFITS

BENEFIT		PREMIUM	PREMIUMS PAYABLE TO
Initial Death Benefit:	\$50,000.00	\$361.00	7/01/2073
Accidental Death Benefit:			
Waiver of Premium:			
Other Benefits:			
Total Annual Premium:		\$361.00	

SCHEDULE OF PREMIUMS

These premiums include the premiums for any benefits provided by rider. When the premium for any benefit changes or ceases to be payable, as shown in the Schedule of Benefits, these premiums change accordingly. For all frequency intervals other than Annual, a processing fee has been added to the premium amount.

Premiums Due	Frequency Of Premium Payment			
Beginning On:	Annual	Semi-Annual	Quarterly	MA
7/01/2008	\$361.00	\$187.72	\$95.67	\$30.58

POLICY SPECIFICATIONS

Policy Number:	0000106
Policy Date:	7/01/2008
Expiry Date:	7/01/2073
Insured:	JOHN DOE
Age of Insured	35
Nearest Birthday:	
Sex:	MALE
Premium Class:	STANDARD NON SMOKER
Initial Death Benefit:	\$50,000.00
Annual Premium:	\$361.00
Owner:	JOHN DOE

TABLE OF BENEFITS

Policy Number: 0000106

Insured: JOHN DOE

Age: 35

Initial Death Benefit: \$50,000.00

*** Note: The death benefit of any one year term insurance purchased by dividend, as defined in the Dividends provision of this policy, would be in addition to the Guaranteed Death Benefit shown in this table.**

Policy Year	Beginning On	Guaranteed Death Benefit *
1	7/01/2008	\$50,000
2	7/01/2009	\$50,000
3	7/01/2010	\$50,000
4	7/01/2011	\$50,000
5	7/01/2012	\$50,000
6	7/01/2013	\$50,000
7	7/01/2014	\$50,000
8	7/01/2015	\$50,000
9	7/01/2016	\$50,000
10	7/01/2017	\$50,000
11	7/01/2018	\$50,000
12	7/01/2019	\$50,000
13	7/01/2020	\$50,000
14	7/01/2021	\$50,000
15	7/01/2022	\$50,000
16	7/01/2023	\$50,000
17	7/01/2024	\$50,000
18	7/01/2025	\$50,000
19	7/01/2026	\$50,000
20	7/01/2027	\$50,000
21	7/01/2028	\$50,000
22	7/01/2029	\$50,000
23	7/01/2030	\$45,100
24	7/01/2031	\$40,500
25	7/01/2032	\$36,100
26	7/01/2033	\$31,800
27	7/01/2034	\$27,750
28	7/01/2035	\$24,250
29	7/01/2036	\$21,300
30	7/01/2037	\$18,850
31	7/01/2038	\$16,800
32	7/01/2039	\$15,100
33	7/01/2040	\$13,550
34	7/01/2041	\$12,250
35	7/01/2042	\$10,950
36	7/01/2043	\$9,800
37	7/01/2044	\$8,600
38	7/01/2045	\$7,600
39	7/01/2046	\$6,700

**TABLE OF BENEFITS
(Continuation)**

Policy Number: 0000106 Insured: JOHN DOE

Policy Year	Beginning On	Guaranteed Death Benefit *
40	7/01/2047	\$5,950
41	7/01/2048	\$5,300
42	7/01/2049	\$4,700
43	7/01/2050	\$4,150
44	7/01/2051	\$3,650
45	7/01/2052	\$3,200
46	7/01/2053	\$2,800
47	7/01/2054	\$2,450
48	7/01/2055	\$2,200
49	7/01/2056	\$1,950
50	7/01/2057	\$1,700
51	7/01/2058	\$1,500
52	7/01/2059	\$1,350
53	7/01/2060	\$1,200
54	7/01/2061	\$1,050
55	7/01/2062	\$950
56	7/01/2063	\$850
57	7/01/2064	\$800
58	7/01/2065	\$700
59	7/01/2066	\$650
60	7/01/2067	\$600
61	7/01/2068	\$550
62	7/01/2069	\$500
63	7/01/2070	\$450
64	7/01/2071	\$450
65	7/01/2072	\$400
66	7/01/2073	-TERMINATES-

SUMMARY OF POLICY BENEFITS

BENEFITS

This policy provides certain rights which may be exercised by the Owner during the Insured's lifetime. These include the right to:

- Change the beneficiary
- Change the contingent owner
- Obtain dividend credits
- Convert the policy to a permanent form of insurance without evidence of insurability

The exercise of these rights is subject to the terms and conditions of this policy.

DEATH BENEFITS

This policy pays death benefits to the beneficiary. The amount payable is the total of the following amounts determined on the date of the Insured's death:

The Guaranteed Death Benefit of this policy as shown in the Table of Benefits,

PLUS Any one year term insurance purchased by dividend;

PLUS Interest from date of death to date of payment at the rate then used by the Company, which in no event shall be less than the rate required by state law;

PLUS Any dividends due but unpaid;

PLUS Any additional insurance on the Insured's life provided by rider;

PLUS Any part of a premium which pays beyond the date of death will be returned;

MINUS Any part of any unpaid premium to the date of death if death occurs during the grace period.

PLEASE READ THIS POLICY FOR FULL DETAILS

GENERAL PROVISIONS AND EXCLUSIONS

THE CONTRACT

The entire contract consists of this policy, including any endorsements, and the attached application. In issuing this policy, the Company has relied upon the statements made in the application. These statements are representations and not warranties, except in the case of fraud. The Company will not use any statement to void this policy or to defend against a claim under it, unless the statement is contained in the attached written application. Policy years are measured from the Policy Date. The only way this contract may be modified is by a written agreement signed by the president, a vice president, or the secretary of the Company. The Company may require that the policy be submitted for endorsement to show any change. No agent has authority to change the policy or to waive any of its provisions.

SUICIDE

If the Insured dies by suicide within 2 years from the Policy Date, the policy proceeds will be limited to the premiums paid, reduced by the amount of any dividends paid in cash.

MISSTATEMENT OF AGE OR SEX

If the Insured's age or sex is incorrectly stated, the amount payable will be the amount which the premiums paid would have purchased for the correct age and sex.

INCONTESTABILITY

Except for nonpayment of premiums, the Company cannot deny a claim unless:

1. Death happens within two years after the Policy Date; and
2. An answer in the application was not true or complete; and
3. If the Company had known the truth, it would not have issued the policy or would not have issued the policy in as large an amount, or at the same premium.

This section does not apply to riders providing accidental death or disability benefits.

TERMINATION OF POLICY

This policy will terminate on the earliest of the following dates or events:

1. On the Expiry Date shown in the Policy Specifications; or
2. if any premium due for this policy is not paid before the end of the grace period; or
3. when this policy is converted as provided ; or
4. upon written request of the Owner, when this policy is returned to the Company; or
5. as otherwise provided elsewhere in this policy.

RIGHTS OF OWNER AND BENEFICIARY

RIGHTS OF OWNER

The Owner on the Policy Date is shown in the Policy Specifications. Unless changed by beneficiary designation or assignment, the Owner, if living (or the contingent owner if the Owner is not living) has all rights in this policy while the Insured lives.

A change of Owner or contingent owner may be made at any time. It must be done on the Company's form. The form must be signed by the current Owner and sent to the Company. The Company will record the change. The change will take effect when the form is signed.

ASSIGNMENT

The Owner may assign the ownership of this policy. No policy assignment will be binding on the Company unless it is in writing in a form satisfactory to the Company and received and recorded by the Company at its Home Office. The assignment will then be effective as of the date it was signed, subject to any payment or other action by the Company before recording. The Company is not responsible for the validity, effect or sufficiency of an assignment.

BENEFICIARY

The beneficiary named in the application will receive the death benefit upon the Insured's death unless the Owner has changed the beneficiary designation. The Owner may change any designation, while the Insured is living, by written notice provided to the Company. To be effective, such written notice must include the full name and address of the new beneficiary and be signed and dated by the current Owner. After being recorded by the Company, the change will take effect as of the date the notice was signed, subject to any payment or other action taken by the Company before recording. If any beneficiary dies before the Insured, that interest will pass to any other beneficiaries according to their respective interests. If no beneficiary survives the Insured, the proceeds will be paid in one sum to the Owner, if living. If the Owner is not living and no beneficiary survives the Insured, the proceeds will be paid in one sum to the contingent owner, if living; otherwise, to the Owner's estate.

PREMIUMS

PREMIUMS

This policy is issued in consideration of the application and the first premium payment. Premiums are due and payable in advance while the Insured is alive. The amount and frequency of premium payments are shown in the Schedule of Premiums. All premiums are payable at the Home Office in Topeka, Kansas, or to an agent of the Company upon delivery of a receipt signed by one or more officers of the Company.

