Filing at a Glance

Company: Standard Life and Accident Insurance Company

Product Name: ADVANTAGE GUARD APPLICATION	SERFF Tr Num: ANTX-126096883	State: Arkansas
TOI: L07I Individual Life - Whole	SERFF Status: Closed-Approved-Closed	State Tr Num: 42035
Sub-TOI: L07I.101 Fixed/Indeterminate Premium - Single Life	Co Tr Num:	State Status: Approved-Closed
Filing Type: Form		Reviewer(s): Linda Bird
	Author: Sherry Wiegman	Disposition Date: 04/03/2009
	Date Submitted: 04/02/2009	Disposition Status: Approved-Closed
Implementation Date Requested: On Approval		Implementation Date:

State Filing Description:

General Information

Project Name: ADVANTAGE GUARD APPLICATION
Project Number: ADVANTAGE GUARD APPLICATION
Requested Filing Mode: Review & Approval
Explanation for Combination/Other:
Submission Type: New Submission
Overall Rate Impact:
Filing Status Changed: 04/03/2009

Deemer Date:
Submitted By: Sherry Wiegman

Status of Filing in Domicile: Pending
Date Approved in Domicile:
Domicile Status Comments:
Market Type: Individual
Group Market Size:
Group Market Type:
Explanation for Other Group Market Type:
State Status Changed: 04/03/2009
Created By: Sherry Wiegman
Corresponding Filing Tracking Number:

Filing Description:

Attached are two new applications to be used with an existing approved individual whole life product (form series 2004, et al). This is a new submission that does not replace any previously approved forms.

Application FEAWL09 will be used for under age 60 applicants and application FEA09 will be used for over age 60 applicants.

Thanking you in advance for your consideration.

Company and Contact

Filing Contact Information

Sherry Wiegman, Sr. Compliance Analyst sherry.wiegman@anico.com
One Moody Plaza, SSH MP, Ste. 200 281-538-4842 [Phone]
Galveston, TX 77550 409-766-2950 [FAX]

Filing Company Information

Standard Life and Accident Insurance Company	CoCode: 86355	State of Domicile: Oklahoma
One Moody Plaza 17th Floor	Group Code: 408	Company Type: Health Insurance
Galveston, TX 77550	Group Name:	State ID Number:
(409) 621-7779 ext. [Phone]	FEIN Number: 73-0994234	

Filing Fees

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

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Standard Life and Accident Insurance Company	$50.00	04/02/2009	26898905

Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Linda Bird	04/03/2009	04/03/2009

Disposition

Disposition Date: 04/03/2009

Implementation Date:

Status: Approved-Closed

Comment:

Rate data does NOT apply to filing.

SERFF Tracking Number:	*ANTX-126096883*	*State:*	*Arkansas*
Filing Company:	*Standard Life and Accident Insurance Company*	*State Tracking Number:*	*42035*
Company Tracking Number:			
TOI:	*L07I Individual Life - Whole*	*Sub-TOI:*	*L07I.101 Fixed/Indeterminate Premium - Single Life*
Product Name:	*ADVANTAGE GUARD APPLICATION*		
Project Name/Number:	*ADVANTAGE GUARD APPLICATION/ADVANTAGE GUARD APPLICATION*		

Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification		Yes
Supporting Document	Application		Yes
Supporting Document	Life & Annuity - Acturial Memo		No
Form	Life Application - Over 60		Yes
Form	Life Application - Under 60		Yes

Form Schedule

Lead Form Number: FEA09 and FEAWL09

Schedule Item Status	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
	FEAWL09	Application/ Enrollment Form	Life Application - Over 60	Initial		50.100	Generic FEAWL09.pdf
	FEA09	Application/ Enrollment Form	Life Application - Under 60	Initial		50.100	Generic FEA09.pdf

Standard Life
A Member of the American National Family of Companies

Application to Standard Life and Accident Insurance Company
An Oklahoma Corporation
Administrative Office: P.O. Box 1850, Galveston, TX 77553-1850
888.519.5819

Issue Ages 26 - 59

This telephone conversation will be recorded and the information you provide is your application for life insurance.

