

SERFF Tracking Number: NDPL-125800827 State: Arkansas
Filing Company: Aviva Life and Annuity Company State Tracking Number: 40296
Company Tracking Number: 2PUUBA09
TOI: L08 Life - Other Sub-TOI: L08.000 Life - Other
Product Name: Life Protector Paid Up Rider - Fixed UL
Project Name/Number: Life Protector Paid Up Rider - Fixed UL/2PUUBA09

Filing at a Glance

Company: Aviva Life and Annuity Company

Product Name: Life Protector Paid Up Rider - Fixed UL SERFF Tr Num: NDPL-125800827 State: ArkansasLH

TOI: L08 Life - Other

SERFF Status: Closed

State Tr Num: 40296

Sub-TOI: L08.000 Life - Other

Co Tr Num: 2PUUBA09

State Status: Approved-Closed

Filing Type: Form

Co Status:

Reviewer(s): Linda Bird

Authors: Angela Vennall, Dana Kelly

Disposition Date: 09/29/2008

Date Submitted: 09/18/2008

Disposition Status: Approved

Implementation Date Requested: On Approval

Implementation Date:

State Filing Description:

General Information

Project Name: Life Protector Paid Up Rider - Fixed UL

Status of Filing in Domicile: Authorized

Project Number: 2PUUBA09

Date Approved in Domicile: 09/15/2008

Requested Filing Mode: Review & Approval

Domicile Status Comments: Approved in our state of domicile, Iowa, effective 9/15/2008.

Explanation for Combination/Other:

Market Type: Individual

Submission Type: New Submission

Group Market Size:

Overall Rate Impact:

Group Market Type:

Filing Status Changed: 09/29/2008

State Status Changed: 09/29/2008

Deemer Date:

Corresponding Filing Tracking Number:

Filing Description:

Enclosed, please find the Life Protector Paid Up Rider for your review and approval.

This rider will replace Form 2PUUAB05, approved by your Department on 11/15/04.

Form 2PUUBA09 will prevent the policy, to which it is attached, from entering the grace period as a result of the

SERFF Tracking Number: NDPL-125800827 State: Arkansas
Filing Company: Aviva Life and Annuity Company State Tracking Number: 40296
Company Tracking Number: 2PUUBA09
TOI: L08 Life - Other Sub-TOI: L08.000 Life - Other
Product Name: Life Protector Paid Up Rider - Fixed UL
Project Name/Number: Life Protector Paid Up Rider - Fixed UL/2PUUBA09

outstanding policy loan exceeding the account value less the surrender charge on any monthly due date subject to certain conditions as outlined in the rider. If the conditions are met, the policy will automatically become paid up coverage.

This rider may be added only at the policy owner's request either at issue or after issue. The issue ages for this rider are 0-85 years. This rider will be available with our fixed universal life products, starting with Form 2UAA09, approved by your Department on 09/02/2008 under SERFF Tracking Number: NDPL-125772539 and State Tracking Number: 40081.

This form is written in simplified and readable language and does not contain any unusual or possible controversial items from normal company or industry standards.

This product will not be marketed with an illustration.

A sample data page is enclosed to demonstrate how the benefit description will be shown. The benefit description will be shown the same way regardless of the base product it is issued with.

You may direct any questions or comments regarding this submission to me at (800) 457-3557, ext. 6749 or e-mail me at angela.vennall@avivausa.com.

Company and Contact

Filing Contact Information

Angela Vennall, Product Compliance Analyst angela.vennall@indianapolislife.com
9200 Keystone Crossing (317) 927-6749 [Phone]
Indianapolis, IN 46240 (317) 927-6510[FAX]

Filing Company Information

Aviva Life and Annuity Company CoCode: 61689 State of Domicile: Iowa
611 Fifth Avenue Group Code: 1225 Company Type:
Des Moines, IA 50309 Group Name: State ID Number:
(317) 927-6749 ext. [Phone] FEIN Number: 42-0175020

SERFF Tracking Number: NDPL-125800827 State: Arkansas
Filing Company: Aviva Life and Annuity Company State Tracking Number: 40296
Company Tracking Number: 2PUUBA09
TOI: L08 Life - Other Sub-TOI: L08.000 Life - Other
Product Name: Life Protector Paid Up Rider - Fixed UL
Project Name/Number: Life Protector Paid Up Rider - Fixed UL/2PUUBA09

Filing Fees

Fee Required? Yes
Fee Amount: \$20.00
Retaliatory? No
Fee Explanation: 1 Rider x \$20.00 = \$20.00
Per Company: No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Aviva Life and Annuity Company	\$20.00	09/18/2008	22581493

SERFF Tracking Number: NDPL-125800827 State: Arkansas
Filing Company: Aviva Life and Annuity Company State Tracking Number: 40296
Company Tracking Number: 2PUUBA09
TOI: L08 Life - Other Sub-TOI: L08.000 Life - Other
Product Name: Life Protector Paid Up Rider - Fixed UL
Project Name/Number: Life Protector Paid Up Rider - Fixed UL/2PUUBA09

Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved	Linda Bird	09/29/2008	09/29/2008

SERFF Tracking Number: NDPL-125800827 *State:* Arkansas
Filing Company: Aviva Life and Annuity Company *State Tracking Number:* 40296
Company Tracking Number: 2PUUBA09
TOI: L08 Life - Other *Sub-TOI:* L08.000 Life - Other
Product Name: Life Protector Paid Up Rider - Fixed UL
Project Name/Number: Life Protector Paid Up Rider - Fixed UL/2PUUBA09

Disposition

Disposition Date: 09/29/2008

Implementation Date:

Status: Approved

Comment:

Rate data does NOT apply to filing.

