

SERFF Tracking Number: PNMU-125942972 State: Arkansas  
Filing Company: Penn Insurance and Annuity Company State Tracking Number: 41940  
Company Tracking Number: PI AT-08, ETC.  
TOI: L04I Individual Life - Term Sub-TOI: L04I.003 Single Life - Single Premium  
Product Name: NonRenewable One Year Term Life Insurance Policy  
Project Name/Number: PI AT-08, etc./PI AT-08, etc.

## Filing at a Glance

Company: Penn Insurance and Annuity Company

Product Name: NonRenewable One Year Term SERFF Tr Num: PNMU-125942972 State: ArkansasLH

Life Insurance Policy

TOI: L04I Individual Life - Term

SERFF Status: Closed

State Tr Num: 41940

Sub-TOI: L04I.003 Single Life - Single Premium Co Tr Num: PI AT-08, ETC.

State Status: Approved-Closed

Filing Type: Form

Co Status:

Reviewer(s): Linda Bird

Authors: Nancy Yannuzzi, Rita

Disposition Date: 01/29/2009

Bellew, Jaime Sperbeck

Date Submitted: 01/22/2009

Disposition Status: Approved

Implementation Date Requested: On Approval

Implementation Date:

State Filing Description:

## General Information

Project Name: PI AT-08, etc.

Status of Filing in Domicile: Pending

Project Number: PI AT-08, etc.

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: 01/29/2009

Deemer Date:

State Status Changed: 01/29/2009

Corresponding Filing Tracking Number: PI AT-08, etc.

Filing Description:

The Penn Insurance and Annuity Company is submitting the following forms for your review and approval:

Form / Title / Form Replaced

PI AT-08(AR) / NonRenewable One Year Term Life Insurance Policy / None

PI5696 / Application for Life Insurance Guaranteed Issue / None

PI5776 / Supplemental Application for Life Insurance Simplified Issue / None

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PM1143 version 10/08 / Life Application / PM1143, appr'd 1/19/06

Forms PI AT-08(AR) is a one year nonrenewable term policy. The policy has a minimum issue age of 0 and a maximum issue age of 85. The policy will provide term insurance coverage for a period of one year from the date of issue and is not renewable. The policy is convertible to permanent insurance prior to the Final Conversion Date shown on the Policy Specifications page, Page 3.

Application PM1143 version 10/08 will be used to apply for this product as well as all of our existing individual life insurance policies and for those that will be approved by your department in the future.

Enclosed is a sample policy and application forms. We have bracketed the variable information on the Policy Cover, Policy Specification and Additional Policy Specification pages. The enclosed Statement of Variability (SOV) provides the range intended for the variability of this information. It is our understanding that only the SOV will need to be refiled if there is any additional change to this information.

The policy will be sold through agents to individuals in the general insurance market.

We do not intend to illustrate this form.

Should you have any questions, please contact Jaime Sperbeck at (215) 956-8692, or via email at Sperbeck.Jaime@pennmutual.com.

## Company and Contact

### Filing Contact Information

Jaime Sperbeck, State Filing Coordinator sperbeck.jaime@pennmutual.com  
600 Dresher Road (215) 956-8692 [Phone]  
Horsham, PA 19044 (215) 956-8145[FAX]

### Filing Company Information

Penn Insurance and Annuity Company CoCode: 93262 State of Domicile: Delaware  
VIM C3G Group Code: 850 Company Type: Life and Annuity  
Philadelphia, PA 19172 Group Name: Penn Mutual Life Ins. State ID Number:

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Co.

(215) 956-8893 ext. [Phone]

FEIN Number: 23-2142731

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## Filing Fees

Fee Required? Yes  
Fee Amount: \$50.00  
Retaliatory? No  
Fee Explanation: State fee is \$50 per filing  
Per Company: No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Penn Insurance and Annuity Company	\$50.00	01/22/2009	25192163

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## Correspondence Summary

### Dispositions

Status	Created By	Created On	Date Submitted
Approved	Linda Bird	01/29/2009	01/29/2009

*SERFF Tracking Number:* PNMU-125942972      *State:* Arkansas  
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## **Disposition**

Disposition Date: 01/29/2009

Implementation Date:

Status: Approved

Comment:

Rate data does NOT apply to filing.

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<b>Item Type</b>	<b>Item Name</b>	<b>Item Status</b>	<b>Public Access</b>
<b>Supporting Document</b>	Certification/Notice		Yes
<b>Supporting Document</b>	Application		No
<b>Supporting Document</b>	Life & Annuity - Acturial Memo		No
<b>Supporting Document</b>	Statement of Variability		Yes
<b>Form</b>	NonRenewable One Year Term Life Insurance Policy		Yes
<b>Form</b>	Application for Life Insurance Guaranteed Issue		Yes
<b>Form</b>	Supplemental Application for Life Insurance Simplified Issue		Yes
<b>Form</b>	Life Application		Yes

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## Form Schedule

**Lead Form Number:** PI AT-08(AR)

Review Status	Form Number	Form Type Form Name	Action	Action Specific Data	Readability	Attachment
	PI AT-08(AR)	Policy/Cont NonRenewable One Year Term Life Insurance Policy Certificate	Initial		52	PI AT-08(AR).pdf
	PI5696	Application/ Enrollment Form	Initial	Application for Life Insurance Guaranteed Issue	51	PI5696 (ZZ).pdf
	PI5776	Application/ Enrollment Form	Initial	Supplemental Application for Life Insurance Simplified Issue	50	PI5776_011509.pdf
	PM1143 Version 10/08	Application/ Enrollment Form	Revised	Replaced Form #: PM1143 Previous Filing #:	50	App for PML,PIA, PM1143 Ver. 10-08.pdf

# The Penn Insurance and Annuity Company

## Wilmington, Delaware

Mailing Address: Philadelphia, PA 19172

Insured

WILLIAM PENN

\$150,000

Specified Amount

Policy Number

0 000 000

JANUARY 1, 2009

Policy Date

The Penn Insurance and Annuity Company agrees, subject to the provisions of this policy, to pay the Death Benefit to the Beneficiary upon receipt of due proof of the death of the Insured occurred prior to the Term Date. Penn Insurance and Annuity Company also agrees to provide all of the other benefits stated in this policy.

This contract is made in consideration of the payment of premiums as provided in this policy.

The provisions on this and the following pages are part of this policy.

Executed on the Date of Issue by The Penn Insurance and Annuity Company.



Secretary and Counsel



Chairman of the Board and  
President

**Free Look Period** - This policy may be canceled by returning it within 10 days after it is received by the policyowner. It must be returned to Penn Insurance and Annuity Company or to the agent through whom it was purchased. This policy will then be considered void as of its inception. Any premium paid on it will be refunded.

**READ YOUR POLICY CAREFULLY.** This policy is a legal contract between the Owner and Penn Insurance and Annuity Company.

## NonRenewable One Year Term Life Insurance Policy

- Death Benefit payable if the death occurs before the Term Date
- Convertible prior to the Final Conversion Date, listed on Page 3
- Non-Participating

The Penn Insurance and Annuity Company, Wilmington, Delaware  
PI AT-08(AR)

# Guide to Policy Sections

1. Policy Specifications
2. Endorsements
3. Premiums
4. Owner and Beneficiary
5. Death Benefit
6. Conversion
7. General Provisions

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# 1. Policy Specifications

INSURED [WILLIAM PENN] [ \$150,000 ] FACE AMOUNT  
POLICY DATE [JANUARY 1, 2009] [JANUARY 1, 2010] EXPIRATION DATE  
POLICY NUMBER [0 000 000]  
AGE [35 MALE] [STANDARD NONSMOKER] PREMIUM CLASS

THE DATE OF ISSUE IS THE POLICY DATE

THE FINAL CONVERSION DATE IS [JANUARY 1, 2010]

OWNER AND BENEFICIARY AS PROVIDED IN APPLICATION

## Schedule of Benefits

DESCRIPTION	AMOUNT
ONE YEAR TERM INSURANCE	[ \$ 150,000 FACE AMOUNT ]

## Schedule of Premiums

PREMIUMS ARE PAYABLE ON OR PRIOR TO DELIVERY OF THIS POLICY:

ANNUAL PREMIUM [ \$60.00 ]

## **2. Endorsements**

To be made only by the Company

**This page is intentionally  
left blank.**

### 3. Premiums

**Payment of Premiums** - Page 3 shows the amount of the premium. The premium must be paid in full on or prior to the delivery of this policy. The premium is payable at the Home Office or to an authorized representative of the Company. A receipt signed by the President or the Secretary will be given on request.

**Premium Adjustment** - We will add to the insurance benefits any part of the premium paid that applies to a period beyond the policy month in which the Insured Person dies.

### 4. Owner and Beneficiary

**Owner** -The Owner of this policy is as stated in the application unless changed by a subsequent owner designation or assignment. While this policy is in force before the death of the Insured, the Owner may exercise all of the rights in it without the consent of any other person.

**Beneficiary** - The Beneficiary of this policy is as stated in the application unless changed by a subsequent beneficiary designation. If no other provision is made, the interest of a Beneficiary who dies before the death of the Insured will pass to the Owner.