1. Proposed Insured _____ (First Name) (Middle Initial) (Last Name)

Birthdate (Mo-Dy-Yr) _____ Age _____ Sex _____ Social Security Number _____

Height _____ Weight _____ Birthstate/Birthplace _____ Driver's License Number (if applicable) _____ (None ❑)

Marital Status: Married ❑ Single ❑ Separated ❑ Widowed ❑ Divorced ❑

Phone (_____) _____ Email Address _____

Residence Address _____ City _____ State _____ Zip _____

Billing Address (if different) _____ City _____ State _____ Zip _____

2. Employed By (if applicable) _____ Kind of Business _____

Date of Employment _____ Occupation _____

Duties (be specific) _____

3. Owner _____ (if other than Proposed Insured) Social Security Number _____ Date of Birth _____

Address _____ City _____ State _____ Zip _____

Email Address _____ Relationship to Proposed Insured _____

4. First Beneficiary _____ Social Security Number _____ Date of Birth _____

Address _____ City _____ State _____ Zip _____

Email Address _____ Relationship to Proposed Insured _____

Second Beneficiary _____ Social Security Number _____ Date of Birth _____

Address _____ City _____ State _____ Zip _____

Email Address _____ Relationship to Proposed Insured _____

5. Plan AdvantageGuard Face Amount _____

Initial Premium Payment _____ Payment Method _____ Payment Mode _____

Special Request

6. a) Total Life Insurance and Annuities in force. If none in force, indicate "none."

Name of Company	Policy Number	Issue Date	Plan Amount	Accidental Death	Disability Income

b) Will the life insurance applied for replace or use cash values of any existing life insurance or annuity policy issued by any company? Yes ❑ No ❑

If Yes, indicate which ones _____

7. Have you ever flown or do you contemplate flying as a pilot or student pilot, or engage in, or intend to engage in any hazardous avocation or sport such as skin diving, parachuting, hang gliding, vehicle racing, scuba diving, or mountain climbing?

If Yes, provide details. ..... Yes ❑ No ❑

8. Have you used nicotine in any form in the past 12 months? (Nicotine includes cigarettes, cigars, pipes, chewing tobacco, nicotine patches or other products containing nicotine.) ..... Yes ❑ No ❑

9. Are you currently on medication or under treatment or therapy? ..... Yes ❑ No ❑

10. Within the past 12 months, have you:

a) Been diagnosed or treated by a member of the medical profession for cancer (other than non-melanoma skin cancer); heart attack or heart surgery, congestive heart failure; Alzheimer's disease; stroke, aneurysm; leukemia or kidney failure? (circle all that apply) ..... Yes ❑ No ❑

b) Been treated for or diagnosed by a member of the medical profession as having acquired immune deficiency syndrome (AIDS), AIDS related complex (ARC), or human immunodeficiency virus (HIV) infection? ..... Yes ❑ No ❑

11. Within the past 5 years, have you:

a) Been advised to have any diagnostic test or hospitalization or surgery that has not been done? ..... Yes ❑ No ❑

b) Had a weight change of more than 10 pounds? ..... Yes ❑ No ❑

c) Been diagnosed or treated for mental or nervous disorder; chronic respiratory disease; insulin dependent diabetes; kidney disease; leukemia, multiple sclerosis, paralysis; chest pains, stroke, transient ischemic attack (TIA), disease of the heart or circulatory system, cardiomyopathy; osteoporosis; cancer or liver disorder? (circle all that apply) ..... Yes ❑ No ❑

d) Received treatment for or been advised to receive treatment for alcohol or drug use? ..... Yes ❑ No ❑

e) Applied for life, disability or health insurance that was declined, postponed, rated or modified? ..... Yes ❑ No ❑

f) Had a driver's license restricted or revoked, or been cited for driving under the influence of alcohol or drugs, or been cited for more than two moving violations? ..... Yes ❑ No ❑