The premium for any rider which provides additional benefits is set forth on Page 3 and is included in the premium for the policy. Premiums may be paid annually, semi-annually, quarterly, or by monthly bank draft. The Owner may change the frequency of premium payments subject to Company rules. A written request must be filed at the Home Office in a form satisfactory to the Company.

CANCELLATION

If this term life insurance policy is cancelled, we will refund any unearned premiums for the remainder of the term for which the premiums were paid. The amount of unearned premiums to be refunded will be equal to the difference between the total premium paid and the amount derived by multiplying 1/3 of the quarterly rate by the number of months the policy was in force.

GRACE PERIOD

A grace period of thirty-one (31) days will be allowed for payment of each premium due after the first. This policy will continue in force during the grace period.

REINSTATEMENT

The Owner may, upon written request, reinstate this policy within five (5) years from the date of the first unpaid premium.

The requirements for reinstatement are:

1. The Insured is alive;
2. Evidence of insurability acceptable to the Company must be submitted;
3. All premiums due and unpaid plus interest compounded on each policy anniversary at a rate of 6.00% per year must be paid.

The effective date of reinstatement will be the date the application for reinstatement is approved. The reinstated policy may be contested on account of misrepresentation of facts material to the reinstatement if death happens within two years after the effective date of reinstatement. Such contest shall be subject to the considerations set forth with respect to contestability after original issuance of the policy.

DIVIDENDS

While this policy is in force, it is eligible to receive dividends. The amount, if any, will be set each year by the Company. Dividends, if any, are payable at the end of each policy year if premiums for the year are paid in full.

The Owner may select one of the options below. The Owner may change the option by written request.

If no dividend option is selected, option A will be automatic.

OPTION A One year term insurance. Under this option, one year term insurance, hereinafter called Term Addition, will be purchased for the Insured at the start of each policy year while this option is in effect. The Term Addition will be in effect for one year. Its effective date will be the anniversary date of the policy. The cost of the Term Addition will be at a rate set by the Company. This rate shall not exceed the net single premium for one year term insurance at the Insured's attained age

based on the Commissioner's 2001 Standard Ordinary Mortality Table, with interest at 4% per year, and assuming deaths occur uniformly throughout the policy year.

The Term Addition will: (a) be paid only if death of the Insured occurs within one year from the date the Term Addition went into effect, and (b) be paid in the same way and under the same conditions as the other policy proceeds, and (c) expire without grace or notice at the end of one year from the effective date.

OPTION B Paid in cash. If the paid in cash option is selected, the one year term insurance option is no longer available unless the Insured is alive and evidence of insurability acceptable to the Company is submitted.

CONVERSION PRIVILEGE

This policy may be converted at any time, while it is in force, until the policy anniversary on which the Insured is 70. It may be converted to any plan of permanent insurance being offered by the Company at that time. Such conversion will be subject to the following conditions:

1. Conversion must be requested in writing and this policy must be surrendered.
2. The amount of insurance under the new policy may not exceed the Guaranteed Death Benefit shown in the Table of Benefits section of this policy at the time of conversion, plus the amount of any additional one year term insurance then in force. It may not be less than the minimum amount at which the new policy form is regularly issued.
3. The new policy will have premiums based on the Insured's age at the time of conversion. It will be issued in the same premium class as this policy.
4. This policy may not be converted to a permanent plan if: (a) the policy includes waiver of premium benefit and, (b) premiums are being waived because the Insured is totally disabled.
5. If waiver of premium benefit and accidental death benefit are not part of this policy, they can be included in the new policy only with the consent of the Company.
6. Accidental death benefits and waiver of premium benefits that are a part of this policy and in force on the date of conversion may be issued with the new policy, only if offered by us at the Insured's attained age on the date of conversion. The new policy will cover only bodily injury or disease which starts after the date of conversion.
7. A new suicide or contestable period will not apply to benefits converted from this policy to a new policy. These periods will be measured from the Policy Date of this policy.

SETTLEMENT OPTIONS PROVISIONS

Settlement Options - The benefit can be paid:

In one lump sum; or
In any way the Company agrees.

Before the Insured dies, the Owner can choose how the benefits are to be paid. After the Insured dies, the beneficiary can choose the way unless the Company is told otherwise in writing by the Owner.

Once payments have started, the election of Settlement Options 1 through 4 shall be final.

Settlement Options are available only with the Company's consent if: (a) this policy is assigned; or (b) the payee is a trust, corporation or any other legally recognized entity other than a natural person.

All payments are subject to the Company's amount limits. If the Company changes the limits, the Company may change the amount and interval of payments to comply with the new limits.

Option 1 – Life Income Only: The Company will pay equal monthly payments for the payee's remaining lifetime. Payments end with the payment due just before the payee's death. There is no death benefit under this Settlement Option.

Option 2 – Life Income with Fixed Period Certain: The Company will pay equal monthly payments for the longer of: (a) the payee's life; or (b) the fixed period certain. The fixed period certain may be 10 years (120 months) or 20 years (240) months), but in no event may such fixed period certain exceed the payee's life expectancy.

If the payee dies during the fixed period certain, the remaining fixed period certain payments will be paid to the Beneficiary until all the remaining payments under the fixed period certain have been paid.

After the payee's death, the Beneficiary may designate a payee to receive any remaining payments payable if the Beneficiary dies before all of the payments under the fixed period certain have been paid.

If the Beneficiary dies before receiving all of the remaining payments and there is no designated payee or a designated payee does not survive the Beneficiary for at least 15 days, the remaining fixed period certain payments will be paid to the Beneficiary's estate. If the payee dies after all payments have been made for the fixed period certain, payments will end with the payment due just before the payee's death.

Option 3 – Fixed Certain Only: The Company will pay equal annual, semiannual, quarterly or monthly payments for a fixed period certain of up to 30 years, but in no event may such fixed period certain exceed the payee's life expectancy. If the payee dies during the fixed period certain, the remaining fixed period certain payments will be paid to the Beneficiary until all the remaining payments under the fixed period certain have been paid.

After the payee's death, the Beneficiary may designate a payee to receive any remaining payments payable if the Beneficiary dies before all of the payments under the fixed period certain have been made.

If the Beneficiary dies before receiving all of the remaining payments and there is no designated payee or a designated payee does not survive the Beneficiary for at least 15 days, the remaining fixed period certain payments will be paid to the Beneficiary's estate.

SETTLEMENT OPTIONS PROVISIONS

(Continued)

Option 4 – Payments of a Fixed Amount:

The Company will pay equal annual, semiannual, quarterly or monthly payments of the amount chosen until the proceeds and interest are fully paid. The payments must total at least \$120 a year for each \$1,000 of proceeds held under this Settlement Option. The final payment will equal the amount of any unpaid balance.

Option 5 – Proceeds Held At Interest Only:

The Company will hold the proceeds as principal, making interest payments annually, semiannually, quarterly or monthly, for a period of not less than five (5) years and no more than twenty (20) years, as elected. Payments under this Settlement Option will begin at the end of the first elected interest period following such date.

Interest Rate: The guaranteed interest rate for all Settlement Options is compounded daily to produce an annual effective rate of 3%. The Company may declare and pay current interest higher than the guaranteed rate at any time.

Other Forms of Payment – Benefits can be provided under any other Settlement Option not described in this section, subject to The Company's agreement and any applicable federal or state law, rule or regulation.

Basis of Computation -- The rates for Settlement Options are based upon the Annuity 2000 Mortality Table, and an annual effective interest rate of not less than 3%.

SETTLEMENT OPTIONS PROVISIONS
(Continued)

Table of Guaranteed Settlement Options

The rates contained in the Tables below will be used to provide a minimum guaranteed monthly income. The rates shown are for each \$1,000 of value applied under the applicable Settlement Option.

Any rates and/or ages not shown in the Tables contained in this section will be provided by the Company upon written request.

Annuity 2000 Mortality Table; 12 payments per year; 3% interest.

