

SERFF Tracking Number: NDPL-126058877 State: Arkansas
Filing Company: Aviva Life and Annuity Company State Tracking Number: 41811
Company Tracking Number: CS APPLICATIONS 2009
TOI: L08 Life - Other Sub-TOI: L08.000 Life - Other
Product Name: CS Applications 2009
Project Name/Number: CS Applications 2009/CS Applications 2009

Filing at a Glance

Company: Aviva Life and Annuity Company

Product Name: CS Applications 2009

TOI: L08 Life - Other

Sub-TOI: L08.000 Life - Other

Filing Type: Form

SERFF Tr Num: NDPL-126058877 State: Arkansas

SERFF Status: Closed-Approved-
Closed State Tr Num: 41811

Co Tr Num: CS APPLICATIONS State Status: Approved-Closed
2009

Authors: Angela Vennall, Ben
Warren, Jaime Gertsen

Date Submitted: 03/16/2009

Reviewer(s): Linda Bird

Disposition Date: 03/18/2009

Disposition Status: Approved-
Closed

Implementation Date:

Implementation Date Requested: On Approval

State Filing Description:

General Information

Project Name: CS Applications 2009

Project Number: CS Applications 2009

Requested Filing Mode: Review & Approval

Explanation for Combination/Other:

Submission Type: New Submission

Overall Rate Impact:

Filing Status Changed: 03/18/2009

Status of Filing in Domicile: Authorized

Date Approved in Domicile: 03/13/2009

Domicile Status Comments:

Market Type: Individual

Group Market Size:

Group Market Type:

Explanation for Other Group Market Type:

State Status Changed: 03/18/2009

Created By: Jaime Gertsen

Corresponding Filing Tracking Number:

Deemer Date:

Submitted By: Ben Warren

Filing Description:

Enclosed for your review and approval are the applications listed below. Any of the applications may be used by an existing policyowner to complete one or more desired transactions, if the transaction is applicable to the existing policy.

The applications do not contain any unusual or possibly controversial items from normal company or industry standards.

These applications will replace previously approved applications as noted below.

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New Form Number-----Form Number Replaced-----Previous Approval Date

11801 7/09-----13519 5/98 AR-----9/9/1998 State Tr Num 13818 5/98 AR
 11802 7/09-----13520 5/98 AR-----9/9/1998 State Tr Num 13818 5/98 AR
 11800 7/09-----13518 5/98 AR-----9/9/1998 State Tr Num 13818 5/98 AR
 11804 7/09-----13522 5/98 AR-----9/9/1998 State Tr Num 13818 5/98 AR

These forms are produced from our Automated Policy Assembly Laser system and are in final print.

If you have questions regarding this submission, please contact me via SERFF, or I may be reached at 800-457-3557 ext. 8801 or via email at Jaime.gertsen@avivausa.com.

Company and Contact

Filing Contact Information

Jaime Gertsen, Product Compliance Analyst jaime.gertsen@avivausa.com
 Aviva Life and Annuity Company 515-242-8761 [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

Fee Required? Yes
 Fee Amount: \$80.00
 Retaliatory? No
 Fee Explanation: \$20.00 x 4 forms = \$80.00
 Per Company: No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Aviva Life and Annuity Company	\$80.00	03/16/2009	26446061

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Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Linda Bird	03/18/2009	03/18/2009

SERFF Tracking Number: NDPL-126058877 *State:* Arkansas
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Disposition

Disposition Date: 03/18/2009

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
Form	Application For Policy Change		Yes
Form	Application For Reissue		Yes
Form	Application For Reinstatement and Insurability Statement		Yes
Form	Application to Convert Term Insurance		Yes

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Form Schedule

Lead Form Number:

Schedule Item Status	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment	
	11800	7/09	Application/ Enrollment Form	Application For Policy Change	Revised	Replaced Form #: 13518 5/98 AR Previous Filing #: 13818 5/98 AR	50.700	11800 - Generic.pdf
	11801	7/09	Application/ Enrollment Form	Application For Reissue	Revised	Replaced Form #: 13519 5/98 AR Previous Filing #: 13818 5/98 AR	51.400	11801 - Generic.pdf
	11802	7/09	Application/ Enrollment Form	Application For Reinstatement and Insurability Statement	Revised	Replaced Form #: 13520 5/98 AR Previous Filing #: 13818 5/98 AR	50.000	11802 - Generic.pdf
	11804	7/09	Application/ Enrollment Form	Application to Convert Term Insurance	Revised	Replaced Form #: 13522 5/98 AR Previous Filing #: 13818 5/98 AR	54.000	11804 - Generic.pdf



Aviva Life and Annuity Company
 { P. O. Box 1555
 Des Moines, Iowa 50306-1555 }

Application For Policy Change

Policy _____
 Insured _____ Date of Birth _____
 Other Insured _____ Date of Birth _____
 Address & Phone Number _____ Current Occupation _____

I request that the following change be made at applicable rates and rules currently in effect:

	Existing Policy	To Be Changed To
Plan		
Amount		
Riders		
Other Changes		

Complete this section if policy change requires evidence of insurability

All statements and answers to questions below are true to the best of the insured's knowledge and belief.

(Please Answer All Questions)

	Insured	Other Insured			
		Insured		Other Insured	
		Yes	No	Yes	No
1. Name, address and phone number of your doctor or health care provider(s) When was your last medical examination and for what purpose? When did you last consult a doctor and why? What medication are you currently taking (prescribed or over the counter, if none, so state)	_____	_____	_____	_____	_____
2. What amount of insurance is in force, all companies?	_____	_____	_____	_____	_____
3. What amount of Accidental Death Benefit is in force, all companies?	_____	_____	_____	_____	_____
4. Since this policy was issued, will any insurance or annuity you now have be replaced or changed by the policy that includes the change being applied for?		Yes <input type="checkbox"/> No <input type="checkbox"/>			
5. (a) Insured: Height _____ Weight _____		Insured		Other Insured	
(b) Other Insured: Height _____ Weight _____		Yes	No	Yes	No
(c) Have you gained or lost more than 10 pounds in the last year?		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(d) Are you now under observation or treatment?		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(e) Have you ever been diagnosed by a medical professional as having or been treated for AIDS or ARC (AIDS-related complex)?		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(f) Have you ever tested positive for antibodies to the AIDS Human T-Cell Lymphotropic (HIV) virus?		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(g) Have you ever requested or received a benefit, military deferment, discharge or rejection, payment or pension because of a disability, injury, or sickness?		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. (a) Do you use any form of tobacco or nicotine based products?		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(b) If no, have you used any form of tobacco or nicotine based products in the past 5 years?		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
If yes, when did you last use tobacco or nicotine based products _____ Type _____ Quantity _____					
7. Within the last 3 years, have you:					
(a) Engaged in any aviation activity other than as a passenger? Or any intention to do so in the next 12 months? ..		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(b) Engaged in ballooning, gliding, boat or vehicle racing, mountain or rock climbing, parachuting, sky diving, under-water diving, or any such hazardous sport or activity? Or is such activity planned in the next 12 months? ..		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(c) Been charged with 2 or more moving violations, reckless or drunken driving, or had your driver's license revoked or suspended, or received a warning letter? (If Yes, give Driver's License No. _____)		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(d) Been arrested for an illegal activity, acquired a criminal record, or currently on probation?		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. Since this policy was issued, have any persons insured:					
(a) been declined, rated or had coverage modified or reinstatement declined by another insurance company?		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(If yes, give reason) _____					
(b) had any other life or health insurance issued or applied for, or planning to apply for?		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(c) become a member of or contemplate joining one of the Armed Forces or an active or reserve military unit?		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(d) in the past 2 years traveled or intend to travel or live outside the United States or Canada?		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>



