

SERFF Tracking Number: HHRN-126152709 State: Arkansas  
Filing Company: Household Life Insurance Company State Tracking Number: 42494  
Company Tracking Number: 09-019-AR  
TOI: L08 Life - Other Sub-TOI: L08.000 Life - Other  
Product Name: Life Application Filing  
Project Name/Number: /09-019-AR

## Filing at a Glance

Company: Household Life Insurance Company

Product Name: Life Application Filing

TOI: L08 Life - Other

Sub-TOI: L08.000 Life - Other

Filing Type: Form

SERFF Tr Num: HHRN-126152709 State: Arkansas

SERFF Status: Closed-Approved-  
Closed State Tr Num: 42494

Co Tr Num: 09-019-AR

State Status: Approved-Closed

Reviewer(s): Linda Bird

Authors: Deborah Fisher, Sherron  
Lawson

Disposition Date: 05/28/2009

Date Submitted: 05/27/2009

Disposition Status: Approved-  
Closed

Implementation Date Requested: On Approval

Implementation Date:

State Filing Description:

## General Information

Project Name:

Project Number: 09-019-AR

Requested Filing Mode: Review & Approval

Explanation for Combination/Other:

Submission Type: New Submission

Overall Rate Impact:

Filing Status Changed: 05/28/2009

Deemer Date:

Submitted By: Deborah Fisher

Filing Description:

RE: Life Insurance Application - HLI-1-203-0409

Life Reinstatement Application – HLI-1-205-0409

NAIC # 93777

FEIN # 38-2341728

Status of Filing in Domicile: Not Filed

Date Approved in Domicile:

Domicile Status Comments: Exempt from filing  
requirements.

Market Type: Individual

Group Market Size:

Group Market Type:

Explanation for Other Group Market Type:

State Status Changed: 05/28/2009

Created By: Miloslav Dait

Corresponding Filing Tracking Number:

Dear Commissioner:

SERFF Tracking Number: HHRN-126152709 State: Arkansas  
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On behalf of Household Life Insurance Company (HLIC), we are submitting the above captioned applications for your review and approval. The enclosed forms are new and do not replace any previously approved form. These applications will be used with previously approved Term Life policy HLI-8-132-0807 and Whole Life policy HLI-8-135 and may be used with any future Term or Whole Life policy approved by the Department. These applications may be available and completed via paper, electronic internet or telesales. The telesales method will utilize a system for recording the telephone conversation and application process and provide a method for electronic signature utilizing an electronic sound, symbol, or process that will be attached to, or logically associated with, a contract or other record. The telephone conversations will be recorded and stored electronically and can be readily accessed.

These forms are anticipated to be offered to the general life insurance market both, direct to consumer and through agent channels. The internet channel will use an electronic signature process and technology that will allow customers to review and sign their applications online electronically. HLIC has systems in place to ensure security and to ensure that the privacy of the applicant is protected. The online application, when printed, will have the exact text as the paper version of the application form filed and approved with your Insurance Department.

In the future, we may provide the opportunity for our customers to receive their policy documents solely electronically. If the Company decides to allow customers with this convenience option, the Company will comply with all applicable laws in obtaining customer consent.

We request approval of bracketed information on a variable basis to reflect different account information. A statement of variability is enclosed. HLIC provides its assurance that no changes to the text other than correction of typographical and grammatical errors will be made to the forms without re-filing them with you. Please note that we may change the appearance, formatting and pagination, but not the text of these forms. No font will be less than a 10-point font size. The color and/or weight of the paper on which these forms are printed may change.

This application is exempt from filing in the company's state of domicile, Michigan

To the best of our knowledge, this filing is complete and intended to comply with the insurance laws of your jurisdiction.

If you have any questions regarding the enclosed submission, please do not hesitate to contact me at 1-800-443-7187, extension 62208 or you may email me at [debbie.a.fisher@us.hsbc.com](mailto:debbie.a.fisher@us.hsbc.com).

Regards,

Deborah A. Fisher  
Product Compliance Officer

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## Company and Contact

### Filing Contact Information

Sherron Lawson, Compliance Officer sherron.n.lawson@us.hsbc.com  
 200 Somerset Corporate Blvd. 908-203-4266 [Phone]  
 Suite 100 908-203-4229 [FAX]  
 Bridgewater, NJ 08807

### Filing Company Information

Household Life Insurance Company CoCode: 93777 State of Domicile: Michigan  
 500 Woodward Ave. Group Code: 352 Company Type:  
 Suite 4000 Group Name: State ID Number:  
 Detroit, MI 48226 FEIN Number: 38-2341728  
 (800) 443-7187 ext. [Phone]

## Filing Fees

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

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Household Life Insurance Company	\$50.00	05/27/2009	28120381

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## Correspondence Summary

### Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Linda Bird	05/28/2009	05/28/2009

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## Disposition

Disposition Date: 05/28/2009

Implementation Date:

Status: Approved-Closed

Comment:

Rate data does NOT apply to filing.

