

SERFF Tracking Number: IASL-126371372 State: Arkansas  
 Filing Company: Sterling Investors Life Insurance Company State Tracking Number: 44109  
 Company Tracking Number: SI LEGACY II AR  
 TOI: L071 Individual Life - Whole Sub-TOI: L071.101 Fixed/Indeterminate Premium - Single Life  
 Product Name: SI LEGACY II AR  
 Project Name/Number: /

## Filing at a Glance

Company: Sterling Investors Life Insurance Company

Product Name: SI LEGACY II AR

SERFF Tr Num: IASL-126371372 State: Arkansas

TOI: L071 Individual Life - Whole

SERFF Status: Closed-Approved-Closed  
 State Tr Num: 44109

Sub-TOI: L071.101 Fixed/Indeterminate  
 Premium - Single Life

Co Tr Num: SI LEGACY II AR

State Status: Approved-Closed

Filing Type: Form

Author: Karen Nowlan

Reviewer(s): Linda Bird

Date Submitted: 11/16/2009

Disposition Date: 11/23/2009

Disposition Status: Approved-Closed

Implementation Date Requested: On Approval

Implementation Date:

State Filing Description:

## General Information

Project Name:

Status of Filing in Domicile: Authorized

Project Number:

Date Approved in Domicile: 10/20/2009

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: 11/23/2009

Explanation for Other Group Market Type:

State Status Changed: 11/23/2009

Deemer Date:

Created By: Karen Nowlan

Submitted By: Karen Nowlan

Corresponding Filing Tracking Number:

Filing Description:

Enclosed please find a letter authorizing Insurance Administrative Solutions, L.L.C. to file the above-captioned forms on behalf of Sterling Investors Life Insurance Company. This is a new filing. A letter of authorization is included for the Department's reference. We are requesting the Department's review and approval of this filing

This is a Whole Life Insurance Policy with the proceeds being paid out annually over 15 years. Premiums will be payable for life, five years or ten years. There will be no lump sum payout. An applicant may designate up to ten beneficiaries to receive an annual benefit payout for 15 years leaving a legacy in their remembrance.

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The Amendment to Application form number SIL2ATA will be used when applicant leaves an answer blank or changes are made to the application without the applicant's initials. The form will be sent to the applicant for their signature. Variable language for SIL2ATA and a "John Doe" form are also enclosed. The Supplemental Application for Life Insurance form number SIL2OAPP1009GN allows for the owner of the policy to be a person other than the proposed insured and to establish an irrevocable beneficiary.

Thank you for your assistance. If you have any questions or comments, please contact me at 1-877-777-2443, extension 2171 or by e-mail at Karen.Nowlan@iasadmin.com. My fax number is 727-584-5613.

## Company and Contact

### Filing Contact Information

Karen Nowlan, Compliance analyst karen.nowlan@iasadmin.com  
 8545 126th Avenue North 727-584-0007 [Phone] 2171 [Ext]  
 Suite 200 727-584-5613 [FAX]  
 Largo, FL 33773-1502

### Filing Company Information

(This filing was made by a third party - insuranceadministrativesolutions)

Sterling Investors Life Insurance Company	CoCode: 89184	State of Domicile: Georgia
210 East Second Avenue, Suite 105	Group Code: -99	Company Type: Life and Health
Rome, GA 30161	Group Name:	State ID Number:
(706) 235-8706 ext. [Phone]	FEIN Number: 59-1838073	

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## Filing Fees

Fee Required?	Yes
Fee Amount:	\$50.00
Retaliatory?	No
Fee Explanation:	
Per Company:	No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Sterling Investors Life Insurance Company	\$50.00	11/16/2009	32063685

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## Correspondence Summary

### Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Linda Bird	11/23/2009	11/23/2009

### Objection Letters and Response Letters

Objection Letters				Response Letters		
Status	Created By	Created On	Date Submitted	Responded By	Created On	Date Submitted
Pending Industry Response	Linda Bird	11/20/2009	11/20/2009	Karen Nowlan	11/23/2009	11/23/2009

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## **Disposition**

Disposition Date: 11/23/2009

Implementation Date:

Status: Approved-Closed

Comment:

Rate data does NOT apply to filing.

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Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification		Yes
Supporting Document	Application		Yes
Supporting Document	Life & Annuity - Actuarial Memo		No
Supporting Document	Letter of authorization		Yes
Supporting Document	Variable Language SIL2ATA and John Doe Form		Yes
Supporting Document	Certification		Yes
Form	Policy		Yes
Form	Application		Yes
Form	Supplemental Beneficiary Form		Yes
Form	Supplemental Application Life Insurance		Yes
Form	Reinstatement Application		Yes
Form	Amendment to Application		Yes
Form	Replacement notice		Yes

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## Objection Letter

Objection Letter Status Pending Industry Response  
Objection Letter Date 11/20/2009  
Submitted Date 11/20/2009  
Respond By Date 12/21/2009

Dear Karen Nowlan,

This will acknowledge receipt of the captioned filing.

Objection 1

No Objections

Comment: Ark. Code Ann. 23-79-138 requires that certain information accompany every policy. Bulletin 15-2009 further address this issue. Please review your issue procedures and assure us that you are in compliance with Ark. Code Ann. 23-79-138.

Regulation 49 requires that a Life and Health guaranty notice be given to each policy owner. Please review your issue procedures and assure us that you are in compliance with Regulation 49.

Regulation 19s10B requires that all new or revised filings submitted must contain a certification that the submission meets the provisions of this rule as well as applicable requirements of this Department.

Please feel free to contact me if you have questions.

Sincerely,

Linda Bird

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## Response Letter

Response Letter Status Submitted to State  
Response Letter Date 11/23/2009  
Submitted Date 11/23/2009

Dear Linda Bird,

### Comments:

Thank you for your prompt response.

### Response 1

Comments: In response to your objection, we submit the required certification.

#### Related Objection 1

Comment:

Ark. Code Ann. 23-79-138 requires that certain information accompany every policy. Bulletin 15-2009 further address this issue. Please review your issue procedures and assure us that you are in compliance with Ark. Code Ann. 23-79-138.

Regulation 49 requires that a Life and Health guaranty notice be given to each policy owner. Please review your issue procedures and assure us that you are in compliance with Regulation 49.

Regulation 19s10B requires that all new or revised filings submitted must contain a certification that the submission meets the provisions of this rule as well as applicable requirements of this Department.

### Changed Items:

#### Supporting Document Schedule Item Changes

Satisfied -Name: Certification

Comment:

No Form Schedule items changed.

No Rate/Rule Schedule items changed.

Thank you.