- | | Insured | | Other Insured | |
|--|--------------------------|--------------------------|--------------------------|--------------------------|
| | Yes | No | Yes | No |
| 9. Have you ever had or have symptoms of or been treated for: | | | | |
| (a) Disease of the heart or circulatory system, including high blood pressure, heart attack, coronary artery disease, or chest pain? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| (b) Heart murmur, rhythm abnormality, heart catheterization, echocardiogram or an exercise treadmill test? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| (c) Cancer, tumors, lymphoma, leukemia, or any growths, lesions, polyps? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| (d) Diabetes, thyroid, glandular or endocrinal disorder? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| (e) Respiratory disorders including asthma, chronic bronchitis, emphysema, pneumonia, shortness of breath, or abnormal chest x-ray? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| (f) Disorder of the stomach, liver, pancreas or intestinal tract, including ulcerative colitis, Crohn's disease, or cirrhosis? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| (g) Disorder of the kidneys, prostate, bladder, reproductive organs, sexually transmitted diseases, sugar, albumin or blood in urine? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| (h) Stroke, transient ischemic attack (TIA), Parkinson's, multiple sclerosis, seizures, epilepsy, chronic headaches, memory changes or fainting? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| (i) Anxiety, depression, attempted suicide, attention deficit disorder or psychosis, mental or nervous system disorder? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| (j) Anemia, hepatitis, or any blood disorder? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| (k) Chronic back pain, arthritis, loss of limb, paralysis, muscle weakness or disease? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 10. Provide details or complete appropriate supplement for any Yes answers in questions 4 - 9. (Attach additional sheet if necessary, sign & date.) | | | | |

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

AUTHORIZATION AND ACKNOWLEDGEMENT

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.

I authorize any physician, medical practitioner, hospital, clinic, other medical or medically related facility, insurance company, the Medical Information Bureau (MIB), consumer reporting organization, or employer having information available as to diagnosis, treatment, or prognosis with respect to any physical or mental condition, evaluation, or treatment of me or my minor children and any other non-medical information of me or my minor children to give to Aviva Life and Annuity Company (Company) or its reinsurers or its authorized representatives any such information.

To facilitate rapid submission of such information, I authorize all said sources, except MIB, to give such records or knowledge to any agency employed by the company to collect and transmit such information.



* 1 1 8 0 0 0 7 0 9 0 2 *

I understand the information obtained by the use of this authorization will be used by the Company or its reinsurers to determine eligibility for insurance, or eligibility for benefits. Any information obtained will not be released by the Company or its reinsurers to any person or organization except to reinsuring companies, MIB, or other persons or organizations performing business or legal services in connection with my application, claim, or as may be otherwise lawfully required or as I may further authorize.

I know that I may request to receive a copy of this Authorization and to be interviewed if an insurance information report is to be made.

I acknowledge receipt of the Disclosure Notice to Proposed Insured.

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 agree:

- That this policy change shall not be effective until approved by the Company; and that if changed the policy or any rider may be written on the policy form and reserve basis now in use; and that a copy of this application shall be a part of the policy.
- That any indebtedness not repaid shall remain against this policy as changed.
- That this policy change shall be made subject to evidence of insurability if it involves an increase in insurance risk and in making such change the Company may rely on the representations made in this application and any other representations made in connection with this change. The period during which the terms of the "Incontestability" and "Suicide" provisions will apply to any change involving an increase in insurance risk will commence on the effective date of the change.
- That the beneficiary provision (including any settlement option or other special provisions) of the policy in force after this policy change shall be the same as the beneficiary, settlement option, and special provisions, if any, designated in the original policy at the time this policy change occurred.
- That the owner of the policy in force after the policy change shall be the same as the owner of the original policy. If the owner is a natural person, ownership will vest in the owner, if living, otherwise the owner's estate unless a contingent owner was designated in the application or by endorsement, in which case all rights of ownership will transfer to such contingent owner.
- That in consideration of the Company making this change, I agree to release the Company from all claims and liability under the original policy and any riders, or portions of any thereof, converted, exchanged or terminated as part of this change.
- I represent that the answers and statements on this application are complete, true and correctly recorded.