Age of Payee	Monthly Income		Monthly Income for Life with a Guaranteed Period of:									
	For Life Only		5 Year		10 Year		15 Year		20 Year			
	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female		
35	3.26	3.13	3.26	3.13	3.25	3.13	3.25	3.13	3.24	3.12		
36	3.29	3.16	3.29	3.16	3.29	3.16	3.28	3.15	3.27	3.15		
37	3.33	3.19	3.33	3.19	3.32	3.19	3.31	3.18	3.30	3.17		
38	3.36	3.22	3.36	3.22	3.36	3.22	3.35	3.21	3.33	3.20		
39	3.40	3.25	3.40	3.25	3.40	3.25	3.38	3.24	3.37	3.23		
40	3.44	3.28	3.44	3.28	3.44	3.28	3.42	3.27	3.40	3.26		
41	3.49	3.32	3.48	3.32	3.48	3.32	3.46	3.31	3.44	3.30		
42	3.53	3.36	3.53	3.36	3.52	3.35	3.50	3.34	3.48	3.33		
43	3.58	3.40	3.57	3.39	3.56	3.39	3.55	3.38	3.52	3.37		
44	3.63	3.44	3.62	3.43	3.61	3.43	3.59	3.42	3.56	3.40		
45	3.68	3.48	3.67	3.48	3.66	3.47	3.64	3.46	3.60	3.44		
46	3.73	3.52	3.73	3.52	3.71	3.51	3.69	3.50	3.65	3.48		
47	3.79	3.57	3.78	3.57	3.77	3.56	3.74	3.55	3.70	3.52		
48	3.85	3.62	3.84	3.62	3.82	3.61	3.79	3.59	3.74	3.57		
49	3.91	3.67	3.90	3.67	3.88	3.66	3.84	3.64	3.79	3.61		
50	3.97	3.73	3.96	3.72	3.94	3.71	3.90	3.69	3.84	3.66		
51	4.04	3.78	4.03	3.78	4.01	3.77	3.96	3.74	3.90	3.71		
52	4.11	3.84	4.10	3.84	4.07	3.83	4.02	3.80	3.95	3.76		
53	4.19	3.91	4.18	3.90	4.14	3.89	4.09	3.86	4.01	3.81		
54	4.27	3.97	4.25	3.97	4.22	3.95	4.16	3.92	4.07	3.87		
55	4.35	4.05	4.34	4.04	4.30	4.02	4.23	3.98	4.12	3.92		
56	4.44	4.12	4.42	4.11	4.38	4.09	4.30	4.05	4.19	3.98		
57	4.53	4.20	4.52	4.19	4.47	4.17	4.38	4.12	4.25	4.04		
58	4.63	4.29	4.61	4.28	4.56	4.25	4.46	4.19	4.31	4.11		
59	4.74	4.38	4.72	4.36	4.65	4.33	4.54	4.27	4.37	4.17		
60	4.85	4.47	4.83	4.46	4.75	4.42	4.63	4.35	4.44	4.24		
61	4.97	4.57	4.95	4.56	4.86	4.51	4.71	4.43	4.50	4.31		
62	5.10	4.68	5.07	4.66	4.97	4.61	4.80	4.52	4.57	4.38		
63	5.24	4.79	5.20	4.78	5.09	4.72	4.90	4.61	4.63	4.45		
64	5.39	4.92	5.35	4.90	5.22	4.83	4.99	4.70	4.69	4.52		
65	5.55	5.05	5.50	5.02	5.35	4.94	5.09	4.80	4.75	4.59		
66	5.71	5.19	5.66	5.16	5.48	5.07	5.19	4.90	4.81	4.66		
67	5.90	5.34	5.83	5.31	5.62	5.20	5.29	5.01	4.87	4.72		
68	6.09	5.50	6.01	5.46	5.77	5.34	5.39	5.11	4.93	4.79		
69	6.29	5.67	6.20	5.63	5.92	5.48	5.49	5.22	4.98	4.86		
70	6.51	5.86	6.40	5.81	6.07	5.63	5.58	5.33	5.03	4.92		
71	6.74	6.06	6.61	6.00	6.23	5.79	5.68	5.44	5.07	4.98		
72	6.99	6.28	6.84	6.21	6.40	5.96	5.77	5.55	5.11	5.03		
73	7.26	6.52	7.07	6.43	6.56	6.13	5.86	5.66	5.15	5.08		
74	7.54	6.78	7.32	6.66	6.73	6.31	5.95	5.77	5.18	5.13		

THE AMERICAN HOME LIFE INSURANCE COMPANY OF KANSAS
Home Office
400 Kansas Avenue, P.O. Box 1497, Topeka, Kansas 66601

NOTICE

If there are any questions about this policy or if anyone seeks to replace this policy, please contact an American Home Life agent or the Home Office of the Company. All inquiries should be in writing, stating the policy number.

TERM LIFE INSURANCE TO AGE 100

Death Benefit Level for a Period Then Decreasing
Insurance Payable at Death Prior to Expiry Date
Participating
Level Premiums Payable to Expiry Date or Until Prior Death
Convertible as Provided Herein

SERFF Tracking Number: *AHLI-125794313* *State:* *Arkansas*
Filing Company: *The American Home Life Insurance Company* *State Tracking Number:* *40099*
Company Tracking Number:
TOI: *L04I Individual Life - Term* *Sub-TOI:* *L04I.313 Decreasing - Single Life -
Fixed/Indeterminate Premium*
Product Name: *Term Life Insurance to Age 100*
Project Name/Number: /

Rate Information

Rate data does NOT apply to filing.

SERFF Tracking Number: AHLL-125794313 State: Arkansas
Filing Company: The American Home Life Insurance Company State Tracking Number: 40099
Company Tracking Number:
TOI: L04I Individual Life - Term Sub-TOI: L04I.313 Decreasing - Single Life -
Fixed/Indeterminate Premium
Product Name: Term Life Insurance to Age 100
Project Name/Number: /

Supporting Document Schedules

Review Status:

Satisfied -Name: Certification/Notice

08/27/2008

Comments:

Attachments:

Cert of Compliance.pdf
Cert of Flesch score.pdf

Review Status:

Satisfied -Name: Application

08/27/2008

Comments:

The Traditional Application, form AHL-U-07-ALT-AR, was approved on 5/29/2008 and will be used with this policy.

Attachment:

AHL-U-07 ALT-AR.pdf

Certificate of Compliance with Arkansas Rule and Regulation 19

Insurer: The American Home Life Insurance Company of Kansas

Form Number(s): FORM 08 LPDT-AR

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



Signature of Company Officer

Les E. Diehl

Name

Vice President-General Counsel

Title

8/27/2008

Date

CERTIFICATION

This is to certify that the following form(s) has achieved the Flesch readability score required in the state of Arkansas.

<u>Form Number</u>	<u>Description</u>	<u>Flesch Readability Score</u>
FORM 08 LPDT-AR	Low Cost Whole Life Policy	46.5

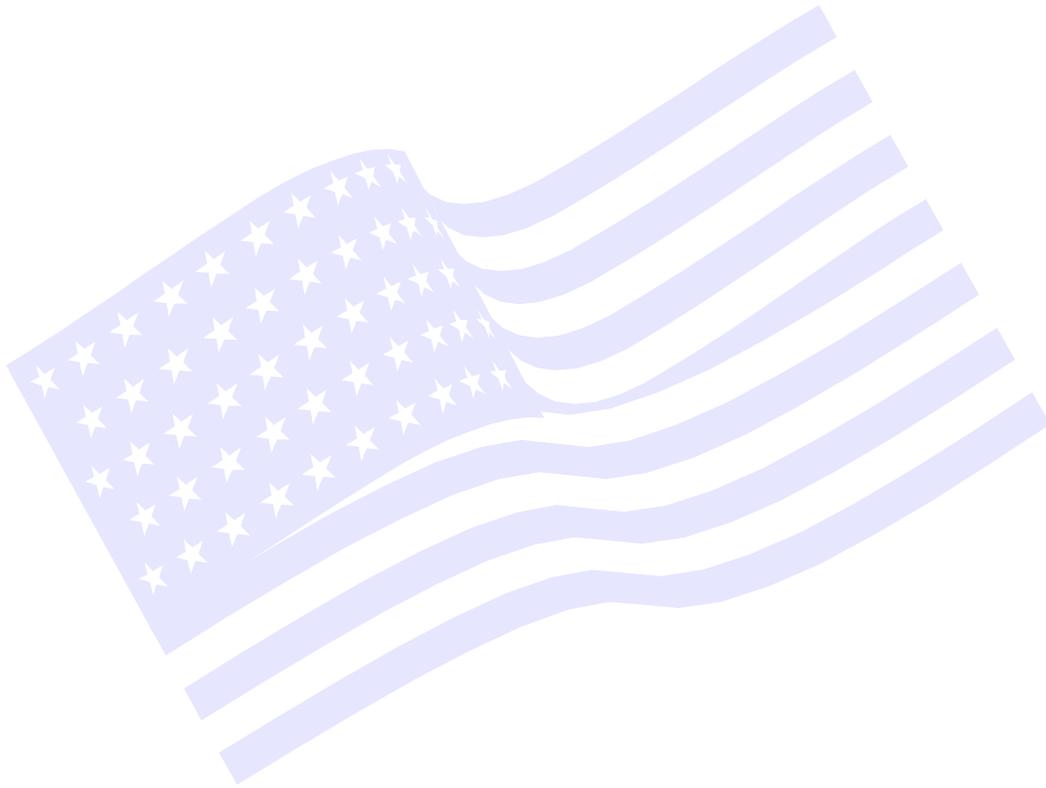


Les E. Diehl
Vice President - General Counsel

August 27, 2008

Date

“A mutual company since 1909”



*Application for Life Insurance**

The American Home Life Insurance Company of Kansas

400 Kansas Avenue, P.O. Box 1497, Topeka, KS 66601

(800)876-0199

www.amhomelife.com

*This application is used with these products.