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Sincerely,  
Karen Nowlan

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## Form Schedule

Lead Form Number: SIL21009AR

Schedule Item Status	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
	SIL21009AR	Policy/Contract Certificate	Policy Fraternal	Initial			SIL21009AR.pdf
	SIL2APP1009AR	Application/Enrollment Form	Application	Initial			SIL2APP1009AR.pdf
	SIL2SAPP1009GN	Other	Supplemental Beneficiary Form	Initial			SIL2SAPP1009GN.pdf
	SIL2OAPP1009GN	Application/Enrollment Form	Supplemental Application Life Insurance	Initial			SIL2OAPP1009GN.pdf
	SIL2RESTAR	Application/Enrollment Form	Reinstatement Application	Initial			SIL2RESTAR.pdf
	SIL2ATA	Application/Enrollment Form	Amendment to Application	Initial			SIL2ATA.pdf
	SIL2REPL	Other	Replacement notice	Initial			SIL2REPL.pdf

**STERLING INVESTORS LIFE INSURANCE COMPANY**

[Rome, Georgia 30161]

**[LIVING LEGACY]  
WHOLE LIFE INSURANCE POLICY**

**This is a Legal Contract between You and Us**

**READ YOUR POLICY CAREFULLY**

In this Policy, "You" and "Your" means the Owner of the Policy shown on the Policy Schedule. "We", "Our" and "Us" refers to Sterling Investors Life Insurance Company.

We promise to pay the Per Beneficiary Annual Payment Amount(s) to each beneficiary for fifteen years upon receipt of due proof of the Insured's death that occurs while this Policy is in force. We make this promise subject to the terms and provisions of this Policy. The following pages are part of the Policy.

**IMPORTANT NOTICE:** The issuance of this Whole Life Insurance Policy is based on the answers to the questions on the application, and any information obtained during telephone interviews. The application is attached to and made a part of this Policy. Omissions or misstatements on the application or during the telephone interview could cause a claim to be denied or the Policy to be rescinded. If, for any reason, the answers are incorrect, contact Us immediately at Our Administrative Office at:

**[P. O. Box 10846  
Clearwater, Florida 33757-8846]  
[Toll Free 1-877-604-5240]**

**Policy Effective Date and Consideration**

The Policy effective date is the Policy Effective Date shown on the Policy Schedule, not the date the application for coverage is signed.

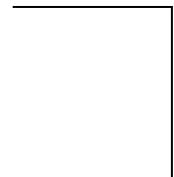
**Thirty Day Right to Examine and Return Policy**

Please read the Policy carefully. If, for any reason, You are not satisfied, You may return the Policy to Us within thirty (30) days after receiving it, and the Policy will be void from its beginning. Any premium paid will be refunded if the policy is void from its beginning.

This Policy is signed for Sterling Investors Life Insurance Company at its Home Office in Rome, Georgia.



**Signature**



**[President]**

**WHOLE LIFE INSURANCE POLICY  
THIS IS A NON-PARTICIPATING POLICY**

## **POLICYHOLDER INFORMATION**

For support and information regarding policy terms, premium payments, claims processing and payment, contact us at:

8545 126<sup>th</sup> Avenue North, Suite 200  
Largo, Florida 33773-1502  
Toll Free 1-877-604-5240

For your information, the following is the name, address and telephone number of your agent:

[Mr. Fred Smith  
123 First Street  
Anywhere, USA 12345  
1-555-555-1234]

The Arkansas Insurance Department can be contacted at:

Arkansas Insurance Department  
Consumer Services  
1200 West Third Street  
Little Rock, Arkansas 72201-1904  
1-501-371-2640

Toll Free Consumer Information Telephone Number  
1-800-852-5494

## Table of Contents

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**POLICY SCHEDULE**

**INSURED:** **POLICY EFFECTIVE DATE:**  
**POLICY NUMBER:** **ISSUE AGE:**  
**SEX:** **STATE OF ISSUE:**  
**MODE AT ISSUE:** **MODAL PREMIUM:**  
**TOBACCO RISK CLASS:**

**\*PER POLICY ANNUAL BENEFIT AMOUNT PAYABLE FOR 15 YEARS:** **[\$XXXXXX]**

**ANNUAL PREMIUM (INCLUDES \$48 POLICY FEE):** **[\$XXXXX]**

**PREMIUM PAYMENT PERIOD:** **[ANNUAL]**

**OWNER:** AS STATED IN THE APPLICATION UNLESS CHANGED AS PROVIDED IN THE POLICY

**PER BENEFICIARY ANNUAL PAYMENT AMOUNT:**

<b>BENEFICIARY:</b> [NUMBER ONE]	\$ [XXX]
<b>[BENEFICIARY:</b> [NUMBER TWO]	\$ [XXX]
<b>[BENEFICIARY:</b> [NUMBER THREE]	\$ [XXX]
<b>[BENEFICIARY:</b> [NUMBER FOUR]	\$ [XXX]
<b>[BENEFICIARY:</b> [NUMBER FIVE]	\$ [XXX]
<b>[BENEFICIARY:</b> [NUMBER SIX]	\$ [XXX]
<b>[BENEFICIARY:</b> [NUMBER SEVEN]	\$ [XXX]
<b>[BENEFICIARY:</b> [NUMBER EIGHT]	\$ [XXX]
<b>[BENEFICIARY:</b> [NUMBER NINE]	\$ [XXX]
<b>[BENEFICIARY:</b> [NUMBER TEN]	\$ [XXX]

**\* The Per Policy Annual Benefit Amount is the sum total of the Per Beneficiary Annual Payment Amounts shown on the policy Schedule. The Per Policy Annual Benefit Amount was used by Your agent to determine the appropriate premium to charge for this Policy and is also used in determining the Table of Guaranteed Policy Values.**

## TABLE OF GUARANTEED POLICY VALUES

THE VALUES SHOWN BELOW ARE FOR THE PER POLICY ANNUAL BENEFIT AMOUNT SHOWN ON THE POLICY SCHEDULE. THEY ARE CALCULATED ASSUMING ALL REQUIRED PREMIUMS ARE PAID TO THE END OF EACH POLICY YEAR. THE VALUES FOR ANY POLICY YEAR NOT SHOWN WILL BE FURNISHED UPON REQUEST USING THE NON-FORFEITURE FACTOR SHOWN BELOW:

END OF POLICY YEAR	ATTAINED AGE	CASH SURRENDER VALUE	EXTENDED TERM INSURANCE	
			YEARS	DAYS
1	66	\$0.00	0	0
2	67	0.00	0	0
3	68	361.40	1	174
4	69	732.90	2	260
5	70	1,116.00	3	249
6	71	1,500.20	4	166
7	72	1,885.40	5	26
8	73	2,269.40	5	201
9	74	2,652.80	5	330
10	75	3,035.90	6	58
11	76	3,418.60	6	122
12	77	3,799.70	6	163
13	78	4,176.60	6	185
14	79	4,546.10	6	191
15	80	4,906.60	6	182
16	81	5,256.50	6	160
17	82	5,595.10	6	128
18	83	5,923.80	6	87
19	84	6,241.80	6	38
20	85	6,547.50	5	351

NONFORFEITURE FACTOR \$56.83213 PER \$100 PER POLICY ANNUAL BENEFIT AMOUNT

**BASIS OF GUARANTEED POLICY VALUES:**

2001 COMMISSIONERS STANDARD ORDINARY TABLE  
 AGE LAST BIRTHDAY  
 MALE or FEMALE, SMOKER or NON-SMOKER  
 ULTIMATE MORTALITY  
 5.00% INTEREST

**BASIS OF RESERVES:**

2001 COMMISSIONERS STANDARD ORDINARY TABLE  
 AGE LAST BIRTHDAY  
 MALE or FEMALE, SMOKER or NON-SMOKER  
 ULTIMATE MORTALITY  
 4.00% INTEREST

## **POLICY BENEFITS**

This is a Whole Life Insurance Policy that DOES NOT have an immediate lump sum death benefit payment option. We will pay the Per Beneficiary Annual Payment Amount(s) less any premium due in fifteen (15) annual installments to each beneficiary shown in the Policy Schedule upon receipt of written proof that the Insured's death occurred while this Policy was in force. We will require surrender of this Policy before any policy benefits will be made. The Per Beneficiary Annual Payment Amount(s) described herein is payable to each beneficiary as shown in the Policy Schedule.