**Change of Owner or Beneficiary** - The Owner may transfer ownership or change the Beneficiary by filing a written designation at the Home Office. The designation will take effect as of the date it is signed by the Owner, subject to any action taken by the Company prior to the time that the designation is received at the Home Office. Unless otherwise stated in a designation, the following rules will apply to terms of kinship:

- (a) A legally adopted child of any person will be considered the child of the adopting parent.
- (b) The brothers and sisters of a person will include those who have only one parent in common with the person, but will not include stepbrothers or stepsisters.
- (c) Any reference to children will not include stepchildren and any reference to parents will not include stepparents.

**Assignment** - The Owner may assign this policy while it is in force before the death of the Insured. The rights of the Owner and of any Beneficiary will be subject to the rights of an assignee under the terms of an assignment. No assignment will bind the Company until the original, or a copy signed by the Owner, has been filed at the Home Office. The Company is not responsible for the effect or the validity of an assignment.

### 5. Death Benefit

**Amount of Benefit** - The Death Benefit payable at the death of the Insured while this policy is in force will include the following amounts:

- (a) The face amount of the policy shown on Page 3;
- (b) Plus any adjustment for the annual premium.

**Suicide Exclusion** - If the Insured dies by suicide, while sane or insane, the Death Benefit will be limited to the premium paid.

## 5. Death Benefit (continued)

**Payment of Benefit** - The Death Benefit will be paid in one sum. The Company will pay interest on this sum from the date of death to the date of payment. The interest rate will be determined each year by the Company, but will not be less than a rate of 3% per year compounded annually or such higher rate as required by law in the jurisdiction in which this policy is delivered. Settlement will be made within 30 days after receipt of due proof of death, the interest of the claimant, and payability of the benefit.

## 6. Conversion

**Right to Convert** - The term insurance under this policy may be converted to a cash value life insurance plan without evidence of insurability at any time before the Expiration Date shown in the Policy Specifications section of Page 3. The conversion will be subject to the following conditions:

- (a) The Owner must apply for the conversion in a form supplied by the Company.
- (b) Premiums for this policy must be paid to the date of conversion.
- (c) The Owner must surrender all rights in this policy in exchange for a new policy.
- (d) On or before the date of conversion, the Owner must pay the first premium for the new policy.
- (e) Unless otherwise specified in the application for conversion, the date of conversion is the date the request for conversion is received by the Company in its Home Office.

**New Policy** - The new policy will be issued:

- (a) on a plan insuring the life of the Insured;
- (b) in an amount not in excess of the Face Amount of this policy; and
- (c) in the same premium class and subject to the same limitations of risk as this policy.

The new policy will be issued at the age of the Insured on the birthday nearest the date of conversion. The premium rates and policy form will be those in use by the Company on the date of conversion. The new policy will be subject to the Company's rules in effect on the date of conversion as to minimum amount, plan of insurance and age at issue. If conversion of this policy occurs before the end of the policy year, the first premium for the new policy will also be reduced by a conversion credit. The conversion credit will be equal to any part of the premium paid that applies to a period beyond the policy month in which the Insured Person converts.

## 7. General Provisions

**The Contract** - This policy and the application for it, a copy of which is attached to and made a part of this policy, constitute the entire contract. Only the President, a Vice President, the Secretary, the Chief Actuary, an Actuary or an Associate Actuary may, on behalf of the Company, modify this contract or waive any of its conditions. No agent is authorized to modify this contract or to make any promise as to the future payment of dividends or interest.

**Incontestability** - All statements made in the application for this policy are representations and not warranties. No statement will void this policy or be used to contest a claim under it unless the statement is contained in the application, a copy of which is attached to and made a part of this policy.

**Policy Date** - The Policy Date shown on Page 3 is the date from which policy years, months and anniversaries are determined.

## 7. General Provisions (continued)

**Age** - The age shown on Page 3 is the insurance age of the Insured. This is the age of the Insured on the birthday nearest the Policy Date. Attained age means the insurance age of the Insured increased by the number of completed years and months after the Policy Date.

**Misstatement of Age or Sex** - If the age or the sex of the Insured has been misstated, any amount payable under this policy will be that amount which the premiums paid would have purchased on the basis of the correct age and sex.

Any date shown on Page 3 which is based on an incorrect age may be changed to be consistent with the correct age.

**Policy Payments** - All payments by the Company under this policy are payable at the Home Office. The Company may require the return of this policy upon payment of the Death Benefit.



**Section A. Proposed Insured**

1. Full Name (First, Middle, Last) <input type="checkbox"/> M <input type="checkbox"/> F <input type="checkbox"/>		2. Date of Birth Mo. Day Yr.	3. Social Security Number - -
4. Home Address: Give No., Street, City, State, and Zip Code.			
5. Phone Numbers Home ( ) - Work ( ) -	6. Marital Status <input type="checkbox"/> M <input type="checkbox"/> D <input type="checkbox"/> S <input type="checkbox"/> W <input type="checkbox"/> Other _____	7. Occupation	8. Date of Hire
9. Employer Name and Address			
10. Job Title		11. Salary	
12. Has the proposed insured been actively at work on a full time basis? (at least 30 hrs. per week for the last 3 months) <input type="checkbox"/> Yes <input type="checkbox"/> No If no, please explain:			

**Section B. Plan and Premium Information**

13. Base Policy:

(a) Plan of Insurance \_\_\_\_\_ (c) Death Benefit Option (**UL Only**):  
 Level Death Benefit  Increasing Death Benefit

(b) Amount \_\_\_\_\_

14. Additional Benefits and/or Riders \_\_\_\_\_

15. Automatic Premium Loan Option (**TL Only**)  Yes  No

16. Premium

(a) Mode of premium payment  Quarterly  Semi-annual  
 Annual  Salary Allotment / List Bill  Other \_\_\_\_\_

(b) Type of Billing:  Single  Group  Individual

**17. Complete for Traditional Plans**

(a) Has full payment for the first premium been made?  Yes  No

(b) For additional Deposit Paid-up Additions only:

(1) Lump sum amount of \$ \_\_\_\_\_ has been paid in full.  Yes  No

(2) Scheduled amount of \$ \_\_\_\_\_ has been paid in full.  Yes  No

(3) Subsequent billing to be scheduled: \$ \_\_\_\_\_  Yes  No

**18. Complete for Universal Life Plans**

(a) Initial premium of \$ \_\_\_\_\_ has been paid in full.  Yes  No  
 Number of months: \_\_\_\_\_

(b) Subsequent 1st year scheduled premium is \$ \_\_\_\_\_

(c) Subsequent scheduled premium for year two and thereafter is \$ \_\_\_\_\_

**Section C. Beneficiary Information**

19. Death Benefit Beneficiary

(a) Primary (Payable in equal shares to such as survive the Insured unless otherwise stated.)

First Name	Middle Initial	Last Name
SS#		Relationship

(b) Secondary (If no Primary Beneficiary survives the Insured, Payable in equal shares to such as survive the Insured unless otherwise stated.)

First Name	Middle Initial	Last Name
SS#		Relationship

(c) If no Primary or Secondary Beneficiary survives the Insured, Payable to the executors or administrators of:

\_\_\_\_\_  
(The Insured, if no one else is named)

**Section D. Owner**

20. Full Name (If trust, give full name of trust and date of trust agreement.)	SSN or Tax ID No.
Address: Give No., Street, City, State, and Zip Code.	Relationship to Proposed Insured

**Section E. Insurance History**

21. Total Insurance on Proposed Insured's Life

Name	Company	Amount	Type	Accid. Death Benefit	Issue Date

	Yes	No
22. (a) Is insurance applied for intended to replace or change any existing life insurance or annuity policy with any insurance company?	<input type="checkbox"/>	<input type="checkbox"/>
(b) If (a) is "Yes", then does any dump-in involve 1035 exchange money?	<input type="checkbox"/>	<input type="checkbox"/>
(c) Will premiums for insurance applied for be paid by policy loan from any existing policy?	<input type="checkbox"/>	<input type="checkbox"/>

**Section F. Tobacco Usage**

23. (a) Has the proposed insured **ever** smoked or used any tobacco or nicotine products?     Yes  No

(b) If "Yes", date last used:     0 - 12 Mo.     13 - 24 Mo.     25 - 36 Mo.     37+ Mo.

(c) Type?     Cigarettes     Cigar     Pipe     Chew     Patch     Other \_\_\_\_\_

**Section G. Fraud Warning Notice**

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

**Section H. Representation**

I represent that the statements and answers in this application are complete and true to the best of my knowledge and belief. I submit them to the Penn Insurance and Annuity Company understanding that Penn Mutual will rely on them in deciding whether or not to approve this application. I also understand and agree that no agent is authorized to make or modify any contract of insurance.

