

SERFF Tracking Number: AEGB-126151084 State: Arkansas
Filing Company: Western Reserve Life Assurance Co. of Ohio State Tracking Number: 42419
Company Tracking Number: U321 0209, U322 0209
TOI: L08 Life - Other Sub-TOI: L08.000 Life - Other
Product Name: U321 0209, U322 0209
Project Name/Number: U321 0209, U322 0209/U321 0209, U322 0209

Filing at a Glance

Company: Western Reserve Life Assurance Co. of Ohio

Product Name: U321 0209, U322 0209

TOI: L08 Life - Other

Sub-TOI: L08.000 Life - Other

Filing Type: Form

SERFF Tr Num: AEGB-126151084 State: Arkansas

SERFF Status: Closed-Approved-
Closed State Tr Num: 42419

Co Tr Num: U321 0209, U322 0209 State Status: Approved-Closed

Reviewer(s): Linda Bird

Author: Theresa Meyers

Date Submitted: 05/14/2009

Disposition Date: 05/20/2009

Disposition Status: Approved-
Closed

Implementation Date:

Implementation Date Requested: On Approval

State Filing Description:

General Information

Project Name: U321 0209, U322 0209

Project Number: U321 0209, U322 0209

Requested Filing Mode: File & Use

Explanation for Combination/Other:

Submission Type: New Submission

Overall Rate Impact:

Filing Status Changed: 05/20/2009

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: 05/20/2009

Created By: Theresa Meyers

Corresponding Filing Tracking Number: U321
0209, U322 0209

Deemer Date:

Submitted By: Theresa Meyers

Filing Description:

Re: WESTERN RESERVE LIFE ASSURANCE CO. OF OHIO NAIC # 468-91413

U321 0209 – WRL Fixed Express Application Part I

U322 0209 – Medical Supplement Part II of WRL Fixed Express Application

Dear Sir/Madam:

Please find attached a copy of the above referenced forms. These are new forms and are not intended to replace any forms previously approved by your Department. These forms have been submitted in final printed form in which they will

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be distributed to Insureds. These forms are subject to only minor modifications in paper size and stock, ink, border, Company logo, Company address, adaptation to computer printing, and Officers' signatures.

WRL Fixed Express Application Part I – This is an individual life insurance application that will be used with our term and universal life portfolios.

Medical Supplement Part II of WRL Fixed Express Application – This is a supplemental medical life application for use with the WRL Fixed Express Application Part I.

We intend to use these forms with the following base policies:

TL05 0107 AR, which was approved by your Department on April 10, 2007;

TL06 0107 AR, which was approved by your Department on April 10, 2007;

UL02 0707 AR, which was approved by your Department on November 2, 2007.

We intend to use these forms in a traditional manner whereby the Owner/Applicant signs the application in ink and submits the application to the Company.

We also plan to make these forms available electronically. It is our intent to use these forms in a variety of electronic environments, including a laptop and web based application process. Regardless of the application process used, we intend to adopt measures to secure both the integrity of the document once signed, and the confidentiality of any information transmitted, including transmission of information via a secured socket layer/secured line. The information contained in the application will be transmitted to our administrative office electronically as well as the electronic signature of the Owner/Applicant. Current technology will be used to ensure that the confidential information is not compromised. All processes used will comply with the Uniform Electronic Transactions Act, and to the extent applicable, the Federal ESIGN Act.

We hereby certify that any electronic signature we obtain will be linked to the date on the electronic application in such a manner that the electronic signature is invalidated if any of the data on the application is changed. We also certify that such electronic signature intended for use with this application will not be affixed to or duplicated on any other document.

A copy of the application, identical to the filed form, will be printed and made part of any policy issued.

Should you have any questions or need any additional information, please do not hesitate to contact me. Thank you.