12. Do you need personal or mechanical assistance in walking, bathing and/or dressing? ..... Yes ❑ No ❑

13. Please provide physician or practitioner name, date, description of disorder and type of treatment for each Yes answer to questions 9-12: _____

_____

14. Your Primary Physician's Name _____ Phone Number _____

Address _____

Date and reason last seen _____

_____

_____

15. Within the past 5 years, have you consulted or been treated by a physician or other licensed medical practitioner not shown above? ..... Yes ❑ No ❑

Question #	Description of Disorder	Date	Type of Treatment	Attending Physician/Hospital

FRAUD WARNING

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.

APPLICATION DECLARATIONS AND AGREEMENTS

In order to complete your application I need to read you some declarations and agreements which will be made part of your application for life insurance:

The Proposed Insured declares for himself/herself, that all of the answers in this application and any supplements to it are complete and true. The Proposed Insured also agrees that:

1. these answers as written:

   a) were given to induce Standard Life and Accident Insurance Company (hereafter referred to as "Standard Life" or "the Company") to issue a policy; and b) shall form the basis for and become part of any policy issued on the application;

2. no policy will be effective until it is:

   a) issued; b) delivered to the Applicant; c) the full first premium paid; and d) all during the lifetime and good health of the Proposed Insured;

3. the Company may issue a policy different from that specified in this application by listing the difference(s) on the policy data page, and acceptance of such different policy will be a ratification of the changes except that no changes in:

   a) specified amount; and b) classification will be effective unless agreed to by the Proposed Insured in writing; and

4. only the President, a Vice President, or Secretary of the Company has the authority to waive any of the Company rights or requirements or to waive or alter any of the provisions of this application or the policy issued on this application.

Normally, we would get your handwritten signature, but, since we are taking your life insurance application over the phone, we have to obtain your consent by voice recording which constitutes an electronic signature under the law. If the information you have provided on the application is true and correct, if you agree to the statements just read to you and if you consent to the use of this recording as our electronically signed application, please state your name, birthdate and "I agree".

Dated at City, State _____ Date _____

Proposed Insured's Signature _____ Owner's Signature _____

AGENT'S STATEMENT

1. What is the purpose of this insurance? Personal ❑ Business ❑
2. If beneficiary is not a relative, explain insurable interest: _____
3. How long have you personally known the Proposed Insured? _____
4. By whom will the premiums be paid? Owner ❑ Applicant ❑ Other ❑ If Other, explain _____
5. As an Agent, do you have knowledge or reason to believe that replacement of existing business may be involved? Yes ❑ No ❑
6. Was the application voluntary or solicited? _____

The agent is usually asked to sign the application as a witness. Since this application is being taken over the phone, we have to obtain the agent's signature by voice recording which constitutes an electronic signature under the law. Please state that you have participated in the telephone application and wish this recording to be your electronic signature by stating your name, birthdate and "I agree".

Date _____

Print Agent's Name _____ Agent's Signature _____ Agent's Code _____

AUTHORIZATION TO OBTAIN, RELEASE AND DISCLOSE MEDICAL INFORMATION

I hereby authorize any: physician, medical practitioner, hospital, clinic or other medical related facility, insurance company, insurance support organization, business partner, pharmacy, government agency, group policyholder, employer, benefit plan administrator, the Medical Information Bureau, the Department of Motor Vehicle Registration, and paramedical facility to provide to STANDARD LIFE AND ACCIDENT INSURANCE COMPANY, or to any agent, attorney, consumer reporting agency or independent administrator, including medical record retreival services or pharmaceutical services, acting on STANDARD LIFE AND ACCIDENT INSURANCE COMPANY'S or its reinsurers' behalf, information concerning advice, care or treatment sought by or provided to me and/or any other Applicant for coverage, including information relating to medical history, medical conditions, treatment, hospitalizations or confinements, ailments, and/or drug, alcohol or tobacco usage of the Applicant(s). It is understood that STANDARD LIFE AND ACCIDENT INSURANCE COMPANY'S underwriters, claim examiners, reinsurers, attorneys, or the medical director may disclose such health information to the aforementioned parties for purposes of underwriting, compliance, record clarification or explanation, or in response to litigation, summons, or subpoenas. I understand that after this information is disclosed, the recipient may redisclose it, resulting in loss of protection by federal regulations.