American
Young American
American Legacy
Young American Legacy

Customer Benefit (SWL)
Enduring Gift (SWL)
LifeForce (SWL)

Ten Year Level Term
Twenty Year Level Term
NovaTerm

INSTRUCTIONS TO THE AGENT

Owner

Complete only if owner is other than the proposed insured.

Signatures

The proposed insured must sign every application unless the proposed insured is not of legal age to contract for insurance. Where the proposed insured is not of legal age to contract for insurance, the parent or guardian must sign on the space allowed for that purpose. The spouse or other insured must sign when the Spouse's Term Rider is requested.

Premium

Do not accept premium for face amounts that exceed \$250,000. Explain to the applicant that the conditional receipt provides no coverage under any circumstances for amounts over \$250,000.

Partial premium payments are not accepted and should not be sent in .

All premium checks must be payable to The American Home Life Insurance Company; do not make check payable to the agent or leave the payee blank.

Complete the **Authorization Agreement** on page 6 if premium is to be paid by automatic bankdraft.

Forms

Complete the Conditional Receipt and Agent's Certificate. Give the Owner's copy of the Conditional Receipt to the applicant.

Notices

Explain all notices before giving to the applicant.

Supplemental Forms

Replacement form if replacing

Hazardous Activities Questionnaire, ONLY if "Avocation" Questions are answered "Yes".

Complete the **Illustration Certification Form.**

Complete the **ABR Summary & Acknowledgment** if this benefit is desired. (Only available at time of application.)

Special Instructions to the Home Office:

Arrange for the **MEDICAL REQUIREMENTS** applicable to the applicant(s) age nearest and face amount.

AMOUNTS	AGES>	MEDICAL REQUIREMENTS (11/99)					
		0-30	31-40	41-45	46-50	51-60	61-Up
0 - 50,000		N	N	N	N	P	P
50,001 - 99,999		N	N	N	P	P	P
100,000 - 200,000		PB	PB	PB	PB	PBE	PBE
200,001 - 300,000		PB	PB	PB	PBE	PBE	PBE
300,001 - 500,000		PB	PB	PBE	PBE	PBE	MBE
500,001 - 1,000,000		PB	PBE	PBE	PBE	MBE	MBE
1,000,001 - 2,000,000		MBE	MBE	MBE	MBE	MBS	MBS
2,000,001 - 5,000,000		MBE	MBE	MBE	MBS	MBS	MBS
Over 5,000,000		CONTACT HOME OFFICE					

SYMBOLS

N - Non Medical Application

M - M. D. Examination and Urine Specimen

E - Resting EKG

P - Basic Paramedical Examination and Urine Specimen

B - Blood Profile

S - Stress/Treadmill EKG

The Company reserves the right to obtain additional information on the insured in order to fully investigate the total risk involved. Confidential information from the MIB, or information on the application may need verification. Underwriting requirements that may be requested include, but are not limited to: examination, urine specimen, blood profile, electrocardiogram, Attending Physician's Statement, prescription history report, inspection report, motor vehicle record, criminal history report, or a copy of citizenship documentation.

THE AMERICAN HOME LIFE INSURANCE CO. OF KANSAS
 400 S. Kansas Avenue, P. O. Box 1497
 Topeka, Kansas 66601-1497
 (800) 876-0199 (800) 876-0194
 Fax (785) 235-1037
 www.amhomelife.com

**APPLICATION FOR INSURANCE
THE AMERICAN HOME LIFE INSURANCE COMPANY OF KANSAS**

Proposed Insured

Name				DOB / /	Age	Birthplace	Sex <input type="checkbox"/> M <input type="checkbox"/> F
Driver's License # & State	Soc. Sec. Number	Ht.	Wt.	Telephone		Work Telephone	
Address							
Employer			Employer Address				
Occupation & Specific Duties							

Life Insurance Applied For and Additional Benefits and Riders

Base Plan _____ Face Amount \$ _____	Rider Plan _____ Face Amount \$ _____	
Sec. Insd. Rider _____ Face Amount \$ _____	Children Term Rider \$ _____	
Additional Benefits	Premium \$ _____	Submitted \$ _____
Accelerated Benefit Rider- <input type="checkbox"/> Proposed Insd. <input type="checkbox"/> Sec. Insd.	Premium Mode	
<input type="checkbox"/> PARider Level Premium \$ _____	<input type="checkbox"/> Annual <input type="checkbox"/> Semi Annual <input type="checkbox"/> Quarterly <input type="checkbox"/> Monthly Bank Draft	
<input type="checkbox"/> PARider Single Premium \$ _____	Dividend Options (If no choice is made, PUA will be used.)	
<input type="checkbox"/> Accidental Death Benefit \$ _____	<input type="checkbox"/> Paid Up Additions <input type="checkbox"/> Interest Accumulate	
<input type="checkbox"/> Guaranteed Insurability Option \$ _____	<input type="checkbox"/> Reduce Premiums <input type="checkbox"/> Cash	
<input type="checkbox"/> Payor Death or Disability _____	<input type="checkbox"/> Automatic Premium Loan <input type="checkbox"/> Waiver of Premium	
<input type="checkbox"/> Payor Death _____		
<input type="checkbox"/> Other _____		

Second Insured

Name				DOB / /	Age	Birthplace	Sex <input type="checkbox"/> M <input type="checkbox"/> F
Driver's License # & State	Soc. Sec. Number	Ht.	Wt.	Telephone		Work Telephone	
Address							
Employer			Employer Address				
Occupation & Specific Duties							

Owner (Complete only if owner is other than the proposed insured.)

Owner	Sex <input type="checkbox"/> M <input type="checkbox"/> F	DOB / /	Soc. Sec. Number
Address			Relationship to Insured

Contingent Owner

Contingent Owner	Sex <input type="checkbox"/> M <input type="checkbox"/> F	DOB / /	Soc. Sec. Number
Address			Relationship to Insured

Premium Payor (If other than Owner)

Premium Payor	Sex <input type="checkbox"/> M <input type="checkbox"/> F	DOB / /	Soc. Sec. Number
Address		Telephone	Relationship to Insured

Children to be Insured

Name(s) (must live in Insureds household)	Sex <input type="checkbox"/> M <input type="checkbox"/> F	DOB / /	Ht.	Wt.	Relationship	Soc. Sec. Number / /
	<input type="checkbox"/> M <input type="checkbox"/> F	/ /				/ /
	<input type="checkbox"/> M <input type="checkbox"/> F	/ /				/ /
	<input type="checkbox"/> M <input type="checkbox"/> F	/ /				/ /
	<input type="checkbox"/> M <input type="checkbox"/> F	/ /				/ /
	<input type="checkbox"/> M <input type="checkbox"/> F	/ /				/ /

Beneficiary (Surviving Beneficiaries will share and share alike unless otherwise designated.)

A. Base Insured	Name	Soc. Sec. Number	Address	Relationship
Primary Beneficiary(ies):				
Contingent Beneficiary(ies):				
B. Second Insured	Name	Soc. Sec. Number	Address	Relationship
Primary Beneficiary(ies):				
Contingent Beneficiary(ies):				

Life Insurance Now In Force

Do you have any existing life insurance policies? Yes No
 Will Life Insurance or Annuities in any company be replaced by coverage requested in this application? Yes No
 If either question is answered "Yes", specify company below and submit all replacement forms required by state regulation.

Name of Company	Face Amount	Policy Number	Year Issued	Other Benefits

Tobacco Use

1. Does any person proposed for coverage currently use tobacco in any form? Yes No
 1a. If "yes", please indicate forms currently used: Cigarettes Cigars Pipe Chew/Snuff
2. If Question 1 above is "No", has any person proposed for coverage used tobacco in any form in the past? Yes No
 2a. If "yes", please indicate form(s) used and date quit: Cigarettes Cigar Pipe Chew/Snuff
 Date (Month and Year) quit _____
3. Is any person proposed for coverage currently using a non-tobacco product containing nicotine such as gum, patch, nasal spray or inhaler? Yes No

Personal Doctor or Health Care Provider

Person	Physicians's Full Name, Address, Telephone Number, Date Last Consulted

Avocation (Please complete U-12 Hazardous Activity Questionnaire for each "Yes" answer for each person proposed for insurance.)

Has any person proposed for insurance ever participated in or have plans to participate in (within the next 12 months) any of the following or similar activities: Yes No

Check all that apply and complete the necessary supplemental questionnaire(s).