SERFF Tracking Number: NDPL-125800827 State: Arkansas
 Filing Company: Aviva Life and Annuity Company State Tracking Number: 40296
 Company Tracking Number: 2PUUBA09
 TOI: L08 Life - Other Sub-TOI: L08.000 Life - Other
 Product Name: Life Protector Paid Up Rider - Fixed UL
 Project Name/Number: Life Protector Paid Up Rider - Fixed UL/2PUUBA09

Item Type	Item Name	Item Status	Public Access
Supporting Document	Certification/Notice		Yes
Supporting Document	Application		Yes
Supporting Document	Actuarial Memorandum		No
Supporting Document	Sample Policy Data Page - LPU		Yes
Supporting Document	Explanation of Variables - 2PUUBA09		Yes
Form	Life Protector Paid Up Rider		Yes

SERFF Tracking Number: NDPL-125800827 State: Arkansas
 Filing Company: Aviva Life and Annuity Company State Tracking Number: 40296
 Company Tracking Number: 2PUUBA09
 TOI: L08 Life - Other Sub-TOI: L08.000 Life - Other
 Product Name: Life Protector Paid Up Rider - Fixed UL
 Project Name/Number: Life Protector Paid Up Rider - Fixed UL/2PUUBA09

Form Schedule

Lead Form Number: 2PUUBA09

Review Status	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
	Form 2PUUBA09	Policy/Cont	Life Protector Paid ract/Fratern Up Rider	Initial		53	2PUUBA09.PDF
		al	Certificate: Amendmen t, Insert Page, Endorseme nt or Rider				



Aviva Life and Annuity Company

(Home Office: 611 Fifth Avenue, Des Moines, Iowa 50309)
(Administrative Office: 611 Fifth Avenue, Des Moines, Iowa 50309)
(1-800-800-9882)

LIFE PROTECTOR PAID UP RIDER

Attached to and made a part of this policy

We agree to prevent your policy from entering the grace period due to the outstanding policy loan exceeding the Account Value less the surrender charge on any monthly due date, subject to the conditions outlined in this Rider. The benefit is subject to the provisions, terms and conditions of this Rider and the policy to which it is attached. This Rider is issued in consideration of the application received for this Rider.

BENEFIT

If, on any monthly due date before the Monthly Deduction is deducted from the Account Value, your Loan Percentage equals or exceeds the Minimum Loan Percentage shown on the Policy Data Page, your policy will automatically become paid up subject to the following conditions:

- a) the Insured's attained age must be equal to or greater than the Minimum Age shown on the Policy Data Page;
- b) the policy must have been in force for at least the Minimum Policy Duration shown on the Policy Data Page; and
- c) the outstanding policy loan is greater than the Face Amount.

The Loan Percentage on any monthly due date is equal to:

- a) the outstanding policy loan; divided by
- b) the Account Value less the Surrender Charge.

COST

When this Rider is exercised, there will be a One Time Charge deducted from the Account Value before calculating the paid up face amount. The One Time Charge will never be more than the Maximum One Time Charge Percentage shown on the Policy Data Page multiplied by the Account Value.

PAID UP POLICY

When this Rider is exercised, your policy coverage will be changed as follows:

- a) The Death Benefit Option will switch to Death Benefit Option 1 unless that option is already in effect. No future Death Benefit Option changes may be made.
- b) No additional policy loans may be made, however, loan interest will continue to accrue at the Loan Interest Rate shown on the Policy Data Page per annum in advance.
- c) No premium payments may be made.
- d) There are no monthly deductions.
- e) No withdrawals may be made.
- f) All other riders attached to your policy will terminate except for the Accelerated Benefit Rider.

The paid up face amount will be equal to:

- a) the Account Value at the time this Rider is exercised less the Surrender Charge less the One Time Charge; multiplied by
- b) the applicable Percentage of Account Value shown in the Table of Minimum Death Benefits on the Policy Data Page.

DEATH BENEFIT

The Death Benefit of the paid up coverage will be equal to the greater of:

- a) the paid up face amount; and
- b) the greater of the Account Value or the outstanding policy loan, multiplied by the applicable Percentage of Account Value shown in the Table of Minimum Death Benefits on the Policy Data Page.

TERMINATION

This Rider will terminate on the earliest of the following dates and events:

- a) when the policy terminates or matures; or
- b) the monthly due date following your written request to terminate this Rider.

REINSTATEMENT

If this Rider was in force at the time the policy lapsed, it may only be reinstated if the policy is reinstated. The requirements for reinstatement of this Rider are the same as those for reinstatement of the policy.

EFFECTIVE DATE

The effective date of this Rider will be the Policy Date, unless a later effective date is shown on the Policy Data Page or endorsement.



Michael H. Miller
Secretary

SERFF Tracking Number: NDPL-125800827 State: Arkansas
Filing Company: Aviva Life and Annuity Company State Tracking Number: 40296
Company Tracking Number: 2PUUBA09
TOI: L08 Life - Other Sub-TOI: L08.000 Life - Other
Product Name: Life Protector Paid Up Rider - Fixed UL
Project Name/Number: Life Protector Paid Up Rider - Fixed UL/2PUUBA09

Rate Information

Rate data does NOT apply to filing.

