

SERFF Tracking Number: GRWE-126158024 State: Arkansas
Filing Company: Great-West Life & Annuity Insurance Company State Tracking Number: 42427
Company Tracking Number: PPVULAPPSA-R1
TOI: L08 Life - Other Sub-TOI: L08.000 Life - Other
Product Name: PPVULappsa-r1
Project Name/Number: PPVULappsa-r1/PPVULappsa-r1

Filing at a Glance

Company: Great-West Life & Annuity Insurance Company

Product Name: PPVULappsa-r1

TOI: L08 Life - Other

Sub-TOI: L08.000 Life - Other

Filing Type: Form

SERFF Tr Num: GRWE-126158024 State: Arkansas

SERFF Status: Closed-Approved-
Closed State Tr Num: 42427

Co Tr Num: PPVULAPPSA-R1

Author: Tanya Gonzales

Date Submitted: 05/19/2009

State Status: Approved-Closed

Reviewer(s): Linda Bird

Disposition Date: 05/22/2009

Disposition Status: Approved-
Closed

Implementation Date:

Implementation Date Requested: On Approval

State Filing Description:

General Information

Project Name: PPVULappsa-r1

Project Number: PPVULappsa-r1

Requested Filing Mode: Review & Approval

Explanation for Combination/Other:

Submission Type: New Submission

Overall Rate Impact:

Filing Status Changed: 05/22/2009

Deemer Date:

Submitted By: Tanya Gonzales

Filing Description:

Flexible Premium Variable Universal Life Application.

Status of Filing in Domicile: Not Filed

Date Approved in Domicile:

Domicile Status Comments: Exempt in state of
domicile.

Market Type: Individual

Group Market Size:

Group Market Type:

Explanation for Other Group Market Type:

State Status Changed: 05/22/2009

Created By: Tanya Gonzales

Corresponding Filing Tracking Number:

Company and Contact

Filing Contact Information

Tanya Gonzales, Associate Manager,

Contracts

8515 E. Orchard Rd. 8T2

tanya.gonzales@gwl.com

800-537-2033 [Phone] 75829 [Ext]

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Greenwood Village, CO 80111 303-737-5444 [FAX]

Filing Company Information

Great-West Life & Annuity Insurance Company CoCode: 68322 State of Domicile: Colorado
 8515 East Orchard Road Group Code: 769 Company Type:
 Greenwood Village, CO 80111 Group Name: State ID Number:
 (303) 737-3992 ext. [Phone] FEIN Number: 84-0467907

Filing Fees

Fee Required? No
 Retaliatory? No
 Fee Explanation:
 Per Company: No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Great-West Life & Annuity Insurance Company	\$20.00	05/19/2009	27992027

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Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Linda Bird	05/22/2009	05/22/2009

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Disposition

Disposition Date: 05/22/2009

Implementation Date:

Status: Approved-Closed

Comment:

Rate data does NOT apply to filing.

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Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification		No
Supporting Document	Application		No
Form	Application		Yes

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Form Schedule

Lead Form Number: PPVULappsa-r1

Schedule Item Status	Form Number	Form Type Form Name	Action	Action Specific Data	Readability	Attachment
	PPVULappsa-r1	Application/ Enrollment Form	Initial			PPVULappsa-r1.pdf

**Flexible Premium Variable Universal Life
Insurance Application**

<p><u>Owner:</u></p> <p>_____</p> <p>Name</p> <p>_____</p> <p>Attention</p> <p>_____</p> <p>Business Address</p> <p>_____</p> <p>City State Zip Code</p> <p>_____</p> <p>Owner's SS# or Tax ID #</p> <p>_____</p> <p>Type of Business</p> <p>_____</p> <p>Daytime Telephone Number</p> <p>_____</p> <p>Evening Telephone Number</p>	<p><u>Insured:</u></p> <p>_____</p> <p>Insured's Name</p> <p>_____</p> <p>Date of Birth Social Security #</p> <p>_____</p> <p>Home Address</p> <p>_____</p> <p>City State Zip Code</p> <p>_____</p> <p>Business Address</p> <p>_____</p> <p>City State Zip Code</p> <p>_____</p> <p>Daytime Telephone Number</p> <p>_____</p> <p>Evening Telephone Number</p> <p align="center"><input type="checkbox"/> See attached Schedule of Insureds</p>
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Owner is: (Please choose one of the following)

a. The Employer

b. A Trust created by the Employer

c. A Trust created by the Insured

d. The Insured

e. Other _____

Policy Information:

Life Insurance or Premium Applied for:

Total Face Amount: _____

Premium Amount: _____

Send Premium Notices to:

Name _____

Address _____

Death Benefit Option:

Please choose one of the following:

Option 1: **Level Death Benefit**

Option 2: **Coverage Plus**

Option 3: **Scheduled Face**

Beneficiary(ies):

Please choose one of the following:

Employer **Trust created by the Employer** **Trust created by the Insured**

If the employer is the beneficiary, the employer certifies, represents and warrants that:

- a. The employer has a lawful and substantial economic interest in the life, health and safety of each proposed insured;
- b. The services of each such proposed insured are such that the employer expects to realize either:
 - A substantial monetary gain through the continued life of the proposed insured; or
 - A substantial monetary loss in the event of the proposed insured's death.
- c. Per the requirements set forth in I.R.C.§101(j), the insured:
 - had "compensation" in excess of the IRC § 414(q) limitation, as adjusted annually for inflation; or
 - is among the highest paid 35% of all employees, determined in accordance with the rules of IRC § 105(h); or
 - is an owner of 5% or more of the employer at any time during the year (or was in the preceding year); or
 - is among the top 5 highest paid officers of the company

Additionally, in order to comply with IRC§101(j), employers must obtain positive written consent from employees that the employer may insure their life. This consent must disclose that the corporation will reside as beneficiary of the policy death benefit and the maximum amount of insurance that may be issued on their life. This information must be obtained PRIOR to the issue of any policy. Failure to do so may result in adverse tax consequences.

Please sign below stating you have read and understand the above conditions.

Employer Name (Please Print)

Title

Employer Signature

Date

Citizenship Status:

Is each individual named on this application a citizen of the United States? Yes No

Please answer the following question for each insured that is a Non-U.S. Citizen:

Does the employee reside in the United States with a permanent resident visa? Yes No

If No, please provide visa information for all Non-U.S. Citizens.

Replacement:

Do you have any existing insurance policies or annuity contracts? Yes No

Will the policy being applied for result in any insurance or annuity contract in this or any other Company being lapsed, surrendered, reduced, subjected to substantial borrowing, or changed to paid-up, extended term or automatic premium loan? Yes No

If yes, details: _____

Company Name: _____

Policy Number: _____

Compliance Information:

The Securities Exchange Act of 1934 requires that we have reasonable grounds to believe, based upon the information provided by you, that your selections are suitable given your objectives and financial situation. Please complete the following relating to the suitability of your investment choices.

I have completed and returned the Confidential Prospective Corporate Purchaser Questionnaire, and I qualify either as an "Accredited Investor" as defined in Regulation D or as a "Qualified Purchaser" as defined in Section 3(C)(7) of the Investment Company Act of 1940, or both. Yes No

Do you understand that, under this policy, all payments and values including cash values and the death benefit are based on the investment experience of the Investment Divisions and are variable? Yes No

Do you believe that this policy will meet your objectives and anticipated financial needs? Yes No

I have received a copy of the current Private Placement Memorandum for this Flexible Premium Variable Universal Life Policy. Yes No

Allocations:

During the Free Look Period, Premiums will be allocated to the Investment Division(s) elected below, provided those Investment Division(s) are available in accordance with the requirements of the applicable Underlying Fund or other Investment.

Premiums to be allocated to Investment Division(s) that are not available in accordance with the requirements of the applicable Underlying Fund or other investment will be allocated to the Money Market Investment Division during the Free Look Period and transferred to the selected Investment Division(s) as soon as those Investment Division(s) become available in accordance with the requirements of the applicable Underlying Fund or other investment.

Investment Division	Allocation %	Investment Division	Allocation %
Fixed Account Option	%		%
	%		%
	%		%
	%		%
	%		%
	%		%
	%		%
	%		%
	%		%
	%		%
	%		%
	%		%
	%		%
	%		%
	%	Total =	100%

Signatures:

I declare and agree that:

All statements and answers to questions made in this application and any supplement to it are true and complete to the best of my knowledge and belief. The information I have provided will be taken into consideration for and will serve as the basis of any contract of insurance based on this application. 1) No Information or answer to any question will be deemed communicated to or binding on the Company unless set out in this application. 2) Only the president, a vice president or the secretary of the Company is authorized to change or waive any terms of this application or any contract of insurance issued.

Any policy issued based on this application shall not take effect until delivered and the first premium paid to the Company, provided no change has taken place in the insurability of the Insured after the application, and any supplement to it is completed, and all proposed Insured's are still living.