I understand that:

1. such information will be used by STANDARD LIFE AND ACCIDENT INSURANCE COMPANY for underwriting and insurability determinations;
2. I may refuse to sign this authorization and that my refusal to sign will affect my ability to obtain life insurance coverage;
3. a picture copy or photocopy of this authorization shall be as valid as the original; and
4. any authorized representative of the Proposed Insured is entitled to receive a copy of this authorization upon request.

This authorization is valid from the date signed for a duration of 24 months. I understand I may revoke the authorization, except to the extent that action has been taken in reliance on this authorization, by sending written notice to the Life New Business Department of STANDARD LIFE AND ACCIDENT INSURANCE COMPANY, P.O. Box 1850, Galveston, Texas 77553. *I may inspect or copy any information used or disclosed under in authorization, if signed.*

Since we are taking your life insurance application over the phone and cannot obtain a physical handwritten signature on this authorization we have to obtain your consent by voice recording which constitutes an electronic signature under the law. If you agree to the authorization just read to you and if you consent to the use of this recording as your electronic signature, please state your name, birthdate and "I agree".

Date

Applicant's Signature

DISCLOSURE NOTICE

Standard Life and Accident Insurance Company

Administrative Office: P.O. Box 1850, Galveston, Texas 77553-1850

In connection with your application, Standard Life and Accident Insurance Company (Standard Life), or its reinsurers, may obtain medical and other information for evaluation purposes. Standard Life may obtain that information from the Medical Information Bureau, Inc. or any medical professional, medically related facility, insurance support organization or insurance company who possesses information about the care, treatment or advice given you or your family. That information could concern drugs, alcoholism or mental illness. Standard Life may also obtain an investigative consumer report on you.

Medical Information Bureau (MIB) Pre-notification – Information regarding your insurability will be treated as confidential. Standard Life or its reinsurers may, however, make a brief report thereon to the MIB, Inc., formerly known as Medical Information Bureau[1], a not-for-profit membership organization of insurance companies, which operates an information exchange on behalf of its members. If you apply to another MIB member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, MIB, upon request, will supply such company with the information about you in its file.

Upon receipt of a request from you, MIB will arrange disclosure of any information in your file. Please contact MIB at 866.692.6901 (TTY 866.346.3642)[2]. If you question the accuracy of the information in MIB's file, you may contact MIB and seek a correction in accordance with the procedures set forth in the federal Fair Credit Reporting Act. The address of MIB's information office is 50 Braintree Hill Park, Suite 400, Braintree, Massachusetts 02184-8734.

Standard Life, or its reinsurers, may also release information from its file to other insurance companies to whom you may apply for life or health insurance, or to whom a claim for benefits may be submitted. Information for consumers about MIB may be obtained on its website at www.mib.com.

Fair Credit Reporting Act Pre-notification – Federal and state laws require notification that, with your application, we may request an investigative consumer report. In addition, such a report may be requested subsequently to update our records or if you apply for additional coverage. Upon written request, we will inform you whether or not an investigative consumer report was requested and, if such report was requested, the address and telephone number of the investigative agency to which the request was made. By contacting the local office and providing the proper identification, you may inspect, or for the appropriate fee, receive a copy of such report. Typically, the report will contain information as to character, general reputation, personal characteristics, and mode of living, which information is obtained through an interview with you or an adult member of your family, employers or business associates, financial sources, friends, neighbors, or others with whom you are acquainted. The information will consist, when applicable, of a confirmation of your identity, age, residence, marital status, and past and present employment including occupational duties, financial information, driving record, sports and recreational activities, health history, use of alcohol or drugs if any, living conditions and type of community.

