

SERFF Tracking Number: HULI-126094738 State: Arkansas
 Filing Company: Heritage Union Life Insurance Company State Tracking Number: 42007
 Company Tracking Number: HU-TL-APP120A
 TOI: L04I Individual Life - Term Sub-TOI: L04I.313 Decreasing - Single Life - Fixed/Indeterminate Premium
 Product Name: HU-TL-APP120A
 Project Name/Number: Life Insurance Application/HU-TL-APP120A

Filing at a Glance

Company: Heritage Union Life Insurance Company

Product Name: HU-TL-APP120A

SERFF Tr Num: HULI-126094738 State: Arkansas

TOI: L04I Individual Life - Term

SERFF Status: Closed-Approved-Closed
 State Tr Num: 42007

Sub-TOI: L04I.313 Decreasing - Single Life - Fixed/Indeterminate Premium

Co Tr Num: HU-TL-APP120A

State Status: Approved-Closed

Filing Type: Form

Author: Kim Hiar

Reviewer(s): Linda Bird

Date Submitted: 03/30/2009

Disposition Date: 04/02/2009

Disposition Status: Approved-Closed

Implementation Date Requested: On Approval

Implementation Date:

State Filing Description:

General Information

Project Name: Life Insurance Application

Status of Filing in Domicile: Not Filed

Project Number: HU-TL-APP120A

Date Approved in Domicile:

Requested Filing Mode: Review & Approval

Domicile Status Comments: This application is exempt from filing in our domiciliary state of Arizona.

Explanation for Combination/Other:

Market Type: Individual

Submission Type: New Submission

Group Market Size:

Overall Rate Impact:

Group Market Type:

Filing Status Changed: 04/02/2009

Explanation for Other Group Market Type:

State Status Changed: 04/02/2009

Deemer Date:

Created By: Kim Hiar

Submitted By: Kim Hiar

Corresponding Filing Tracking Number:

Filing Description:

The attached application is being filed for general use with our existing term life insurance products and any future products that may be developed and filed for approval. This application will be used with the following previously approved forms:

AL-TL-POL300B-AR

<i>SERFF Tracking Number:</i>	<i>HULI-126094738</i>	<i>State:</i>	<i>Arkansas</i>
<i>Filing Company:</i>	<i>Heritage Union Life Insurance Company</i>	<i>State Tracking Number:</i>	<i>42007</i>
<i>Company Tracking Number:</i>	<i>HU-TL-APP120A</i>		
<i>TOI:</i>	<i>L04I Individual Life - Term</i>	<i>Sub-TOI:</i>	<i>L04I.313 Decreasing - Single Life - Fixed/Indeterminate Premium</i>
<i>Product Name:</i>	<i>HU-TL-APP120A</i>		
<i>Project Name/Number:</i>	<i>Life Insurance Application/HU-TL-APP120A</i>		
	AL-TL-POL101B-AR		

The Additional Information page will only be used if the applicant provides additional information to questions on the application.

The Payment Authorization form will only be used to record information when the applicant elects to pay modal premiums through an EFT or credit card payment method.

The Good Health Statement is used if the time needed to underwrite the application takes longer than the standard 60 days the date of application. In that event, the Good Health Statement would be requested to confirm that there has been no significant change in the applicant's health status.

Company and Contact

Filing Contact Information

Kim Hiar, Compliance Manager	kimberly.hiar@heritageunion.com
1805 Monument Avenue	804-212-2818 [Phone]
Suite 201	804-213-0051 [FAX]
Richmond, VA 23220	

Filing Company Information

Heritage Union Life Insurance Company	CoCode: 62421	State of Domicile: Arizona
1805 Monument Avenue	Group Code: 181	Company Type: Life & Health Insurer
Suite 201	Group Name:	State ID Number: 2058
Richmond, VA 23220	FEIN Number: 41-0880965	
(804) 212-2818 ext. [Phone]		

Filing Fees

Fee Required?	Yes
Fee Amount:	\$60.00
Retaliatory?	No
Fee Explanation:	3 forms @ \$20.00/form
Per Company:	No

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COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Heritage Union Life Insurance Company	\$60.00	03/30/2009	26796327