- Vehicle Racing Parasailing Hang Gliding Rodeo Flying other than as an airline passenger
 Skydiving Scuba Diving Ballooning Other _____

4. To the best of your knowledge and belief, has any person proposed for coverage: <i>(This question must be answered)</i>	YES	NO
a. Made claim for or received payment for sickness or injury?	<input type="checkbox"/>	<input type="checkbox"/>
b. Made application for LIFE or HEALTH insurance to another company, which is now pending?	<input type="checkbox"/>	<input type="checkbox"/>
c. Any plans to change occupations; to travel or to reside outside of the USA or Canada?	<input type="checkbox"/>	<input type="checkbox"/>
d. Been arrested and/or convicted for other than traffic violations?	<input type="checkbox"/>	<input type="checkbox"/>
e. Had driver's license suspended or revoked?	<input type="checkbox"/>	<input type="checkbox"/>
5. Has any person proposed for coverage been diagnosed by or received treatment from a licensed medical professional for any disorder, disease, injury, or physical deformity of: <i>(Give details of any "Yes" answers in the space below)</i>		
a. the eyes, ears, nose or throat, including impaired sight, speech, hearing?	<input type="checkbox"/>	<input type="checkbox"/>
b. the nervous system, including, mental illness, convulsions, epilepsy, paralysis, multiple sclerosis?	<input type="checkbox"/>	<input type="checkbox"/>
c. the lungs or respiratory system, including asthma, emphysema, tuberculosis, bronchitis?	<input type="checkbox"/>	<input type="checkbox"/>
d. the heart or circulatory system, including chest pain, heart attack, rheumatic fever, high blood pressure, irregular heart beat, heart murmur, phlebitis, varicose veins, stroke?	<input type="checkbox"/>	<input type="checkbox"/>
e. the stomach or digestive tract, including ulcer, colitis, Crohn's disease, gallbladder disease, hernia, recurrent indigestion, hepatitis/liver disease, rectal disorder?	<input type="checkbox"/>	<input type="checkbox"/>
f. the genito-urinary system, including sugar, blood, pus, albumin in the urine - kidney, bladder, prostate disease or disorder of genital organs?	<input type="checkbox"/>	<input type="checkbox"/>
g. the endocrine system, including diabetes, goiter, thyroid disorder, glandular and/or growth problems?	<input type="checkbox"/>	<input type="checkbox"/>
h. the skin/bones, including deformity, lameness, arthritis, gout, rheumatism?	<input type="checkbox"/>	<input type="checkbox"/>
i. the lymph glands or for cancer, tumor, cyst or polyp?	<input type="checkbox"/>	<input type="checkbox"/>
j. the breasts, uterus, ovaries, including pregnancy or delivery?	<input type="checkbox"/>	<input type="checkbox"/>
6. Does any person proposed for coverage now use or ever used barbiturates, heroin, opiates, cocaine, amphetamines, marijuana, or other narcotics? Any history of alcohol abuse, treatment or advice from a licensed medical professional or counselor?	<input type="checkbox"/>	<input type="checkbox"/>
7. Is any person proposed for coverage taking medication prescribed by a licensed medical professional or receiving medical treatment from a licensed medical professional?	<input type="checkbox"/>	<input type="checkbox"/>
8. Has any person proposed for coverage been to a licensed medical professional or medical facility in the last 5 years?	<input type="checkbox"/>	<input type="checkbox"/>
9. Have you been diagnosed or treated by a medical professional, for an immune deficiency disorder, HIV, AIDS, or AIDS related complex (ARC), or tested positive on an AIDS related blood test?	<input type="checkbox"/>	<input type="checkbox"/>
10. Is any person proposed for coverage now under medical observation or treatment by a licensed medical professional other than as stated above?	<input type="checkbox"/>	<input type="checkbox"/>

No.	Name of Proposed Insured	Disease/Condition	Date of Diagnosis	Duration	Degree of Recovery	Physician, Hospital Address

AUTHORIZATION

By this form, I **authorize** any licensed physician, medical practitioner, or records custodian for any clinic, hospital, other medical or medically-related facility, the Veterans Administration, the Medical Information Bureau (MIB), an employer, consumer reporting agency, laboratory, pharmacy or pharmacy benefit manager, or other insurance companies that have records about me or any children to be insured (if applicable) to release this information to The American Home Life Insurance Company of Kansas. This information may be about: (a) employment; (b) occupation; (c) avocations; (d) other insurance coverage; (e) driving record; (f) age; (g) prescription drug usage; (h) any medical history, condition, care or advice relative to the proposed insured's physical or mental health; and (i) other personal characteristics. This AUTHORIZATION extends to information on the use of alcohol, drugs and tobacco; and the diagnosis or treatment of HIV (the virus that causes AIDS) infection or other sexually transmitted disease. I understand that this information will be used by The American Home Life Insurance Company of Kansas, its representatives or reinsurers in the evaluation of this application to determine eligibility for insurance and/or to investigate claims. The American Home Life Insurance Company of Kansas or its representatives may release information covered by this AUTHORIZATION to the American Home Agent(s) listed in my application for insurance, to its subsidiaries, reinsurers, the MIB, or other insurance companies. The American Home Life Insurance Company of Kansas may also release this information to others who I authorize in writing.

This AUTHORIZATION may be used for a period of 24 months from the date signed below unless sooner revoked. I may revoke this AUTHORIZATION at any time by notifying The American Home Life Insurance Company of Kansas in writing at Underwriting Department, The American Home Life Insurance Company of Kansas, P.O. Box 1497, Topeka, KS 66601. My revocation will not be effective to the extent The American Home Life Insurance Company of Kansas, its reinsurers, or any other person already has disclosed or collected information or taken other action in reliance on the AUTHORIZATION. I understand that my application for insurance will not be considered unless this AUTHORIZATION is signed and dated. The information The American Home Life Insurance Company of Kansas or its reinsurers obtains through this AUTHORIZATION may become subject to further disclosure, as required by law. For example, The American Home Life Insurance Company of Kansas or its reinsurers may be required to provide it to an insurance regulatory or other government agency. In this case, the information may no longer be protected by the rules governing this AUTHORIZATION. I agree that a photocopy of this AUTHORIZATION is as valid as the original. I understand that I have the right to receive a copy of this AUTHORIZATION upon request. I understand that there is no benefit paid for suicide for the first two policy years (for residents of Colorado, North Dakota, and Missouri, one policy year).

Signature of Proposed Insured

Date

Signature of Second Insured

Date

Signature of Parent/Guardian if Proposed Insured is a Minor

Date

Printed Name of Parent/Guardian

Date

AGREEMENT

This application will include: (a) Application Questions; (b) Statement to Medical Examiner, if required by the Company's rules; and (c) any supplements. This application, with any policy issued as a result of this application, will form the entire contract of insurance.

Any insurance issued by the Company as a result of this application will not be effective until: (a) a policy is delivered while the persons proposed for insurance are alive and a risk insurable; and (b) the full first premium for that policy is paid. An earlier Effective Date will apply only as specified in the conditional receipt.

Only an Officer of the Company may make, modify or discharge any insurance contract on its behalf. **NO AGENT OR MEDICAL EXAMINER HAS THE AUTHORITY TO: (A) ACCEPT RISKS; (B) DETERMINE INSURABILITY; (C) MAKE OR MODIFY ANY CONTRACTUAL PROVISION; OR (D) WAIVE ANY OF THE COMPANY'S RIGHTS OR REQUIREMENTS:**

The Company may amend this application by endorsement. Such an endorsement will be used to: (a) correct apparent errors or omissions; and (b) conform the application to any policy that may be issued. Any amendments will be deemed to be approved by the undersigned if and when such a policy is accepted.

I was given a copy of the Notice Regarding Medical Information Bureau, Notice Regarding Fair Credit Reporting Act, and Notice of Information Practices before signing this form, I understand that I may request in writing to be interviewed if any investigative consumer report is prepared in connection with this application and upon written request I am entitled to receive a copy.

I understand that I may attend any and all meetings of the policyholders of the Company. If I do not attend, the Executive Committee of the Board of Directors will act as my lawful proxy, until that proxy is revoked by me, in writing. The annual meeting of policyholders shall be held at 10:00 a.m. on the second Tuesday in March, each year. I understand that I may appoint a secondary addressee at any time by written notice to the company.

I certify, under penalty of perjury that the social security numbers shown on the application are correct.

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.

I REALIZE THAT ANY FALSE STATEMENTS OR MISREPRESENTATIONS IN THIS APPLICATION WHICH WOULD AFFECT THE COMPANY'S DECISION TO ISSUE THE POLICY APPLIED FOR MAY RESULT IN LOSS OF COVERAGE, SUBJECT TO THE INCONTESTABILITY PROVISION OF THE POLICY.

The signatures below indicate acceptance of the "Agreement" section above. Please read this section carefully.