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 DC: 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.

Residents of KY: 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.

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

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.

Date

Signature of Insured

Signature of Other Insured or Joint Insured

Signature of Owner

Submitted by _____
Agency Code

Producer _____
Name Code

Producer's Signature

Producer's Telephone No.





Aviva Life and Annuity Company
 { P. O. Box 1555
 Des Moines, Iowa 50306-1555 }

Application For Reissue

Policy _____

Insured _____

Date of Birth _____

Other Insured _____

Date of Birth _____

Cancel this policy and issue a new policy, as follows _____

Notice: The original policy, or at least page 3 of the original policy, must be returned with this Application for Reissue, and no coverage will be provided under the original policy.

Plan	Amount
Riders	
Other Benefits	

Premiums payable: Annually Semi-Annually Quarterly Monthly

Policy Date _____ (may be subject to short term charge if original policy has been delivered and is in force.) (if other than original policy date)

Other _____

Settlement (all reissues must be with full required premium and all outstanding delivery requirements) Check all that apply:

Amount attached \$ _____ Use premium from the policy to be cancelled

Effective Date of Coverage

- If payment of the first premium was not made with the Application, or if this Application For Reissue is for a policy with a larger first premium or face amount, the Effective Date shall be determined as if a new Application was completed on the date of this Application For Reissue, subject to the following conditions:
 - The Company has received payment in full for the first premium due; and
 - No insurance under the terms of the policy applied for shall take effect until (i) the date of the last of any medical examinations or tests required under the rules and standards of the Company, or (ii) the date of this Application for Reissue, whichever shall be the later; and
 - The proposed insured is in good health, and in the sole opinion of the Company's authorized officers, is insurable and acceptable for the amount of insurance, plan of insurance and rate of premium applied for, determined under the rules and standards of the Company.
 If any of the foregoing conditions listed in paragraph 1(a) through 1(c) above are not satisfied, there shall be no liability on the part of the Company except to return any payment made with this Application For Reissue or with the Application.
- If payment of the first premium was made with the original Application, the Effective Date will be the date of the Application, subject to the terms and conditions of the Conditional Life Insurance Agreement of that Application, and subject to the following conditions:
 - If this Application For Reissue is for a policy with a larger first premium or face amount than that originally applied for in the Application; and/or
 - If this Application For Reissue is for a policy with a current date, then the Effective Date is determined as set forth in paragraph 1, inclusive, above.

Representations: Since the date of the original Application have any persons insured:

	Yes	No
1. Had any injury, ailment, or disease, or received a disability benefit?	<input type="checkbox"/>	<input type="checkbox"/>
2. Consulted a doctor? If yes, give details below	<input type="checkbox"/>	<input type="checkbox"/>
3. Used any medication?	<input type="checkbox"/>	<input type="checkbox"/>
4. Been diagnosed by a medical professional as having or been treated for AIDS or ARC (AIDS-related complex)?	<input type="checkbox"/>	<input type="checkbox"/>
5. Tested positive for antibodies to the AIDS Human T-Cell Lymphotropic (HIV) virus?	<input type="checkbox"/>	<input type="checkbox"/>
6. Used any form of tobacco or nicotine based products?	<input type="checkbox"/>	<input type="checkbox"/>
If yes, Type _____ Quantity _____		
7. Been declined, rated, or had coverage modified or reinstatement declined by another insurance company?	<input type="checkbox"/>	<input type="checkbox"/>
8. Engaged in or contemplate any aviation activities other than as a passenger?	<input type="checkbox"/>	<input type="checkbox"/>
9. Engaged in or contemplate ballooning, gliding, boat or vehicle racing, mountain or rock climbing, parachuting, sky diving, under-water diving, or any such hazardous activity?	<input type="checkbox"/>	<input type="checkbox"/>
10. Been charged with any moving violations, reckless or drunken driving, or had their driver's license restricted, suspended or revoked, or received a warning letter?	<input type="checkbox"/>	<input type="checkbox"/>
11. Proposed insured, owner, or beneficiary a resident or citizen of or an entity organized under the laws of a country other than the U.S.?	<input type="checkbox"/>	<input type="checkbox"/>
12. Been arrested for an illegal activity or acquired a criminal record?	<input type="checkbox"/>	<input type="checkbox"/>
13. A member of or do you contemplate joining one of the Armed Forces or an active or reserve military unit?	<input type="checkbox"/>	<input type="checkbox"/>
14. In the past 2 years traveled or do you intend to travel or live outside the United States or Canada?	<input type="checkbox"/>	<input type="checkbox"/>