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Product Name: HU-TL-APP120A
Project Name/Number: Life Insurance Application/HU-TL-APP120A

Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved- Closed	Linda Bird	04/02/2009	04/02/2009

SERFF Tracking Number: HULI-126094738 *State:* Arkansas
Filing Company: Heritage Union Life Insurance Company *State Tracking Number:* 42007
Company Tracking Number: HU-TL-APP120A
TOI: L04I Individual Life - Term *Sub-TOI:* L04I.313 Decreasing - Single Life -
Fixed/Indeterminate Premium

Product Name: HU-TL-APP120A
Project Name/Number: Life Insurance Application/HU-TL-APP120A

Disposition

Disposition Date: 04/02/2009

Implementation Date:

Status: Approved-Closed

Comment:

Rate data does NOT apply to filing.

SERFF Tracking Number: HULI-126094738 State: Arkansas
 Filing Company: Heritage Union Life Insurance Company State Tracking Number: 42007
 Company Tracking Number: HU-TL-APP120A
 TOI: L04I Individual Life - Term Sub-TOI: L04I.313 Decreasing - Single Life -
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Form Schedule

Lead Form Number: HU-TL-APP120A

Schedule Item Status	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
	HU-TL-APP120A	Application/ Term Life Enrollment Form	Application/ Term Life Application Initial Enrollment Form	Initial		48.700	HU-TL-APP120A 3-27-09.pdf
	HU-TL-APP320A	Application/ Term Life Enrollment Form	Application/ Term Life Application Initial Enrollment Form	Initial		48.700	HU-TL-APP320A 3-27-09.pdf
	HU-GHS100	Other	Good Health Statement	Initial		53.600	HU-GHS100 Good Health Statement.pdf

ABOUT PROPOSED INSURED (Please answer each question completely)

First Name _____

Last Name _____

Street _____

City _____ State _____ Zip _____

Primary Phone _____
 Best time to call: Morning Afternoon Early Evening

Alternate Phone _____
 Best time to call: Morning Afternoon Early Evening

Email Address _____

Current Occupation _____

Annual Salary \$ _____ Male Female

Product _____

Monthly Benefit Amount \$ _____

[Payout Period] _____

Rider(s)/Amount _____

Date of Birth _____ Age _____ Birthplace _____
 month day year state or country

Height ____ feet _____ inches Weight _____ pounds

SS# _____

Driver's License # _____ State Issued _____

Are you a citizen of the United States? Yes No

If no, do you have a permanent Visa (green card)? Yes No

POLICY OWNER'S INFORMATION (If different from Proposed Insured)

Policy Owner's Name: _____

Policy Owner's Street: _____

Policy Owner's City _____ State _____ Zip _____

Policy Owner's SS# or Tax Payer ID#: _____

BENEFICIARY INFORMATION

Name, Relationship and Designated %:

APPLICANT HISTORY (Check YES or NO for each question. If yes, provide details.)

1. a. Do you have other life insurance applications pending with any other company? Yes No
 - b. By applying for the proposed policy do you intend to replace, discontinue or change an existing policy or contract? Yes No
- If yes, provide details as follows. Attach a separate sheet if more space is needed (*Indicate Type of Coverage: I=Individual; B=Business; or G=Group)

INSURED NAME	INSURANCE COMPANY	POLICY NO.	AMOUNT	*TYPE	PENDING	ISSUE DATE
					<input type="checkbox"/>	
					<input type="checkbox"/>	

