

SERFF Tracking Number: AEGB-125981307 State: Arkansas
Filing Company: Western Reserve Life Assurance Co. of Ohio State Tracking Number: 41303
Company Tracking Number: U000316 CGI REV
TOI: L06I Individual Life - Variable Sub-TOI: L06I.002 Single Life - Flexible Premium
Product Name: U000316 CGI REV
Project Name/Number: Individual Life Insurance Application/U000316 CGI REV

Filing at a Glance

Company: Western Reserve Life Assurance Co. of Ohio

Product Name: U000316 CGI REV SERFF Tr Num: AEGB-125981307 State: ArkansasLH
TOI: L06I Individual Life - Variable SERFF Status: Closed State Tr Num: 41303
Sub-TOI: L06I.002 Single Life - Flexible Co Tr Num: U000316 CGI REV State Status: Approved-Closed
Premium
Filing Type: Form Co Status: Reviewer(s): Linda Bird
Author: Mara Carberry Disposition Date: 01/13/2009
Date Submitted: 01/09/2009 Disposition Status: Approved
Implementation Date Requested: On Approval Implementation Date:

State Filing Description:

General Information

Project Name: Individual Life Insurance Application Status of Filing in Domicile: Pending
Project Number: U000316 CGI REV Date Approved in Domicile:
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: 01/13/2009
State Status Changed: 01/13/2009 Deemer Date:
Corresponding Filing Tracking Number: U000316 CGI REV
Filing Description:
Form Number: U000316 CGI REV - Individual Life Applications (Replaces U000316 CGI)

Your department recently approved applications U000315 CSI, U000316 CGI, U000317 on August 6, 2008, SERFF Tracking Number AEGB-125735080. We have discovered an error with application U000316 CGI. The heading on page 2, section 10 is titled "GUARANTEED ISSUE QUESTIONS FOR PROPOSED INSURED". We intend to change the title in section 10 to "QUESTIONS FOR PROPOSED INSURED".

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We are attaching a sample of the revised application form for your records. This application form will replace the form that was provided in the initial filing. We certify that there have been no other changes made to the application form other than those listed above and a revised form number.

This application is intended for use with our variable life portfolio.

Company and Contact

Filing Contact Information

Mara Carberry, Policy Analyst mcarberry@aegonusa.com
 4333 Edgewood Rd. NE (319) 355-3497 [Phone]
 Cedar Rapids, IA 52499 (319) 355-2501[FAX]

Filing Company Information

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

Filing Fees

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

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Western Reserve Life Assurance Co. of Ohio	\$20.00	01/09/2009	24923048

SERFF Tracking Number: AEGB-125981307 State: Arkansas
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Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved	Linda Bird	01/13/2009	01/13/2009

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Disposition

Disposition Date: 01/13/2009

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		No
Supporting Document	Application		No
Supporting Document	Life & Annuity - Acturial Memo		No
Supporting Document	Cover Letter		Yes
Supporting Document	Flesch Score		Yes
Form	Individual Life Insurance Application		Yes

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Form Schedule

Lead Form Number: U000316 CGI REV

Review Status	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
	U000316 CGI REV	Application/ Individual Life Enrollment Form	Insurance Application	Initial		51	U000316 CGI STD REV.pdf

[WRL Xcelerator Exec]