Sincerely,

WESTERN RESERVE LIFE ASSURANCE CO. OF OHIO

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Theresa Meyers
 Policy Analyst
 Contract Development
 (319) 355-7520 (collect)
 Fax #: (319) 355-2501
 thmeyers@aegonusa.com

Company and Contact

Filing Contact Information

Theresa Meyers, Policy Analyst thmeyers@aegonusa.com
 4333 Edgewood Rd. NE 319-355-7520 [Phone]
 MS 2225 319-355-2501 [FAX]
 Cedar Rapids, IA 52499

Filing Company Information

Western Reserve Life Assurance Co. of Ohio CoCode: 91413 State of Domicile: Ohio
 4333 Edgewood Road NE Group Code: 468 Company Type:
 Cedar Rapids, IA 52499 Group Name: State ID Number:
 (319) 398-7888 ext. [Phone] FEIN Number: 43-1162657

Filing Fees

Fee Required? Yes
 Fee Amount: \$40.00
 Retaliatory? No
 Fee Explanation: \$20.00 per form X 2 forms = \$40.00
 Per Company: No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Western Reserve Life Assurance Co. of Ohio	\$40.00	05/14/2009	27891237

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Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Linda Bird	05/20/2009	05/20/2009

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Disposition

Disposition Date: 05/20/2009

Implementation Date:

Status: Approved-Closed

Comment:

Rate data does NOT apply to filing.

SERFF Tracking Number: *AEGB-126151084* *State:* *Arkansas*
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Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification		Yes
Supporting Document	Application		No
Form	WRL Fixed Express Application Part I		Yes
Form	Medical Supplement Part II		Yes

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Form Schedule

Lead Form Number: U321 0209, U322 0209

Schedule Item Status	Form Number	Form Type Form Name	Action	Action Specific Data	Readability	Attachment
	U321 0209	Application/WRL Fixed Express Enrollment Application Part I Form	Initial		52.000	U321 0209 STD.pdf
	U322 0209	Application/Medical Supplement Enrollment Part II Form	Initial		51.700	U322 0209 STD.pdf



1 PROPOSED INSURED

Last Name _____ First Name _____ M.I. _____

Street Address (Cannot be a PO Box) _____

City _____ State _____ Zip _____

Daytime Telephone Number _____

Date of Birth (Month/Day/Year) _____ Place of Birth (State/Country) _____

Social Security Number _____ Sex _____

Driver's License Number _____ State _____

2 APPLICANT/OWNER The person or entity exercising the policy's granted rights.

Same as proposed Insured
 If ownership is a corporation, partnership or institutional body, please complete the Entity Certification of Authority Form. If ownership is a trust, please complete the Trustee Certification Trust Form. Attach a copy of the first page and the signature page of the trust.

Last Name _____ First Name _____ M.I. _____

Street Address (Cannot be a PO Box) _____

City _____ State _____ Zip _____

SSN/Tax ID _____ DOB _____ Relationship _____

Are you a citizen of USA Other Country _____

Type of VISA _____

3 BENEFICIARY

If percentage shares are not listed below, they will be divided equally among beneficiaries.

Primary

1. _____
 Relationship _____ %

2. _____
 Relationship _____ %

Contingent

1. _____
 Relationship _____ %

2. _____
 Relationship _____ %

4 INSURANCE

Plan: WRL Term Plus w/ROP 20 30
 WRL Term Plus 10 15 20 30
 WRL Lifetime

Specified Amount: \$ _____

(Minimum Specified Amount for Term must be \$100,000.00)
 (Minimum Specified Amount for UL must be \$100,001.00)

Rate Classes: Not all classes available with all products.
 Preferred Elite Preferred Plus Preferred
 Non-Tobacco Preferred Tobacco Tobacco

Additional Benefits:

Not all items available with all products.
 Disability Income Rider (monthly benefit) \$ _____
 Disability Waiver of Monthly Deductions Rider
 Disability Waiver of Premium Rider
 Accidental Death Benefit Rider \$ _____
 Critical Illness Rider \$ _____
 Guaranteed Insurability Benefit \$ _____

5 PAYMENT Planned Premium

5a Check One:
 I have enclosed a check, made payable to Western Reserve Life Assurance Co. of Ohio, for my initial payment of \$ _____.

5b I want to make payments of \$ _____.
 Monthly Semiannually None
 Quarterly Annually

5c I have enclosed a voided check and bank draft authorization form. Yes No

5d A secondary addressee may be named who will receive copies of premium notices and letters regarding possible lapse in coverage.

Name _____

Street Address (Cannot be a PO Box) _____

City _____ State _____ Zip _____

6 INFORMATION ABOUT THE PROPOSED INSURED

6a Best days and times to call for telephone interview?

Telephone Number: _____

6b Name of Employer: _____

Occupations/Duties _____

6c Gross Income Current Year \$ _____

Gross Income Previous Year \$ _____

Net Worth \$ _____

NOTE: Complete a Confidential Financial Questionnaire for coverage over \$1,000,000.