We will pay the Per Beneficiary Annual Payment Amount shown on the Policy Schedule upon receipt of written due proof of loss proving that the Insured's death occurred while this Policy was in force. If there is any outstanding premium due at the time of the Insured's death, payments to each beneficiary will be reduced pro rata until the due premium is collected.

In the event one or more beneficiaries dies before the Insured, the interest of any deceased beneficiary will be divided equally among the remaining living beneficiaries, excluding institutional beneficiaries, at the time of the Insured's death.

Receipt of an annual benefit payment may be taxable. Each beneficiary should consult with a personal tax advisor regarding the impact of receiving life insurance benefits in annual installments.

## **PREMIUMS**

### **Payment**

Premiums are payable in advance at Our Administrative Office in the amount shown on the Policy Schedule. The first premium is due on the date of issue. Each premium after the first is due at the beginning of the period to which it applies. Premiums may be paid as follows: annual or monthly payments for life, five (5) annual payments, or ten (10) annual payments. Monthly premium payments are available only as an Automatic Bank Draft. Annual payments may be changed to monthly bank draft, or monthly bank draft may be changed to annual payments by filing a written request with Our Administrative Office.

The payment of a premium will not keep the Policy in force beyond the next premium due date, except as provided elsewhere in the Policy. Any premium not paid on or before its due date is in default.

### **Grace Period**

A thirty-one (31) day grace period is allowed for the payment of each premium after the first premium is paid. No interest is charged on the late payment. The Policy continues in force during the grace period. If a premium remains in default at the end of the grace period, the Policy lapses, subject to the Options Upon Nonpayment of Premium provision. If the Insured dies during the grace period, the pro-rata premium due is deducted from the proceeds of the Policy.

### **Reinstatement**

If Your Policy has lapsed because You did not pay a premium, You may ask Us to put it back in force. We will reinstate the Policy if the following conditions are met:

1. Not more than three (3) years have passed since the due date of the unpaid premium.
2. You have not surrendered Your Policy for its cash surrender value.
3. You submit evidence satisfactory to Us that the Insured is still insurable according to Our normal rules.
4. All unpaid premiums are paid with interest at 6% compounding annually.

## GENERAL POLICY PROVISIONS

**Entire Contract:** This Policy, including the endorsements, application, and other attached documents, if any, constitutes the entire contract of insurance. No change in this Policy shall be valid until approved by one of Our executive officers and unless such approval be endorsed hereon or attached hereto. No agent has authority to change this Policy or to waive any of its provisions.

**Incontestability:** Except for nonpayment of premiums, this Policy is incontestable after it has been in force during the lifetime of the Insured for two (2) years from the Policy effective date.

**Legal Action:** No action at law or in equity shall be brought to recover on this Policy prior to the expiration of sixty (60) days after written proof of loss has been furnished in accordance with the requirements of this Policy. No such action shall be brought after the expiration of three (3) years after the time written proof of loss is required to be furnished.

**Clerical Error:** Clerical error on Our part will not invalidate insurance otherwise in force nor continue insurance otherwise terminated. Upon discovery of any error, an equitable adjustment will be made in the premiums. Complete proof must be supplied, documenting any clerical errors.

**Misstatement of Age or Sex:** If the age or sex of the Insured has been misstated, the amount payable under this Policy shall be such as the premium paid would have purchased at the correct age or sex.

If according to the correct age, We would not have issued this Policy, We will not pay any benefits and will refund all premiums paid.

**Misstatement of Tobacco Use:** If the information regarding the non-use of tobacco has been misstated in the application, the amount payable under this Policy shall be such as the premium paid would have purchased if the use of tobacco had been correctly disclosed in the application.

**Suicide:** If within two (2) years from the date of issue of this Policy, the Insured dies by suicide, the amount payable by Us in place of all other benefits is the sum of premiums paid, without interest.

**Non-Participating:** This is a non-participating Policy. It will not share in any distribution of the Company's surplus earnings.

### Return of Unearned Premium Upon Death

We will return any unearned premium due upon the Insured's death equally to all beneficiaries.

## OWNER AND BENEFICIARY (IES)

### Owner

At issue, the Owner of this Policy is the person named on the Policy Schedule. During the Insured's lifetime, You have the power to exercise all Policy rights and receive Policy values, subject to any assignment on file with Us. Ownership rights may be exercised without consent of the Insured or a revocable beneficiary. The Per Beneficiary Annual Payment Amount is paid to each beneficiary and not to You unless You are the beneficiary. If You are not the Insured and You predecease the Insured while this Policy is in force, the ownership will pass to the Insured.

## **OWNER AND BENEFICIARY (IES) – CONTINUED**

### **Beneficiary (ies)**

The beneficiary (ies) is named in the application or in the most recently recorded beneficiary change. The interest of any beneficiary, whether revocable or irrevocable (an irrevocable beneficiary cannot be changed, except upon said beneficiary's written consent), ceases when the beneficiary dies before the Insured.

Unless otherwise stated, the interest of any deceased beneficiary passes equally to the surviving beneficiaries, excluding institutional beneficiaries. In the event a beneficiary dies during the payout period, any due but unpaid proceeds will be paid in a lump sum to the beneficiary's estate or legal representative.

If no beneficiary survives the Insured, the Per Beneficiary Annual Payment Amount(s) is paid to You, if living, otherwise to Your estate.

### **Assignment**

This Policy may be assigned as collateral security without changing the rights of Ownership. Your interests and the interests of any beneficiary are subordinate to the interest of any assignee.

An assignment of the Policy is not binding on Us until it is received at Our Administrative Office. We assume no responsibility for the validity of any assignment.

### **Change of Owner or Beneficiary**

During the Insured's lifetime, You have the right to transfer the ownership or change the beneficiary (unless the beneficiary designation is irrevocable) by giving written notice in a form acceptable to Us. Any change is effective when the notice is signed, but will not affect any payment made or any other action taken by Us before We receive the notice. We may require that the Policy be returned for endorsement for any change requested.