[1] "Medical Information Bureau" changed its name in 1978 to "MIB, Inc." to reflect its status as a Delaware corporation. As noted in Comment 2 to the MIB General Rules (which was amended in the 2007 MIB Handbook and Directory), the use of "Medical Information Bureau" alone (without the accompanying use of "MIB, Inc.") is not technically accurate and should be changed.

[2] The toll free number and hearing impairment facility were added in 2004 in order to comply with the Fair and Accurate Credit Transactions Act of 2003 (FACTA), which amended the Fair Credit Reporting Act and required MIB to provide free annual file disclosure to consumers, among other things.

AUTHORIZATION TO MY BANK

PREAUTHORIZED CHECK AUTHORIZATION

Bank Information

❑ **Checking** ❑ **Savings**

Name

City State Zip

We will not draft from your account until underwriting approves your application.

As a convenience to me, I hereby request and authorize you to pay and charge to my account, checks or electronic debits drawn on my account by and payable to the order of Standard Life and Accident Insurance Company, provided there are sufficient collected funds in said account to pay the same upon presentation. I agree that your rights in respect to each such check or electronic debit shall be the same as if it were a check drawn on you and signed personally by me. This authority is to remain in effect until revoked by me in writing, and until you actually receive such notice I agree that you shall be fully protected in honoring any such checks. I further agree that should any such checks or electronic debits be dishonored, whether with or without cause and whether intentionally or inadvertently, you shall be under no liability whatsoever even though such dishonor results in the forfeiture of insurance.

If you want this voice recording to constitute your electronic signature on this authorization to your bank, please state your name, birthdate and “I agree to this authorization”.

Date Signed

✓ Signature

Account Number Routing Number

Standard Life
A Member of the American National Family of Companies

Application to Standard Life and Accident Insurance Company
An Oklahoma Corporation
Administrative Office: P.O. Box 1850, Galveston, TX 77553-1850
888.519.5819
Issue Ages 60 - 80

This telephone conversation will be recorded and the information you provide is your application for life insurance.

1. Proposed Insured _____
First Name Middle Initial Last Name
Birthdate (Mo-Day-Yr) _____ Age _____ Sex _____ Social Security Number _____
Height _____ Weight _____ Birthstate/Birthplace _____
Marital Status: ❑ Married ❑ Single ❑ Separated ❑ Widowed ❑ Divorced
Phone Number (_____) _____ Email Address _____
Residence Address _____ City_____State _____ Zip_____
Billing Address _____ City_____State _____ Zip_____
(if different)
2. Owner _____ Social Security Number _____ Date of Birth _____
(if other than Proposed Insured)
Address _____ Relationship _____
City State Zip
3. First Beneficiary _____ Social Security Number _____ Date of Birth _____
Address _____ Relationship _____
City State Zip
Second Beneficiary _____ Social Security Number _____ Date of Birth _____
Address _____ Relationship _____
City State Zip
Plan AdvantageGuard Initial Premium Payment _____ Face Amount _____
Payment Method _____ Payment Mode _____
Special Request _____
4. a) Do you have any existing insurance or annuities in force? If none in force, indicate "none"_____

Name of Company	Policy Number	Issue Date	Plan Amount	Accidental Death	Disability Income