2. Have you, in the past 2 years, used Tobacco or Nicotine products in any form? Yes No
3. Within the past 3 years, have you been refused life insurance or been issued a policy on a modified or rated basis? Yes No
4. Have you, in the past 3 years, participated in or do you plan to participate in any in any of the following activities: aeronautics, including hang gliding, sky diving, parachuting, or ballooning; racing, including car, motorcycle, or boat; scuba/skin diving; hiking, including mountain/trail climbing or rock climbing; or any similar hazardous activities? Yes No
5. Have you, in the past 3 years, piloted an aircraft, or do you have any intention of flying in the future other than as a passenger on a scheduled airline? Yes No
6. Do you contemplate residence or travel, including military deployment, outside the US during the next 2 years? Yes No
7. Have you, in the past 3 years, had your driver's license suspended, revoked, cancelled, or withdrawn, had 3 or more moving violations, or in the past 5 years pleaded guilty or no contest to or been convicted of driving under the influence (DUI/DWI) or reckless driving? Yes No
8. Have you, in the past 10 years, pled guilty or no contest to or been convicted of a felony offense, or been on probation or parole for a felony offense, or are felony charges currently outstanding against you? Yes No
9. Have you, in the past 10 years, used illegal drugs, or consulted a physician or other healthcare provider or been treated, hospitalized, or taken medication for abuse of alcohol or drugs (including prescription drugs)? Yes No

10. Have you, in the past 10 years, had, consulted a physician or other healthcare provider, or been treated, hospitalized or taken medication for: any diseases or disorders of the heart including rheumatic fever, circulatory system, diabetes/endocrine/thyroid, blood, kidneys, liver, digestive system, lungs including allergies, sleep apnea, respiratory disorder, emphysema, or chronic asthma; any mental or nervous disorders, including depression or anxiety; muscular, spinal, joint, or bone disorders or injuries; including concussions; high blood pressure; high cholesterol; cancer; stroke; epilepsy/seizures, including dizziness or fainting; arthritis; congenital defects or physical impairments; or sexually transmitted diseases? Yes No
11. Have you ever tested positive for, or been treated for, been hospitalized for, or been diagnosed by a member of the medical profession as having HIV (Human Immunodeficiency Virus) antibodies or antigens or AIDS (Acquired Immunodeficiency Syndrome) or ARC (AIDS Related Complex) or any immune deficiency disorder? Yes No
12. Have you, in the past 12 months, been confined to a hospital or medical facility of any kind for more than 24 hours? Yes No
13. In the past 12 months have you scheduled or been advised to have surgery, a diagnostic test, an x-ray, electrocardiogram, blood test or any other laboratory tests, or evaluation of any kind? Yes No
14. In the last 5 years, have you:
- a. Been disabled, received disability income benefits, or been unable to work or perform and carry out your normal daily functions and activities? Yes No
- b. Taken prescription drugs for longer than 15 days? Yes No
15. Have any of your immediate family members (parents or siblings) been diagnosed or died from coronary artery disease, cancer or diabetes prior to age 60? Yes No

PAYMENT OPTIONS (Choose One):

Payer: Proposed Insured Policy Owner (if different than proposed insured) Choose a billing frequency: Monthly Quarterly
 Semi-annually Annually

Agreement/Authorization to Obtain and Disclose Information: I have read all the questions and answers on this application. All responses are true and complete to the best of my knowledge and belief. A copy of this application will be attached to and made a part of the insurance contract. Any insurance issued as a result of this application will not take effect until the full first premium is paid and a policy is delivered to and accepted by the Proposed Insured during his/her lifetime and while such person is in the state of health described in all parts of this application. I acknowledge receiving the "NOTIFICATION" regarding MIB, Inc. and Fair Credit Reporting Act in the enclosed materials. For use in determining insurability, research, or any other purpose not prohibited by law, I authorize any licensed physician, medical practitioner, MIB, Inc., any pharmacy related service organization, or consumer reporting agency that has any records or knowledge of the Proposed Insured's medical history to give any such information to Heritage Union Life Insurance Company, its representatives, or reinsurers. This authorization is valid for 24 months from the date signed. A photocopy or facsimile of this authorization will be as valid as the original. I may revoke this authorization for information not then obtained by notifying the Company in writing. Such revocation will not be effective until received by the Company. I understand that any information that is disclosed pursuant to this authorization may no longer be covered by federal rules governing privacy and confidentiality of health information, but it will not be re-disclosed by the Company except as authorized by me or as required by law. I understand that I or any authorized representative will receive a copy of this authorization upon request. I understand that I may request to be interviewed in connection with the preparation of an investigative consumer report. All applications are subject to underwriting approval which may include, but is not limited to, income verification, medical examination, laboratory testing, MVR, prescription records, and telephone interview.