Signed on \_\_\_\_\_  
at \_\_\_\_\_, State of \_\_\_\_\_

\_\_\_\_\_  
Signature of Proposed Insured  
\_\_\_\_\_  
Signature of Applicant if not Proposed Insured

**To be answered by agent:**

To the best of your knowledge is replacement involved?     Yes  No

\_\_\_\_\_  
Signature of Soliciting Agent - Licensed Resident Agent Where Required by Law

\_\_\_\_\_  
Name of Soliciting Agent

\_\_\_\_\_  
State License Identification Number

\_\_\_\_\_  
Agency Code

\_\_\_\_\_  
Agent Code

\_\_\_\_\_  
Agent Identification

\_\_\_\_\_  
Percentage

**Special Instructions**

Home Office Amendments and Corrections (For use only if permitted by state statute or regulation)

Proposed Insured _____	Date of Birth _____
------------------------	---------------------

	YES	NO	DETAILS (If answered YES)
1. Within the past two years, has the Proposed Insured:			
(a) Flown or taken instruction as a pilot or crew member or intend to do so? (If "Yes", complete Aviation Supplement)	<input type="checkbox"/>	<input type="checkbox"/>	
(b) Engaged in any kind of racing, scuba or sky diving, hang gliding, rock climbing or other hazardous avocation or intend to do so? (If "Yes", complete appropriate questionnaire.)	<input type="checkbox"/>	<input type="checkbox"/>	
(c) Been convicted of a moving violation or had your driver's license revoked? If yes, Driver's license number _____ and State of issue _____	<input type="checkbox"/>	<input type="checkbox"/>	
2. Has the Proposed Insured ever:			
(a) Used amphetamines, barbiturates, hallucinogens, marijuana or narcotics?	<input type="checkbox"/>	<input type="checkbox"/>	
(b) Been counseled or treated for use of alcohol or drugs?	<input type="checkbox"/>	<input type="checkbox"/>	
3. Does the Proposed Insured intend to reside or travel outside the United States?			
	<input type="checkbox"/>	<input type="checkbox"/>	
4. (a) Height (in shoes) _____ ft. _____ in. (b) Weight (clothed) _____ lbs.			
5. Has the Proposed Insured ever been treated for, or had indication of: chest pain, high blood pressure, or other circulatory disorder; cancer, or tumor; mental or nervous disorder; diabetes; colitis or any liver or gastrointestinal disorder; kidney or other genitourinary disorder; asthma, emphysema or other respiratory disorder; an immune deficiency disorder, Acquired Immune Deficiency Syndrome (AIDS), AIDS related complex (ARC), or tested positive for the HIV virus?			
	<input type="checkbox"/>	<input type="checkbox"/>	
6. Within the past 5 years have you:			
(a) Consulted a physician for any reason; had an electrocardiogram or other diagnostic test?	<input type="checkbox"/>	<input type="checkbox"/>	
(b) Been in a clinic, hospital or medical facility for observation or treatment?	<input type="checkbox"/>	<input type="checkbox"/>	
(c) Been advised to have any diagnostic test, hospitalization or surgery which was not done?	<input type="checkbox"/>	<input type="checkbox"/>	
(d) Requested or received any pension or insurance benefits because of sickness or disability?	<input type="checkbox"/>	<input type="checkbox"/>	
(e) Had a natural parent or sibling die before the age of 60 as a result of coronary artery disease or cancer? If yes, provide details, including age at death?	<input type="checkbox"/>	<input type="checkbox"/>	

**AUTHORIZATION**

I(we), \_\_\_\_\_ hereby authorize: (a) any physician, health care provider, health plan, medical professional, hospital, clinic, laboratory, pharmacy or other medical or health care facility that has provided payment, treatment or services to me(us) or on my(our) behalf; (b) any insurance company; and, (c) the Medical Information Bureau, Inc. (MIB), to disclose my(our) entire medical record and any other protected health information concerning me(us) to the Underwriting Department of The Penn Insurance and Annuity Company, its subsidiaries, affiliates, third party administrators and reinsurers (herein Company).

I(we) understand that such information may include records relating to my(our) physical or mental condition such as diagnostic tests, physical examination notes, and treatment histories, which may include information regarding the diagnosis and treatment of human immunodeficiency virus (HIV) infection, sexually transmitted diseases, and mental illness, and the use of alcohol, drugs and tobacco, but shall not include psychotherapy notes.

I(we) acknowledge that any agreements I(we) have made to restrict my(our) protected health information do not apply to the Authorization, and I(we) instruct any physician, health care professional, hospital, clinic, medical facility or other health care provider to release and disclose my(our) entire medical record without restriction.

I(we) understand that this information will be used by the Company to determine eligibility for insurance.

I(we) hereby authorize the Company to disclose any information it obtains about me(us) to the Medical Information Bureau, Inc., or any other life insurance company with which I(we) do business. I(we) understand that the Company will not disclose information it obtains about me(us) except as authorized by this Authorization, as may be required or permitted by law, or as I(we) may further authorize. I(we) understand that if information is redisclosed as permitted by this Authorization, it may no longer be protected by applicable federal privacy law.

I(we) understand that: (a) this Authorization shall be valid for 30 months from the date I(we) sign it; (b) I(we) may revoke it at any time by providing written notice to the Underwriting Department of the Company subject to the rights of any person who acted in reliance on it prior to receiving notice of its revocation; and (c) my(our) authorized representative and I(we) are entitled to receive a copy of the Authorization upon request and (d) a copy of this Authorization shall be as valid as the original.

I(we) acknowledge receiving an MIB, Inc. Notice, a Fair Credit Reporting Act Notice and a Notice of Information Practices and authorize The Penn Insurance and Annuity Company, to obtain an investigative or other consumer report as described in the Fair Credit Reporting Act Notice.

Signed on \_\_\_\_\_

\_\_\_\_\_  
Signature of Proposed Insured

at \_\_\_\_\_, State of \_\_\_\_\_

\_\_\_\_\_  
Please print Applicant's full name

\_\_\_\_\_  
Signature of Applicant if not Proposed Insured

## **Notice of Insurance Information Practices**

Penn Mutual / Penn Insurance and Annuity Company (PIA) wishes to thank you for your application for insurance. In order for us to accurately underwrite this application, it is necessary to obtain some personal information about you. This information is necessary and vital to our business because it enables us to classify each applicant appropriately according to the risk he or she represents.

We at the Company are and always have been acutely aware of the responsibility placed upon us as possessors of private information. We safeguard such information and disclose it only for legitimate business or legal reasons. Below we will outline some of our underwriting procedures and explain certain rights that you have.

### **How We Collect Our Information**

In addition to the information included in the application, the Company, its subsidiaries or its reinsurers will, as a part of our underwriting procedures, collect information relating to any proposed insured's physical and mental condition, health history, mode of living, general character and reputation, personal characteristics, habits, finances, occupation, other insurance coverage or participation in hazardous activities.

This information may be obtained from you personally or from physicians, medical professionals, hospitals, clinics or other medical care institutions which have provided care to you or to members of your family, from the MIB, Inc., public records, consumer reporting agencies, financial sources (such as your lawyer and/or accountant), other insurance companies, agents, friends, neighbors, employers, or business associates. We may obtain this information through exchanges of correspondence, by telephone, or by personal contact.

An investigative consumer report may be necessary. You have the right to obtain a copy of this report and to be interviewed personally as part of this process. If you desire this personal interview, please inform your agent. Should you want a copy of this report, write to us, and we will furnish the name and address of the consumer reporting agency. You may then contact this agency and request a copy. Should an investigative consumer report be obtained, the consumer reporting agency may retain that information in its files. Federal law prohibits such organizations from disclosing such information to other parties without your authorization.

We will also ask you some marketing questions which we will use solely for marketing analysis.

### **Access To This Information**

The information about you, which we obtain and keep in our files, will not be disclosed to others without your authorization except to the extent necessary for the conducting of our business. For example, necessary items of information may be disclosed to persons or organizations which perform a business, professional or insurance function for us.

We may occasionally disclose certain information to a State Insurance Department, or when required, to law enforcement or other governmental authority to prevent or prosecute fraud or other unlawful activities.

Information about you may be given to other insurers, agents or insurance support organizations to enable them to perform a business function concerning an insurance transaction with you, or to help detect or prevent insurance fraud or misrepresentation. For your benefit we may disclose to your physician a medical problem of which you may not be aware. In addition, we may give information about you to an affiliated company so that it can inform you of insurance products or services.

### **How To Obtain This Information**

You have the right of access to this information which the Company maintains in its files about you and which you reasonably describe. Within 30 business days of our receipt of your written request, you may have access to recorded information about you which is retrievable. However, medical information will be released only to a physician whom you designate. Your right of access does not extend to information which relates to and in connection with, or in reasonable anticipation of, a claim or civil or criminal proceeding. We will inform you of the nature and substance of the information and identify any institution source which gave us information. If recorded, we will advise you of those persons to whom such information has been disclosed within two years prior to the request, or if not recorded, we will give you the names of the persons or organizations to whom such information is normally disclosed. If you wish, we can arrange for you to see this information or obtain a copy by mail. You may request correction, amendment or deletion of any information in our files pertaining to you, and we will respond within 30 days.

**DETACH AND LEAVE WITH PROPOSED INSURED**

We will tell you if we complied with your request. If we do not agree with you, we will notify you of our refusal, give you our reasons and give you the opportunity to file a concise statement of dispute with us. Your statement will be sent with any disclosure of the information which we make.