I understand that I am applying for a Flexible Premium Variable Universal Life Insurance Policy, Form PPVUL, issued by Great-West Life & Annuity Insurance Company. I declare that all statements made on this application are true to the best of my knowledge and belief. I believe the policy is suitable for my insurance needs. **I understand that all amounts are based on the investment experience of the investment divisions and are not guaranteed as to amount; they are variable and may increase or decrease accordingly.** I hereby direct that my telephone instructions to the Company be honored for transactions unless otherwise notified by me in writing. I understand that telephone calls may be recorded to monitor the quality of service I receive and to verify policy transaction information. **I certify under penalty of perjury that the Social Security or tax identification number listed on this application is correct. The Internal Revenue Service does not require your consent to any provision of this document other than the certifications required to avoid backup withholding.**

Please sign below stating you have read and understand the above conditions.

Owner Signature

Date

Agent Use Only:

- a. Purpose of Insurance _____
- b. Does the applicant have existing life insurance policies or annuity contracts? Yes No
- c. Do you have reason to believe the life insurance applied for will replace any insurance or annuity with us or any other company? Yes No

Agent's Declaration - I certify that I have asked and have fully recorded the proposed Insured's answers to all questions in this application. I know nothing that is material to the insurability of this life that has not been recorded herein.

Signature of Agent

Agent's Name: _____
Agency/Institution: _____
Office: _____
Address: _____

Agent Share %: _____

Agent's Name: _____
Agency/Institution: _____
Office: _____
Address: _____

Agent Share %: _____

Agent's Name: _____
Agency/Institution: _____
Office: _____
Address: _____

Agent Share %: _____

Date

Agent's Name: _____
Agency/Institution: _____
Office: _____
Address: _____

Agent Share %: _____

Agent's Name: _____
Agency/Institution: _____
Office: _____
Address: _____

Agent Share %: _____

Agent's Name: _____
Agency/Institution: _____
Office: _____
Address: _____

Agent Share %: _____

This section must be completed for all simplified issue and fully underwritten cases.

INSURED'S PERSONAL AND MEDICAL INFORMATION PART I

Name: _____ Occupation _____

Total life insurance in force: \$ _____ Driver's License # _____ State: _____

1. Have you applied for insurance in the past 6 months? Yes No
2. Have you ever been refused life insurance? Yes No
3. During the past 12 months have you used tobacco or nicotine products in any form? Yes No

During the past three years have you:

4. Flown as a private pilot or do you contemplate flying as a student pilot or crew member? (If yes, please complete the aviation questionnaire.) Yes No
5. Participated in or do you contemplate participating in any hazardous sport such as racing (automobile, snowmobile, motorcycle, boat), scuba diving, hang gliding, mountain or rock climbing? (If yes, please complete the hazardous sports questionnaire.) Yes No
6. **In the past three years**, have you been charged with driving under the influence of alcohol or drugs (DUI), or have you had your driver's license suspended or revoked? Yes No
7. **In the past 10 years**, have you been medically advised that you have, or received any type of treatment for a positive test for Human Immunodeficiency Virus (HIV), Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC)? Yes No

If you answered yes to questions 1-7, provide details: _____

This section must be completed for simplified issue only.

INSURED'S PERSONAL AND MEDICAL INFORMATION PART II

Height: _____

Weight: _____

1. Do you have a personal physician? If yes, please provide name and address: Yes No
2. Please provide date last seen, reason seen and results: _____
3. Have any members of your immediate family died before age 60? Yes No
4. Are you currently taking any medication(s)? Yes No
5. Have you ever been hospitalized? (If yes, give details below including date(s) and reason(s)) Yes No

Within the past 10 years, has a member of the medical profession diagnosed you as having or treated you for any of the following:

6. Any permanent disease or disorder, including those requiring medical or surgical intervention of the heart, lungs, liver, kidneys, gastrointestinal system? Yes No
7. Elevated blood pressure, stroke, paralysis, or any chronic or progressive disease or disorder of the brain, spinal cord or central nervous system? Yes No
8. Blood disorders including chronic anemia? Yes No
9. Diabetes, cancer or malignancy? Yes No
10. Treatment for alcohol or drug use, or have you been medically advised to do so? Yes No
11. Any counseling or treatment for mental, nervous or emotional disorders? Yes No
12. Any physical impairments or diseases not listed above? Yes No

If you answered yes to questions 1-12, provide details: _____

This authorization must be completed for all simplified issue and fully underwritten cases.