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. **CO Residents:** It is unlawful to knowingly provide false, incomplete or misleading facts or information to an insurance company for the

purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies. **DC Residents:** WARNING: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include, imprisonment and/or fines. In addition, an insurer may deny insurance benefits, if false information materially related to a claim was provided by the applicant. **KY Residents:** Any person who knowingly and with intent to defraud any insurance company or other person files and 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. **MD Residents:** Any person who knowingly and willfully presents a false or fraudulent claim for payment of a loss or benefit or 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. **OH Residents:** 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 false or deceptive statement is guilty of insurance fraud. **OK Residents:** Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony. **OR Residents:** 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 may be guilty of a crime and may be subject to fines and confinement in prison. **TN Residents:** 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 and denial of insurance benefits.

Signed at City _____ State _____ Date _____

Signature of Proposed Insured (Required – Do not print) _____

Policy Owner Signature (If Different than Proposed Insured) _____

ADDITIONAL APPLICATION INFORMATION BELOW

Authorization For Payment by Electronic Funds Transfer or Credit Card

POLICY OWNER INFORMATION

First Name _____ MI _____

Last Name _____ Suffix _____

Street _____

City _____ State _____ Zip _____

SS# _____

PAYMENT OPTIONS (Choose One):

Choose a billing frequency: Monthly Quarterly Semi-annually Annually

Automatically Deduct Premium from: Savings Checking

Bank Name _____

Account Holder (Payer) Name (Please Print) _____

Account Number: _____

Routing Transit No.: _____

Example of routing/transit and account numbers found on the bottom of your personal check



OR Charge Premium to: Visa MasterCard Discover American Express

Credit Card Number: _____ Expiration Date: _____

BILLING ADDRESS

Same as Mailing Address Above

Street _____

City _____ State _____ Zip _____

I authorize Heritage Union Life Insurance Company to deduct from my account indicated above and I authorize the above named financial institution to honor the withdrawal. I understand that this authorization is to remain in effect until cancelled by me, Heritage Union Life Insurance Company or the Financial Institution named above. To terminate or change this service, I must notify Heritage Union Life Insurance Company at least 30 business days prior to the day that my premium is due to prevent electronic payment drafting.

Signature (Required – Do not print) _____

ABOUT PROPOSED INSURED (Please answer each question completely)

First Name _____

Last Name _____

Street _____

City _____ State _____ Zip _____

Primary Phone _____

Best time to call: Morning Afternoon Early Evening

Alternate Phone _____

Best time to call: Morning Afternoon Early Evening

Email Address _____

Current Occupation _____

Annual Salary \$ _____ Male Female

Product _____

Monthly Benefit Amount \$ _____

[Payout Period] _____

Rider(s)/Amount _____

Date of Birth _____ Age _____ Birthplace _____
month day year state or country

Height ____ feet _____ inches Weight _____ pounds

SS# _____

Driver's License # _____ State Issued _____

Are you a citizen of the United States? Yes No

If no, do you have a permanent Visa (green card)? Yes No

POLICY OWNER'S INFORMATION (If different from Proposed Insured)

Policy Owner's Name: _____

Policy Owner's Street: _____

Policy Owner's City _____ State _____ Zip _____

Policy Owner's SS# or Tax Payer ID#: _____

BENEFICIARY INFORMATION

Name, Relationship and Designated %:

APPLICANT HISTORY (Check YES or NO for each question. If yes, provide details.)

1. a. Do you have other life insurance applications pending with any other company? Yes No
 - b. By applying for the proposed policy do you intend to replace, discontinue or change an existing policy or contract? Yes No
- If yes, provide details as follows. Attach a separate sheet if more space is needed (*Indicate Type of Coverage: I=Individual; B=Business; or G=Group)

INSURED NAME	INSURANCE COMPANY	POLICY NO.	AMOUNT	*TYPE	PENDING	ISSUE DATE
					<input type="checkbox"/>	
					<input type="checkbox"/>	