* 1 1 8 0 1 0 7 0 9 0 1 *

Details of questions answered "Yes". Identify if other than the insured, give name and address of doctors.
(Attach additional sheets if necessary, sign & date.)

AGREEMENTS AND REPRESENTATIONS

I hereby represent, agree and understand all of the following:

That the answers and statements on the application(s) and any Supplements required are complete, true and correctly recorded. I agree and understand that 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 reissued policy, and it is agreed that the reissued 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.

The reissued policy will take effect and coverage will begin if all of the following are true: (1) the Company has been paid full settlement for the reissued policy; (2) the Proposed Insured(s) is (are) a risk insurable under the Company's rules, limits and standards for the amount of insurance and plan of insurance applied for (as determined by the Company's authorized Officers at its Home Office); and (3) the Proposed Insured(s) is (are) living, and the answers and statements in the application(s) and any Supplements are, and continue to be, complete and true at the time of delivery of the reissued policy.

That the provisions I requested for the original policy, such as the beneficiary designation, benefit settlement options and/or other special provisions shall be the same as for the reissued policy unless I have specifically requested otherwise in this Application for Reissue.

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.**

SIGNATURES

- I understand, acknowledge and agree that the Producer has no authority to make any promise, representation or waiver regarding coverage or the terms of either the original or reissued 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.
- I acknowledge that I received the Disclosure Notice to Proposed Insured with the original application and signed the authorizations and acknowledgements as documented on the original application.

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 DC: 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.

Residents of KY: 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.

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

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.

Date

Signature of Insured

Signature of Other Insured or Joint Insured

Signature of Owner

Submitted by _____
Agency Code

Producer _____
Name Code

Producer's Signature

Producer's Telephone No.



* 1 1 8 0 1 0 7 0 9 0 2 *

AGREEMENTS AND REPRESENTATIONS

I hereby represent, agree and understand all of the following:

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 at its Home Office.

That the life insurance policy and coverage will be reinstated only if and when all of the following are true: (1) the Company has received full and good settlement for the reinstated policy while the Proposed Insured(s) is (are) living; (2) the Proposed Insured(s) is (are) a risk insurable under the Company's rules, limits and standards for the amount of insurance and plan of insurance applied for (as determined by the Company's authorized Officers at its Home Office); and (3) the Proposed Insured(s) is (are) living, and the answers and statements in the application(s) and any Supplements are, and continue to be, complete and true at the time of reinstatement.

AUTHORIZATION AND ACKNOWLEDGEMENT

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.

I authorize any physician, medical practitioner, hospital, clinic, other medical or medically related facility, insurance company, the Medical Information Bureau (MIB), consumer reporting organization, or employer having information available as to diagnosis, treatment, or prognosis with respect to any physical or mental condition, evaluation, or treatment of me or my minor children and any other non-medical information of me or my minor children to give to Aviva Life and Annuity Company (Company) or its reinsurers or its authorized representatives any such information. To facilitate rapid submission of such information, I authorize all said sources, except MIB, to give such records or knowledge to any agency employed by the company to collect and transmit such information.

