

SERFF Tracking Number: NDPL-126045593 State: Arkansas
Filing Company: Aviva Life and Annuity Company State Tracking Number: 41679
Company Tracking Number: SI/GI APP 4/09
TOI: L08 Life - Other Sub-TOI: L08.000 Life - Other
Product Name: SI/GI App 4/09
Project Name/Number: SI/GI App 4/09/SI/GI App 4/09

Filing at a Glance

Company: Aviva Life and Annuity Company

Product Name: SI/GI App 4/09

TOI: L08 Life - Other

Sub-TOI: L08.000 Life - Other

Filing Type: Form

SERFF Tr Num: NDPL-126045593 State: Arkansas

SERFF Status: Closed-Approved-
Closed State Tr Num: 41679

Co Tr Num: SI/GI APP 4/09

State Status: Approved-Closed

Authors: Allison Roush, Jason
Kaster

Reviewer(s): Linda Bird

Disposition Date: 03/02/2009

Date Submitted: 02/27/2009

Disposition Status: Approved-
Closed

Implementation Date Requested: On Approval

Implementation Date:

State Filing Description:

General Information

Project Name: SI/GI App 4/09

Project Number: SI/GI App 4/09

Requested Filing Mode: Review & Approval

Explanation for Combination/Other:

Submission Type: New Submission

Overall Rate Impact:

Filing Status Changed: 03/02/2009

Deemer Date:

Submitted By: Allison Roush

Filing Description:

Aviva Life and Annuity Company

Status of Filing in Domicile: Authorized

Date Approved in Domicile: 02/23/2009

Domicile Status Comments: Filed and approved
in our state of domicile, Iowa, effective 2/23/09.

Market Type: Individual

Group Market Size:

Group Market Type:

Explanation for Other Group Market Type:

State Status Changed: 03/02/2009

Created By: Allison Roush

Corresponding Filing Tracking Number: SI/GI
App 4/09

Enclosed for your review and approval is Form 17146 4/09 – Life Insurance Application for Simplified Issue/Guaranteed Issue.

This is an abbreviated application form completed by an applicant when applying for simplified issue or guaranteed

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issue underwriting. This form will be used when applying for coverage under our previously approved universal life policies referenced below. Also, previously approved Conditional Life Insurance Agreement will be used to provide conditional life insurance on the life of the Insured when the first premium is received at the time of application.

Form Number _____ Approval Date _____ SERFF and/or State Tracking Number _____

Form 2ECI06 _____ 8/11/06 and 9/10/08 _____ CMPL-125792497/40160
 Form 2EDB08 _____ 3/04/08 _____ NDPL-125480487/38245
 Form 15876 2/07 _____ 8/28/06 _____ USPH-6SRPJV431/33534

This application form is new and does not replace any forms previously approved by your Department. This form is written in simplified and readable language and does not contain any unusual or possible controversial items from normal company or industry standards. This form is in final print.

Enclosed for informational purposes is the Producer's Report for Simplified Issue/Guaranteed Issue, Form 17145 4/09, to be used in conjunction with this application. The Producer's Report includes the required agent/producer replacement question.

You may direct any questions or comments regarding this submission to me at (800) 457-3557, ext. 8802 or e-mail me at allison.roush@avivausa.com.

Company and Contact

Filing Contact Information

Allison Roush, Product Compliance Specialist allison.roush@avivausa.com
 Aviva Life and Annuity Company 515-242-8756 [Phone]
 611 Fifth Avenue
 Des Moines, IA 50309

Filing Company Information

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

Filing Fees

SERFF Tracking Number: NDPL-126045593 State: Arkansas
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Fee Required? Yes
Fee Amount: \$20.00
Retaliatory? No
Fee Explanation: 1 form x \$20 = \$20.00
Per Company: No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Aviva Life and Annuity Company	\$20.00	02/27/2009	26021831

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Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Linda Bird	03/02/2009	03/02/2009