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

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

SECTION 1. PROPOSED INSURED					Specified Amount \$ _____	
1. Last Name			First Name		M.I.	
2. Address (Cannot be a P.O. Box)			Apt#	City		
State	Zip Code	3. Years at Address	4. Home Phone ()		5. Driver License Number	State
6. Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	7. Date of Birth MM-DD-YYYY	8. Insurable Age	9. Place of Birth – State/Country		10. Social Security Number	
11. Height (ft. in.)	12. Weight (lbs)	13. Marital Status	14. Employer		Hire Date	Years
15. Employer's Address					16. Salary	
17. Occupation & Duties					18. Business Phone Number ()	
19. Rate Class Quoted: <input type="checkbox"/> Non-Tobacco <input type="checkbox"/> Tobacco						
SECTION 2. APPLICANT/OWNER Proposed Insured will be Owner unless specified otherwise - If ownership is corporation, partnership or institutional body, please complete the Entity Certification of Authority form. If ownership is a trust, please complete the Trustee Certification Trust form. Attach a copy of the first page and the signature page of the Trust.						
1. Name			2. Relationship		3. Date of Birth MM-DD-YYYY	
4. <input type="checkbox"/> Individual <input type="checkbox"/> Corporation <input type="checkbox"/> Partnership <input type="checkbox"/> Trustee & Date of Trust						
5. Social Security Number, Tax or Employer ID				6. Telephone Number ()		
7. Address (Cannot be a P.O. Box)			City		State	Zip Code
8. Billing Address (if other than above)			City		State	Zip Code
9. Are you a citizen of <input type="checkbox"/> USA <input type="checkbox"/> Other Country _____ Type of VISA _____						
SECTION 3. PRIMARY BENEFICIARY – If percentage shares are not listed below, they will be divided equally among the beneficiaries. If ownership or beneficiary is a corporation, partnership or institutional body, please complete the Entity Certification of Authority form. If ownership or beneficiary is a trust, please complete the Trustee Certification Trust form. Attach a copy of the first page and the signature page of the Trust.						
Name		Percent	Relationship		Social Security Number/Tax ID#	
Total		1 0 0				
SECTION 4. CONTINGENT BENEFICIARY – If percentage shares are not listed below, they will be divide equally among the beneficiaries.						
Name		Percent	Relationship		Social Security Number/Tax ID#	
Total		1 0 0				
SECTION 5. DEATH BENEFIT OPTION						
<input type="checkbox"/> A) Level Benefit <input type="checkbox"/> B) Increasing Benefit						

SECTION 6. LIFE INSURANCE COMPLIANCE TEST (Only Choose One)

Cash Value Accumulation Test (CVAT) Guideline Premium Test

SECTION 7. PREMIUMS PAYABLE

Initial Planned Premium \$ _____ Electronic (bank draft) _____ Draft Date (1st through 28th)
 Direct Bill Single Premium Annually Semiannually Quarterly Monthly Other _____

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

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

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

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

Secondary Addressee

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

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

SECTION 8. PREMIUM ALLOCATION OPTIONS

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

SECTION 9. OTHER INSURANCE IN FORCE FOR THE PROPOSED INSURED

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

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

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

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

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

IS THIS INTENDED TO BE A 1035 EXCHANGE? Yes No

Anticipated Cash Value Transfer \$ _____

SECTION 10. QUESTIONS FOR PROPOSED INSURED

A) Have you used Tobacco or any other product containing nicotine in the last 5 years? Yes No
Date last used: _____

B) Are you actively at work performing the regular duties of your job in the usual manner and at the usual place of employment or business for at least 30 hours per week? Yes No

C) Within the last 12 months have you been hospitalized or treated on an outpatient basis at any time? Yes No

D) During the last 6 months have you missed 5 or more working days due to illness or medical condition? Yes No

E) Within the last 10 years, has the proposed Insured been told by a member of the medical profession that he or she had a diagnosis of AIDS (Acquired Immune Deficiency Syndrome), ARC (AIDS Related Complex), or the HIV (Human Immunodeficiency Virus) infection? Yes No

SECTION 11. DETAILS TO "YES" ANSWERS ABOVE IN SECTION 10 Identify question number; state diagnosis, dates, duration, treatment, medications and results of each illness or injury. List the name, full address, phone number, and dates of each health care provider consulted.

Question #	Date, Diagnosis, Duration, Treatment, Medication, and Results	Name, Address and Phone # of Attending Doctor and Hospital

SECTION 12. RESIDENCY AND FOREIGN TRAVEL Each question must be individually asked and answered for the proposed Insured.

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

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

SECTION 13. SUITABILITY FOR VARIABLE LIFE INSURANCE POLICY – Complete for all variable plans.

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

SECTION 14. TRANSFER AUTHORIZATION – To be completed by Applicant/Owner

(See Prospectus for transfer procedures.)

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

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

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

FRAUD WARNING

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

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

COLORADO: It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

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

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

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

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

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

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

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

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

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

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

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

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

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

SECTION 15. AUTHORIZATION TO OBTAIN AND DISCLOSE INFORMATION

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

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

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

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

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

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

Signature of proposed Insured/Owner

Print Registered Rep.

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

Registered Rep. Number

Signature of Registered Rep.