In either event, we will notify any insurance support organization that furnished the information to us and any person whom you designate and who may have received such information within the preceding two years of the dispute regarding the information. Your statement of dispute will be sent to these parties if we did not comply with your request.

**Please direct all requests involving the above procedures to the Penn Mutual Life Insurance Company, Attn.: Life New Business Department, 600 Dresher Rd., Horsham, PA 19044. Give your full name, address, date of birth and policy number. You may also call us at (800) 523-0650, and ask for the Life New Business Department.**

### **Fair Credit Reporting Act Notice**

As part of our regular underwriting procedures, an investigative consumer report may be obtained through personal interviews with your neighbors, friends, or others with whom you are acquainted. This inquiry will include information as to your character, general health, general reputation, personal characteristics, driving record, criminal activity, and mode of living. As part of your application for insurance, you have authorized the Company to obtain such a report, and you should understand that you have the right to make a written request within a reasonable period of time to the Company's Underwriting Department to receive additional detailed information about the nature and scope of this investigation. You should also understand that upon written request, you will be informed whether such a report has actually been ordered, and if it has, you will be furnished the name and address of the consumer reporting agency to whom the request was made. You may contact this consumer reporting agency and request a copy of any such report.

### **MIB, Inc. Notice**

Information regarding your insurability will be treated as confidential. The Penn Mutual Life Insurance Company or Penn Insurance and Annuity Company or its reinsurers may, however, make a brief report thereon to the MIB Inc., formerly known as Medical Information Bureau, a not-for-profit membership organization of insurance companies, which operates an information exchange on behalf of its members. If you apply to another MIB company for life or health insurance coverage, or a claim for benefits is submitted to such a company, MIB, upon request, will supply such company with the information about you in its file.

Upon receipt of a request from you, MIB will arrange disclosure of any information in your file. Please contact MIB at 866-692-6901 (TTY 866-346-3642). If you question the accuracy of the information in MIB's file, you may contact MIB and seek a correction in accordance with the procedures set forth in the federal Fair Reporting Credit Act. The address of MIB's information office is [50 Braintree Hill Park, Suite 400, Braintree, Massachusetts 02184-8734].

The Penn Mutual Life Insurance Company or Penn Insurance and Annuity Company, or its reinsurers, may also release information from its file to other insurance companies to whom you may apply for life or health insurance, or to whom a claim for benefits may be submitted. Information for consumers about MIB may be obtained on its website at [www.mib.com](http://www.mib.com).

**DETACH AND LEAVE WITH PROPOSED INSURED**

**CHECK BOX OF APPLICABLE COMPANY**

- The Penn Mutual Life Insurance Company  
Philadelphia, PA 19172
- The Penn Insurance and Annuity Company  
Philadelphia, PA 19172

**Application for Life Insurance**

**PART 1**

<b>A. PROPOSED INSURED 1 (PI 1)</b>	1. Name of First Insured (First, Middle, Last)			2. Sex <input type="checkbox"/> Male <input type="checkbox"/> Female		3. Date of Birth Month Day Year		
	4. Social Security No. — —		5. Birth Place		6. Citizen of (Country)		7. For Non-US citizen Visa # and Type (attach copy)	
	8. Residence: Street			City		State Zip		
	9. Years at this Address		10. Marital Status <input type="checkbox"/> M <input type="checkbox"/> D <input type="checkbox"/> S <input type="checkbox"/> W		11. Home Phone No. ( )		12. Email Address	
	13. Occupation (include duties)					14. Drivers License State and No.		
	15. Employer			16. How Long		17. Area Code and Business Phone No. ( )		
	18. Street			City		State Zip		
<b>B. PROPOSED INSURED 2 (PI 2)</b>	1. Name of Second Insured (First, Middle, Last)			2. Sex <input type="checkbox"/> Male <input type="checkbox"/> Female		3. Date of Birth Month Day Year		
	4. Social Security No. — —		5. Birth Place		6. Citizen of (Country)		7. For Non-US citizen Visa # and Type (attach copy)	
	8. Residence: Street			City		State Zip		
	9. Years at this Address		10. Marital Status <input type="checkbox"/> M <input type="checkbox"/> D <input type="checkbox"/> S <input type="checkbox"/> W		11. Home Phone No. ( )		12. Email Address	
	13. Relationship to First Insured			14. Occupation (include duties)			15. Drivers License State and No.	
	16. Employer			17. How Long		18. Area Code and Business Phone No. ( )		
	19. Street			City		State Zip		
Complete for  <input type="checkbox"/> Survivorship Plan  <input type="checkbox"/> Additional Insured Rider  (If multiple additional insureds complete form PM5023)  If info for PI 1 is same as PI 2 indicate same.	<b>C. PLAN OF INSURANCE</b>							
DEATH BENEFIT	2. Face Amt. (Base Only) \$ _____		3. Supplement Term Face Amt. \$ _____		4. Total Initial Coverage \$ _____			
DEATH BENEFIT OPTION (UL and VUL only)	5. Check One		<input type="checkbox"/> Level Death Benefit		<input type="checkbox"/> Increasing Death Benefit			
PREMIUM TEST (UL and VUL only)	6. Check One		<input type="checkbox"/> Guideline Premium		<input type="checkbox"/> Cash Value			

**D. ADDITIONAL BENEFITS AND RIDERS**

Select desired benefits and riders for product plan elected in Section C

Product	Available Elected Riders
<p>Accumulation Builder IUL</p>	<ul style="list-style-type: none"> <li><input type="checkbox"/> Accidental Death Benefit \$ _____</li> <li><input type="checkbox"/> Additional Insured Rider (Complete Section B of application) \$ _____</li> <li><input type="checkbox"/> Child Rider (Complete Form PM5023)</li> <li><input type="checkbox"/> Disability Completion Benefit</li> <li><input type="checkbox"/> Guaranteed Insurability Agreement \$ _____</li> <li><input type="checkbox"/> Over-Loan Protection Rider</li> <li><input type="checkbox"/> Waiver of Monthly Deductions</li> <li>Other _____</li> </ul>
<p>Diversified Growth VUL</p> <p><i>Complete form PM0304-R2 (PM0304-RS in NY and VT) and all forms required by your broker dealer for variable life business.</i></p>	<ul style="list-style-type: none"> <li><input type="checkbox"/> Accidental Death Benefit \$ _____</li> <li><input type="checkbox"/> Additional Insured Rider (Complete Section B of application) \$ _____</li> <li><input type="checkbox"/> Business Accounting Benefit</li> <li><input type="checkbox"/> Cash Value Enhancement Rider</li> <li><input type="checkbox"/> Child Rider (Complete Form PM5023)</li> <li><input type="checkbox"/> Disability Completion Benefit</li> <li><input type="checkbox"/> Extended No-Lapse Guarantee Rider</li> <li><input type="checkbox"/> Guaranteed Insurability Agreement \$ _____</li> <li><input type="checkbox"/> Over-Loan Protection Rider</li> <li><input type="checkbox"/> Return of Premium Rider</li> <li><input type="checkbox"/> Supplemental Term Rider \$ _____</li> <li><input type="checkbox"/> Waiver of Monthly Deductions</li> </ul>
<p>Estate Protection UL</p>	<ul style="list-style-type: none"> <li><input type="checkbox"/> Estate Preservation Term Insurance Rider \$ _____</li> <li><input type="checkbox"/> Return of Premium Rider</li> <li><input type="checkbox"/> Single Life Flexible Period Term Rider \$ _____</li> <li><input type="checkbox"/> Other _____</li> </ul>
<p>Flexible Choice Whole Life</p>	<ul style="list-style-type: none"> <li><input type="checkbox"/> Accidental Death Benefit \$ _____</li> <li><input type="checkbox"/> Child Rider (Complete Form PM5023)</li> <li><input type="checkbox"/> Flexible Protection Rider \$ _____</li> <li><input type="checkbox"/> Guaranteed Insurability Agreement \$ _____</li> <li><input type="checkbox"/> Over-Loan Protection Rider</li> <li><input type="checkbox"/> Paid Up Additions (Select only one and complete questions 2 and 3 in Section K) <ul style="list-style-type: none"> <li><input type="checkbox"/> Accelerated Paid Up Additions Rider</li> <li><input type="checkbox"/> Supplemental Paid Up Additions Rider</li> </ul> </li> <li><input type="checkbox"/> Waiver of Premium (Select only one) <ul style="list-style-type: none"> <li><input type="checkbox"/> Waiver of Premium Rider</li> <li><input type="checkbox"/> Enhanced Waiver of Premium Rider</li> </ul> </li> <li><input type="checkbox"/> Other _____</li> </ul>