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Disposition

Disposition Date: 03/02/2009

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		No
Supporting Document	Producer's Report - Info only		Yes
Supporting Document	AR Certification Regulation 19		Yes
Supporting Document	AR Certification Regulation 49		Yes
Form	Life Insurance Application for Simplified Issue/Guaranteed Issue		Yes

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Form Schedule

Lead Form Number: Form 17146 4/09

Schedule Item Status	Form Number	Form Type Form Name	Action	Action Specific Data	Readability	Attachment
	Form 17146 4/09	Application/Life Insurance Enrollment Form Simplified Issue/Guaranteed Issue	Initial		53.600	17146-final brackets.pdf



Life Insurance Application for Simplified Issue/ Guaranteed Issue

PRODUCER CODE # _____

(In this application, "Company" refers to the insurance company named above.)

PROPOSED INSURED

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

Address _____ Gender M F Maiden Name _____

City _____ State _____ Zip _____

Birth Date _____ Birth State _____ U.S. Citizen? Yes No Permanent Resident? Yes No

Home Ph. (____) _____ Bus. Ph. (____) _____ Social Security Number _____

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

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

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

Occupation _____ Length of Employment _____

Duties _____

Annual earned income \$ _____

TOBACCO USE: Do you use any form of tobacco or nicotine based products? Yes No

If no, have you used any tobacco or nicotine based products within the last 5 years? Yes No

If yes, when did you last use tobacco or nicotine based products? _____ Type _____ Quantity _____

EMPLOYER / ASSOCIATION INFORMATION

Employer / Association Name _____

If this application is submitted as part of an Association group, please skip to the Owner Information section of the application.

Employer Address _____ City _____ State _____ Zip _____

1. Have you been absent from work due to illness or medical treatment for a period of more than 5 consecutive working days in the last 90 days (exclusive of weekends, holidays, and vacations.) (If yes, please give details below.) Yes No

2. Are you actively at work, at least 30 hours per week, performing all duties of regular occupation at customary place of employment? (If no, please give details below.) Yes No

Details for 1 and 2 (attach separate sheet if necessary) _____

OWNER INFORMATION

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

Name (Owner, Business or Trustee) _____

Address _____ City _____ State _____ Zip _____

(If different from Employer information above)

Birth Date _____ If trust, name of trust _____

Relationship _____ Social Security # or Taxpayer ID # _____

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

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

CONTINGENT OWNER

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

Where Issued _____ Issue Date _____ Expiry Date _____



OWNER INFORMATION (continued)

Mail notices to Insured Owner Other (specify) _____

Other Notice Address _____ City _____ State _____ Zip _____

Tax Qualification Type Qualified Plan: Type: Profit Sharing Plan 401(k) Other Defined Benefit Non-Qualified Plan: Type: Deferred Comp Split Dollar Executive Bonus Other Neither

BENEFICIARY INFORMATION

PRIMARY BENEFICIARY(IES) - Applies to primary insured only. (If trust, complete name and date of trust.)
(If necessary, use separate sheet for additional details, signature of Owner & date.)

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

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

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

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

CONTINGENT BENEFICIARY(IES)

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

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

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

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

POLICY INFORMATION

PRIMARY INSURED

Base Plan _____ Amt. of Ins. \$ _____

Additional Coverage _____ Amt. of Ins. \$ _____ Premium \$ _____

Riders (Complete Supplemental Application if applicable)

Other Riders (Type/Amount): _____

Other Riders (Type/Amount): _____

UL Death Benefit Option: Level Increasing Death Benefit Return of Premium Rider

Premium Direction/Interest Crediting Strategy: 1 Year Point-to-Point _____% 2 Year Point-to-Point _____%

1 Year Monthly Average _____% 1 Year Monthly Cap _____% 1 Year Average Multiple Index _____% 5 Year Fixed Term _____%

1 Year Fixed Term _____% Other _____%

Levelized Strategy Transfer Yes No

PREMIUM INFORMATION

PREMIUM Planned Premium \$ _____ Additional Premium (Lump Sum) \$ _____

Billing Frequency Annual Semi-Annual Quarterly PAC (Complete Authorization) Other _____