SERFF Tracking Number: NDPL-125800827 State: Arkansas
Filing Company: Aviva Life and Annuity Company State Tracking Number: 40296
Company Tracking Number: 2PUUBA09
TOI: L08 Life - Other Sub-TOI: L08.000 Life - Other
Product Name: Life Protector Paid Up Rider - Fixed UL
Project Name/Number: Life Protector Paid Up Rider - Fixed UL/2PUUBA09

Supporting Document Schedules

Review Status:

Satisfied -Name: Certification/Notice 09/03/2008

Comments:

Attached are: Guarantee Association Notice, Policyowner Notice, Readability Certification, Reg 19 Certification, and Reg 49 Certification.

Attachments:

AR1703.PDF
AR1705.PDF
AR RDCRT - Aviva.pdf
ARreg19_Aviva.pdf
ARreg49_ALAC.pdf

Review Status:

Satisfied -Name: Application 09/03/2008

Comments:

A copy of the Application used to apply for this rider is attached - Form 14530 2/07. It was approved by your Department on 8/28/06.

Attachment:

14530_2-07.pdf

Review Status:

Satisfied -Name: Sample Policy Data Page - LPU 09/09/2008

Comments:

Attachment:

LPU Sample Data Page - STD GLP.pdf

Review Status:

Satisfied -Name: Explanation of Variables - 2PUUBA09 09/18/2008

Comments:

Attachment:

Explanation of Variables - 2PUUBA09.pdf



AVIVA

Aviva Life and Annuity Company

Home Office: 611 Fifth Avenue, Des Moines, Iowa 50309

Administrative Office: 611 Fifth Avenue, Des Moines, Iowa 50309

1-800-800-9882

APPENDIX A

LIMITATIONS AND EXCLUSIONS UNDER THE ARKANSAS LIFE AND HEALTH INSURANCE GUARANTY ASSOCIATION ACT

Residents of this state who purchase life insurance, annuities or health and accident insurance should know that the insurance companies licensed in this state to write these types of insurance are members of the Arkansas Life and Health Insurance Guaranty Association ("Guaranty Association"). The purpose of this Guaranty Association is to assure that policy and contract owners will be protected, within certain limits, in the unlikely event that a member insurer becomes financially unable to meet its obligations. If this should happen, the Guaranty Association will assess its other member insurance companies for the money to pay the claims of policy owners who live in this state and, in some cases, to keep coverage in force. The valuable extra protection provided by the member insurers through the Guaranty Association is not unlimited, however. And, as noted in the box below, this protection is not a substitute for consumers' care in selecting insurance companies that are well managed and financially stable.

DISCLAIMER

The Arkansas Life and Health Insurance Guaranty Association ("Guaranty Association") may not provide coverage for this policy. If coverage is provided, it may be subject to substantial limitations or exclusions and require continued residency in this state. You should not rely on coverage by the Guaranty Association in purchasing an insurance policy or contract.

Coverage is NOT provided for your policy or contract or any portion of it that is not guaranteed by the insurer or for which you have assumed the risk, such as non-guaranteed amounts held in a separate account under a variable life or variable annuity contract.

Insurance companies or their agents are required by law to provide you with this notice. However, insurance companies and their agents are prohibited by law from using the existence of the Guaranty Association to induce you to purchase any kind of insurance policy.

The Arkansas Life and Health Insurance Guaranty Association
c/o The Liquidation Division
1023 West Capital
Little Rock, Arkansas 72201

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

The state law that provides for this safety-net is called the Arkansas Life and Health Insurance Guaranty Association Act ("Act"). Below is a brief summary of the Act's coverages, exclusions and limits. This summary does not cover all provisions of the Act; nor does it in any way change anyone's rights or obligations under the Act or the rights or obligations of the Guaranty Association.

COVERAGE

Generally, individuals will be protected by the Guaranty Association if they live in this state and hold a life, annuity or health insurance contract or policy, or if they are insured under a group insurance contract issued by a member insurer. The beneficiaries, payees or assignees of policy or contract owners are protected as well, even if they live in another state.

EXCLUSIONS FROM COVERAGE

However, persons owning such policies are NOT protected by the Guaranty Association if:

- They are eligible for protection under the laws of another state (this may occur when the insolvent insurer was incorporated in another state whose guaranty association protects insureds who live outside that state);
- The insurer was not authorized to do business in this state;
- Their policy or contract was issued by a nonprofit hospital or medical service organization, an HMO, a fraternal benefit society, a mandatory state pooling plan, a mutual assessment company or similar plan in which the policy or contract owner is subject to future assessments, or by an insurance exchange.

The Guaranty Association also does NOT provide coverage for:

- Any policy or contract or portion thereof which is not guaranteed by the insurer or for which the owner has assumed the risk, such as non-guaranteed amounts held in a separate account under a variable life or variable annuity contract;
- Any policy of reinsurance (unless an assumption certificate was issued);
- Interest rate yields that exceed an average rate;
- Dividends and voting rights and experience rating credits;
- Credits given in connection with the administration of a policy by a group contract holder;
- Employers' plans to the extent they are self-funded (that is, not insured by an insurance company, even if an insurance company administers them);
- Unallocated annuity contracts (which give rights to group contractholders, not individuals);
- Unallocated annuity contracts issued to/in connection with benefit plans protected under Federal Pension Benefit Corporation ("FPBC")(whether the FPBC is yet liable or not);
- Portions of an unallocated annuity contract not owned by a benefit plan or a government lottery (unless the owner is a resident) or issued to a collective investment trust or similar pooled fund offered by a bank or other financial institution);
- Portions of a policy or contract to the extent assessments required by law for the Guaranty Association are preempted by State or Federal law;
- Obligations that do not arise under the policy or contract, including claims based on marketing materials or side letters, riders, or other documents which do not meet filing requirements, or claims for policy misrepresentations, or extra-contractual or penalty claims;
- Contractual agreements establishing the member insurer's obligations to provide book value accounting guarantees for defined contribution benefit plan participants (by reference to a portfolio of assets owned by a nonaffiliate benefit plan or its trustees).