6d Are you a citizen of

USA Other Country _____

Type of VISA _____

6e Will you be traveling outside of the United States in the next 12 months?

Yes Destination _____

No

Have you:

6f Used TOBACCO or any other product containing nicotine in the past 5 years? Yes No

If Yes, please give type and date last used:

Type: _____

Date Last Used: _____

6g To the best of your knowledge and belief, during the last 10 years, been diagnosed or treated by a licensed member of the medical profession for heart, liver, kidney, lung, brain or mental or nervous disorder, stroke, diabetes, cancer, AIDS or ARC (AIDS Related Complex), alcohol or drug abuse?

Yes No If Yes, please provide personal physician or clinic information and details:

Name: _____

Address: _____

Telephone Number: _____

Details (including date last consulted):

6h Flown in the past 2 years or plan to fly within the next 2 years, except as a passenger on a regularly scheduled flight?

Yes No

If Yes, complete Avocation & Aviation Questionnaire.

6i Within the past 2 years, have you participated in:

a) Aeronautics such as hang-gliding, ballooning, ultra-light flying or skydiving? Yes No

b) Organized motor vehicle, motorcycle, boat or powered vehicle racing? Yes No

c) Skin or scuba diving, mountain climbing, canyoneering, rodeos or competitive skiing? Yes No

If Yes, complete Avocation & Aviation Questionnaire.

6j Had your driver's license suspended, restricted, revoked, or been cited for a moving violation in the past 5 years?

Yes No If Yes, please explain:

6k Been convicted of a misdemeanor (other than a minor traffic violation) or felony, or been on probation or parole in the past 10 years?

Yes No If Yes, please explain:

6l Have you ever had life, disability, or health insurance declined, rated, modified, issued with an exclusion rider, cancelled or non-renewed? Yes No If Yes, please explain:

7 REPLACEMENT OF OTHER CONTRACTS

7a Does the proposed Insured have existing life insurance policies or annuity contracts inforce? Yes No

7b Total amount Life Insurance inforce \$ _____

7c Company _____

Amount of Insurance \$ _____ Year Issued _____

Replacement? Yes No 1035 Exchange? Yes No

Anticipated Cash Value \$ _____

Company _____

Amount of Insurance \$ _____ Year Issued _____

Replacement? Yes No 1035 Exchange? Yes No

Anticipated Cash Value \$ _____

7d Is there an application for life, accident or sickness insurance now pending or contemplated on the proposed Insured in this or any other company? Yes No

If Yes, give details.

AGENT TO COMPLETE QUESTIONS 7e AND 7f

7e Will the insurance applied for on the proposed Insured discontinue, replace or change any existing life or annuity policy? Yes No

If Yes, complete replacement forms, if appropriate.

7f Did you present and leave the Applicant/Owner company approved sales material? Yes No

8 AUTHORIZATION TO OBTAIN AND DISCLOSE INFORMATION Western Reserve Life Assurance Co. of Ohio (the Company)

I, the proposed Insured, and I, the Applicant/Owner if different, hereby represent that the statements and answers given in this application are true, complete and correctly recorded. I/we agree: (A) this application shall consist of Part 1, Part 2, and any required application supplement(s)/amendment(s), and shall be the basis for any insurance issued on this application; (B) that the agent does not have the authority to waive any question on this application, to decide if insurance will be issued, or to modify any term or provision of any insurance which may be issued based on this application. No waiver or modification shall be binding upon the Company unless in writing and signed by the President or a Vice President and the Secretary or an Assistant Secretary; (C) except as provided in the Conditional Receipt, if issued, with the same proposed Insured as on this application, any policy issued on this application shall not take effect until after all of the following conditions have been met: 1) the minimum initial premium must be paid and received by the Company; 2) the Applicant/Owner has personally received and accepted the policy during the lifetime of and while the proposed Insured is in good health, and 3) on the date of the later of either 1) or 2) above, all of the statements and answers given in this application must be true and complete as of the date of Owner's personal receipt of the contract and that the insurance policy will not take effect if the facts have changed.