Group Bill Group Bill # _____

Has the premium for the policy applied for been given to the producer? Yes No Amount \$ _____

How Paid? Check Other (specify) _____

Additional Policy Specifications

Policy Date (optional) _____ Other _____



EXISTING COVERAGE

INSURANCE IN FORCE ON PROPOSED INSURED

1. Are any life insurance or annuity contracts in force? Yes No
 If yes, complete section below. (Attach separate sheet if necessary)

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

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

COMPLETE FOR SIMPLIFIED ISSUE ONLY (If this application is for Guaranteed Issue, skip this section)

1. PHYSICIAN INFORMATION

a. Name, address and phone # of your doctor(s) or health care provider(s): _____

 b. When did you last consult a doctor and why? _____

 c. What medication(s) (prescribed or over the counter) are you now taking? (If none, so state) _____

2. **BUILD:** Height _____ ft. _____ in. Weight _____ lbs.
 3. In the past 10 years, have you been diagnosed or treated for high blood pressure, heart disease, chest pain, diabetes, digestive disorder, lung disorder, cancer, kidney disease, liver disorder, muscle disorder or nervous disorder? Yes No
 4. In the past 5 years, have you been examined or treated by a physician or health care provider, or been examined or treated in a hospital? Yes No
 5. a. Have you ever been diagnosed by a medical professional as having or been treated for AIDS or ARC (AIDS-related complex)? . . Yes No
 b. Have you ever tested positive for antibodies to the AIDS Human T-Cell Lymphotropic (HIV) virus? Yes No
 6. In the past 5 years, have you been convicted of (i) two or more moving violations, or (ii) driving under the influence of alcohol or other drugs (unless prescribed by a doctor), or (iii) had your driver's license suspended or revoked? Yes No
 7. Have you ever (i) sought or received advice, counseling or treatment by a medical professional for the use of alcohol or drugs, including prescription drugs, or (ii) used cocaine, marijuana, heroin, controlled substances or any other drug, except as legally prescribed by a physician? Yes No
 If yes, please complete the Alcohol / Drug Questionnaire(s).
 8. Within the past 2 years, have you flown as a pilot, student pilot or crew member, or engaged in skin or scuba diving, racing of any kind, parachuting, sky diving or hang gliding, mountain, rock or technical climbing? Yes No
 If yes, please complete the Aviation / Avocation Questionnaire(s).

Details (if yes for any question 1-8, please provide details - name, address, reason and treatment. If necessary, attach a separate sheet with signature of Owner and date.)



TAXPAYER IDENTIFICATION

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

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

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

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

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

Backup Withholding - You are subject to backup withholding if:

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

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

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

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

AGREEMENTS AND REPRESENTATIONS

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

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

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

IMPORTANT INFORMATION ABOUT THE USA PATRIOT ACT

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



AUTHORIZATION AND ACKNOWLEDGMENT (For Simplified Issues Only)

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

Personal Health Information

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

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

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

Personal Private Information

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

Limitations, Revocation and Rights

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



SIGNATURES

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

I understand that if I am applying for simplified issue underwriting and am not approved, I may choose to submit a fully underwritten application. I will not automatically receive a policy underwritten on a guaranteed issue basis.

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

All states (except as noted below): Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit, or knowingly presents false information in an application for insurance may be guilty of a crime and subject to fines and confinement in prison, depending on state law.

Residents of NM: 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.

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

Signed / Dated at _____
City, State

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

On _____
Date

X _____
Signature of Owner if other than Proposed Insured

X _____
Signature of Licensed Producer

Parent/Guardian or Witness (if required)

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

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



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Supporting Document Schedules

	Item Status:	Status Date:
Satisfied - Item: Flesch Certification		
Comments:		
Attachment: AR RDCRT - Aviva.pdf		

	Item Status:	Status Date:
Bypassed - Item: Application		
Bypass Reason: Form submitted is an application.		
Comments:		

	Item Status:	Status Date:
Satisfied - Item: Producer's Report - Info only		
Comments: The required replacement question appears as item #1 on attached form.		
Attachment: 17145.pdf		