LIMITS ON AMOUNT OF COVERAGE

The Act also limits the amount the Guaranty Association is obligated to cover: The Guaranty Association cannot pay more than what the insurance company would owe under a policy or contract. Also, for any one insured life, the Guaranty Association will pay a maximum of \$300,000 - no matter how many policies and contracts there were with the same company, even if they provided different types of coverages. Within this overall \$300,000 limit, the Association will not pay more than \$300,000 in health insurance benefits, \$300,000 in present value of annuity benefits, or \$300,000 in life insurance death benefits or net cash surrender values - again, no matter how many policies and contracts there were with the same company, and no matter how many different types of coverages. There is a \$1,000,000 limit with respect to any contract holder for unallocated annuity benefits, irrespective of the number of contracts held by the contract holder. These are limitations for which the Guaranty Association is obligated before taking into account either its subrogation and assignment rights or the extent to which those benefits could be provided out of the assets of the impaired or insolvent insurer.



AVIVA

Aviva Life and Annuity Company

Home Office: 611 Fifth Avenue, Des Moines, Iowa 50309
Administrative Office: 611 Fifth Avenue, Des Moines, Iowa 50309
1-800-800-9882

TO: Aviva Life Policyowner

FROM: Aviva Life and Annuity Company

Bulletin number 6-87, Act 197 of 1987 from the Arkansas Department of Insurance requires effective January 1, 1988 that we provide you with information on our Company, our Agent servicing your policy and on the Arkansas Department of Insurance. Listed below are the names and addresses in the event you would like to contact one of us for more information on your policy.

Aviva Life and Annuity Company
611 5th Avenue
Des Moines, IA 50309

Telephone: 1-800-800-9882

Agent Name: XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
Agent Address: XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
XX
XX
Agent Telephone: XXXXXXXXXXXXXXX

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

Telephone: 1-800-852-5494

AR

ARKANSAS READABILITY CERTIFICATION

This is to certify that the attached, Form 2PUUBA09 – Life Protector Paid Up Rider, has achieved a Flesch Reading Ease Score of 52.9 and complies with the requirements of Arkansas Statute Ann. 66-3251 through 66-3258, cited as the Life and Disability Insurance Policy Language Simplification Act.

Aviva Life and Annuity Company



Chris Guttin
ASA / Vice President-Product Operations

September 18, 2008
Date

RD/CRT/AR

**Arkansas Certification
Regulation 19**

I certify that this submission meets the provisions of Regulation 19, Section 10B, as well as all applicable statutes, regulations, and bulletins of the State of Arkansas.

Aviva Life and Annuity Company



**Chris Guttin, ASA
Vice-President-Product Operations**

09/18/2008

Date

Form Numbers

2PUUBA09 – Life Protector Paid Up Rider

Regulation 19

**Arkansas Certification
Regulation 49**

We have reviewed Regulation 49 against the issue procedures of the Company and certify that we are in compliance with the requirements of Regulation 49.

Aviva Life and Annuity Company



**Chris Guttin, ASA
Vice-President-Product Operations**

09/18/2008

Date

Form Numbers

Form 2PUUBA09 – Life Protector Paid Up Rider

Regulation 49

Aviva Life and Annuity Company
Home Office: Des Moines, IA
Mailing Address:
P.O. Box 1555
Des Moines, IA 50306-1555
Fax: 1-800/531-0038

Indianapolis Life Insurance Company
Home Office: Indianapolis, IN
Mailing Address:
P. O. Box 14590
Des Moines, IA 50306-3590
Fax: 1-888/329-1329



Application for Insurance

Please check appropriate company. **ONE BOX MUST BE CHECKED.**
(In this application, "Company" refers to the insurance company whose name is checked above.)

APPLICANT INFORMATION

1. PROPOSED INSURED

Name (First, Middle, Last) _____ Is Insured also the Owner? Yes No

Address _____ E-Mail: _____

City _____ Home Ph. (____) _____ Bus. Ph. (____) _____

State _____ Zip _____ Gender M F Maiden Name _____

Birth Date _____ Birth State _____ Social Security Number _____

Marital Status Married Single Divorced or Separated Widow or Widower U.S. Citizen? Yes No Permanent Resident? Yes No

Driver's License # _____ State _____ Issue Date _____ Expiry Date _____

Or, if you do not have a driver's license, other government issued photo ID: Document Type _____

Document # _____ Where Issued _____ Issue Date _____ Expiry Date _____

Employer _____ How Long? _____ Occupation/Duties _____

Annual earned income \$ _____ Annual unearned income \$ _____ Net worth \$ _____

If multiple life product, (2nd app required for multiple life)

Joint Insured Names: (1st): _____ (2nd): _____

2. OWNER (If different from Proposed Insured) Individual Business Trust (date of trust) _____

Name (Owner, Business or Trustee) _____ Birth Date _____

If trust, name of trust _____

Address _____ City _____ State _____ Zip _____

Relationship to Proposed Insured _____ Social Security # or Taxpayer ID # _____

Owner's or Trustee's personal driver's license # or other government issued photo ID document, or corporate license:

Document Type _____ Document # _____ Where Issued _____ Issue Date _____ Expiry Date _____

Contingent Owner (If none specified, policy provisions will apply.) _____

Driver's License # or other government issued photo ID document:

Document Type _____ Document # _____ Where Issued _____ Issue Date _____ Expiry Date _____

Mail notices to Insured Owner Other (specify) _____

Other Notice Address _____ City _____ State _____ Zip _____

Tax Qualification Type

Qualified Plan:

Type: Profit Sharing Plan

401(k)

412(i)

Other Defined Benefit

Non-Qualified Plan:

Type: Welfare Benefit Plan:

single employer

multiple employer

VEBA

Deferred Comp

Split Dollar

Executive Bonus

Other _____

Neither

3. PRIMARY BENEFICIARY(IES) - Applies to primary insured only. (If trust, complete name and date of trust.)

(If necessary, use an additional page for additional details, signature of owner & date.)