**D. ADDITIONAL BENEFITS AND RIDERS (Continued)**

Select desired benefits and riders for product plan elected in Section C

Product	Available Elected Riders
Guaranteed Protection UL	<input type="checkbox"/> Accidental Death Benefit \$ _____ <input type="checkbox"/> Additional Insured Rider (Complete Section B of application) \$ _____ <input type="checkbox"/> Business Accounting Benefit <input type="checkbox"/> Child Rider (Complete Form PM5023) <input type="checkbox"/> Disability Completion Benefit <input type="checkbox"/> Guaranteed Insurability Agreement \$ _____ <input type="checkbox"/> Over-Loan Protection Rider <input type="checkbox"/> Waiver of Monthly Deductions
Guaranteed Term 10-15-20	<input type="checkbox"/> Accidental Death Benefit \$ _____ <input type="checkbox"/> Child Rider (Complete Form PM5023) <input type="checkbox"/> Waiver of Premium Rider – Option A <input type="checkbox"/> Waiver of Premium Rider – Option B <input type="checkbox"/> Other _____
Protection for Life UL	<input type="checkbox"/> Accidental Death Benefit \$ _____ <input type="checkbox"/> Additional Insured Rider (Complete Section B of application) \$ _____ <input type="checkbox"/> Child Rider (Complete Form PM5023) <input type="checkbox"/> Disability Completion Benefit <input type="checkbox"/> Guaranteed Insurability Agreement \$ _____ <input type="checkbox"/> Return of Premium Rider <input type="checkbox"/> Waiver of Monthly Deductions <input type="checkbox"/> Other _____
Survivorship Growth VUL  <i>Complete form PM0304-R2 (PM0304-RS in NY and VT) and all forms required by your broker dealer for variable life business.</i>	<input type="checkbox"/> Enhanced Coverage Rider \$ _____ <input type="checkbox"/> Estate Growth Benefit % _____ <input type="checkbox"/> Estate Preservation Term Insurance Rider \$ _____ <input type="checkbox"/> Guaranteed Continuation of Policy (all states except NJ, NY, TX) <input type="checkbox"/> Return of Premium Rider <input type="checkbox"/> Single Life Flexible Period Term Rider \$ _____ <input type="checkbox"/> Other _____
Survivorship Plus IUL	<input type="checkbox"/> Estate Growth Benefit % _____ <input type="checkbox"/> Estate Preservation Term Insurance Rider \$ _____ <input type="checkbox"/> Extended No-Lapse Guarantee Rider <input type="checkbox"/> First Death Benefit Rider \$ _____ <input type="checkbox"/> Over-Loan Protection Rider <input type="checkbox"/> Return of Premium Rider <input type="checkbox"/> Single Life Flexible Period Term Rider \$ _____ <input type="checkbox"/> Supplemental Term Rider \$ _____

<b>E. DIVIDEND OPTIONS</b>	Universal Life	Traditional Plans
	<input type="checkbox"/> Cash <input type="checkbox"/> Credited to Cash Value	<input type="checkbox"/> Cash <input type="checkbox"/> Accumulate at Interest <input type="checkbox"/> Paid-up Additions <input type="checkbox"/> Other _____ <input type="checkbox"/> Premium Reduction (Not available with Penn Check or Salary Allotment)

<b>F. OWNER</b> <i>Complete <b>only</b> if Owner is other than Proposed Insured 1. If Trust, give name of Trust, Trustee and date of Trust</i>	1. Name(s) (First, Middle, Last) of Owner(s) or Complete Name of Entity	2. Relationship to Proposed Insured
<b>Note:</b> <i>If Owner is a Trust or Insured's business <b>omit</b> questions 4, 9.</i>	3. Address (Street, City, County, State, Zip)	
	4. Date of Birth	5. Soc. Sec. # / Tax ID
	6. Telephone # (    )	
	7. Name of Trustee(s)	
	8. Date of Trust	9. Occupation

<b>G. PAYOR</b> <i>Complete only if Payor is other than the Proposed Insured or Owner or if a different address is requested.</i>	1. Name(s) (First, Middle, Last) of Payor(s)	2. Relationship to Proposed Insured
	3. Address: (Street, City, State, Zip)	
	4. Mailing Address (if different from above): (Street, City, State, Zip)	5. Soc. Sec. # or Tax ID #
	What is the amount of life insurance carried on the life of the payor? Please provide details as to why the Payor is paying the premiums. _____	
	_____	
	_____	

<b>H. PRIMARY BENEFICIARY</b> <i>Note: If no beneficiary survives the insured, proceeds revert to the Estate of the Insured.</i>	Unless " Per Stirpes" is requested, the share of any beneficiary reflected in Sections H, I or J below, who predeceases the insured, will be split equally among the surviving beneficiaries as reflected in the applicable section				
	Name	Date of Birth or Date of Trust	Soc. Sec. or Tax ID #	Relationship	%

<b>I. CONTINGENT BENEFICIARY</b>	Name	Date of Birth or Date of Trust	Soc. Sec. or Tax ID #	Relationship	%

<b>J. RIDER BENEFICIARY</b> <i>If no beneficiary is named or survives the insured, proceeds revert to the owner.</i>	Name	Date of Birth or Date of Trust	Soc. Sec. or Tax ID #	Relationship	%

**K. PREMIUM**

**If money was collected with this application, please complete and submit the Temporary Insurance Agreement (TIA). No TIA can be provided unless premium has been collected.**

1. Billing Mode:       Single Premium       Annual       Semi-annual       Quarterly  
 Penn Check      add to existing account # \_\_\_\_\_  
 Salary Allotment      add to existing account # \_\_\_\_\_

2. Premium to be billed \_\_\_\_\_ ; billed premium to be used for scheduled ADPUA \_\_\_\_\_  
(Whole Life Only) Automatic Premium Loan     Yes     No  
(Whole life only if selected)

3. Additional premium expected via 1035 exchange \_\_\_\_\_ or dump-in ; \_\_\_\_\_  
Additional premium to be used for lump sum ADPUA ( whole life only if selected )  
from 1035 exchange \_\_\_\_\_ ; from dump-in \_\_\_\_\_

4. Premium allocation for Indexed Flexible Premium Adjustable Life  
I elect to have \_\_\_\_\_ % of my premium payment allocated directly to the Indexed Account.  
I elect to have \_\_\_\_\_ % of my premium payment allocated to the DCA Account. (Not available on Accumulation Builder IUL)  
The remaining premium will be allocated to the Fixed Account. This election will continue for new premium payments until I elect a change. Note: If electing the Survivorship Plus IUL Extended No-Lapse Guarantee Rider, the allocation to the Fixed Account will be restricted.  
Each premium payment or transfer from the Fixed Account will create a new segment. A change in the allocation percentage will not take effect until the next payment date. Transfers from an Indexed Account segment can only be made on the segment maturity date, which is 1 year from the date the premium is posted to the Indexed Account.

5. What is the source of the premiums? (indicate all that apply for any part of the premium)

a. <input type="checkbox"/> Applicant's personal income	e. <input type="checkbox"/> Premium finance company (identify lender below)
b. <input type="checkbox"/> Applicant's personal liquid assets	f. <input type="checkbox"/> Applicant's family member (identify and describe their source below)
c. <input type="checkbox"/> Applicant's personal illiquid assets	g. <input type="checkbox"/> Other person or entity (identify and describe their source below)
d. <input type="checkbox"/> Mortgage or home equity loan (identify lender below)	h. <input type="checkbox"/> Annuity payments (identify type of annuity, source of annuity premiums, reasons for annuity below)

If anyone other than the applicant is paying any part of the premium, describe any arrangement which has been established or is being considered for repayment by the applicant, the insured if other than the applicant, or any trust established by the insured or the applicant. Indicate whether any such promised or potential repayment will or would come from the policy cash value or death benefit, and describe any other source of repayment.

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**L. PENN CHECK ACCOUNT INFORMATION**

*Complete only if Penn Check mode is selected and this is a new account. Also attach a Void Check or deposit slip*

1. Bank Name		2. Bank Routing and Account No.	
3. Account Type <input type="checkbox"/> Checking <input type="checkbox"/> Savings <input type="checkbox"/> Pershing <input type="checkbox"/> Other		4. Draw Date: <input type="checkbox"/> 1 <sup>st</sup> <input type="checkbox"/> 8 <sup>th</sup> <input type="checkbox"/> 15 <sup>th</sup> <input type="checkbox"/> 22 <sup>nd</sup>	
5. Bank Address (Street, City, County, State, Zip)			
6. Name (First, Middle, Last) of First Depositor		7. Name (First, Middle, Last) of Second Depositor	

**M. INTENT TO TRANSFER & LIFE EXPECTANCY EVALUATION**

1. Is there any arrangement that has been established, or is being considered, to transfer the policy, or any part of the policy, or any interest in the policy (including a collateral assignment)?  
 Yes     No    If Yes, explain.

2. Has there been a life expectancy evaluation of the insured in the past 2 years or is there an arrangement which has been established or is being considered to perform one in the future?  
 Yes     No    If Yes, explain.

3. Have you settled a life insurance policy in the past 5 years?  
 Yes     No    If yes, indicate which policy (listed in Section N) was settled and explain.