## **POLICY VALUES**

### **Net Cash Surrender Value**

The net cash surrender value is the cash surrender value shown in the Table of Guaranteed Policy Values. The cash surrender value at any time other than at the end of a Policy year is determined by making allowance for the lapse in time and for the part of the year that premiums are paid. Surrender within thirty-one (31) days after a Policy anniversary is treated as a surrender on the anniversary.

### **Surrender For Cash**

You may surrender the Policy at any time for its net cash surrender value while the Insured is living. If You request surrender within sixty (60) days after the due date of an unpaid premium, the net cash surrender value is determined as of the due date.

## **POLICY VALUES –CONTINUED**

### **Basis of Computation**

All cash surrender values, reserves (the amount that is held for payment of future benefits), and net single premiums are based on the mortality tables and interest rates shown in the Table of Guaranteed Policy Values.

A detailed statement of the method of computing cash surrender values and reserves is filed with the insurance supervisory official in all states where this Policy is issued. Cash surrender values are calculated in accordance with the Standard Nonforfeiture Method. These values equal or exceed the minimum values required by law.

### **Loans**

Loans are not permitted under this Policy.

### **Options Upon Nonpayment of Premium**

If a premium is in default beyond the grace period, the insurance under the Policy lapses except as may be provided in the following options. One of the following options may be elected by Your written request in a form acceptable to Us no later than sixty (60) days after the premium due date and prior to the Insured's death. If no option is elected within the sixty (60) day time period, the automatic option is Extended Term Insurance.

### **Cash Surrender**

Upon lapse, during the lifetime of the Insured, You may surrender the Policy for its net cash surrender value subject to the Surrender for Cash provision of the Policy Values section of this Policy

### **Extended Term Insurance**

The Policy may be continued from the due date of the premium in default as paid-up term insurance. The amount of insurance continued in force will be the Per Beneficiary Annual Payment Amount(s) in the policy year of the last premium paid. The term of insurance is that which the net cash surrender value will purchase using the net single premium for the Insured's attained age on the due date of the Premium in default.

**[LIVING LEGACY]**

**STERLING INVESTORS LIFE INSURANCE COMPANY**

Home Office: [Rome, Georgia]

Administrative Office: [P.O. Box 10846, Clearwater, FL 33757-8846]

**APPLICATION FOR LIFE INSURANCE**

**PROPOSED OWNER/INSURED**

<b>Name</b> <i>(First, Middle, Last)</i>	<b>Birth Date</b> <i>(mm/dd/yyyy)</i>	<b>Age</b>	<b>Sex</b>	<b>Social Security Number</b>
<b>Street</b>	<b>City</b>	<b>State</b>	<b>Zip Code</b>	<b>Telephone Number</b>
<b>Marital Status</b>	<b>Place of Birth</b> <i>(state)</i>			

**COVERAGE, PREMIUM MODE AND PREMIUM AMOUNT**

Annual Benefit Applied For: \$ \_\_\_\_\_ with 15 years certain payout  Yes  No

Monthly Bank Draft: \$ \_\_\_\_\_ Draft Initial Payment When Policy is Issued:  Yes  No

Other Premium Payment Options: Annual Payments: \$ \_\_\_\_\_ 5 Annual Payments: \$ \_\_\_\_\_

10 Annual Payments: \$ \_\_\_\_\_

**TOBACCO RISK CLASSIFICATION QUESTION**

Have you used any form of tobacco in the last 5 years?  Yes  No

**PART I - ELIGIBILITY QUESTIONS**

*(If you answer "Yes" to one or more of the following questions you are not eligible for coverage).*

1. Have you been diagnosed, received medical treatment or been advised to have treatment, surgery or prescription medication for Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC) or Human Immunodeficiency Virus (HIV) infection?  Yes  No
2. Have you been treated for or diagnosed with a terminal illness?  Yes  No
3. Have you been hospitalized three or more times in the past 12 months, are you currently hospitalized, confined to a nursing facility, bedridden, currently receiving hospice, are you confined to a wheelchair, or do you require the use of a motorized mobility aid?  Yes  No
4. In the past two years have you had:
  - a. Heart Attack, Aneurysm, Stroke or Transient Ischemic Attack (TIA), Atrial Fibrillation or heart valve surgery, cardiac pacemaker implanted or replaced or been treated with a heart defibrillating device?  Yes  No
  - b. Surgery or tests (related to conditions listed in Part I) recommended by a physician but not performed?  Yes  No
5. Within the past five years have you been diagnosed with, received medical treatment or advised to have treatment, including prescription medication for any of the following:
  - a. Parkinson's Disease, Myasthenia Gravis, Multiple or Amyotrophic Lateral Sclerosis, Lupus, Down Syndrome, Cerebral Palsy, Alzheimer's Disease, or Dementia?  Yes  No
  - b. Insulin Dependent Diabetes with uncontrolled High Blood Pressure or requiring more than 60 units of insulin a day or any Kidney Disease requiring dialysis?  Yes  No
  - c. Emphysema, Chronic Obstructive Pulmonary Disease (COPD), or Chronic Pulmonary condition?  Yes  No
  - d. Internal cancer, Leukemia, Malignant Melanoma, Hodgkin's Disease or Lymphoma?  Yes  No
  - e. Congestive Heart Failure?  Yes  No
  - f. Cirrhosis of the liver, Hepatitis, Schizophrenia, Alcohol or Drug Abuse?  Yes  No
  - g. Had an organ transplant or been advised to have an organ transplant?  Yes  No

Mail Policy to the Agent  or the Insured  (if unanswered will mail to agent)

## [LIVING LEGACY]

### PART II – BENEFICIARY DESIGNATION (Maximum of Ten Beneficiaries)

Name of Beneficiary		Relationship	Sex	Birth Date
Address (City/State)	Per Beneficiary Annual Payment Amount	Greeting Name in Card	Sender Name in Card	
Occasion Card (1 to 5)	Occasion Date	Message in Card		
Name of Beneficiary		Relationship	Sex	Birth Date
Address (City/State)	Per Beneficiary Annual Payment Amount	Greeting Name in Card	Sender Name in Card	
Occasion Card (1 to 5)	Occasion Date	Message in Card		
Name of Beneficiary		Relationship	Sex	Birth Date
Address (City/State)	Per Beneficiary Annual Payment Amount	Greeting Name in Card	Sender Name in Card	
Occasion Card (1 to 5)	Occasion Date	Message in Card		
Name of Beneficiary		Relationship	Sex	Birth Date
Address (City/State)	Per Beneficiary Annual Payment Amount	Greeting Name in Card	Sender Name in Card	
Occasion Card (1 to 5)	Occasion Date	Message in Card		
Name of Beneficiary		Relationship	Sex	Birth Date
Address (City/State)	Per Beneficiary Annual Payment Amount	Greeting Name in Card	Sender Name in Card	
Occasion Card (1 to 5)	Occasion Date	Message in Card		
Name of Beneficiary		Relationship	Sex	Birth Date
Address (City/State)	Per Beneficiary Annual Payment Amount	Greeting Name in Card	Sender Name in Card	
Occasion Card (1 to 5)	Occasion Date	Message in Card		