Print Full Name _____ Birth Date _____ Relationship _____ Percentage _____ Social Security # or Taxpayer ID # _____

4. CONTINGENT BENEFICIARY(IES)

Print Full Name _____ Birth Date _____ Relationship _____ Percentage _____ Social Security # or Taxpayer ID # _____



POLICY INFORMATION

5. **PRIMARY INSURED** Nonsmoker/Nontobacco Smoker/Tobacco
 Base Plan _____ Amt. of Ins. \$ _____
 Additional Coverage _____ Amt. of Ins. \$ _____ Premium \$ _____
 Additional Coverage _____ Amt. of Ins. \$ _____ Premium \$ _____
Riders (Complete Supplemental Application if applicable)
 Waiver Type _____ Other Riders (Type/Amount): _____
 Spouse Rider \$ _____ Child Rider \$ _____
6. **UL Death Benefit Option:** Level Increasing Death Benefit Return of Premium Rider
 Premium Direction/Interest Crediting Strategy: 1 Year Point-to-Point _____% 2 Year Point-to-Point _____% 1 Year Monthly Average _____%
 1 Year Monthly Cap _____% 1 Year Average Multiple Index _____% 5 Year Fixed Term _____% 1 Year Fixed Term _____% _____%
 Levelized Strategy Transfer Yes No
7. **WHOLE LIFE** APL (If applicable) Yes No Direct Recognition (if available) Yes No

PREMIUM INFORMATION

8. **PREMIUM** Planned Premium \$ _____ Additional Premium (Lump Sum) \$ _____
 Billing Frequency Annual Semi-Annual Quarterly PAC (Complete Authorization) Other _____
 Govt. Allotment (if available) Group Bill Group Bill # _____
 Has the premium for the policy applied for been given to the agent? Yes No Amount \$ _____
 How Paid? Check Other (specify) _____

Additional Policy Specifications

Policy Date (optional) _____ Other _____

9. **Are you financing or refinancing a mortgage and/or a home equity loan or contemplating the use of any kind of mortgage financing strategy in connection with the purchase of or the payment of premiums on the life insurance policy?** Yes No
 (If yes, please review and acknowledge by signing the Mortgage Financing Disclosure Statement.)
10. **Will you borrow money to pay the premiums for this policy or have someone else pay these premiums for you, in return for you assigning part of or all of the policy values to someone else?** Yes No (If yes, please review and acknowledge by signing the Premium Financing Applicant Acknowledgement and Disclosure Statement.)

NON-MEDICAL INFORMATION

11. **INSURANCE IN FORCE ON PROPOSED INSURED**
 a. Are any life insurance or annuity contracts in force? Yes No
 If yes, complete section below. (Attach separate sheet if necessary)

Company	Amount	WP ?	Personal/Business	Year Issued	Replacing ?	Amount ADB

- b. Will any annuity or life insurance presently or recently inforce be replaced or changed by this policy applied for? Yes No
 c. Have you ever been declined, rated, or had coverage modified or withdrawn, or reinstatement declined by any insurance company? Yes No
 d. Within the last year, has any other life, health or long term care insurance been issued or applied for, or is any to be applied for? ... Yes No

12. OTHER NON-MEDICAL INFORMATION

- a. Do you use any form of tobacco or nicotine based products? Yes No
 If no, have you used any form of tobacco or nicotine based products in the last 5 years? Yes No
 If yes, when did you last use tobacco or nicotine based products? _____ Type _____ Quantity _____
- b. Have you engaged in the last 3 years, or do you intend within the next 12 months to engage:
 1. In any aviation activity other than as a passenger? Yes No
 2. In ballooning, gliding, boat or vehicle racing, mountain or rock climbing, parachuting, sky diving, underwater diving or any other hazardous sport or activity? Yes No
- c. Within the last 5 years, have you filed for bankruptcy (personal or business)? Yes No
 d. Within the last 5 years, have you been charged with reckless driving, driving under the influence of alcohol or drugs, or 2 or more moving violations, or had your driver's license revoked or suspended, or received a warning letter? Yes No
 e. Have you been arrested for an illegal activity, acquired a criminal record, or are you currently on probation, parole, or under investigation? . Yes No
 f. Are you a member of or do you contemplate joining one of the Armed Forces or an active or reserve military unit? Yes No
 g. Have you in the past 2 years traveled or do you intend to travel or live outside the United States or Canada? Yes No
 h. Is any proposed insured, owner or beneficiary a resident or citizen of or an entity organized under the laws of a country other than the U.S.? Yes No
 i. Do you intend to sell or transfer all or any portion of this policy to another person, any group of investors or other entity? Yes No



Give complete details of any **YES** answers to questions 11 and 12. (If necessary, use an additional page for additional details, **signed by the applicant and dated.**) _____

13. PHYSICIAN INFORMATION

- a. Name, address and phone # of your doctor(s) or health care provider(s): _____
- b. When did you last consult a doctor and why? _____
- c. What medication(s) (prescribed or over the counter) are you now taking? (If none, so state) _____

MEDICAL INFORMATION If medical exam is required, questions 14-17 do not need to be completed.