b) Will the life insurance applied for replace or use cash values of any existing life insurance or annuity policy issued by any company? ..... ❑ Yes ❑ No
If Yes, indicate which ones _____
5. Have you used nicotine in any form in the past 12 months? (Nicotine includes cigarettes, cigars, pipes, chewing tobacco, nicotine patches or other products containing nicotine.) ..... ❑ Yes ❑ No
6. Are you currently on medication or under treatment or therapy? ..... ❑ Yes ❑ No
7. Within the past 12 months, have you:
a) Been diagnosed or treated by a member of the medical profession for cancer (other than non-melanoma skin cancer); heart attack or heart surgery, congestive heart failure; Alzheimer's disease; stroke, aneurysm; leukemia or kidney failure? (circle all that apply)..... ❑ Yes ❑ No
b) Been treated for or diagnosed by a member of the medical profession as having acquired immune deficiency syndrome (AIDS), AIDS related complex (ARC), or human immunodeficiency virus (HIV) infection?..... ❑ Yes ❑ No
8. Within the past 5 years, have you:
a) Had a weight change of more than 10 pounds?..... ❑ Yes ❑ No
b) Been advised to have any diagnostic test or hospitalization or surgery that has not been done? ..... ❑ Yes ❑ No
c) Been diagnosed or treated for mental or nervous disorder; chronic respiratory disease; insulin dependent diabetes; kidney disease; leukemia, multiple sclerosis, paralysis; chest pains, stroke, transient ischemic attack (TIA), disease of the heart or circulatory system, cardiomyopathy; osteoporosis; cancer or liver disorder? (circle all that apply)..... ❑ Yes ❑ No
d) Received treatment for or been advised to receive treatment for alcohol or drug use?..... ❑ Yes ❑ No
9. Do you need personal or mechanical assistance in walking, bathing and/or dressing? ..... ❑ Yes ❑ No

10. Please provide physician or practitioner name, date, description of disorder and type of treatment for each Yes answer to questions 6 - 9: _____

_____

11. Your Primary Physician's Name_____ Phone Number _____

Address _____ Date and Reason Last Seen _____

12. Within the past 5 years, have you consulted or been treated by a physician or other licensed medical practitioner not shown above? ..... ❑ Yes ❑ No

If Yes, please provide physician or practitioner name, date, description of disorder and type of treatment: _____

_____

FRAUD WARNING

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.

APPLICATION DECLARATIONS AND AGREEMENTS

In order to complete your application I need to read you some declarations and agreements which will be made part of your application for life insurance:

The Proposed Insured declares for himself/herself, that all of the answers in this application and any supplements to it are complete and true. The Proposed Insured also agrees that:

1. these answers as written: a) were given to induce the Company to issue a Policy; and b) shall form the basis for and become part of any Policy issued on the application;
2. no Policy will be effective until it is: a) issued; b) delivered to the Applicant; c) the full first premium paid; and d) all during the life time and good health of the Proposed Insured;
3. the Company may issue a Policy different from that specified in this application by listing the difference(s) on the Policy Data Page, and acceptance of such different Policy will be a ratification of the changes except that no changes in:
   a) specified amount; and b) classification will be effective unless agreed to by the Proposed Insured in writing; and
4. only the President, a Vice President, or Secretary of the Company has the authority to waive any of the Company rights or requirements or to waive or alter any of the provisions of this application or the Policy issued on this application.

Normally, we would get your handwritten signature, but, since we are taking your life insurance application over the phone, we have to obtain your consent by voice recording which constitutes an electronic signature under the law. If the information you have provided on the application is true and correct, if you agree to the statements just read to you and if you consent to the use of this recording as our electronically signed application, please state your name, birthdate and "I agree".

_____ _____

Dated at City, State Date

_____ _____

Proposed Insured's Signature Owner's Signature

AGENT'S STATEMENT

1. What is the purpose of this insurance? ❑ Personal ❑ Business
2. If beneficiary is not a relative, explain insurable interest: _____
3. How long have you personally known the Proposed Insured? _____
4. By whom will the premiums be paid? ❑ Owner ❑ Applicant ❑ Other If Other, explain: _____
5. As an agent, do you have knowledge or reason to believe that replacement of existing business may be involved?..... ❑ Yes ❑ No
6. Was the application voluntary or solicited? _____

The agent is usually asked to sign the application as a witness. Since this application is being taken over the phone, we have to obtain the agent's signature by voice recording which constitutes an electronic signature under the law. Please state that you have participated in the telephone application and wish this recording to be your electronic signature by stating your name, birthdate and "I agree".