2. Have you, in the past 2 years, used Tobacco or Nicotine products in any form? Yes No
3. Within the past 3 years, have you been refused life insurance or been issued a policy on a modified or rated basis? Yes No
4. Have you, in the past 3 years, participated in or do you plan to participate in any in any of the following activities: aeronautics, including hang gliding, sky diving, parachuting, or ballooning; racing, including car, motorcycle, or boat; scuba/skin diving; hiking, including mountain/trail climbing or rock climbing; or any similar hazardous activities? Yes No
5. Have you, in the past 3 years, piloted an aircraft, or do you have any intention of flying in the future other than as a passenger on a scheduled airline? Yes No
6. Do you contemplate residence or travel, including military deployment, outside the US during the next 2 years? Yes No
7. Have you, in the past 3 years, had your driver's license suspended, revoked, cancelled, or withdrawn, had 3 or more moving violations, or in the past 5 years pleaded guilty or no contest to or been convicted of driving under the influence (DUI/DWI) or reckless driving? Yes No
8. Have you, in the past 10 years, pled guilty or no contest to or been convicted of a felony offense, or been on probation or parole for a felony offense, or are felony charges currently outstanding against you? Yes No
9. Have you, in the past 10 years, used illegal drugs, or consulted a physician or other healthcare provider or been treated, hospitalized, or taken medication for abuse of alcohol or drugs (including prescription drugs)? Yes No

- 10.** Have you, in the past 10 years, had, consulted a physician or other healthcare provider, or been treated, hospitalized or taken medication for: any diseases or disorders of the heart including rheumatic fever, circulatory system, diabetes/endocrine/thyroid, blood, kidneys, liver, digestive system, lungs including allergies, sleep apnea, respiratory disorder, emphysema, or chronic asthma; any mental or nervous disorders, including depression or anxiety; muscular, spinal, joint, or bone disorders or injuries; including concussions; high blood pressure; high cholesterol; cancer; stroke; epilepsy/seizures, including dizziness or fainting; arthritis; congenital defects or physical impairments; or sexually transmitted diseases? Yes No
- 11.** Have you ever tested positive for, or been treated for, been hospitalized for, or been diagnosed by a member of the medical profession as having HIV (Human Immunodeficiency Virus) antibodies or antigens or AIDS (Acquired Immunodeficiency Syndrome) or ARC (AIDS Related Complex) or any immune deficiency disorder? Yes No
- 12.** Have you, in the past 12 months, been confined to a hospital or medical facility of any kind for more than 24 hours? Yes No
- 13.** In the past 12 months have you scheduled or been advised to have surgery, a diagnostic test, an x-ray, electrocardiogram, blood test or any other laboratory tests, or evaluation of any kind? Yes No
- 14.** In the last 5 years, have you:
- a. Been disabled, received disability income benefits, or been unable to work or perform and carry out your normal daily functions and activities? Yes No
- b. Taken prescription drugs for longer than 15 days? Yes No
- 15.** Have any of your immediate family members (parents or siblings) been diagnosed or died from coronary artery disease, cancer or diabetes prior to age 60? Yes No

PAYMENT OPTIONS (Choose One):

Payer: Proposed Insured Policy Owner (if different than proposed insured) Choose a billing frequency: Monthly Quarterly Semi-annually Annually

Agreement/Authorization to Obtain and Disclose Information: I have read all the questions and answers on this application. All responses are true and complete to the best of my knowledge and belief. A copy of this application will be attached to and made a part of the insurance contract. Any insurance issued as a result of this application will not take effect until the full first premium is paid and a policy is delivered to and accepted by the Proposed Insured during his/her lifetime and while such person is in the state of health described in all parts of this application. I acknowledge receiving the "NOTIFICATION" regarding MIB, Inc. and Fair Credit Reporting Act in the enclosed materials. For use in determining insurability, research, or any other purpose not prohibited by law, I authorize any licensed physician, medical practitioner, MIB, Inc., any pharmacy related service organization, or consumer reporting agency that has any records or knowledge of the Proposed Insured's medical history to give any such information to Heritage Union Life Insurance Company, its representatives, or reinsurers. This authorization is valid for 24 months from the date signed. A photocopy or facsimile of this authorization will be as valid as the original. I may revoke this authorization for information not then obtained by notifying the Company in writing. Such revocation will not be effective until received by the Company. I understand that any information that is disclosed pursuant to this authorization may no longer be covered by federal rules governing privacy and confidentiality of health information, but it will not be re-disclosed by the Company except as authorized by me or as required by law. I understand that I or any authorized representative will receive a copy of this authorization upon request. I understand that I may request to be interviewed in connection with the preparation of an investigative consumer report. All applications are subject to underwriting approval which may include, but is not limited to, income verification, medical examination, laboratory testing, MVR, prescription records, and telephone interview.