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**N. LIFE INSURANCE IN FORCE OR PENDING**

Proposed Insured 1      Proposed Insured 2

1. Have you ever applied for life, health or disability insurance and been declined, postponed or charged an increased premium?       YES    NO       YES    NO

2. Do you have any formal or informal applications pending with any other life insurance company now?       YES    NO       YES    NO

If answered "Yes" to above questions, please give details for each Proposed Insured including Company, Face Amount, and total amount to be placed for Question # 2.

Proposed Insured 1 \_\_\_\_\_

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Proposed Insured 2 \_\_\_\_\_

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3. List all Insurance In Force on any Proposed Insured. **If none, check this box.**

Insured's Name & Company	Face Amount	Policy Number	Issue Year	Is this Policy being Replaced or Changed?	Check if 1035 Exchange
				<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/>
				<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/>
				<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/>
				<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/>
				<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/>

**O. REPLACEMENT AND 1035 EXCHANGE INFORMATION**

1. a) Are you considering stopping premium payments, surrendering, replacing, forfeiting, assigning to the insurer or reducing your benefits under an existing policy or contract?       YES    NO

b) Are you considering using or borrowing funds from your existing policies or contracts to pay premiums due on the new or applied for policy?       YES    NO

If answered "Yes" to either question, please complete and sign all required replacement forms.

2. If 1035 Exchange, will loan be carried over?    YES    NO      If Yes, amount   \$ \_\_\_\_\_

**O. REPLACEMENT AND 1035 EXCHANGE INFORMATION (Continued)**

Loan Election for policy with an Indexed Loan feature

Loans being carried over to a policy with an Indexed Loan feature must elect the option to apply to the transferred loan. Please make one of the selections below:

Traditional Loan Option

Indexed Loan Option

**P. TOBACCO AND/OR NICOTINE USE**

1. Does any person proposed for coverage, currently use or have they ever used tobacco or nicotine products in any form? (e.g., cigarettes, cigars, pipes, chewing tobacco, nicotine gum, or patches, or any other nicotine delivery system)?

PI 1    YES    NO      PI 2    YES    NO

2. If "Yes":      **PI1**    Type \_\_\_\_\_      Frequency \_\_\_\_\_      Date Last Used \_\_\_\_\_

**PI2**    Type \_\_\_\_\_      Frequency \_\_\_\_\_      Date Last Used \_\_\_\_\_

**Q. PERSONAL INFORMATION**

*Complete for all Proposed Insureds*

*Provide details to any yes answers in the "Details" section*

	PI 1	PI 2
1. Annual earned income from occupation (After deduction of business expenses)	\$	\$
2. Other income (give source) _____	\$	\$
3. Net Worth _____	\$	\$

	PI 1		PI 2	
	YES	NO	YES	NO
4. Has any Proposed Insured declared bankruptcy? (If "Yes" has it been discharged and date of discharge)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Does any Proposed Insured intend to reside or travel outside the United States within the next 24 months? (If "Yes" complete foreign travel questionnaire <b>EXCEPT</b> for vacations of not more than 2 weeks duration, provide complete details including Dates, Destinations, and Duration in the Details section)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. Is any Proposed Insured a member, or intending to become a member, of any armed forces or military reserve?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. Within the past three years, has any Proposed Insured:				
(a) Flown or taken instruction as a pilot or crew member or intend to do so? (If "Yes", complete Aviation Supplement)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(b) Engaged in any kind of racing, scuba or sky diving, hang gliding, rock climbing, or other hazardous avocation or intend to do so? (If "Yes", complete appropriate questionnaire)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(c) Been convicted of a moving violation or had their driver's license suspended or revoked?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. Has any Proposed Insured <b>ever</b> :				
(a) Used amphetamines, barbiturates, hallucinogens, marijuana, cocaine, narcotics, or other controlled substances, except as prescribed by a physician?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(b) Been counseled or treated for use of alcohol or drugs?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(c) Been convicted of a DUI (driving under the influence of alcohol or drugs)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. Has any proposed insured been convicted of, or currently charged with, the commission of any criminal offense – other than the violation of a motor vehicle law – within the last 10 years?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

<b>Q. PERSONAL INFORMATION (Continued)</b>		<b>PI 1</b>		<b>PI 2</b>																			
		YES	NO	YES	NO																		
<p><i>Complete for all Proposed Insureds.</i></p> <p><i>Provide details to any yes answers in "Details" Section</i></p>	10. Is there any family history of cancer, diabetes, heart disease, Huntington's Chorea, neuromuscular disorder, stroke, TIA (transient ischemic attack) or other cerebrovascular disorder? If yes, give details to include the family member, diagnosis and age at diagnosis.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>																		
	11. Is any Proposed Insured currently receiving, or within the past 10 years have they received or applied for, any disability benefits, including Workers Compensation, Social Security Disability Insurance, or any other form of disability insurance? (If Yes, give details)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>																		
	12. Do you engage in regular exercise?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>																		
	a) What type of exercise _____																						
	b) How many times per week _____																						
	c) How Long ( Hours/ minutes per occasion) _____																						
	13. In the past year have you participated in any organized fitness events such as a run, bike race etc. (If Yes, give details)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>																		
	14. Within the past five years, have you had a routine health screening that included a colonoscopy, prostate exam, mammogram or PAP test? If yes, give details to include the type of test, the frequency of testing, the date of the last test, and the results.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>																		
	Detail of any YES answers in Section Q: _____																						
	_____																						
	_____																						
	_____																						
	_____																						
	_____																						
_____																							
<b>R. FINANCIAL NEEDS/ BENEFITS</b>	Financial needs/benefits (check all that apply)																						
<i>Complete for all Proposed Insureds.</i>	<input type="checkbox"/> Death Benefit/Enhanced Death Benefit <input type="checkbox"/> Savings, Accumulation <input type="checkbox"/> Retirement Funding <input type="checkbox"/> Education/College Funding <input type="checkbox"/> Estate Planning <input type="checkbox"/> Debt Protection <input type="checkbox"/> Charitable Giving <input type="checkbox"/> Buy/Sell <input type="checkbox"/> Key Person <input type="checkbox"/> Deferred Compensation <input type="checkbox"/> Other _____																						
<b>S. PERSONAL PHYSICIAN</b>	<table border="1" style="width:100%; border-collapse: collapse;"> <tr> <td style="width:50%; padding: 5px;">1. <b>Proposed Insured 1:</b> Physician Name</td> <td style="width:20%; padding: 5px;">2. Phone No. (       )</td> <td style="width:30%; padding: 5px;">3. Date Last Seen</td> </tr> <tr> <td colspan="3" style="padding: 5px;">4. Address: (Street, City, State, Zip)</td> </tr> <tr> <td colspan="3" style="padding: 5px;">5. Reason Last Seen:</td> </tr> <tr> <td style="padding: 5px;">6. <b>Proposed Insured 2:</b> Physician Name</td> <td style="padding: 5px;">7. Phone No. (       )</td> <td style="padding: 5px;">8. Date Last Seen</td> </tr> <tr> <td colspan="3" style="padding: 5px;">9. Address: (Street, City, State, Zip)</td> </tr> <tr> <td colspan="3" style="padding: 5px;">10. Reason Last Seen:</td> </tr> </table>					1. <b>Proposed Insured 1:</b> Physician Name	2. Phone No. (       )	3. Date Last Seen	4. Address: (Street, City, State, Zip)			5. Reason Last Seen:			6. <b>Proposed Insured 2:</b> Physician Name	7. Phone No. (       )	8. Date Last Seen	9. Address: (Street, City, State, Zip)			10. Reason Last Seen:		
1. <b>Proposed Insured 1:</b> Physician Name	2. Phone No. (       )	3. Date Last Seen																					
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5. Reason Last Seen:																							
6. <b>Proposed Insured 2:</b> Physician Name	7. Phone No. (       )	8. Date Last Seen																					
9. Address: (Street, City, State, Zip)																							
10. Reason Last Seen:																							
<i>If no personal physician, list physician last consulted, date and reason last consulted</i>																							

**T. MEDICAL HISTORY**

*Complete for all Proposed Insureds not requiring an examination (see Penn Mutual medical evidence chart for details). Completion for Proposed Insureds being examined is optional, but encouraged.*