14. PROPOSED INSURED

- a. Height in shoes _____ feet _____ inches Weight in clothes _____ pounds
- b. Have you gained or lost more than 10 pounds in the last year? Yes No
- c. Are you now under observation or treatment? Yes No
- d. Have you ever been diagnosed by a medical professional as having or been treated for AIDS or ARC (AIDS-related complex)? Yes No
- e. Have you ever tested positive for antibodies to the AIDS Human T-Cell Lymphotropic (HIV) virus? Yes No
- f. Have you ever requested or received a benefit, military deferment, discharge or rejection, payment or pension because of a disability, injury, or sickness? Yes No

15. HAVE YOU EVER HAD OR HAVE SYMPTOMS OF OR BEEN TREATED FOR:

- a. Disease of the heart or circulatory system, including high blood pressure, heart attack, coronary artery disease, or chest pain? Yes No
- b. Heart murmur, rhythm abnormality, heart catheterization, echocardiogram or an exercise treadmill test? Yes No
- c. Cancer, tumors, lymphoma, leukemia, or any growths, lesions, polyps? Yes No
- d. Diabetes, thyroid, glandular or endocrinal disorder? Yes No
- e. Respiratory disorders including asthma, chronic bronchitis, emphysema, pneumonia, shortness of breath, or abnormal chest x-ray? Yes No
- f. Disorder of the stomach, liver, pancreas or intestinal tract, including ulcerative colitis, Crohn's disease, or cirrhosis? Yes No
- g. Disorder of the kidneys, prostate, bladder, reproductive organs, sexually transmitted diseases, sugar, albumin or blood in urine? Yes No
- h. Stroke, transient ischemic attack (TIA), Parkinson's, multiple sclerosis, seizures, epilepsy, chronic headaches, memory changes or fainting? Yes No
- i. Anxiety, depression, attempted suicide, attention deficit disorder or psychosis, mental or nervous system disorder? Yes No
- j. Anemia, hepatitis, or any blood disorder? Yes No
- k. Chronic back pain, arthritis, loss of limb, paralysis, muscle weakness or disease? Yes No

16. WITHIN THE LAST FIVE YEARS, OTHER THAN AS NOTED ABOVE, HAVE YOU:

- a. Seen a doctor, health care provider, counselor, therapist, or had any illness, injury, surgery, diagnostic test or treatment, or been advised to have any diagnostic test, surgery or treatment not yet completed? Yes No
- b. Been a patient of a clinic or hospital emergency room, or had any diagnostic test that was not normal? Yes No
- c. Used any drug, narcotic or controlled substance not prescribed by a physician, or been arrested, counseled, treated, or participated in a support group because of alcohol, controlled substance or drug use? Yes No
- d. Do you currently use alcoholic beverages? Yes No
If yes, what is the average number of drinks per day? 2 or less 3-5 6 or more.

17. FAMILY HISTORY

- a. Is there a family history of diabetes, cancer, heart disease, mental illness, or any hereditary disorders? Yes No
- b. Family information (natural parents, brothers, sisters):

Family Member	Age if Living	Age at Death	Cause of Death
Father			
Brother(s)			

Family Member	Age if Living	Age at Death	Cause of Death
Mother			
Sister(s)			

Give complete details of any **YES** answers to questions 14 through 17. (If necessary, use an additional page for additional details, **signed by the applicant & dated.**)

Question Number	Date	Details, Include Diagnosis, Treatment, Duration, Result	Name, Address and Phone Number of Doctor / Medical Facility

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 may be guilty of a crime and subject to fines and confinement in prison, depending on state law.



TAXPAYER IDENTIFICATION

Instructions (Section references are to the Internal Revenue Code.)

Use this form to report the taxpayer identification number (TIN) of the **policy owner**.

Payors must generally withhold a specified percentage of taxable interest, dividend, and certain other payments if you fail to furnish payors with the correct taxpayer identification number (this is referred to as backup withholding). For most individual taxpayers, the taxpayer identification number is the social security number.

To prevent backup withholding on these payments, be sure to notify payors of the correct taxpayer identification number and properly certify that you are not subject to backup withholding under Section 3406(a)(1)(C).

Use this area to certify that the taxpayer identification number you are giving the payor is correct and that you are not subject to backup withholding.

Backup Withholding - You are subject to backup withholding if:

- (1) You fail to furnish your taxpayer identification number to the payor; OR
- (2) The Internal Revenue Service (IRS) notifies the payor that you furnished an incorrect taxpayer identification number; OR
- (3) You are notified that you are subject to backup withholding [under Section 3406(a)(1)(C)]; OR
- (4) For an interest or dividend account opened after December 31, 1983, you fail to certify to the payor that you are not subject to backup withholding under (3) above, or fail to certify your taxpayer identification number.

Payees Exempt From Backup Withholding - Certain payees, such as corporations, government agencies, etc. may be exempt from backup withholding.

What Number to Give the Payor - Give the social security number or employer identification number of the record owner of the account. If the account belongs to you as an individual, give your social security number. If the account is owned by a corporation, give the employer identification number of the corporation.

Obtaining a Number - If you don't have a taxpayer identification number or you don't know your number, obtain **Form SS-5**, Application for a Social Security Number Card, or **Form SS-4**, Application for Employer Identification Number, at the local office of the Social Security Administration or the Internal Revenue Service and apply for a number. Write "applied for" in place of your number. When you get a number, submit a new Form W-9 to the payor.