I authorize MIB Group, Inc. and its members or affiliates, my employer or former employer, any consumer reporting agency or governmental agency, medical provider, or any insurer or reinsurer to provide medical or personal information about me that is reasonably required for the purposes stated in this authorization to Western Reserve Life Assurance Co. of Ohio, its administrators, representatives or its reinsurers. I understand the information obtained by use of the authorization will be used by Western Reserve Life Assurance Co. of Ohio to determine eligibility for insurance, and eligibility for benefits under an existing policy. Any information obtained will not be released by Western Reserve Life Assurance Co. of Ohio to any person or organization except to reinsurers, MIB Group, Inc. and its members or affiliates, 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 authorize. This authorization will expire 30 months (24 months in Iowa, Kentucky, New Mexico, and Wyoming) from the date signed. A copy of this authorization shall be as valid as the original. Either my authorized representative or I may receive a copy of this authorization upon request.

The Company shall have sixty days from the date hereof within which to consider and act on this application and if within such period a policy has not been received by the applicant or if notice of approval or rejection has not been given, then this application shall be deemed to have been declined by the Company.

I acknowledge receipt of the (1) Notice to Persons Applying for Insurance Regarding Investigative Report, (2) MIB Group, Inc. Pre-Notification, and (3) Notice of Insurance Information Practices.

I understand that any omissions or misstatements in this application could cause an otherwise valid claim to be denied under any insurance issued from this application.

I also understand that I will not receive any insurance coverage for any money paid with this application unless a policy is issued except in accordance with the terms of the Conditional Receipt.

Taxpayer Identification Certification

Under current federal tax laws, the Company is required to obtain your Taxpayer Identification Number (e.g., a social security or employer identification number, or "TIN") and certification that you are not subject to backup withholding. Please review the following certification and sign accordingly.

Under penalties of perjury, I certify that (1) the TIN listed in this application is my correct TIN; (2) I have not been notified that I am subject to backup withholding or I am not subject to backup withholding because I am an exempt recipient; and (3) I am a U.S. Person, (U.S. citizen/legal resident). If not a U.S. Person, I have completed the appropriate Form W-8BEN. The IRS does not require your consent to any provision of this form other than this certification.

Signature of Owner

Date

FRAUD WARNING: Any person who knowingly presents a false statement in an application for insurance may be guilty of a criminal offense and subject to penalties under state law.

Signed at _____
City and State

On _____
Month/Day/Year

Signature of proposed Insured

Signature of Applicant/Owner if other than proposed Insured
(If business insurance, show title of officer and name of firm)

Signature of Agent

Print Agent's Name

Agent Number

CONDITIONAL RECEIPT

(Detach and leave with applicant only if money is submitted with application. **If within the past 12 months the proposed Insured has been diagnosed or treated by a member of the medical profession for heart trouble, stroke or cancer, no payment may be accepted with the application.** Do not accept money unless all required signatures below are obtained.)

PLEASE READ THIS CAREFULLY

No coverage will become effective prior to the delivery of the policy applied for unless and until all conditions of this receipt have been fulfilled exactly. No agent or field representative is authorized to waive or modify any of the provisions of the conditional receipt.

Make all checks payable to the Company. Do not make checks payable to the agent or leave the payee blank or you may jeopardize the insurance for which you have applied.

Received from _____, the sum of \$_____ for the insurance application dated _____, with _____ as the proposed Insured(s). The policy you applied for will not become effective unless and until a policy contract is delivered to you and all other conditions of coverage are met. However, subject to the conditions and limitations of this Receipt, conditional insurance under the terms of the policy applied for may become effective as of the later of (1) the date of completing Part 1 and Part 2 of the application and (2) the date of the last medical examination, tests, and other screenings required by the Company, if any (the "Effective Date"). Such conditional insurance will take effect as of the Effective Date, so long as all of the following requirements are met:

1. The proposed Insured is found to have been insurable as of the Effective Date, exactly as applied for in accordance with the Company's underwriting rules and standards, without any modifications as to plan, amount, or premium rate;
2. As of the Effective Date, all statements and answers given in Part 1 and Part 2 of the application must be true;
3. The payment made with the application must not be less than the full initial premium for the mode of payment chosen in the application and must be received at our Administrative Office within the lifetime of the proposed Insured to whom the conditional coverage would apply and, if in the form of check or draft, must be honored for payment;
4. All medical examinations, tests, and other screenings required of the proposed Insured by the Company are completed and the results received at our Administrative Office within 60 days of the date the application was completed; and
5. All of Part 1 and Part 2 of the application, any supplemental application, questionnaires, addendum and/or amendment to the application are signed and received at our Administrative Office.