Signed at _____ on _____
City and State Month, Day, Year

Signature of Proposed Insured

Signature of Applicant/Owner

Signature of Second Insured

Signature of Parent or Guardian if Primary insured is a minor

Signature of Agent

Print Agent Name

Agent Number (Company Number)

COMPANY'S COPY OF THE CONDITIONAL RECEIPT

All Premium Checks Must Be Payable to American Home Life Insurance Company of Kansas; Do Not Make Check Payable To The Agent Or Leave The Payee Blank.

Received \$ _____ from _____ in connection with the application for life insurance, including any riders for which application has been made.

1. **NO INSURANCE WILL BECOME EFFECTIVE PRIOR TO DELIVERY OF THE POLICY UNLESS AND UNTIL EACH AND EVERY ONE OF THE FOLLOWING CONDITIONS HAVE BEEN FULFILLED EXACTLY:**
 - (a) **If the proposed insured(s) is/are a tobacco user**, the amount of payment taken with the application must be at least equal to the amount of the full first premium at tobacco premium rates for the mode of payment selected in the application and for the amount of insurance which may become effective prior to delivery of the policy;
 - (b) **If the proposed insured(s) is/are NOT a tobacco user**, the amount of payment taken with the application must be at least equal to the amount of the full first premium at non-tobacco premium rates for the mode of payment selected in the application and for the amount of insurance which may become effective prior to delivery of the policy;
 - (c) all medical examinations, tests, x-rays, and electrocardiograms required by the Company must be completed and received at its Home Office within 60 days from the date of completion of the application;
 - (d) on the Effective Date, as defined below, the Company at its Home Office must be satisfied that each person proposed for insurance in this application is a risk insurable by the company at no greater than standard tobacco or standard non-tobacco premium rates under its rules, limits, and standards for the plan and the amount applied for without any modification either as to plan, amount, riders, or supplemental agreements; and
 - (e) on the Effective Date the state of health and all factors, including tobacco usage, affecting the insurability of each person proposed for insurance must be as stated in the application.
2. Subject to the conditions of paragraph 1, insurance, as provided by the terms and conditions of the policy applied for and in use on the Effective Date, but for an amount not exceeding that specified in paragraph 3, will become effective as of the Effective Date. "Effective Date", as used herein, is the latest of: (a) the date of completion of the application questions, or (b) the date of completion of all medical examinations, prescription checks, tests, x-rays, and electrocardiograms required by the Company, or (c) the date of issue, if any, requested in the application.
3. **The total amount of insurance which may become effective on any person proposed for insurance shall not exceed \$250,000 of life insurance.**
4. If one or more of the conditions of paragraph 1 have not been fulfilled exactly, there shall be no liability on the part of the Company except to return the applicable payment in exchange for this Receipt.
5. **NO AGENT OR ANY OTHER PERSON IS AUTHORIZED BY THE COMPANY TO WAIVE OR MODIFY IN ANY WAY ANY OF THE PROVISIONS OF THIS CONDITIONAL RECEIPT.**

Dated at _____

Signature of Agent

this _____ day of _____ Year _____

I acknowledge possession of this receipt and I certify that I have read it and the agreement in the application. The terms and conditions of this receipt, to which I agree, and the agreement in the application have been explained to me fully by the agent and I understand them.

Signature of the Owner

Authorization Agreement for Preauthorized Payments

PLEASE COMPLETE THIS SECTION TO PAY BY OUR CONVENIENT MONTHLY AUTOMATIC BANK WITHDRAWAL PLAN.
IMPORTANT: ATTACH VOID CHECK AND RETURN WITH POLICY

in favor of The American Home Life Insurance Company of Kansas, P.O. Box 1497 • Topeka, Kansas 66601, ID# 48-0119710

I (we) hereby authorize The American Home Life Insurance Company of Kansas, hereinafter called the COMPANY, to initiate debit entries to my (our) Checking Savings account (select one) indicated below and the depository named below, hereafter called DEPOSITORY, to debit same to such account.

DEPOSITORY NAME _____ BRANCH _____
(Please Print)

CITY _____ STATE _____ ZIP _____

TRANSIT/ABA NO. _____ ACCOUNT NO. _____

This authority is to remain in full force and effect until COMPANY and DEPOSITORY have received written notification from me (or either of us) of its termination. For any changes to this authority, including termination thereof, please allow Seven (7) business days after COMPANY has received such notification to afford COMPANY and DEPOSITORY a reasonable opportunity to act on it.

NAME(S) _____ SSN. _____
(Please Print)

DATE _____ SIGNED _____

Preferred Withdrawal Date:
_____ (of each month)

AGENT'S CERTIFICATION

Prior to completing the application, deliver the NOTICES on page 9. Also, if the application is \$250,000 or less and the modal premium is being submitted, please complete and detach the Conditional Receipt. (If the amount exceeds \$250,000, no premium should be submitted and the Conditional Receipt should not be given.)

1. How long have you known the proposed Insured(s)? _____
2. Are you related? YES NO How? _____
3. Is each Proposed Insured a citizen of the USA? YES NO (If no, give green card # and details) _____
4. Does the Proposed Insured(s) have any obvious deformity, incapacity not otherwise specified in this application? YES NO
(Details) _____
5. Did you personally see the Proposed Insured(s) and Applicant(s) sign this application? YES NO
6. Did you present the Proposed Insured(s) with the required NOTICES? YES NO
7. To the best of your knowledge, will any insurance or annuities be lapsed, or surrendered subject to borrowing by reason of the transaction proposed in this application? YES NO (Details under Remarks)
8. Can we call the Proposed Insured(s)? YES NO

Telephone Number (Residence)	Time Zone (Circle) E C M P
Telephone Number (Business)	Best Time to Contact:
Cell Phone Number	Most Convenient Place:
E-mail address	To be Contacted in: <input type="checkbox"/> English <input type="checkbox"/> Spanish

9. Have you arranged for the medical requirements as needed for amount? YES NO

Premium Notices To: Insured Owner

Mail Policy To: Agent Insured Owner

Remarks/Requests: _____

I hereby certify that, to the best of my knowledge, there is is not existing life insurance and/or annuity contract(s) on the life of the insured. If there is, I have presented and read the applicant a notice regarding replacement, if required by applicable state law. If there is existing coverage, I certify that the insurance hereby applied for will will not replace any existing life insurance or annuity contract. I further certify that: 1) the above answers are full, complete and true to the best of my knowledge; 2) that I know of no factors affecting the insurability of any proposed insured except as stated on the application; 3) that the above signatures are those they are represented to be; and 4) that the application was signed by all proposed insureds in my presence.

Agent Signature _____ Agent Number (Company) _____
 Date _____
 Agents Telephone Number _____ Agents Fax Number _____

OWNER'S COPY OF THE CONDITIONAL RECEIPT

All Premium Checks Must Be Payable to American Home Life Insurance Company of Kansas; Do Not Make Check Payable To The Agent Or Leave The Payee Blank.

1. **NO INSURANCE WILL BECOME EFFECTIVE PRIOR TO DELIVERY OF THE POLICY UNLESS AND UNTIL EACH AND EVERY ONE OF THE FOLLOWING CONDITIONS HAVE BEEN FULFILLED EXACTLY:**
 - (a) **If the proposed insured(s) is/are a tobacco user**, the amount of payment taken with the application must be at least equal to the amount of the full first premium at tobacco premium rates for the mode of payment selected in the application and for the amount of insurance which may become effective prior to delivery of the policy;
 - (b) **If the proposed insured(s) is/are NOT a tobacco user**, the amount of payment taken with the application must be at least equal to the amount of the full first premium at non-tobacco premium rates for the mode of payment selected in the application and for the amount of insurance which may become effective prior to delivery of the policy;
 - (c) all medical examinations, tests, x-rays, and electrocardiograms required by the Company must be completed and received at its Home Office within 60 days from the date of completion of the application;
 - (d) on the Effective Date, as defined below, the Company at its Home Office must be satisfied that each person proposed for insurance in this application is a risk insurable by the company at no greater than standard tobacco or standard non-tobacco premium rates under its rules, limits, and standards for the plan and the amount applied for without any modification either as to plan, amount, riders, or supplemental agreements; and
 - (e) on the Effective Date the state of health and all factors, including tobacco usage, affecting the insurability of each person proposed for insurance must be as stated in the application.
2. Subject to the conditions of paragraph 1, insurance, as provided by the terms and conditions of the policy applied for and in use on the Effective Date, but for an amount not exceeding that specified in paragraph 3, will become effective as of the Effective Date. "Effective Date", as used herein, is the latest of: (a) the date of completion of the application questions, or (b) the date of completion of all medical examinations, tests, x-rays, and electrocardiograms required by the Company, or (c) the date of issue, if any, requested in the application.
3. **The total amount of insurance which may become effective on any person proposed for insurance shall not exceed \$250,000 of life insurance.**
4. If one or more of the conditions of paragraph 1 have not been fulfilled exactly, there shall be no liability on the part of the Company except to return the applicable payment in exchange for this Receipt.
5. **NO AGENT OR ANY OTHER PERSON IS AUTHORIZED BY THE COMPANY TO WAIVE OR MODIFY IN ANY WAY ANY OF THE PROVISIONS OF THIS CONDITIONAL RECEIPT.**

I acknowledge possession of this receipt and I certify that I have read it and the agreement in the application. The terms and conditions of this receipt, to which I agree, and the agreement in the application have been explained to me fully by the agent and I understand them.