AGREEMENTS AND REPRESENTATIONS

It is hereby represented that the answers and statements on the application(s) and any Supplements required are complete, true and correctly recorded. Information not recorded on the application(s) and any Supplements will not be treated as known to the Company. A copy of the application(s) and any Supplements shall be a part of the policy, and it is agreed that the policy and copy of the application(s) and any Supplements constitute the entire contract. No changes will be made unless the owner agrees and the change is authorized in writing by an officer of the Company.

If a Conditional Life Insurance Agreement was delivered in consideration of the payment of the first premium and is in effect, its terms will apply. Otherwise the policy will take effect and coverage will begin on the issue date specified in the policy if the full first premium is paid, the Proposed Insured(s) is (are) living, and the answers and statements in the application(s) and any Supplements continue to be complete and true at the time of delivery of the policy.

Under penalties of perjury, I certify that (1) the social security or federal tax identification number shown on page 1 of this application for me as the owner of this policy is my correct taxpayer identification number, AND (2) I am a U.S. person (including a U.S. resident alien), AND (3) I am not subject to backup withholding because (a) I am exempt from backup withholding, or (b) I have not been notified by the IRS that I am subject to backup withholding as a result of failure to report all interest or dividends, or (c) the IRS has notified me that I am no longer subject to backup withholding. NOTE: You must cross out item 3 in the above certification if you have been notified by the IRS that you are currently subject to backup withholding. The IRS does not require your consent to any provision of this document other than the certifications required to avoid backup withholding.

IMPORTANT INFORMATION ABOUT THE USA PATRIOT ACT

To help fight the funding of terrorism and money-laundering activities, the U.S. government has passed the USA PATRIOT Act, which requires financial institutions to obtain, verify and record information that identifies persons who engage in certain transactions with or through a financial institution, including insurance companies. This means that the Company will need to verify the **name, residential or street address (no P.O. Boxes), date of birth and social security number, drivers license and/or other identification information of all policy owners as may be required by law.**



AUTHORIZATION AND ACKNOWLEDGMENT

This authorization complies with the HIPAA Privacy Rule. I understand that if I refuse to sign this authorization, the Company may not be able to process my application for life insurance. I acknowledge that I have the right to request and receive a copy of this authorization.

Personal Health Information

I authorize any physician, health care professional, hospital, clinic, laboratory, pharmacy, medical facility, health care provider, health plan, insurer, and/or any other entity subject to the Health Insurance Portability and Accountability Act of 1996 (HIPAA) that has provided treatment, service, payment, or coverage to me within the past 10 years to disclose my entire medical record and any other protected health information concerning me to the Company, its agents, employees, representatives, insurance support organizations, and reinsurers ("the Company"). Protected health information includes but is not limited to: hospital records, treatment records/office notes, consultation reports, workers' compensation information, diagnosis, prescriptions, and test results. It also includes information concerning the diagnosis or treatment of Human Immunodeficiency Virus (HIV) infection and sexually transmitted diseases, and information on the diagnosis and treatment of mental illness and the use of alcohol, drugs, and tobacco, but excludes psychotherapy notes.

By my signature, I acknowledge that any agreements I have made to restrict my protected health information do not apply to this authorization and I instruct any physician, health care professional, hospital, clinic, laboratory, pharmacy, medical facility, health care provider, health plan, insurer, and/or other entity subject to HIPAA to release and disclose such information without restriction.

I understand that, unless prohibited by state and/or federal law, the protected health information is to be disclosed under this authorization so that the Company may: 1) underwrite my application for coverage, make eligibility, risk rating, policy issuance and enrollment determinations; 2) obtain reinsurance; 3) administer claims and determine or fulfill responsibility for coverage and provision of benefits; 4) administer coverage; and 5) conduct other legally permissible activities that relate to any coverage I have, have applied for, or may in the future apply for with the Company. I understand any information disclosed under this authorization may no longer be covered by federal rules governing privacy and confidentiality of health information and may be subject to re-disclosure.

Personal Private Information

I understand that an investigative consumer report may be prepared in connection with this application. I authorize any consumer reporting organization or employer having non-medical information about me to release such information to the Company, its reinsurers, or its authorized representatives. I authorize the Company to prepare an investigative consumer report. I understand that I may request to be personally interviewed if an investigative consumer report is prepared in connection with this application and not to have personal information disclosed for marketing purposes. Any information obtained will not be released by the Company, its reinsurers, or representatives to any person or organization except to reinsuring companies, the Medical Information Bureau, or other persons or organizations performing business or legal services in connection with my application, claim, as may be permitted or required by law, or as I may further authorize.

Limitations, Revocation and Rights

This authorization shall remain in force for 24 months following the date of my signature below, and a copy of this authorization is as valid as the original. I understand that I have the right to revoke this authorization at any time. The request for revocation must be in writing and sent to the attention of the Underwriting Department of the Company. I understand that a revocation is not effective to the extent that the Company has already relied on this authorization or to the extent that the Company has a legal right to contest a claim under an insurance policy or to contest the policy itself. Such revocation shall not apply to any use or disclosure of my protected health information specifically allowed without authorization by HIPAA and no action relating to this authorization shall be construed as creating any restriction on the uses that HIPAA allows without my authorization.

SIGNATURES

I have reviewed and understand the information contained above in the "Taxpayer Identification", "Agreements and Representations", including reviewing the answers and statements on the application(s) and any Supplements for accuracy, "Important Information About the USA Patriot Act", and "Authorization and Acknowledgment" sections, and further acknowledge receipt of the Disclosure Notice to Proposed Insured.