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purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies. **DC Residents:** WARNING: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include, imprisonment and/or fines. In addition, an insurer may deny insurance benefits, if false information materially related to a claim was provided by the applicant. **KY Residents:** Any person who knowingly and with intent to defraud any insurance company or other person files and 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. **MD Residents:** Any person who knowingly and willfully presents a false or fraudulent claim for payment of a loss or benefit or 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. **OH Residents:** 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 false or deceptive statement is guilty of insurance fraud. **OK Residents:** Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony. **OR Residents:** 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 may be guilty of a crime and may be subject to fines and confinement in prison. **TN Residents:** 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 and denial of insurance benefits.

Signed at City _____ State _____ Date _____
 Signature of Proposed Insured (Required – Do not print) _____
 Policy Owner Signature (If Different than Proposed Insured) _____

FOR AGENT USE

To the best of my knowledge, replacement of an existing life insurance policy or annuity contract is is not involved in this transaction.

Agent Signature _____
 Agent Name (Printed) _____
 Agent Number _____
 Signed at City _____ State _____ Date _____

ADDITIONAL APPLICATION INFORMATION BELOW

Authorization For Payment by Electronic Funds Transfer or Credit Card

POLICY OWNER INFORMATION

First Name _____ MI _____

Last Name _____ Suffix _____

Street _____

City _____ State _____ Zip _____

SS# _____

PAYMENT OPTIONS (Choose One):

Choose a billing frequency: Monthly Quarterly Semi-annually Annually

Automatically Deduct Premium from: Savings Checking

Bank Name _____

Account Holder (Payer) Name (Please Print) _____

Account Number: _____

Routing Transit No.: _____

Example of routing/transit and account numbers found on the bottom of your personal check



OR Charge Premium to: Visa MasterCard Discover American Express

Credit Card Number: _____ Expiration Date: _____

BILLING ADDRESS

Same as Mailing Address Above

Street _____

City _____ State _____ Zip _____

I authorize Heritage Union Life Insurance Company to deduct from my account indicated above and I authorize the above named financial institution to honor the withdrawal. I understand that this authorization is to remain in effect until cancelled by me, Heritage Union Life Insurance Company or the Financial Institution named above. To terminate or change this service, I must notify Heritage Union Life Insurance Company at least 30 business days prior to the day that my premium is due to prevent electronic payment drafting.

Signature (Required – Do not print) _____

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Supporting Document Schedules

	Item Status:	Status Date:
Satisfied - Item: Flesch Certification		
Comments:		
Attachment: Certification of Compliance - HU-TL-APP120.pdf		

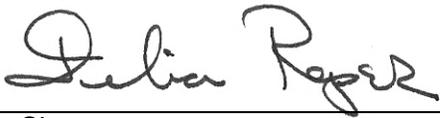
	Item Status:	Status Date:
Bypassed - Item: Application		
Bypass Reason: This application is to be used with previously approved policy forms as stated in the General Information tab. It may also be used with policy forms filed for approval in the future.		
Comments:		

	Item Status:	Status Date:
Bypassed - Item: Life & Annuity - Actuarial Memo		
Bypass Reason: This filing is an application only. An actuarial memorandum is not required.		
Comments:		

CERTIFICATION OF COMPLIANCE

I certify that in preparation of this filing all statutes, regulations, rules and bulletins have been reviewed, including Rule 19 and Rule 49.

I also certify that all forms contained in this filing comply with the minimum flesch score of 40 as required in Arkansas ACA 23-80-206.



Signature

March 30, 2009

Date

Julie Roper

Name

President

Title