_____

Date

_____ _____ _____

Print Agent's Name Agent's Signature Agent's Code

AUTHORIZATION TO OBTAIN, RELEASE AND DISCLOSE MEDICAL INFORMATION

I hereby authorize any: physician, medical practitioner, hospital, clinic or other medical related facility, insurance company, insurance support organization, business partner, pharmacy, government agency, group policyholder, employer, benefit plan administrator, the Medical Information Bureau, the Department of Motor Vehicle Registration, and paramedical facility to provide to STANDARD LIFE AND ACCIDENT INSURANCE COMPANY, or to any agent, attorney, consumer reporting agency or independent administrator, including medical record retreival services or pharmaceutical services, acting on STANDARD LIFE AND ACCIDENT INSURANCE COMPANY'S or its reinsurers' behalf, information concerning advice, care or treatment sought by or provided to me and/or any other Applicant for coverage, including information relating to medical history, medical conditions, treatment, hospitalizations or confinements, ailments, and/or drug, alcohol or tobacco usage of the Applicant(s). It is understood that STANDARD LIFE AND ACCIDENT INSURANCE COMPANY'S underwriters, claim examiners, reinsurers, attorneys, or the medical director may disclose such health information to the aforementioned parties for purposes of underwriting, compliance, record clarification or explanation, or in response to litigation, summons, or subpoenas. I understand that after this information is disclosed, the recipient may redisclose it, resulting in loss of protection by federal regulations.

I understand that:

1. such information will be used by STANDARD LIFE AND ACCIDENT INSURANCE COMPANY for underwriting and insurability determinations;
2. I may refuse to sign this authorization and that my refusal to sign will affect my ability to obtain life insurance coverage;
3. a picture copy or photocopy of this authorization shall be as valid as the original; and
4. any authorized representative of the Proposed Insured is entitled to receive a copy of this authorization upon request.

This authorization is valid from the date signed for a duration of 24 months. I understand I may revoke the authorization, except to the extent that action has been taken in reliance on this authorization, by sending written notice to the Life New Business Department of STANDARD LIFE AND ACCIDENT INSURANCE COMPANY, P.O. Box 1850, Galveston, Texas 77553. *I may inspect or copy any information used or disclosed under in authorization, if signed.*

Since we are taking your life insurance application over the phone and cannot obtain a physical handwritten signature on this authorization we have to obtain your consent by voice recording which constitutes an electronic signature under the law. If you agree to the authorization just read to you and if you consent to the use of this recording as your electronic signature, please state your name, birthdate and "I agree".

_____ Date

_____ Applicant's Signature

DISCLOSURE NOTICE

Standard Life and Accident Insurance Company

Administrative Office: P.O. Box 1820, Galveston, Texas 77553-1820

In connection with your application, Standard Life and Accident Insurance Company (Standard Life), or its reinsurers, may obtain medical and other information for evaluation purposes. Standard Life may obtain that information from the Medical Information Bureau, Inc. or any medical professional, medically related facility, insurance support organization or insurance company who possesses information about the care, treatment or advice given you or your family. That information could concern drugs, alcoholism or mental illness. Standard Life may also obtain an investigative consumer report on you.

Medical Information Bureau (MIB) Pre-notification – Information regarding your insurability will be treated as confidential. Standard Life or its reinsurers may, however, make a brief report thereon to the MIB, Inc., formerly known as Medical Information Bureau[1], a not-for-profit membership organization of insurance companies, which operates an information exchange on behalf of its members. If you apply to another MIB member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, MIB, upon request, will supply such company with the information about you in its file.

Upon receipt of a request from you, MIB will arrange disclosure of any information in your file. Please contact MIB at 866.692.6901 (TTY 866.346.3642)[2]. If you question the accuracy of the information in MIB's file, you may contact MIB and seek a correction in accordance with the procedures set forth in the federal Fair Credit Reporting Act. The address of MIB's information office is 50 Braintree Hill Park, Suite 400, Braintree, Massachusetts 02184-8734.