I understand, acknowledge and agree that the Agent has no authority to make any promise, representation or waiver regarding coverage or the terms of the policy. I also understand, acknowledge and agree that the Agent has no authority to provide any legal or tax advice on behalf of the Company. If any such legal or tax advice has been given, I understand, acknowledge and agree it has been done without Company authority and has not been given on behalf of the Company. I understand, acknowledge and agree that I am responsible for obtaining independent legal or tax advice with respect to any such matters. I understand, acknowledge and agree that all premium payments after the first are to be provided directly to the Company and that the Agent has no authority to receive, transmit, sign, endorse, deposit or process any subsequent payments made on the policy.

Signed / Dated at _____
City, State

X _____
Signature of Owner/Proposed Insured
(or signature of Insured's Personal Representative*)

On _____
Date

X _____
Signature of Owner if other than Proposed Insured

X _____
Signature of Licensed Agent

Parent/Guardian or Witness (if required)

If Owner is a corporation, business firm or trust, give full name and
an Authorized person must sign and provide title

*If you are the Proposed Insured's Personal Representative, describe the scope and/or basis of your authority to act on the Proposed Insured's behalf:



POLICY DATA PAGE

POLICY NUMBER: [AVIVA]
INSURED: [JOHN DOE]
POLICY DATE: [August 1, 2008]

FACE AMOUNT: [\$100,000]

INITIAL PREMIUM: [\$952.00]
PLANNED PREMIUM: [\$952.00 Annually]

DEATH BENEFIT COMPLIANCE TEST:
[Guideline Premium Test]

Computed from the Policy Date
DEATH BENEFIT OPTION: [Option 1] [Option 2]

<u>BENEFIT</u>	<u>FACE AMOUNT</u> <u>AT ISSUE</u>	<u>EXPIRY</u> <u>DATE</u>
INSURED: [JOHN DOE] RATE CLASS [Non-tobacco] ISSUE AGE: [35] SEX: [M] PLAN: Flexible Premium Adjustable Life Insurance	[\$100,000]	Death of Insured

PLEASE SEE NEXT PAGE FOR ADDITIONAL BENEFITS

The Minimum Monthly Premium of [\$42.50] is for a Minimum Premium Period of [20] years from the Policy Date.

Note: It is possible that coverage will end before the death of the Insured if either no premiums are paid after the Initial Premium or if subsequent premiums are insufficient to continue coverage for the lifetime of the Insured.

Following the Insured's attained age 100, this policy may or may not qualify as life insurance under the Internal Revenue Code. You should consult your tax advisor.

This policy, including any riders, was issued based on the answers to the questions on the application. A copy of the application is included in this policy. If the answers are incorrect, we may deny benefits or rescind this policy. The best time to clear up any question is now, before a claim arises. If, for any reason, any of the answers are incorrect, contact us at our Home Office.

[The following will print on qualified cases only:

Non-transferable - Notwithstanding any provision to the contrary, this policy may not be sold, assigned, discounted or pledged as collateral for a loan or as security for the performance of an obligation or for any other purpose to any person other than this Company, except that this non-transferable provision shall not preclude the transfer of this policy to the Insured where such transfer represents an interest to which he is entitled pursuant to the provision of any plan or trust agreement under which this policy is purchased.

The Automatic Premium Loan provision, if contained in this policy, shall not be available. If this policy is issued under a 412i plan, the Loan Provisions shall not be available.]

POLICY DATA PAGE (continued)

POLICY NUMBER: [AVIVA]
INSURED: [JOHN DOE]

<u>BENEFIT</u>	<u>FACE AMOUNT AT ISSUE</u>	<u>EXPIRY DATE</u>
Accelerated Benefit Rider	N/A	Death of Insured
Life Protector Paid Up Rider	N/A	Death of Insured
Minimum Loan Percentage:	[95.50%]	
Minimum Age:	[75]	
Minimum Policy Duration:	[15 years]	
Maximum One Time Charge Percentage	[4.00%]	

FORM 2PUUBA09

Explanation of Variability:

Life Protector Paid Up Rider – This benefit description will appear on the policy data page only when the LPU Rider is chosen by the Owner either at issue or after issue. Different ‘triggers’ apply based on whether the policy is issued using the Guideline Premium Test or Cash Value Accumulation Test. The triggers are as follows:

Minimum Loan Percentage – A condition that must be met before the Life Protector Paid Up Rider benefit is invoked. It is the lowest indebtedness that will involve the benefit. The percentage is not changed once a rider is issued. Future riders may have larger or smaller percentages that differ from in force riders. **Range is 75% to 95.5%.**

Minimum Age – A condition that must be met before the Life Protector Paid Up Rider benefit is invoked. It is the youngest age that will involve the benefit. The age is not changed once a rider is issued. Future riders may have younger or older ages that differ from in force riders. **Range is from 65 years to 85 years.**

Minimum Policy Duration – A condition that must be met before the Life Protector Paid Up Rider benefit is invoked. It is the earliest duration that will involve the benefit. The duration is not changed once a rider is issued. Future riders may have earlier or later durations that differ from in force riders. **Range is from 5 years to 20 years.**

Maximum One Time Charge Percentage – The cost of the Life Protector Paid Up Rider. The percentage is applied to the Account Value at the time the rider benefit is invoked. The charge is not changed once a rider is issued. Future riders may have lower or higher charges that differ from in force riders. **Range is from 0.1% to 24.9%.**