	Item Status:	Status Date:
Satisfied - Item: AR Certification Regulation 19		
Comments:		
Attachment: AR Reg19.pdf		

	Item Status:	Status Date:
Satisfied - Item: AR Certification Regulation 49		
Comments:		

<i>SERFF Tracking Number:</i>	<i>NDPL-126045593</i>	<i>State:</i>	<i>Arkansas</i>
<i>Filing Company:</i>	<i>Aviva Life and Annuity Company</i>	<i>State Tracking Number:</i>	<i>41679</i>
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<i>Product Name:</i>	<i>SI/GI App 4/09</i>		
<i>Project Name/Number:</i>	<i>SI/GI App 4/09/SI/GI App 4/09</i>		

Attachment:

AR reg49.pdf

AR

ARKANSAS READABILITY CERTIFICATION

This is to certify that the following forms have achieved a Flesch Reading Ease Score of as indicated below and comply with the requirements of Arkansas Statute Ann. 66-3251 through 66-3258, cited as the Life and Disability Insurance Policy Language Simplification Act.

FORM NUMBER

AND NAME

Form 17146 4/09 Life Insurance Application for Simplified Issue/Guaranteed Issue

FLESCH SCORE

53.6

Aviva Life and Annuity Company



Chris Guttin

ASA / Vice President-Product Operations

2/20/09

Date

RD/CRT/AR



Aviva Life and Annuity Company
 P.O. Box 1555
 Des Moines, Iowa 50306-1555
 800/800-9882
 Fax: 800/531-0038

Producer's Report for Simplified Issue/ Guaranteed Issue

1. a. Does the proposed insured have any life insurance or annuity contract(s) currently active with our company or any other company? Yes No
 (If Yes, and if required by state regulation, any Replacement Comparison, Notice or Statement must accompany this application.)
 b. Will any annuity or life insurance presently or recently in force be replaced or changed by this policy applied for? Yes No
 1035 Exchange (attach required forms) External Internal _____
2. a. Did the producer personally see all the persons to be covered and were the answers recorded exactly as given? Yes No
 If No, explain and arrange for additional evidence of insurability _____
 b. I personally viewed all driver's licenses or other government issued photo identification documents Yes No
3. Is proposed insured a U.S. citizen? Yes No If no, how long in U.S.? _____ Permanent resident? ... Yes No
 If not a U.S. citizen/permanent resident, type of Visa? _____
4. Does the proposed insured and owner speak and understand English? Yes No
5. What is the proposed insured's: Annual earned income \$ _____
6. Remarks _____

PRODUCER'S CERTIFICATION

I certify that I saw and know the proposed insured(s) to be the person(s) described in this application, and have reviewed the appropriate documentation, and have truly and accurately recorded the information supplied by the applicant, that I know of no condition affecting the eligibility or insurability of the applicant not fully set forth in the application, and that I have made no declaration, representation, or waiver regarding coverage or the provisions or terms of the application or policy. Other than policy-related information, I have given the proposed insured or owner(s) nothing of value in connection with this application or policy. I further certify that I am licensed in the state in which this application was completed and have delivered all required notices and disclosures and fully complied with all privacy and replacement regulations. I also assume full responsibility for the delivery of the policy and the submission of the first premium.

Agency No. _____ Agency Name _____
 List of all producers (please print) _____ Producer code# _____ Commission share _____

List of all producers (please print)	Producer code#	Commission share

Signed at _____ Signed (writing producer) _____ Date _____
 Phone # _____ E-Mail _____ Fax # _____
 Preferred mode of communication? Phone E-Mail Fax



**Arkansas Certification
Regulation 19**

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

Aviva Life and Annuity Company



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

2/20/09

Date

**Form Numbers
Form 17146 4/09**

Regulation 19

**Arkansas Certification
Regulation 49**

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

Aviva Life and Annuity Company



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

2/20/09

Date

**Form Numbers
Form 17146 4/09**

Regulation 49