AUTHORIZATION TO OBTAIN AND DISCLOSE INFORMATION

The Company, its reinsurers, insurance support organizations, and their authorized representative, may obtain medical and other information in order to evaluate my application for life insurance. Any physician, practitioner, hospital, clinic, other medical or medically related facility, the Veterans Administration, the Medical Information Bureau, Inc., my employer and consumer reporting agency, credit reporting agency or insurance company who possesses information of care, treatment or advice of me may furnish such information to the Company upon presenting this authorization or a photocopy. This authorization includes information about drugs, alcoholism and mental illness. The Company or its reinsurers may make a brief report regarding me to other companies to whom I have applied or may apply. This authorization will be valid from the date signed for a period of two and one-half years. I have read this authorization and understand I have the right to receive a copy. I have received the Notice of Insurance Information Practices and Notice Regarding Medical Information Bureau. I consent to a consumer report containing personal or credit information or both that may be requested in connection with my application.

All statements and answers to questions made in this application and any supplement to it are true and complete to the best of my knowledge and belief. The information I have provided will be taken into consideration for and will serve as the basis of any contract of insurance based on this application. 1) No Information or answer to any question will be deemed communicated to or binding on the Company unless set out in this application. 2) Only the president, a vice president or the secretary of the Company is authorized to change or waive any terms of this application or any contract of insurance issued.

Signed at _____ this _____ day of _____ year _____
City and State

Name of Proposed Insured (Please Print)
Insured

X _____
Signature of Proposed

X _____
Witness

X _____
Signature of Owner

FRAUD WARNINGS

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

Colorado: 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.

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

Florida: Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

Kentucky: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime.

Massachusetts and Oregon: Any person who knowingly and with the intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which may be a crime and may subject such person to criminal and civil penalties.

New Jersey: Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

Washington: 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

All Other States: 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.]

**Notice of Insurance Information
Practices and Notice Regarding
Medical Information Bureau**

This is to inform you that, as part of our procedure for processing your application, an investigative consumer report may be prepared whereby information is obtained through personal interviews with your business associates, friends, or others with whom you are acquainted. This inquiry includes information as to your character, general reputation, personal characteristics, financial information and mode of living. You have the right to make a written request within a reasonable period of time to receive additional detailed information about the nature and scope of this investigation. You have the right to access information upon written request. You may request correction, amendment or deletion of any information which you believe to be inaccurate.

In connection with your application for insurance you may receive a telephone call from an authorized person to obtain some personal and financial information. You may be assured that the information is considered confidential and will be used to assess your eligibility for insurance. The interview normally takes from five to ten minutes and will be conducted at a time convenient for you. In the event you are not in when the interviewer calls, the interviewer will leave his or her name and telephone number so that you can return the call at no charge to you and supply the necessary information.

Inquiries on the above notices should be addressed to:

[Great-West Life & Annuity Insurance
Company
Department 690, P.O. Box 1700
Denver, CO 80201]

Information regarding your insurability will be treated as confidential. The Company, or its reinsurers, may, however, make a brief report thereon to the Medical Information Bureau, a non-profit membership organization of life insurance companies, which operates an information exchange on behalf of its members. If you apply to another Bureau member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, the Bureau, upon request, will supply such company with the information it may have in its file.

Upon receipt of a request from you, the Bureau will arrange disclosure of any information it may have in your file. If you question the accuracy of information in the Bureau's file, you may contact the Bureau and seek a correction in accordance with the procedures set forth in the federal Fair Credit Reporting Act. The address of the Bureau's information office is:

[MIB, Inc.
50 Braintree Hill Park, Suite 400
Braintree, MA 02184-8734
Phone: 866-692-6901 (TTY 866-346-3642)]

The Company, or its reinsurers, may also release information in its file to other life insurance companies to whom you may apply for life or health insurance, or to whom a claim for benefits may be submitted.

THIS STANDARD DISCLOSURE IS
REQUIRED OF ALL LIFE INSURANCE
PROVIDERS. BE ASSURED THAT
GREAT-WEST'S BUSINESS PRACTICES
MEET THE HIGHEST INDUSTRY
STANDARDS.

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Supporting Document Schedules

	Item Status:	Status Date:
Bypassed - Item: Flesch Certification		
Bypass Reason: This application will be used to apply for a Private Placement Variable product exempt from Flesch Readability scores.		
Comments:		

	Item Status:	Status Date:
Bypassed - Item: Application		
Bypass Reason: Application being filed for approval, included under Form Schedule.		
Comments:		