#### Occasion Card Selection:

1 – Happy Birthday    2 – Happy Birthday/Religious    3 – Merry Christmas    4 – Happy Holiday    5 – On This Special Occasion

### PART III – REPLACEMENT INFORMATION

Does the proposed owner/insured have existing life insurance or annuity coverage?  Yes     No

\_\_\_\_\_  
**Proposed Owner/Insured's Signature      Date                                      Agent's Signature                                      Date**

*If the answer to the above question is "No, the agent has no further replacement duties. If the answer is "Yes", the Replacement Notice and the Replacement Memorandum must be completed and submitted with this application. A copy of each completed form must be left with the proposed owner/insured.*

[LIVING LEGACY]

**PART IV - AUTHORIZATION AND CERTIFICATION**

I hereby authorize any licensed physician, medical practitioner, hospital, clinic, laboratory, pharmacy, pharmacy benefit manager or other medical facility, insurance or reinsurance company, Medical Information Bureau (MIB), consumer reporting agency, Division of Motor Vehicles, the Veterans Administration or other medical or medically-related facility, insurance company or Medicare, that has any records or knowledge of me or my health to give Sterling Investors Life Insurance Company, or its reinsurers, any such information. I understand that I am authorizing Sterling Investors Life Insurance Company to receive my health information and prescription drug usage history. The released information received by Sterling Investors Life Insurance Company will remain protected by federal and/or state regulations as long as it is maintained by the insurance plan. Any information that is disclosed pursuant to this authorization may be redisclosed as provided herein or as required or authorized by law and may then no longer be covered by federal rules governing privacy and confidentiality of health information.

I understand that the information requested is necessary for evaluation and underwriting of my application for the insurance policy for which I have applied; to determine eligibility for insurance, risk rating or policy issue determinations; obtain reinsurance; administer claims and determine or fulfill responsibility for coverage and provision of benefits; and to conduct other legally permissible activities that relate to any coverage I have, or have applied for, with Sterling Investors Life Insurance Company. I understand that telephone interviews may be a part of the application process and that any information obtained from such telephone interviews may be used to decline my application for coverage. I understand that failure to provide the authorization to Sterling Investors Life Insurance Company will result in the rejection of the insurance policy coverage. I understand that I may revoke this authorization at any time by notifying Sterling Investors Life Insurance Company in writing at their Administrative Office: P.O. Box 10846, Clearwater, Florida 33757-8846. I understand that such revocation will not have any effect on actions Sterling Investors Life Insurance Company took prior to their receiving the revocation notice. I understand that this authorization will be valid for twenty-four (24) months from the date signed if used in connection with an application for an insurance policy, reinstatement of an insurance policy, or change in policy benefits. A photocopy of this authorization will be treated in the same manner as the original. I understand that I or my authorized representative am entitled to a copy of this authorization.

To the best of my knowledge and belief, all of the answers to the questions contained in this application are true and complete and I understand and agree that: (a) the insurance shall not take effect unless and until the application has been accepted and approved by the Company, the full first premium has been paid, and the policy has been delivered to the owner; and (b) oral statements between the agent and myself are not binding on the Company unless accepted by the Company in writing. The undersigned applicant certifies that the applicant has read, or had read to him, the completed application and that he realizes that any false statements or misrepresentations therein material to the risk may result in loss of coverage under the policy to which this application is a part. I understand that any change in my health history prior to delivery of this policy may be used in the underwriting evaluation process.

**YOUR RIGHTS REGARDING THE RELEASE AND USE OF GENETIC INFORMATION:** No applicant or individual family member who is presently covered under a policy or plan shall be required to be the subject of a genetic test or release genetic test information or to be subjected to questions relating to the genetic information or medical conditions of persons not being insured under such policy or plan.

**ANY PERSON WHO KNOWINGLY PRESENTS A FALSE OR FRAUDULENT CLAIM FOR PAYMENT OF A LOSS OR BENEFIT OR KNOWINGLY PRESENTS FALSE INFORMATION IN AN APPLICATION FOR INSURANCE IS GUILTY OF A CRIME AND MAY BE SUBJECT TO FINES AND CONFINEMENT IN PRISON.**

I understand the policy that I am applying for pays annual benefits for 15 years to the beneficiaries selected by the Owner. I further understand that this policy does not provide a lump sum death benefit.

Signed At: \_\_\_\_\_  
(City /State)

Owner/Insured's Signature

Date (Month/Day/Year)

Agent's Signature

Date (Month/Day/Year)

Agent's Printed Name

Agent's Number

**STERLING INVESTORS LIFE INSURANCE COMPANY**

Home Office: [Rome, Georgia]

Administrative Office: [P.O. Box 10846, Clearwater, FL 33757-8846]

**SUPPLEMENTAL BENEFICIARY FORM**

TO BE ATTACHED TO THE APPLICATION AND MADE A PART OF THE POLICY

Name of Beneficiary		Relationship	Sex	Birth Date
Address (City/State)	Per Beneficiary Annual Payment Amount	Greeting Name in Card	Sender Name in Card	
Occasion Card (1 to 5)	Occasion Date	Message in Card		

Name of Beneficiary		Relationship	Sex	Birth Date
Address (City/State)	Per Beneficiary Annual Payment Amount	Greeting Name in Card	Sender Name in Card	
Occasion Card (1 to 5)	Occasion Date	Message in Card		

Name of Beneficiary		Relationship	Sex	Birth Date
Address (City/State)	Per Beneficiary Annual Payment Amount	Greeting Name in Card	Sender Name in Card	
Occasion Card (1 to 5)	Occasion Date	Message in Card		

Name of Beneficiary		Relationship	Sex	Birth Date
Address (City/State)	Per Beneficiary Annual Payment Amount	Greeting Name in Card	Sender Name in Card	
Occasion Card (1 to 5)	Occasion Date	Message in Card		

Name of Beneficiary		Relationship	Sex	Birth Date
Address (City/State)	Per Beneficiary Annual Payment Amount	Greeting Name in Card	Sender Name in Card	
Occasion Card (1 to 5)	Occasion Date	Message in Card		

**Occasion Card Selection:**

1 – Happy Birthday    2 – Happy Birthday/Religious    3 – Merry Christmas    4 – Happy Holiday    5 – On This Special Occasion

Proposed Insured's Signature		Date (Month/Day/Year)
Owner's Signature (if different from Proposed Insured)		Date (Month/Day/Year)

**STERLING INVESTORS LIFE INSURANCE COMPANY**

Home Office: [Rome, Georgia]

Administrative Office: [P.O. Box 10846, Clearwater, FL 33757-8846]

**SUPPLEMENTAL APPLICATION FOR LIFE INSURANCE  
TO BE ATTACHED TO THE APPLICATION AND MADE A PART OF THE POLICY**

**PROPOSED OWNER, IF DIFFERENT FROM PROPOSED INSURED**

<b>Name</b> ( <i>First, Middle, Last</i> )	<b>Birth Date</b> ( <i>mm/dd/yyyy</i> )	<b>Age</b>	<b>Sex</b>	<b>Social Security Number</b>
<b>Street</b>	<b>City</b>	<b>State</b>	<b>Zip Code</b>	<b>Telephone Number</b>
<b>Marital Status</b>	<b>Place of Birth</b> ( <i>state</i> )			

**BENEFICIARY DESIGNATION**

<b>Name of Beneficiary</b>	<b>Relationship</b>	<b>Address (City/State)</b>	<b>Birth Date</b>
<b>Per Beneficiary Annual Payment Amount</b>	<b>Greeting Name in Card</b>	<b>Sender Name in Card</b>	<b>Occasion Date</b>

Message on Card (Maximum of 150 characters)

I, the Owner, choose and acknowledge the election of an irrevocable beneficiary on this policy.