Standard Life, or its reinsurers, may also release information from its file to other insurance companies to whom you may apply for life or health insurance, or to whom a claim for benefits may be submitted. Information for consumers about MIB may be obtained on its website at www.mib.com.

Fair Credit Reporting Act Pre-notification – Federal and state laws require notification that, with your application, we may request an investigative consumer report. In addition, such a report may be requested subsequently to update our records or if you apply for additional coverage. Upon written request, we will inform you whether or not an investigative consumer report was requested and, if such report was requested, the address and telephone number of the investigative agency to which the request was made. By contacting the local office and providing the proper identification, you may inspect, or for the appropriate fee, receive a copy of such report. Typically, the report will contain information as to character, general reputation, personal characteristics, and mode of living, which information is obtained through an interview with you or an adult member of your family, employers or business associates, financial sources, friends, neighbors, or others with whom you are acquainted. The information will consist, when applicable, of a confirmation of your identity, age, residence, marital status, and past and present employment including occupational duties, financial information, driving record, sports and recreational activities, health history, use of alcohol or drugs if any, living conditions and type of community.

[1] "Medical Information Bureau" changed its name in 1978 to "MIB, Inc." to reflect its status as a Delaware corporation. As noted in Comment 2 to the MIB General Rules (which was amended in the 2007 MIB Handbook and Directory), the use of "Medical Information Bureau" alone (without the accompanying use of "MIB, Inc.") is not technically accurate and should be changed.

[2] The toll free number and hearing impairment facility were added in 2004 in order to comply with the Fair and Accurate Credit Transactions Act of 2003 (FACTA), which amended the Fair Credit Reporting Act and required MIB to provide free annual file disclosure to consumers, among other things.

AUTHORIZATION TO MY BANK

PREAUTHORIZED CHECK AUTHORIZATION

Bank Information

❏ **Checking** ❏ **Savings**

Name

City State Zip

We will not draft from your account until underwriting approves your application.

As a convenience to me, I hereby request and authorize you to pay and charge to my account, checks or electronic debits drawn on my account by and payable to the order of Standard Life and Accident Insurance Company, provided there are sufficient collected funds in said account to pay the same upon presentation. I agree that your rights in respect to each such check or electronic debit shall be the same as if it were a check drawn on you and signed personally by me. This authority is to remain in effect until revoked by me in writing, and until you actually receive such notice I agree that you shall be fully protected in honoring any such checks. I further agree should any such checks or electronic debits be dishonored, whether with or without cause and whether intentionally or inadvertently, you shall be under no liability whatsoever even though such dishonor results in the forfeiture of insurance.

If you want this voice recording to constitute your electronic signature on this authorization to your bank, please state your name, birthdate and “I agree to this authorization”.

Date Signed

✓ Signature

Account Number _____ Routing Number _____

Supporting Document Schedules

Item Status: **Status Date:**

Satisfied - Item: Flesch Certification
Comments:
Attachment:
Readability Certification SL.pdf

Item Status: **Status Date:**

Satisfied - Item: Application
Comments:
New applications are included on the forms tab. These are being filed for use with approved form 2004-891 et al.

Item Status: **Status Date:**

Bypassed - Item: Life & Annuity - Acturial Memo
Bypass Reason: n/a
Comments:

Standard Life
AND ACCIDENT INSURANCE COMPANY
League City, Texas
A MEMBER OF THE AMERICAN NATIONAL FAMILY OF COMPANIES

READABILITY CERTIFICATION

We hereby certify that FEAWL09 and FEA09 have achieved Flesch scale readability scores which meet the minimum reading ease score as required by your state.

Steve Schouweiler

Digitally signed by Steve Schouweiler
DN: cn=Steve Schouweiler, c=US, o=Standard Life and Accident Insurance Company, ou=Sr. Vice President, email=steve.schouweiler@anico.com
Date: 2009.04.01 13:20:27 -05'00'

Steve Schouweiler
Sr. Vice President, Health Operations

04/01/2009

Date of Signature