I understand the information obtained by the use of this authorization will be used by the Company or its reinsurers to determine eligibility for insurance, or eligibility for benefits. Any information obtained will not be released by the Company or its reinsurers to any person or organization except to reinsuring companies, MIB, or other persons or organizations performing business or legal services in connection with my application, claim, or as may be otherwise lawfully required or as I may further authorize.

I know that I may request to receive a copy of this Authorization and to be interviewed if an insurance information report is to be made.



* 1 1 8 0 2 0 7 0 9 0 2 *

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 "Agreements and Representations", including reviewing the answers and statements on the application(s) and any Supplements for accuracy, and the "Authorization and Acknowledgment" sections, and further acknowledge receipt of the Disclosure Notice to Proposed Insured.
- 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.
- I understand, acknowledge and agree that all future premium payments 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.
- I represent that the statements and answers shown above are true, complete and correctly recorded and I agree that they may be considered the basis of any insurance issued or reinstated. I also represent that all persons covered by this policy are living and in good health.
- I understand and agree that all statements made herein are considered representations and not warranties, that a copy of this application shall be a part of the policy, and that if the life insurance policy and coverage is reinstated it will be contestable for two years during the Insured's lifetime from the date of reinstatement. I also agree that this policy, if lapsed, will not be reinstated until approved by the Company, subject to collection of any check given in payment of premiums.

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 DC: 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.

Residents of KY: 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.

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

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.

Date

Signature of Insured

Signature of Other Insured or Joint Insured

Signature of Owner

Submitted by _____
Agency Code

Producer _____
Name Code

Producer's Signature _____

Producer's Telephone No. _____

IMPORTANT NOTE: IF LAPSED MORE THAN 6 MONTHS, ALSO COMPLETE AN APPLICATION FOR POLICY CHANGE FORM.
IF LAPSED MORE THAN 12 MONTHS—REQUIREMENTS ARE THE SAME AS NEW BUSINESS.





Aviva Life and Annuity Company
 { P. O. Box 1555
 Des Moines, Iowa 50306-1555 }

Application to Convert Term Insurance

You must complete and attach the Application for Policy Change Form for all increases.

Policy Number _____ **Amount to be converted \$** _____ **Amount to Retain in existing \$** _____

1. OWNER

NAME (FIRST, MIDDLE, LAST) _____ Social Security Number _____ Date of Birth _____ / _____ / _____ Sex _____

Address _____ City _____ State _____ Zip _____

2. INSURED

NAME (FIRST, MIDDLE, LAST) _____ Date of Birth _____ / _____ / _____ Sex _____

Address _____ City _____ State _____ Zip _____

3. PLAN OF INSURANCE _____ **Amt. (total Death Benefit) \$** _____

4. RIDERS (Will require insurability if not on original policy)

If the Total Death Benefit converted exceeds the convertible amount allowed, or a rider is added, an Application for Policy Change, with Evidence of Insurability, must be completed.

5. OPTIONS

Level Increasing Death Benefit Return of Premium Rider

Premium Direction/Interest Crediting Strategy:

1 Year Point-to-Point: _____ % 2 Year Point-to-Point: _____ % 1 Year Monthly Average: _____ %

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

1 Year Fixed Term: _____ % _____ %

Levelized Strategy Transfer Yes No

6. BILLING FREQUENCY

Initial Premium \$ _____ Planned Premium \$ _____

- Annual Monthly by Pre-Authorized Check
- Semi-Annual (Attach Authorization Form and voided check)
- Quarterly Add to existing bank authorization _____

Policy Number

Government Allotment/List Bill/Group Bill Number _____

7. HAVE YOU USED ANY FORM OF TOBACCO OR NICOTINE BASED PRODUCT WITHIN THE LAST 12 MONTHS? Yes No

This question is only required if you were under 18 when you purchased your insurance. Your answer can only be used to provide you with a better rate class.