\_\_\_\_\_  
Owner's Signature

\_\_\_\_\_  
Date (Month/Day/Year)

**STERLING INVESTORS INSURANCE COMPANY OF AMERICA**

Home Office: [Rome, Georgia]

Administrative Office: [P. O. Box 10846 Clearwater, Florida 33757-8846]

**APPLICATION FOR REINSTATEMENT**

I, \_\_\_\_\_ hereby apply for reinstatement of my policy number \_\_\_\_\_.

1. To the best of your knowledge and belief, have you had any illness or personal injury, or consulted with, been prescribed for, operated on, or treated by any physician or other person during the past two years?

Yes  No If your answer is "Yes" give details as follows:

Nature of Sickness, Disease	Dates of Each Occurrence From - To	Surgery Yes/No	Degree of Recovery	Hospitalized Yes/No	Hospital Name & Address If Confined (or Physician if not confined)

2. Name and address of your family physician: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

I hereby reaffirm the correctness of the answers to the questions in my original application for the above-numbered policy, and I hereby represent that I am in good health and free from injury. I agree that if this policy is reinstated, such reinstatement shall be in accordance with the terms of the policy and shall not take effect until this application for reinstatement and the premium payment accompanying this application have been accepted and approved by the Company.

**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.**

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

Signed at \_\_\_\_\_ On \_\_\_\_\_  
City State Month Day Year

HOME OFFICE ONLY:

Reinstatement Effective Date \_\_\_\_\_

Approved By: \_\_\_\_\_

## **AUTHORIZATION FOR RELEASE OF INFORMATION**

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**Applicant Name:**

**Date of Birth:**

**Policy Number:**

**Person/Organizations providing the information:**

Any licensed physician, medical practitioner, hospital, clinic, laboratory, pharmacy, pharmacy benefit manager or other medical facility, insurance or reinsurance company, Medicare, Medical Information Bureau (MIB), consumer reporting agency, Division of Motor Vehicles, the Veterans Administration, or other medical or medical related facility, insurance company that has my records, knowledge of me or my health, information as to diagnosis, treatment or prognosis with respect to the physical or mental condition concerning me.

**Persons/Organizations receiving the information:**

Sterling Investors Life Insurance Company  
Post Office Box 10846  
Clearwater, Florida 33757-8846

**Description of information to be released:**

The entire medical record and any other protected health information or other information concerning me within the past ten (10) years, without restrictions.

**Description of Reason for Disclosure:**

The protected information is to be disclosed under this authorization so that the company may underwrite my application for life insurance, determine eligibility for insurance, risk rating or certificate (policy) issuance determinations; obtain reinsurance and determine or fulfill responsibility for coverage and provision of benefits; administer coverage; and conduct other legally permissible activities that relate to any coverage I have, or have applied for.

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I hereby authorize the use or disclosure of my individually identifiable health information as described above.

- I understand that if I refuse to sign this authorization to release the complete medical records and protected health information, or have any restriction on the release of the protected health information of me, the company will not be able to process the application, or if coverage has been issued, may not be able to make any benefit payments.
- I understand that any information that is disclosed pursuant to this authorization may be redisclosed as provided herein or as required or authorized by law and may then no longer be covered by federal rules governing privacy and confidentiality of health information.
- I understand that I may revoke this authorization at any time by notifying the Requesting Person or Organizations in writing at the address above. I understand that such revocation will not have any effect on actions the plan took prior to their receiving the revocation notice.
- I understand that I or my authorized representative am entitled to a copy of this form upon request.
- I understand that this authorization will expire 24 months from the date of this authorization.

\_\_\_\_\_  
**Signature of Applicant or Applicant's Authorized Representative\***

\_\_\_\_\_  
**Date**

**\*If signed by the Applicant's Authorized Representative, documentation of representative's authority to act on behalf of Applicant must be attached to this form. Examples: Power of Attorney, Guardianship, Court Order, or Notarized Letter of Authorization from the Applicant.**

**STERLING INVESTORS LIFE INSURANCE COMPANY**

Home Office: ROME, GEORGIA

**Mail To:**

**Sterling Investors Life Insurance Company**

**Administrative Office**

**P.O. Box 10846**

**Clearwater, Florida 33755-8846**

**AMENDMENT TO APPLICATION**

I hereby agree that the following changes shall be an amendment to and form a part of the said application and of Policy Number \_\_\_\_\_ if any, and that they shall be binding on any person who shall have or claim any interest under such policy.

Acceptance is acknowledged by:

\_\_\_\_\_  
Insured

\_\_\_\_\_  
Date

**[Signature]**

**[President]**

# STERLING INVESTORS LIFE INSURANCE COMPANY

Home Office: Rome, Georgia 30161

Administrative Office: P.O. Box 10846, Clearwater, Florida 33755-8846 1-877-604-5240

## IMPORTANT NOTICE: REPLACEMENT OF LIFE INSURANCE OR ANNUITIES

This document must be signed by the applicant and the producer, if there is one, and a copy left with the applicant.

You are contemplating the purchase of a life insurance policy or annuity contract. In some cases this purchase may involve discontinuing or changing an existing policy or contract. If so, a replacement is occurring. Financed purchases are also considered replacements.

A replacement occurs when a new policy or contract is purchased and, in connection with the sale, you discontinue making premium payments on the existing policy or contract, or an existing policy or contract is surrendered, forfeited, assigned to the replacing insurer, or otherwise terminated or used in a financed purchase.

A financed purchase occurs when the purchase of a new life insurance policy involves the use of funds obtained by the withdrawal or surrender of or by borrowing some or all of the policy values, including accumulated dividends, of an existing policy to pay all or part of any premium or payment due on the new policy. A financed purchase is a replacement.

You should carefully consider whether a replacement is in your best interests. You will pay acquisition costs and there may be surrender costs deducted from your policy or contract. You may be able to make changes to your existing policy or contract to meet your insurance needs at less cost. A financed purchase will reduce the value of your existing policy and may reduce the amount paid upon the death of the insured.

We want you to understand the effects of replacements before you make your purchase decision and ask that you answer the following questions and consider the questions on the back of this form.