Any conditional coverage provided by this Receipt will terminate on the earliest of: (a) 60 days from the date Part 1 of the application was signed; (b) the date the Company either mails notice to the applicant of the rejection of the application and/or mails a refund of any amounts paid with the application; (c) when the insurance applied for goes into effect under the terms of the policy applied for; or (d) the date the Company offers to provide insurance on terms that differ from the insurance for which you have applied.

If one or more of this Receipt's conditions have not been met exactly, or if the proposed Insured dies by suicide, the Company will not be liable except to return any payment made with the application.

If the Company does not approve and accept the application for insurance within 60 days of the date you signed Part 1 of the application, the application will be deemed to be rejected by the Company and there will be no conditional insurance coverage. In that case, the Company's liability will be limited to returning any payment(s) you have made upon return of this Receipt to the Company.

The aggregate amount of conditional coverage provided under this Receipt, if any, and any other conditional receipt issued by the Company shall be limited to the lesser of the amount(s) applied for or \$500,000 of life insurance. There is no conditional coverage for riders or any additional benefits, if any, for which you have applied.

Authorization (All Signatures Required)

I certify that I have read and reviewed the Conditional Receipt and the Authorization to Obtain and Disclose Information in the application. The terms and conditions of the Conditional Receipt have been explained to me fully by the agent and I understand them.

Dated at _____ on _____
City, State Date Signature of proposed Insured

Signature of Applicant (if other than proposed Insured) Signature of Agent or Authorized Company Rep

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NOTICES

DETACH AND LEAVE THIS PAGE WITH APPLICANT

NOTICE TO PERSONS APPLYING FOR INSURANCE REGARDING INVESTIGATIVE REPORT

To proposed Insured: In connection with this application, an investigative consumer report may be prepared about you. Such reports are part of the process of evaluating risks for life and health insurance. Typically, this report will contain information about your character, general reputation, personal characteristics and mode of living. The information in the report may be obtained by talking with you or members of your family, business associates, financial sources, neighbors, and others you know. You may ask to be interviewed in connection with the preparation of any such report. Also, we may have the report updated if you apply for more coverage.

Upon your written request, we will let you know whether a report was prepared and we will give you the name, address, and telephone number of the agency preparing the report. By contacting that agency and providing proper identification, you may obtain a copy of the report.

MIB GROUP, INC. (MIB) PRE-NOTIFICATION

To proposed Insured and other persons proposed to be insured, if any. Information regarding your insurability will be treated as confidential. We or our reinsurer(s) may, however, make a brief report on this information to MIB Group, Inc., a non-profit membership organization of insurance companies that 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 may, upon request, supply such company with the information in its file.

Upon receipt of a request from you, MIB will arrange disclosure of any information it may have in your file. If you question the accuracy of 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, Suite 400, Braintree, Massachusetts 02184-8734; and telephone number is 866-692-6901 (TTY 866-346-3642 for hearing impaired).

NOTICE OF INSURANCE INFORMATION PRACTICES

To proposed Insured: Personal information may be collected from persons other than the individual(s) proposed for coverage. Such information as well as other personal or privileged information subsequently collected by us or our agent may in certain circumstances be disclosed to third parties without authorization. Upon request, you have the right to access your personal information and ask for corrections. You may obtain a complete description of our Information Practices by writing to Western Reserve Life Assurance Co. of Ohio, Attn: Director of Underwriting, [4333 Edgewood Road NE, Cedar Rapids, Iowa 52499].

**PLEASE PROVIDE A COPY OF THIS NOTICE TO THE PROPOSED INSURED
IF NOT A HOUSEHOLD MEMBER.**

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9 PROPOSED INSURED INFORMATION

Last Name: _____ First Name: _____ M.I. _____
 Date of Birth (Month/Day/Year) _____ Marital Status: _____
 Social Security No. _____ Height (Ft., In.): _____ Weight (Lbs): _____
 Name, address and telephone number of your primary care physician? (If none check box) None _____

 Date and reason last consulted? _____
 What treatment was given or medication prescribed? _____