Signature of Registered Rep. (Split)

SECTION 16. TAXPAYER IDENTIFICATION CERTIFICATION

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

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

Signature of Owner _____ **Date** _____

SECTION 17. OTHER INSURANCE--TO BE COMPLETED BY THE REGISTERED REPRESENTATIVE

A) Will the policy applied for discontinue, replace or change any existing life insurance policy or annuity? Yes No

B) If replacement of existing insurance is involved, have you complied with all state requirements, including any Disclosure and Comparison Statements? Yes No N/A

If No, explain _____

C) Did you present and leave the Applicant/Policy Owner approved sales material? Yes No

**This page intentionally
left blank**

NOTICES

DETACH AND LEAVE THIS PAGE WITH APPLICANT

NOTICE TO PERSONS APPLYING FOR INSURANCE REGARDING INVESTIGATIVE REPORT

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

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

MIB GROUP, INC. (MIB) PRE-NOTIFICATION

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

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

NOTICE OF INSURANCE INFORMATION PRACTICES

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

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

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Rate Information

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Supporting Document Schedules

Review Status:

Satisfied -Name: Cover Letter 01/09/2009
Comments:
Attachment:
U000316 AR REV WRL Cover Letter.pdf

Review Status:

Satisfied -Name: Flesch Score 01/09/2009
Comments:
Attachment:
U000316 REV Flesch Score.pdf



January 9, 2009

Commissioner of Insurance
Arkansas Department of Insurance
Compliance - Life/Health
1200 West Third Street
Little Rock, AR 72201-1904

Western Reserve Life Assurance
Co. of Ohio
Administrative Office:
4333 Edgewood Road NE
Cedar Rapids, IA 52499
Home Office:
Columbus, Ohio
www.westernreserve.com

Attn.: Policy Examination Division (Individual Life)

RE: **WESTERN RESERVE LIFE ASSURANCE COMPANY OF OHIO**
NAIC #468-91413
FEIN #43-1162657
Form Number: U000316 CGI REV - Individual Life Applications (Replaces U000316 CGI)

Dear Sir/Madam:

Your department recently approved applications U000315 CSI, U000316 CGI, U000317 on August 6, 2008, SERFF Tracking Number AEGB-125735080. We have discovered an error with application U000316 CGI. The heading on page 2, section 10 is titled "GUARANTEED ISSUE QUESTIONS FOR PROPOSED INSURED". We intend to change the title in section 10 to "QUESTIONS FOR PROPOSED INSURED".

We are attaching a sample of the revised application form for your records. This application form will replace the form that was provided in the initial filing. We certify that there have been no other changes made to the application form other than those listed above and a revised form number.

This application is intended for use with our variable life portfolio.

WRL uses technology that provides a robust online signature solution, including allowing agents to collect owners and insured's electronic signatures. The electronic application and signature process is only available to those who specifically consent to do business with WRL electronically, and at any time, such consent can be revoked and the applicant can return to a hard copy application process.

The solution consists of an online module, integrated with the platform that allows users to pull up an electronic version of the filed and approved application, review its content, view all signatures required associated with the document, and, if there is no change or correction to the document as presented, apply an electronic signature for each signature required. Each signature will be captured separately. The E-Signature solution generates all of the documents for one application in separate documents, and each document contains its own metadata that is locked and bound after the signing ceremony is complete. If any document is changed during the course of the signing ceremony, any signatures captured for such document are effectively revoked, and the document must be resigned completely. Once the application is submitted to the carrier it can never be changed and is held at the carrier in a locked down status.

All processes used will comply with the Uniform Electronic Transactions Act, and to the extent applicable, the Federal E-SIGN Act.



Thank you in advance for your time and attention to this matter.

Sincerely,

WESTERN RESERVE LIFE ASSURANCE CO. OF OHIO

Mara L Carberry

Mara Carberry
Policy Analyst
Contract Development
(319) 355-3497 (collect)
Fax #: (319) 369-2501
mcarberry@aegonusa.com

Western Reserve Life Assurance
Co. of Ohio

Administrative Office:
4333 Edgewood Road NE
Cedar Rapids, IA 52499

Home Office:
Columbus, Ohio

www.westernreserve.com

FLESCH READABILITY CERTIFICATION

Form Number (may vary by state)

Flesch Score

U000316 CGI REV

51.1

I certify that the machine scored Flesch Readability score for the above mentioned form is accurate.

Cheryl Bock, Assistant Vice President of Contract Development