1. Are you considering discontinuing making premium payments, surrendering, forfeiting, assigning to the insurer, or otherwise terminating your existing policy or contract?  YES  NO
2. Are you considering using funds from your existing policies or contracts to pay premiums due on the new policy or contract?  YES  NO

If you answered "yes" to either of the above questions, list each existing policy or contract you are contemplating replacing (include the name of the insurer, the insured or annuitant, and the policy or contract number if available) and whether each policy or contract will be replaced or used as a source of financing:

	INSURER NAME	CONTRACT OR POLICY NUMBER	INSURED OR ANNUITANT	REPLACED (R) OR FINANCING (F)
1.	_____	_____	_____	_____
2.	_____	_____	_____	_____
3.	_____	_____	_____	_____

Make sure you know the facts. Contact your existing company or its agent for information about the old policy or contract. If you request one, an in force illustration, policy summary or available disclosure documents must be sent to you by the existing insurer. Ask for and retain all sales material used by the agent in the sales presentation. Be sure that you are making an informed decision.

The existing policy or contract is being replaced because \_\_\_\_\_.

I certify that the responses herein are, to the best of my knowledge, accurate:

\_\_\_\_\_  
Applicant's Signature and Printed Name Date

\_\_\_\_\_  
Producer's Signature and Printed Name Date

**I do not want this notice read aloud to me. \_\_\_\_\_ (Applicants must initial only if they do not want the notice read aloud.)**

A replacement may not be in your best interest, or your decision could be a good one. You should make a careful comparison of the costs and benefits of your existing policy or contract and the proposed policy or contract. One way to do this is to ask the company or agent that sold you your existing policy or contract to provide you with information concerning your existing policy or contract. This may include an illustration of how your existing policy or contract is working now and how it would perform in the future based on certain assumptions. Illustrations should not, however, be used as a sole basis to compare policies or contracts. You should discuss the following with your agent to determine whether replacement or financing your purchase makes sense:

**PREMIUMS:** Are they affordable?  
Could they change?  
You're older—are premiums higher for the proposed new policy?  
How long will you have to pay premiums on the new policy? On the old policy?

**POLICY VALUES:** New policies usually take longer to build cash values and to pay dividends.  
Acquisition costs for the old policy may have been paid, you will incur costs for the new one.  
What surrender charges do the policies have?  
What expense and sales charges will you pay on the new policy?  
Does the new policy provide more insurance coverage?

**INSURABILITY:** If your health has changed since you bought your old policy, the new one could cost you more, or you could be turned down.  
You may need a medical exam for a new policy.  
Claims on most new policies for up to the first two years can be denied based on inaccurate statements.  
Suicide limitations may begin anew on the new coverage.

**IF YOU ARE KEEPING THE OLD POLICY AS WELL AS THE NEW POLICY:**

How are premiums for both policies being paid?  
How will the premiums on your existing policy be affected?  
Will a loan be deducted from death benefits?  
What values from the old policy are being used to pay premiums?

**IF YOU ARE SURRENDERING AN ANNUITY OR INTEREST SENSITIVE LIFE PRODUCT:**

Will you pay surrender charges on your old contract?  
What are the interest rate guarantees for the new contract?  
Have you compared the contract charges or other policy expenses?

**OTHER ISSUES TO CONSIDER FOR ALL TRANSACTIONS:**

What are the tax consequences of buying the new policy?  
Is this a tax free exchange? (See your tax advisor.)  
Is there a benefit from favorable "grandfathered" treatment of the old policy under the federal tax code?  
Will the existing insurer be willing to modify the old policy?  
How does the quality and financial stability of the new company compare with your existing company?

SERFF Tracking Number: IASL-126371372 State: Arkansas  
 Filing Company: Sterling Investors Life Insurance Company State Tracking Number: 44109  
 Company Tracking Number: SI LEGACY II AR  
 TOI: L071 Individual Life - Whole Sub-TOI: L071.101 Fixed/Indeterminate Premium - Single Life  
 Product Name: SI LEGACY II AR  
 Project Name/Number: /

## Supporting Document Schedules

	<b>Item Status:</b>	<b>Status Date:</b>
<b>Satisfied - Item:</b> Flesch Certification		
<b>Comments:</b>		
<b>Attachment:</b> Sterling Flesch Cert.pdf		

	<b>Item Status:</b>	<b>Status Date:</b>
<b>Satisfied - Item:</b> Application		
<b>Comments:</b> The application is attached under the Form Schedule tab.		

	<b>Item Status:</b>	<b>Status Date:</b>
<b>Satisfied - Item:</b> Letter of authorization		
<b>Comments:</b>		
<b>Attachment:</b> 2009 05 SILIC IAS Authorization letter.pdf		

	<b>Item Status:</b>	<b>Status Date:</b>
<b>Satisfied - Item:</b> Variable Language SIL2ATA and John Doe Form		
<b>Comments:</b>		
<b>Attachments:</b> VariableLanguageSIL2ATA.pdf SIL2ATA JohnDoe.pdf		

	<b>Item Status:</b>	<b>Status Date:</b>

*SERFF Tracking Number:* IASL-126371372      *State:* Arkansas  
*Filing Company:* Sterling Investors Life Insurance Company      *State Tracking Number:* 44109  
*Company Tracking Number:* SI LEGACY II AR  
*TOI:* L071 Individual Life - Whole      *Sub-TOI:* L071.101 Fixed/Indeterminate Premium - Single Life

*Product Name:* SI LEGACY II AR  
*Project Name/Number:* /

**Satisfied - Item:** Certification

**Comments:**

**Attachment:**

AR Certificate of Compliance.pdf

# READABILITY COMPLIANCE CERTIFICATION

**Name and Address of Insurer:**

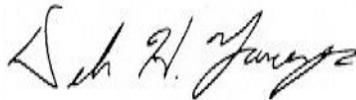
**Sterling Investors Life Insurance Company  
210 E. Second Avenue, Suite 30161  
Rome, Georgia 30161**

**I hereby certify that the Flesch Reading Ease Test Score of the forms listed below are as follows:**

<b>Type and/ or Title of Form(s)</b>	<b>Form Number(s)</b>	<b>Flesch Score</b>
Legacy Life Policy Application	SIL21009AR SIL2APP1009AR	42.2 Scored as a part of the policy.

The type size of the text is at least 10-pointed leaded.

I also certify to the best of my knowledge and belief that the form is in compliance with the Insurance Code and with all other applicable requirements of the Insurance Department in this state.



President

Date: November 10, 2009

STERLING<sup>TM</sup>

## STERLING INVESTORS LIFE INSURANCE COMPANY

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210 E. Second Avenue  
Ste. 105  
Rome, Georgia 30161  
Tel (706) 235-8154  
Fax (866) 889-4054

May 22, 2009

Ms. Darcey Shaffer, FLMI, ACS  
Compliance Manager  
Insurance Administrative Solutions, L.L.C.  
8545 126<sup>th</sup> Avenue North, Suite 200  
Largo, Florida 33773-1502

Re: Life and Health Filings for Rate Increases, Forms and Reporting Requirements for Sterling Investors Life Insurance Company

Dear Ms. Shaffer:

This letter authorizes Insurance Administrative Solutions, L.L.C. to file on behalf of Sterling Investors Life Insurance Company, rate increases, forms and reporting requirements for the Company's Life and Health Insurance Policies with the State Insurance Departments. Insurance Administrative Solutions, L.L.C. may correspond with the State Insurance Departments regarding any questions they may have concerning the filings.