10 MEDICAL INFORMATION ABOUT THE PROPOSED INSURED

- A) For the last 180 days have you been actively at work, on a full time basis, at your usual place of business or employment? Yes No
- B) To the best of your knowledge, have you within the last 10 years, had or been told by a member of the medical profession that you have, or been diagnosed with or treated for:
 - 1) High blood pressure, heart attack, murmur, chest pain, palpitation, anemia, or any disease of the heart, blood vessels or blood? Yes No
 - 2) Asthma, chronic bronchitis, pneumonia, emphysema, tuberculosis, or any disease or abnormality of the lungs or respiratory system? Yes No
 - 3) Cancer, tumor, polyp or cyst? Yes No
 - 4) Sugar, protein, or blood in the urine, sexually transmitted disease, or any disease or abnormality of the kidney, bladder, prostate, breasts, ovaries or reproductive system? Yes No
 - 5) Stroke, seizure, epilepsy, fainting, loss of consciousness, tremor, paralysis, multiple sclerosis, or any disease of the brain or nervous system? Yes No
 - 6) Anxiety, depression, suicide attempt, or any psychiatric, mental or nervous or emotional condition or disorder? Yes No
 - 7) Diabetes, or any disease or abnormality of the thyroid, adrenal, pancreas, pituitary or other glands? Yes No
 - 8) Ulcer, colitis, hepatitis, cirrhosis, or any disease or abnormality of the esophagus, stomach, intestines, rectum, gallbladder or liver? Yes No
 - 9) Arthritis, gout, connective tissue disease, back trouble or any disease or abnormality of the joints, muscles or bones or any physical deformity or amputation? Yes No
- 10) Any disease or abnormality of the eyes, ears, nose, throat or skin? Yes No
- C) To the best of your knowledge, have you within the last 10 years:
 - 1) Used amphetamines, heroin, cocaine, marijuana, or any other illegal or controlled substance except as prescribed by a physician? Yes No
 - 2) Sought or been advised to seek treatment, limit or discontinue use of alcohol, drugs or other substance or joined an organization for alcohol or drug dependence or abuse? Yes No
 - 3) Been on or are now on prescribed medication or prescribed diet? Yes No
 - 4) Had or been advised to have any hospitalization, surgery, or any diagnostic test including, but not limited to, electrocardiograms, blood studies, scans, MRI's or other test? Yes No
 - 5) Had an examination, treatment or consultation with a doctor or health care provider other than above? Yes No
- D) Within the last 10 years, have you been told by a member of the medical profession that you have or had a diagnosis of AIDS (Acquired Immune Deficiency Syndrome), ARC (AIDS Related Complex), or the HIV (Human Immunodeficiency Virus) infection? Yes No
- E) Have you had a parent, brother, or sister, who has/had coronary artery or cardiovascular disease, internal cancer, or melanoma, prior to age 60? Yes No
- F) Has your weight changed by more than 15 pounds in the past year? Yes No

11 DETAILS Give details for "No" answer to question 10A and all "Yes" answers to 10B, C, D, E and F

Question No.	Diagnosis, disease, symptom, injury, etc.	Dates	Duration	Treatments/Results?	Name and Address of Attending Physicians and Hospitals

12 CERTIFICATION

I represent that I have read and understand all the statements and answers herein, based on the information provided to the Company during a telephone interview on a recorded line or to this examiner; and in Part I of my application; that they are complete and true to the best of my knowledge and belief, and are correctly recorded. I fully understand and agree that if any material information has been omitted from the application, it could provide the basis for the Company to rescind coverage and to refund all my premium as though my coverage had never been in force. I agree that this application and any policy or policies issued based on this application shall constitute the entire contract of insurance. Acceptance of the policy by me is acknowledgment and ratification of any corrections made in the application. I further acknowledge that the information contained in Parts 1 and 2 of this form is being obtained on behalf of Western Reserve Life Assurance Co. of Ohio and that such information will be released to the Company, its agents, employees, representatives and reinsurers.

Date _____ Signature of proposed Insured _____
 Signature of Examiner _____ Print Examiner's Name _____
 U322 0209

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Supporting Document Schedules

	Item Status:	Status Date:
Satisfied - Item: Flesch Certification Comments: Attachment: Flesch Score W.pdf		

	Item Status:	Status Date:
Bypassed - Item: Application Bypass Reason: N/A Comments:		

**WESTERN RESERVE LIFE ASSURANCE CO. OF OHIO
FLESCH READABILITY CERTIFICATION**

Form Number (may vary by state)

Flesch Score

U321 0209

52.0

U322 0209

51.7

I certify that the machine scored Flesch Readability score(s) for the above mentioned form(s) is/are accurate.

Cheryl Bock, Assistant Vice President of Contract Development