8. Primary Beneficiary*

Print Full Name _____ Date of Birth _____ / _____ / _____ Relationship _____ Social Security # _____

Contingent Beneficiary

Print Full Name _____ Date of Birth _____ / _____ / _____ Relationship _____ Social Security # _____

any living children born to or legally adopted by the insured to share equally

* If beneficiary section is not completed the beneficiary from original policy will be used.

9. Special Instructions (Attach additional sheet if necessary, sign & date.) _____



* 1 1 8 0 4 0 7 0 9 0 1 *

AGREEMENTS AND REPRESENTATIONS

I hereby represent, agree and understand all of the following:

That if the term life insurance policy is not yet incontestable, as determined by the incontestability provisions of the term life insurance policy, then the new policy will be subject to the same incontestability provisions, based on the date of the term life insurance policy.

That the answers and statements on the application(s) and any Supplements required are complete, true and correctly recorded. I agree and understand that 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, notwithstanding any contestable and/or incontestable provisions of the term life insurance policy. No changes will be made unless the owner agrees and the change is authorized in writing by an officer of the Company.

The new policy will take effect and coverage will begin when all the requirements of the conversion provisions under the term life insurance policy have been met, including any required settlement for the new policy. I understand if I have elected to retain any of the term insurance as part of this conversion application, then I must continue to pay the corresponding term life insurance premiums that will be separate from any premiums required for the converted insurance.

SIGNATURES

I have reviewed and understand the information contained above in the "Agreements and Representations", including reviewing the answers and statements on the application(s) and any Supplements for accuracy.

I understand, acknowledge and agree that the Producer has no authority to make any promise, representation or waiver regarding coverage or the terms of either the original or reissued 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.

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 CA: For your protection, California law requires the following statement to appear on this application. Any person who knowingly presents a false or fraudulent claim for payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

Residents of DC: 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.

Residents of KY: 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.

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

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

_____ Signature of Insured

_____ Signature of Owner

_____ Social Security Number of Owner

If the owner's Social Security Number is not certified please submit Request for Taxpayer's Certification Form #9393-W9

Submitted by _____ Agency Code

Producer _____ Name Code

Producer's Signature _____

Producer's Telephone No. _____



SERFF Tracking Number: NDPL-126058877 State: Arkansas
Filing Company: Aviva Life and Annuity Company State Tracking Number: 41811
Company Tracking Number: CS APPLICATIONS 2009
TOI: L08 Life - Other Sub-TOI: L08.000 Life - Other
Product Name: CS Applications 2009
Project Name/Number: CS Applications 2009/CS Applications 2009

Supporting Document Schedules

Item Status:

**Status
Date:**

Satisfied - Item: Flesch Certification

Comments:

Attachments:

AR RDCRT - ALAC.pdf

ARreg19_ALAC.pdf

ARreg49_ALAC.pdf

Item Status:

**Status
Date:**

Bypassed - Item: Application

Bypass Reason: N/A

Comments:

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

FLESCH SCORE

11800 7/09	Application For Policy Change	50.7
11801 7/09	Application For Reissue	51.4
11802 7/09	Application For Reinstatement and Insurability Statement	50.0
11804 7/09	Application to Convert Term Insurance	54.0

Aviva Life and Annuity Company



Chris Guttin

ASA / Vice President-Product Operations

3/16/2009

Date

RD/CRT/AR

**Arkansas Certification
Regulation 19**

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

Aviva Life and Annuity Company



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

March 16, 2009

Date

Form Numbers

11800 7/09
11801 7/09
11802 7/09
11804 7/09

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**

March 16, 2009

Date

Form Numbers

11800 7/09
11801 7/09
11802 7/09
11804 7/09

Regulation 49