A copy of this letter is as valid as the original. This authorization will be valid for twelve months from the date of this letter.

Sincerely,

  
Elwood Whitacre  
Secretary and Treasurer

**STERLING INVESTORS LIFE INSURANCE COMPANY**

**VARIABLE INFORMATION  
Form SIL2ATA**

**THE FOLLOWING IS A LIST OF THE VARIABLE INFORMATION THAT WOULD APPEAR ON THE APPLICATION AMENDMENT FORM SIL2ATA**

Incorrect, Misspelled or Left Blank - Last or First Name – Example: Jane Smyth is changed to Jayne Smith

Incorrect or Left Blank Middle Initial – Example: M is changed to N

Incorrect, Misspelled or Left Blank - Street – Example: Changed from 1<sup>st</sup> Street to 1<sup>st</sup> Avenue

Incorrect, Misspelled or Blank City – Example: Janesville is changed to Jonesville

Incorrect, Misspelled or Blank State –State: XX

Incorrect or Left Blank -Zip Code – Zip Code: XXXXX-XXXX

Incorrect or Left Blank Age – Example: Age is changed from 65 to 66

Incorrect or Left Blank Date of Birth – Date of Birth: XX/XX/XXXX

Incorrect or Left Blank Sex – SEX: Male

Incorrect, Incomplete or Left Blank Telephone Number – Example: Changed from 000-000-0000 to 123-456-7890

Incorrect, Incomplete or Left Blank Social Security Number – Social Security Number: XXX-XX-XXXX

Incorrect or Left Blank - Marital Status – Example: Single

Incorrect or Left Blank Place of Birth – Example CT

**Coverage, Premium Mode and Premium Amount** Incorrect, Incomplete or Left Blank

Incorrect, Incomplete or Left Blank -Annual Benefit Applied For: Example \$3000

Incorrect or Left Blank - Monthly Draft

Incorrect or Left Blank -Draft Initial Payment When Policy is Issued \_\_\_ Yes \_\_\_ NO :

Incorrect, Incomplete or Left Blank -Other Premium Payment Options:

**Tobacco Risk Classification Question:** - Incorrect, Incomplete or Left Blank

Have you used any form of tobacco in the last 5 years? \_\_\_ Yes \_\_\_ NO :

**PART I - ELIGIBILITY QUESTIONS – Incorrect, Incomplete, Left Blank**

1. **Have you tested positive for exposure to the HIV infection or been diagnosed as having ARC or AIDS caused by the HIV infection or other sickness or condition derived from such infection? Answer: No**
2. **Have you been diagnosed with or treated by a licensed member of the medical profession for a terminal illness? Answer: No**
3. **Have you been hospitalized three or more times in the past 12 months, are you currently hospitalized, confined to a nursing facility, bedridden, currently receiving hospice, are you confined to a wheelchair, or do you require the use of a motorized mobility aid? Answer No**
4. **In the past two years have you:**
  - a) **been advised by a licensed member of the medical profession that you had a Heart Attack, Aneurysm, Stroke, Transient Ischemic Attack (TIA), or Atrial Fibrillation, or have you had heart valve surgery, a cardiac pacemaker implanted or replaced or been treated with a heart defibrillating device? Answer: No**
  - b) **had Surgery or tests (related to conditions listed in Part I) recommended by a licensed member of the medical profession but not performed? Answer No**
5. **Within the past five years have you been diagnosed with, received medical treatment or advised to have treatment, including prescription medication by a licensed member of the medical profession for any of the following:**
  - a) **Parkinson’s Disease, Myasthenia Gravis, Multiple or Amyotrophic Lateral Sclerosis, Lupus, Down Syndrome, Cerebral Palsy, Alzheimer’s Disease, or Dementia? Answer No**
  - b) **Insulin Dependent Diabetes with uncontrolled High Blood Pressure or requiring more than 60 units of insulin a day or any Kidney Disease requiring dialysis? Answer No**
  - c) **Emphysema, Chronic Obstructive Pulmonary Disease (COPD), or Chronic Pulmonary condition? Answer No**
  - d) **Internal cancer, Leukemia, Malignant Melanoma, Hodgkin’s Disease or Lymphoma Answer No**
  - e) **Congestive Heart Failure? Answer No**

**PART II BENEFICIARY - Incorrect, Incomplete or Left Blank**

Name of Beneficiary : Jane Doe  
Relationship: Sister  
Sex: Female  
Date of Birth: 06/04/1949  
Address: 123 Elm Street, Any City, Florida  
Per Beneficiary Annual Payment Amount: \$100  
Greeting Name or Sender Name in Card: Dear Jane  
Occasion Card: Birthday  
Occasion Date: 06/04/1949  
Message in Card: Happy Birthday

**PART III - REPLACEMENT INFORMATION**

**Not answered or Incomplete**

**Signature(s) and/or Date missing**

**PART IV - SECONDARY ADDRESSEE**

**Not answer; Incomplete; Signature and/or Date missing**

**PART V - AUTHORIZATION AND CERTIFICATION**

**Box Not Checked**

I understand the policy that I am applying for pays annual benefits for 15 years to the beneficiaries selected by the Owner. I further understand that this policy does not provide a lump sum death benefit.

**Incomplete or Left Blank - Signed At \_\_\_\_\_**

**Signature(s) and/ or Date missing**

**STERLING INVESTORS LIFE INSURANCE COMPANY**

Home Office: ROME, GEORGIA

**Mail To:**

**Sterling Investors Life Insurance Company**

**Administrative Office**

**P.O. Box 10846**

**Clearwater, Florida 33755-8846**

**AMENDMENT TO APPLICATION**

I hereby agree that the following changes shall be an amendment to and form a part of the said application and of Policy Number **123456**

if any, and that they shall be binding on any person who shall have or claim any interest under such policy.

[Misspelled Last Name – Smyth is changed to Smith]

[Incorrect City - Janesville is changed to Jonesville]

Acceptance is acknowledged by:

\_\_\_\_\_  
Insured

\_\_\_\_\_  
Date

**[Signature]**

**[President]**

## ARKANSAS COMPLIANCE CERTIFICATION

**Name and Address of Insurer:**

**Sterling Investors Life Insurance Company  
210 E Second Street Suite 105  
Rome, Georgia 30161**

The Company has reviewed the enclosed form and certifies that, to the best of its knowledge and belief, this submission complies with the requirements of Regulation 19s 10B as well as applicable requirements of the Department. The Company further certifies compliance with Regulation 49, and Ark Code Ann. 23-79-138, and Bulletin 15-2009.

Signed for the Company by an Officer



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Signature

President

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Title

November 20, 2009

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Date