AUTHORIZATION

By this form, I **authorize** any licensed physician, medical practitioner, or records custodian for any clinic, hospital, other medical or medically-related facility, the Veterans Administration, the Medical Information Bureau (MIB), an employer, consumer reporting agency, laboratory, pharmacy or pharmacy benefit manager, or other insurance companies that have records about me or any children to be insured (if applicable) to release this information to The American Home Life Insurance Company of Kansas. This information may be about: (a) employment; (b) occupation; (c) avocations; (d) other insurance coverage; (e) driving record; (f) age; (g) prescription drug usage; (h) any medical history, condition, care or advice relative to the proposed insured's physical or mental health; and (i) other personal characteristics. This AUTHORIZATION extends to information on the use of alcohol, drugs and tobacco; and the diagnosis or treatment of HIV (the virus that causes AIDS) infection or other sexually transmitted disease. I understand that this information will be used by The American Home Life Insurance Company of Kansas, its representatives or reinsurers in the evaluation of this application to determine eligibility for insurance and/or to investigate claims. The American Home Life Insurance Company of Kansas or its representatives may release information covered by this AUTHORIZATION to the American Home Agent(s) listed in my application for insurance, to its subsidiaries, reinsurers, the MIB, or other insurance companies. The American Home Life Insurance Company of Kansas may also release this information to others who I authorize in writing.

This AUTHORIZATION may be used for a period of 24 months from the date signed below unless sooner revoked. I may revoke this AUTHORIZATION at any time by notifying The American Home Life Insurance Company of Kansas in writing at Underwriting Department, The American Home Life Insurance Company of Kansas, P.O. Box 1497, Topeka, KS 66601. My revocation will not be effective to the extent The American Home Life Insurance Company of Kansas, its reinsurers, or any other person already has disclosed or collected information or taken other action in reliance on the AUTHORIZATION. I understand that my application for insurance will not be considered unless this AUTHORIZATION is signed and dated. The information The American Home Life Insurance Company of Kansas or its reinsurers obtained through this AUTHORIZATION may become subject to further disclosure, as required by law. For example, The American Home Life Insurance Company of Kansas or its reinsurers may be required to provide it to an insurance regulatory or other government agency. In this case, the information may no longer be protected by the rules governing this AUTHORIZATION. I agree that a photocopy of this AUTHORIZATION is as valid as the original. I understand that I have the right to receive a copy of this AUTHORIZATION upon request. I understand that there is no benefit paid for suicide for the first two policy years (for residents of Colorado, North Dakota, and Missouri, one policy year).

MEDICAL INFORMATION BUREAU: Information regarding your insurability will be treated as confidential. The American Home Life Insurance Company of Kansas, or its reinsurers may, however, make a brief report thereon to the Medical Information Bureau, a nonprofit membership organization of life insurance companies which operates an information exchange on behalf of its members. If you apply to another Bureau member company for life or health insurance coverage, or a claim for benefits is submitted to such company, the Bureau, upon request will supply such company with the information it may have in its file.

Upon receipt of a request from you, the Bureau will arrange disclosure of any information it may have in your file. If you question the accuracy of information in the Bureau's file, you may contact the Bureau and seek a correction in accordance with the procedures set forth in the Federal Credit Reporting Act. The address of the Bureau's information office is Post Office Box 105, Essex Station, Boston, Massachusetts 02112, Telephone number (617) 426-3660.

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

FAIR CREDIT REPORTING ACT: You are entitled to know that, as a part of our regular procedures, we may request an investigative consumer report concerning the insurability of each person proposed for coverage. This report would include information as to character, general reputation, personal characteristics and mode of living, except as may be related directly or indirectly to your sexual orientation, obtained through personal interviews with friends, neighbors, and associates of the Proposed Insured(s).

Upon receipt of written request to our Home Office, we will inform you whether an investigative consumer report has, in fact, been obtained and the name and address of the consumer reporting agency from whom the report was requested. Copies of the report may be obtained from the consumer reporting agency.

INFORMATION PRACTICES: To properly underwrite and administer your life insurance coverage, American Home Life Insurance Co. of Kansas must collect certain information. The primary source of information is your application and any supporting amendments, questionnaires, etc. However, it may be necessary to obtain more information from sources such as medical professionals and institutions which have provided care to you or members of your family who have applied for coverage. We may contact your employers, business associates, friends and neighbors, public records, and other insurance companies to which you may have applied. Information from these sources may be obtained by correspondence, phone, or personal contact. In some cases, we may ask an insurance support organization to complete an investigative consumer report for us. That organization may retain a copy of the report and may disclose its contents to others for whom it performs such services.

By law, The American Home Life Insurance Company of Kansas either directly or through an agent, may disclose information about you to others without your specific authorization. When asked to do so, we provide only that which is reasonably necessary to accomplish the intended purpose. The following summary describes disclosures which may be made, although The American Home Life Insurance Company may not always choose to make such disclosures:

1. To other persons or organizations who perform business, professional or insurance services for us, and whose proper performance for us requires that we disclose certain information to them.
2. To another insurance company to which you have applied for coverage or benefits.
3. To your AHL agent to assist in providing proper service to you.
4. To insurance support organizations formed to prevent or detect fraud in insurance transactions.
5. To our reinsurers if we ask them to accept a portion of the risk under your policy.
6. To a medical care institution or medical professional to verify that you have coverage with us. Also, if a medical examination for insurance purposes reveals a condition or problem unknown to the individual, we may inform the individual's personal medical professional.
7. To state regulatory authorities who conduct examinations and audits of company operations.
8. To law enforcement agencies to assist in the prevention or prosecution of fraud, or to alert them to the possibilities of illegal conduct.

You have certain rights concerning access to information about you that we have collected and retained in our files. To maintain security of that information, access will be permitted only after proper identification has been submitted to us. If you would like access to this information you must send a signed, written request to the Underwriting Department, The American Home Life Insurance Company of Kansas, P.O. Box 1497, Topeka, Kansas 66601. The request must include full name, address, telephone number and policy number. Within 30 business days after receiving your request we will tell you the nature and substance of the information in our files. If you wish to see and copy the records in person, we will advise you of the location of the records. There may be a charge for each copy made. Also we will tell you to whom we have disclosed information about you within the last two years or to whom such information normally would have been disclosed. There are limitations of access. We will identify sources of information which comes from institutions such as hospitals, clinics, doctors or insurance support organizations, but we will not identify sources of information which was obtained from individuals such as friends or neighbors. Also, we are not obligated to provide access to information obtained in connection with or in anticipation of a claim for policy benefits or a civil or criminal proceeding. Medical information will be provided only through a doctor or some other medical professional, designated by you, who is licensed to provide medical care relevant to the nature of the information. If you believe, after reviewing information in our files, that it is incorrect, you may request, in writing, that we correct, amend or delete any item of information. Requests should be directed to the Underwriting Department, The American Home Life Insurance Company of Kansas, P.O. Box 1497, Topeka, Kansas 66601. We will respond within thirty business days of receipt of your written request. If we agree that certain changes should be made, we will notify any person to whom we may have disclosed the original information during the preceding two years. We will also notify any insurance support organization to whom we have disclosed the information or who may have furnished the original information. If we do not agree to change our records, you may file with us a brief written statement setting forth what you believe to be the correct, relevant or fair information and why you disagree with our decision not to change the original information. Your statement will become a permanent part of our file and will be disclosed in the future with the original information. Also, copies of your statement will be sent to any person or insurance support organization to whom the original information was furnished.

The American Home Life Insurance Company of Kansas

PO Box 1497, Topeka, KS 66601

Phone: (785) 235-6276

**Underwriting Department
Illustration Certification Form**

Proposed Insured's Name _____ Application/Policy Number _____

- Check Part A if an illustration was not used during the Application Process.
- Check Part B if the application does not match the illustration.
- Check and complete Part C if a computer screen illustration was used AND no hard copy of the illustration was provided to the applicant.

CHECK ONLY ONE BOX

PART A - No illustration used in the application process

The undersigned agent hereby certifies that an illustration was not used in connection with the application for insurance to The American Home Life Insurance Company of Kansas submitted by the applicant. The undersigned applicant hereby acknowledges that no illustration was used in connection with the application for insurance. The applicant further acknowledges his or her understanding that an illustration, conforming to the policy as issued, will be provided no later than the time of delivery of the policy.