*Provide details to any yes answers in "Details" Section U*

	Proposed Insured 1		Proposed Insured 2	
1. Height (in shoes)	ft.	in.	ft.	in.
2. Weight (clothed)	lbs.		lbs.	
3. Weight change in last year?	Yes_____	No_____	Yes_____	No_____
If "Yes":	No. of lbs.	Reason:	No. of lbs.	Reason:
4. Birth weight if under 6 mo. old	lbs.		lbs.	
			PI 1	PI 2
			YES	NO
			YES	NO
5. Are you presently taking medication, supplements or homeopathic remedies, either prescribed or over the counter? If yes, provide full details including name, dosage, and prescribing physician. (if applicable)			<input type="checkbox"/>	<input type="checkbox"/>
6. Within the past five years, has any Proposed Insured:				
(a) Consulted a physician for any reason, had an electrocardiogram or other diagnostic tests?			<input type="checkbox"/>	<input type="checkbox"/>
(b) Been in a clinic, hospital or medical facility for observation or treatment?			<input type="checkbox"/>	<input type="checkbox"/>
(c) Been advised to have any diagnostic test, hospitalization or surgery which was not done?			<input type="checkbox"/>	<input type="checkbox"/>
7. Has any Proposed Insured ever been treated for, or been diagnosed with:				
(a) Chest pain, high blood pressure, stroke, TIA (transient ischemic attack), heart murmur, palpitations, rhythm disturbance, or other disorder of the heart, cardiovascular or cerebrovascular systems.			<input type="checkbox"/>	<input type="checkbox"/>
(b) Cancer, cyst, growth, tumor?			<input type="checkbox"/>	<input type="checkbox"/>
(c) Anxiety, depression, dizziness, convulsions, epilepsy or any mental or nervous disorder?			<input type="checkbox"/>	<input type="checkbox"/>
(d) Diabetes, thyroid or other glandular disease?			<input type="checkbox"/>	<input type="checkbox"/>
(e) Colitis, hepatitis, or any liver, stomach or other gastrointestinal disorder?			<input type="checkbox"/>	<input type="checkbox"/>
(f) Breast, prostate or reproductive disorder?			<input type="checkbox"/>	<input type="checkbox"/>
(g) Kidney, bladder or other genitourinary disorder?			<input type="checkbox"/>	<input type="checkbox"/>
(h) Asthma, emphysema, chronic obstructive pulmonary disease (C.O.P.D.), sleep apnea, or other respiratory disorder?			<input type="checkbox"/>	<input type="checkbox"/>
(i) An immune deficiency disorder, Acquired Immune Deficiency Syndrome (AIDS), Aids Related Complex (ARC), or tested positive for the HIV virus?			<input type="checkbox"/>	<input type="checkbox"/>

U. DETAILS FOR MEDICAL HISTORY QUESTIONS	Question No. and Letter	Person	Date	Details (include full names and address of physicians, hospitals, etc.)

V. FAMILY HISTORY  <i>* Complete amount of Insurance only if Primary Insured is under age 17.</i>	1. Proposed Insured 1	Age if Living	State of Health	Amount of Insurance *	Age at Death	Cause of Death
	Father					
	Mother					
	Brothers and Sisters No. Living _____ No. Dead _____					
	1. Proposed Insured 2	Age if Living	State of Health	Amount of Insurance *	Age at Death	Cause of Death
	Father					
	Mother					
	Brothers and Sisters No. Living _____ No. Dead _____					

<b>SPECIAL INSTRUCTIONS</b>	
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<b>NON-CONFORMING ILLUSTRATION ACKNOWLEDGEMENT (NON-VARIABLE ONLY)</b>	<p>I acknowledge that the life insurance policy illustration shown to me differs from the policy application I have completed. I understand that if a policy is issued, an illustration conforming to the policy, as issued, will be provided to me for my signature no later than at the time the policy is delivered.</p> <p><input type="checkbox"/> check if applicable</p>
<b>AUTHORIZATION FOR FUND TRANSFER (VARIABLE ONLY)</b>	<p>The agent/registered representative may request transfers of account values pursuant to my instruction unless I check this box.</p> <p><input type="checkbox"/> check if applicable</p>
<b>PENN CHECK AUTHORIZATION</b>	<p>By completing Section L of this application, I authorize monthly payments from my checking or savings account, or from my Pershing Resource Checking or Pro Cash Plus account to the Penn Mutual Life Insurance Company, its subsidiaries, affiliates, and third party administrators (herein Company) for premiums on this policy, beginning with the next periodic payment that comes due under the contract, until such time as a payment cannot be made due to insufficient funds or the Company gives the other parties at least 30 days' advance written notice of the termination of such payment plan. I am able to cancel the payment plan at any time by either calling the Company at 1-800-523-0650 or in writing. Monthly payments will be drawn from my account on or about the date specified in this application. <b>If no date has been selected in Question 4 of Section L, the draw date will be the 15th of the month.</b></p> <p>I further agree that if any such check be dishonored, whether with or without cause and whether intentionally or inadvertently, the Company shall be under no liability whatsoever even though such dishonor results in the forfeiture of insurance.</p>
<b>NOTICE AND CONSENT FOR CORPORATE OWNED INSURANCE</b>	<p>I consent to being insured for an initial maximum amount of insurance as indicated in Section C of this application. I understand that my employer when written in Section F and Section H of this application will be the owner and beneficiary of the life insurance policy and may continue to maintain the insurance coverage beyond the term of my employment.</p>
<b>INDEXED ACCOUNT DISCLOSURE</b>	<p>Premium allocated to a segment of the Indexed Account is eligible to receive index credits based on the performance of Standard &amp; Poor's® * Composite Stock Price Index (S&amp;P 500® Index®*) over the segment's duration, subject to a Participation Percentage and a Cap Percentage. The Participation Percentage and the Cap Percentage are set by the Company but are guaranteed to be no less than the guaranteed minimum percentage amount and minimum interest rate stated in the policy form.</p> <p>"Standard &amp; Poor's®", "S&amp;P 500®", "Standard &amp; Poor's 500®", and "500®" are trademarks of the McGraw-Hill Companies, Inc. and have been licensed for use by The Penn Mutual Life Insurance Company and its affiliates. The Product is not sponsored, endorsed, sold or promoted by Standard &amp; Poor's® and Standard &amp; Poor's® makes no representations regarding the advisability of investing in the Product.</p>
<b>REPRESENTATIONS</b>	<p>I(we), the Proposed Insured(s), or Applicant(s) if Proposed Insured(s) is(are) age 17 or less, represent that the statements and answers in this part I of the application are written as made by me(us) and are complete and true to the best of my (our) knowledge and belief. I(we) the Proposed Insured(s), or the Applicant(s) if other than the Proposed Insured(s) agree that they will be a part of the contract of insurance if issued; that I(we) will be bound by such statements and answers, and that the Company, believing them to be true, will rely and act upon them. I(we) also understand and agree that:</p> <ol style="list-style-type: none"> <li><b>Subject to the provisions of the temporary insurance agreement attached to this application, no insurance will be in force until the first premium is paid in full and the policy is delivered while the health, habits, occupation and other facts relating to the Proposed Insured(s) and to the Payor, if a Payor Benefit is issued, are the same as described in this Part I of the application, any Part II required by the Company and any amendments or supplements to them.</b></li> <li>Notice to or knowledge of an agent or a medical examiner is not notice to or knowledge of the Company, and no agent or medical examiner is authorized to accept risks, to pass upon acceptability for insurance or to modify any contract of insurance.</li> <li>Acceptance of any policy issued based on this application will be a ratification of any amendments or corrections noted by the Company in the space headed "Home Office Amendments and Corrections", except that if required by state statute or regulation, any change in amount, age, plan of insurance, additional benefits or classification must be agreed to in writing.</li> </ol>

**FRAUD WARNING**

*Applies to all states except those specifically listed.*

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or a 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.

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, and 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: **WARNING** 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 application containing any false, incomplete, or misleading information is guilty of a felony in 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.

Louisiana: 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.

Maine & Tennessee: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purposes 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 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 the 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 for an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

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

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.

Virginia: Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submit an application or files a claim containing a false or deceptive statement may have violated state law.

Vermont: 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 may be proven guilty or fraud.

Washington: Any person who knowingly presents a false or fraudulent claim for payment of a loss or knowingly makes a false statement in an application for insurance may be guilty of a criminal offense under state law.