PART B - The illustration does not conform to the application

The undersigned agent hereby certifies that the policy has been applied for other than as illustrated. The undersigned applicant hereby acknowledges that the illustration does not conform to the policy as applied for. The applicant further acknowledges his or her understanding that an illustration, conforming to the policy as issued, will be provided no later than the time of delivery of the policy.

PART C - Computer Screen Illustration used, no hard copy furnished to applicant

AGENT: By signing below, I certify that I displayed a computer screen illustration that complies with state requirements and for which no hard copy was furnished. The illustration was based on the following personal and policy information:

- | | |
|---|--------------------------------|
| 1. Gender: _____ Male _____ Female _____ Unisex | 4. Age: _____ |
| 2. Underwriting or Rating Class: _____ | 5. Type of Policy/Rider: _____ |
| 3. Initial Death Benefit: \$ _____ | 6. Dividend Option: _____ |

APPLICANT: By signing below, I acknowledge that I viewed a computer screen illustration as stated above. No hard copy of the illustration was furnished. I further understand that an illustration conforming to the policy as issued will be provided to me no later than at policy delivery.

Date

Agent's Signature

Applicant's (Policyowner) Signature

Agent's Name (Please Print) / License Number (where required)

Applicant's Name (please print)

Hazardous Activities Questionnaire

***DO NOT COMPLETE THIS PAGE, UNLESS "AVOCATION" QUESTIONS WERE ANSWERED "YES"**

AVIATION

1. I participate(d) in aviation as a:

- pilot student pilot crewmember
- a. Type of license _____ Grade or class _____
- b. Issue date _____ Date of last flight _____
- c. How long have you participated in aviation? _____
- d. Total number of solo hours flown?
civilian _____ hrs. military _____ hrs.
- e. Principal type of aircraft flown? _____
- f. Do you own your own plane? Yes No
Who maintains it? _____
- g. Do you ever fly outside the U.S.? Yes No
- h. Have you ever been grounded for violation of regulations? Yes No

2. If you do not fly as a pilot, do you intend to in the future? Yes No

REMARKS: (Include complete details to any "yes" answers)

3. Type of Flying

	13-24 Months Ago	Last 12 Months	Estimated Next 12 Months
Pleasure			
Business			
Student			
Private Aircraft			
Full-Time Copilot			
Scheduled Airline			
Charter Service			
*Military-active duty			
*Reserve/Natl. Guard			
Crop Dusting			
Instructing			
Other (specify)			
Total Hours Flown			

*Give branch of service and type of aircraft flown.

SPORTS OR HOBBIES

1. Auto or motorcycle racing:

- a. Type of auto racing? drag stockcar
 sportcar champion other _____
- b. Type of motorcycle racing? hill climbing
 scrambles champion other _____
- c. Type of course road dragstrip
 oval track other _____
- d. Number of races last 12 months? _____
- e. Maximum speed reached? _____ MPH.
- f. How long have you been participating? _____
- g. Do you hold a competition driver's license from any organization? Yes No

2. Rodeo competition:

- a. Type of events? _____
- b. How often? _____ last 12 mo. _____ next 12 mo.
- c. Participation is local only national

REMARKS: (Include complete details to any "yes" answers)

3. Underwater diving:

- a. Type of diving: skin scuba hardhat
 other _____
- b. Number of dives last 12 months? _____
Number anticipated next 12 months? _____
- c. Usual depth of dives? _____
Maximum depth? _____
- d. How long have you participated? _____
- e. Do you dive commercially or intend to do so? Yes No

4. Sky diving, parachuting, soaring, or hang gliding:

- a. Type of jumps made? _____
- b. Total number of jumps? _____
- c. How long have you been participating? _____
- d. Number of jumps last 12 months? _____
Number anticipated next 12 months? _____
- e. Are you a member of an association or club? Yes No

5. Other hazardous activities (Give Complete Details)

I declare that the above statements and answers are true and complete to the best of my knowledge and belief and agree that this form shall be a part of the application to The American Home Life Insurance Company.

_____ Date

_____ Witness

_____ Signature of Proposed Insured

ACCELERATED BENEFIT RIDER SUMMARY AND ACKNOWLEDGMENT

ABR may be added to any new American Home Life policy, at issue. There is no additional premium charge for the Rider. We are required to provide this Summary and Acknowledgment and obtain your signature, verifying your receipt and review.

BRIEF DESCRIPTION: This Rider enables the Owner to claim a portion of the policy's death benefit prior to the actual death of the Insured, when the Insured is diagnosed as having a "Terminal Illness". ABR is treated as an advance against the death benefit, reducing the policy's death benefit accordingly. Descriptions of major provisions and an illustration of the effect on policy values are shown below.

AVAILABILITY: May be added to any new American Home Life policy at issue, when requested in writing by the Insured or Owner.

PREMIUM: None. However, we will make an actuarial discount of the benefit at a rate not to exceed the current yield on 90 day treasury bills or the current maximum policy interest rate in effect on the date of the request, with a maximum of 10%. In addition, we will charge a one-time administration fee of \$150.

MINIMUM BENEFIT: \$5000

MAXIMUM BENEFIT: The lesser of \$200,000 or 50% of the face amount of the policy PLUS 50% of any term rider attached to the policy PLUS 50% of any paid-up life insurance purchased by dividends or premium. This amount is subject to the following adjustments: 1.) The actuarial discount. 2.) Repayment of a portion of any outstanding policy loan. 3.) Payment of any premiums due within the policy's grace period and unpaid at the time the Accelerated Benefit is approved for payment. 4.) One-time administration fee of \$150.

BENEFIT QUALIFICATION: To make a claim for the Accelerated Benefit, the Insured must be diagnosed as having a "Terminal Illness". That is, a noncorrectable condition which, with reasonable medical certainty, will cause the death of the Insured in 12 months or less. We reserve the right to obtain the opinion of a second physician.

BENEFITS AND ADJUSTMENTS:

The following sample illustration shows how the amount available for payment as an Accelerated Benefit is calculated:

Base Policy:	\$100,000	Cash Value:	\$15,000		
Paid Up Additions:	2,000	Cash Value:	+1,000		
Term Rider:	+40,000	Total:	\$16,000		
Eligible Death Benefit:	\$142,000	Policy Loan:	\$5,000		
Maximum (Gross) Accelerated Benefit:	\$71,000	(\$142,000 X .50 = \$71,000)			
Requested Accelerated Benefit:	\$71,000				
Benefit Ratio:	50%	(71,000 ÷ 142,000 = 50%)			
Adjustments:	Actuarial Discount	Loan Repayment	Premiums Due	Admin Fee	Total Adjustments
	\$71,000	\$5,000			
	x.05*	x.50			
	\$3,550	\$2,500	\$100	\$150	= \$6,300

*Discount rate is variable; 5% used as example only.

Maximum (Net) Accelerated Benefit: \$64,700 (\$71,000 – \$6,300 = \$64,700)

EFFECT ON POLICY VALUES: This shows how the benefits of the policy are altered after an Accelerated Benefit is paid:

Base Policy:	\$50,000	(100,000 x .50 = 50,000)
Paid-Up Additions:	1,000	(2,000 x .50 = 1,000)
Term Rider:	+20,000	(40,000 x .50 = 20,000)
Benefit at Death:	\$71,000	
Cash Value:	\$8,000	(16,000 x .50 = 8,000)
Policy Loan:	-2,500	(5,000 x .50 = 2,500)
Remaining Cash Value:	\$5,500	(8,000 – 2,500 = 5,500)
Premium Before Benefit:	\$1,200.00 per year	
Premium After Benefit:	\$600.00 per year	(1,200 x .50 = 600)

ACCELERATED BENEFITS AND TAXATION: The benefit paid under this Rider may or may not be taxable. Tax liability created by the payment of this benefit depends on how the IRS interprets applicable portions of the Tax Code. As with all tax questions, the Owner is advised to consult a personal tax advisor to assess the impact of this benefit.

ACCELERATED BENEFITS AND MEDICAID: Receipt of accelerated benefits may affect eligibility for public assistance programs such as medical assistance (Medicaid), Aid to Families with Dependent Children (AFDC), supplementary social security income (SSI) and drug assistance programs. Consult a qualified tax advisor and social service agencies concerning how receipt of accelerated benefits will affect eligibility for public assistance.

I hereby acknowledge receipt of the Summary and Acknowledgement form.

_____ Signature of Agent	_____ Date	_____ Signature of Proposed Insured (if different than Owner)	_____ Date
_____ Signature of Owner	_____ Date	_____ Signature of Second Insured (if different than Owner)	_____ Date