<p><b>AUTHORIZATION</b></p> <p><i>Write in names of all Proposed Insureds.</i></p>	<p>I(we), _____ hereby authorize: (a) any physician, health care provider, health plan, medical professional, hospital, clinic, laboratory, pharmacy or other medical or health care facility that has provided payment, treatment or services to me(us) or on my(our) behalf; (b) any insurance company; and, (c) the Medical Information Bureau, Inc. (MIB), to disclose my(our) entire medical record and any other protected health information concerning me(us) to the Underwriting Department of The Penn Mutual Life Insurance Company, its subsidiaries, affiliates, third party administrators and reinsurers (herein Company).</p> <p>I(we) understand that such information may include records relating to my(our) physical or mental condition such as diagnostic tests, physical examination notes, and treatment histories, which may include information regarding the diagnosis and treatment of human immunodeficiency virus (HIV) infection, sexually transmitted diseases, and mental illness, and the use of alcohol, drugs and tobacco, but shall not include psychotherapy notes.</p> <p>I(we) acknowledge that any agreements I(we) have made to restrict my(our) protected health information do not apply to the Authorization, and I(we) instruct any physician, health care professional, hospital, clinic, medical facility or other health care provider to release and disclose my(our) entire medical record without restriction.</p> <p>I(we) understand that this information will be used by the Company to determine eligibility for insurance.</p> <p>I(we) hereby authorize the Company to disclose any information it obtains about me(us) to the Medical Information Bureau, Inc., or any other life insurance company with which I(we) do business. I understand that the Company will not disclose information it obtains about me(us) except as authorized by this Authorization, as may be required or permitted by law, or as I(we) may further authorize. I(we) understand that if information is redisclosed as permitted by this Authorization, it may no longer be protected by applicable federal privacy law.</p> <p>I(we) understand that: (a) this Authorization shall be valid for 30 months from the date I(we) sign it; (b) I(we) may revoke it at any time by providing written notice to the Underwriting Department of the Company subject to the rights of any person who acted in reliance on it prior to receiving notice of its revocation; and (c) my(our) authorized representative and I(we) are entitled to receive a copy of the Authorization upon request and (d) a copy of this Authorization shall be as valid as the original.</p> <p>I(we) acknowledge receiving an MIB, Inc. Notice, a Fair Credit Reporting Act Notice and a Notice of Information Practices and authorize Penn Mutual to obtain an investigative or other consumer report as described in the Fair Credit Reporting Act Notice.</p>														
<p><b>CERTIFICATION OF OWNER'S TAXPAYER ID #</b></p>	<p>Under penalty of perjury, I the owner certify that:</p> <ol style="list-style-type: none"> <li>1. The number shown in this application as my social security number or taxpayer identification number is correct; and</li> <li>2. I am not subject to backup withholding because I have not been notified by the IRS that I am subject to backup withholding as a failure to report all interest or dividends, or the IRS has notified me that I am no longer subject to backup withholding, or I am exempt from backup withholding.</li> <li>3. I am a U.S. person (including a U.S. resident alien)</li> </ol> <p><input type="checkbox"/> Check this box if you are subject to backup withholding under section 3406(a)(1)(c) of the Internal Revenue Code.</p>														
<p><b>SIGNATURES</b></p>	<p>Signed and Dated by the Applicant in:</p> <table border="0" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 33%; border-bottom: 1px solid black;"></td> <td style="width: 33%; border-bottom: 1px solid black;"></td> <td style="width: 33%; border-bottom: 1px solid black;"></td> </tr> <tr> <td style="text-align: center;">City</td> <td style="text-align: center;">State</td> <td style="text-align: center;">Month/Day/Year</td> </tr> </table> <p style="background-color: #cccccc; padding: 2px;">SIGNATURE OF INSURED - OR PARENT IF INSURED IS UNDER THE AGE OF 18</p> <table border="0" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 50%; border-bottom: 1px solid black;">X _____</td> <td style="width: 50%; border-bottom: 1px solid black;">X _____</td> </tr> <tr> <td style="text-align: center;">Proposed Insured 1</td> <td style="text-align: center;">Proposed Insured 2</td> </tr> </table> <p style="background-color: #cccccc; padding: 2px;">SIGNATURE OF OWNER AND/OR APPLICANT - IF OTHER THAN THE PROPOSED INSURED</p> <table border="0" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 50%; border-bottom: 1px solid black;">X _____</td> <td style="width: 50%; border-bottom: 1px solid black;">X _____</td> </tr> <tr> <td style="text-align: center;">Owner*</td> <td style="text-align: center;">Applicant</td> </tr> </table> <p>*If a Corporation, the signature and title of any authorized officer other than the Proposed Insured(s) is required and the full name of the corporation must be shown. If a Trust, the signature of the Trustee(s), as required by the Trust document.</p>				City	State	Month/Day/Year	X _____	X _____	Proposed Insured 1	Proposed Insured 2	X _____	X _____	Owner*	Applicant
City	State	Month/Day/Year													
X _____	X _____														
Proposed Insured 1	Proposed Insured 2														
X _____	X _____														
Owner*	Applicant														

**AGENTS  
CERTIFICATION**

*Be sure to check  
appropriate block.  
Each agent present at  
solicitation must sign.*

I certify to the best of my knowledge the answers to the questions in all parts of this application are true and correct. I further certify to the best of my knowledge this policy  **will**  **will not** replace or change any existing life insurance or annuity policy now in force.

X \_\_\_\_\_  
Agent

**HOME OFFICE  
AMENDMENTS  
AND  
CORRECTIONS**

*Not applicable in  
Pennsylvania.*

*SERFF Tracking Number:* PNMU-125942972      *State:* Arkansas  
*Filing Company:* Penn Insurance and Annuity Company      *State Tracking Number:* 41940  
*Company Tracking Number:* PIAT-08, ETC.  
*TOI:* L04I Individual Life - Term      *Sub-TOI:* L04I.003 Single Life - Single Premium  
*Product Name:* NonRenewable One Year Term Life Insurance Policy  
*Project Name/Number:* PIAT-08, etc./PIAT-08, etc.

## **Rate Information**

Rate data does NOT apply to filing.

SERFF Tracking Number: PNMU-125942972 State: Arkansas  
Filing Company: Penn Insurance and Annuity Company State Tracking Number: 41940  
Company Tracking Number: PIAT-08, ETC.  
TOI: L04I Individual Life - Term Sub-TOI: L04I.003 Single Life - Single Premium  
Product Name: NonRenewable One Year Term Life Insurance Policy  
Project Name/Number: PIAT-08, etc./PIAT-08, etc.

## Supporting Document Schedules

### Review Status:

**Satisfied -Name:** Certification/Notice

12/11/2008

**Comments:**

**Attachments:**

Certification of Compliance - AR - PIA.pdf  
Flesch Certification - AR - PIA.pdf

### Review Status:

**Satisfied -Name:** Statement of Variability

01/22/2009

**Comments:**

**Attachments:**

Stmnt of Variability - PIA.pdf  
Stmnt of Variability - PIA - application 1143.pdf

**Arkansas Certification of Compliance  
Penn Insurance and Annuity Company**

- We confirm we are in compliance with Ark. Code Ann 23-79-138 in that each policy issued shall be accompanied by complete address, telephone number, 800 number of our policyholder's service office; the name, address and telephone number of the soliciting agent; and the address, telephone number and 800 number of the state insurance department.
- We confirm that we are in compliance with Regulation 49 in that a guaranty fund notice will be given to each policy owner.
- We confirm that we are in compliance with Regulation 19 in that there will be no unfair discrimination in the sale of insurance by the Company.



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Raymond G. Caucci, FSA, MAAA  
Vice President and Life Product Actuary

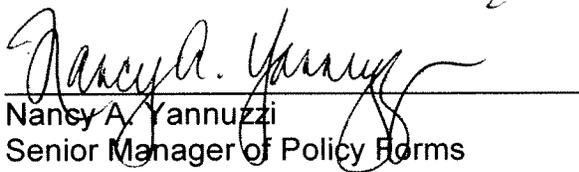
January 21, 2009

**The Penn Insurance and Annuity Company**

**CERTIFICATION**

"This is to certify that the form listed below is in compliance with the requirements of Ark. Stat. Ann. 66-3251 through 66-3258, cited as the Life and Disability Insurance Policy Language Simplification Act."

<u>Form No.</u>	<u>Title</u>	<u>Flesch Score</u>
PI AT-08(AR)	NonRenewable One Year Term Life Insurance Policy	51.7
PI5696	Application for Life Insurance Guaranteed Issue	51.2
PI5776	Supplemental Application for Life Insurance Simplified Issue	50.5
PM1143 version 10/08	Life Application	50.1

  
\_\_\_\_\_  
Nancy A. Yannuzzi  
Senior Manager of Policy Forms

January 21, 2009

**THE PENN INSURANCE AND ANNUITY COMPANY**

**STATEMENT OF VARIABILITY**

Form Number(s): PI AT-08

Any use of variability shall be administered in a uniform and non-discriminatory manner. Any changes will be filed with the state .

<u>Page Number</u>	<u>Description</u>
Pg 3, Front Cover	A- Face Amount will vary based on the owner's financial objective.
Pg 3	B- Age will vary as the issue ages are 0-85. Male will vary based on the insured's gender (if applicable).If this were a unisex policy, nothing would print (neither male nor female).The same rates apply to either sex.
Pg 3	C- Premium Class will vary based on the insured's rate classification from one of the following: Elite Preferred Nontobacco, Preferred Plus Nontobacco, Preferred Nontobacco, Standard Nontobacco, Preferred Tobacco, Standard Tobacco.
Pg 3	D- The Expiration Date and The Final Conversion Date is one year from the Policy Date. The dates will vary depending on the Policy Date.
Pg 3	E. The Annual Premium will vary based on the face amount of the policy and the insured's premium class and rate classification.



Jay T. Lewellen, FSA, MAAA  
Assistant Vice President & Actuary

Date: November 25, 2008

**THE PENN INSURANCE & ANNUITY COMPANY**

**STATEMENT OF VARIABILITY**

Date: 12/05/08

Form Number(s): PM1143 version 10/08

Any use of variability shall be administered in a uniform and non-discriminatory manner. Any changes will be filed with the state

**Page Number**

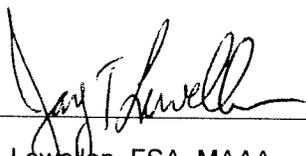
**Description**

Pg 2 &3

A - We have placed brackets around the riders because as we get new products approved we'd like to have the option to add these to the application without having to refile the application each time.

Pg 5

B - We placed brackets around the draw dates so if our system is able to produce draw dates on any additional dates we would like the insured to have those options.



Jay T. Lewellen, FSA, MAAA  
Assistant Vice President & Actuary

Date: December 5, 2008