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Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification		Yes
Supporting Document	Application		No
Supporting Document	Statement of Variability		Yes
Form	Life Application		Yes
Form	Reinstatement Application		Yes

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## Form Schedule

### Lead Form Number: HLI-1-203-0409

Schedule Item Status	Form Number	Form Type Form Name	Action	Action Specific Data	Readability	Attachment
	HLI-1-203-0409	Application/ Life Application Enrollment Form	Initial		47.300	HLI-1-203-0409 Individual Life Application.pdf
	HLI-1-205-0409	Application/ Reinstatement Enrollment Application Form	Initial		47.000	HLI-1-205-0409 Reinstatement Application.pdf

# HOUSEHOLD LIFE INSURANCE COMPANY

[Home Office: 500 Woodward Avenue, Suite 4000, Detroit, MI 48226-3425  
Administrative Office: 200 Somerset Corporate Blvd., Suite 100, Bridgewater, NJ 08807  
Toll Free 800-443-7187 www.\_\_\_\_\_]

## APPLICATION FOR INDIVIDUAL [TERM LIFE/TERM LIFE WITH ENDOWMENT/WHOLE LIFE] INSURANCE

### Your Information

Proposed Insured:

\_\_\_\_\_  
Last Name      First Name      MI      Gender      Date of Birth      [State or Province/Country of Birth]

\_\_\_\_\_  
Height (feet inches)      Weight (lbs)      Social Security Number

\_\_\_\_\_  
Current Address (Street, City, State & Zip Code)

\_\_\_\_\_  
[Home Phone Number]      Email Address      [Driver's License Number & State of Issue]  
[Optional]

\_\_\_\_\_  
[Occupation]      [Annual Income of Proposed Insured \$]

[Are you a US Citizen or permanent US Resident who holds a valid current Green Card?     Yes     No ]

[Owner (if different from Proposed Insured):

\_\_\_\_\_  
Last Name      First Name      MI      Date of Birth      [State or Province/Country of Birth]

\_\_\_\_\_  
Social Security Number

\_\_\_\_\_  
Current Address (Street, City, State & Zip Code, Country)

\_\_\_\_\_  
Home Phone Number      Email Address

Relationship to Proposed Insured: \_\_\_\_\_]

### Beneficiary

\_\_\_\_\_  
[Primary Beneficiary First Name      Last Name      MI      Relationship    %]

\_\_\_\_\_  
[Current Address(Street, City, State & Zip Code)      Social Security Number]

\_\_\_\_\_  
[Contingent Beneficiary First Name      Last Name      MI      Relationship    %]

\_\_\_\_\_  
[Current Address(Street, City, State & Zip Code)      Social Security Number]

**Plan Applied For:**

[Term Life:  Ten Years]       Fifteen Years]       Twenty Years]       Thirty Years]  
[Term Life with Endowment:       Twenty Years]       Twenty-Five Years]       Thirty Years]  
[Whole Life:  ]  
[Automatic Premium Loan  Yes  No]

**[Additional Coverage Applied For:**       Return of Premium Benefit Rider       Secondary Insured Term Benefit Rider  
 Accidental Death Benefit Rider       Dependent Child Benefit Rider  
 Waiver of Premium Benefit Rider       Accelerated Death Benefit Rider]

**Coverage Amount:**    \$ [                    ]

**Payment Frequency:**

Annual       Semi-Annual       Quarterly       Monthly]

**Payment Method:**

Charge my credit card:     Visa       MasterCard       Discover       American Express

Account # \_\_\_\_\_ Exp. Date \_\_\_\_\_

Debit my [checking/savings] account: Bank Name \_\_\_\_\_ Account # \_\_\_\_\_  
ABA Number \_\_\_\_\_  
(first 9 numbers in the lower left-hand corner of your check)

**Replacement:**

[Do you own an existing life insurance policy or annuity contract insuring the proposed insured’s life?  
 Yes       No

Do you plan to discontinue, replace, change or modify any existing life insurance as a result of this application?  
(if yes, additional forms may be required, depending upon state requirements)  
 Yes       No]

**Underwriting Information:**

1) In the past 12 months, have you used tobacco or nicotine in any form?

Yes       No

2) In the past 10 years, have you been advised to have treatment for, or have you been treated for, or consulted a physician or other practitioner for any of the following?

- Heart or coronary artery disease or disorder
- Stroke, transient ischemic attack (TIA), aneurysm, or other blood vessel disease or disorder
- Peripheral vascular disease
- Cancer (other than basal cell carcinoma)
- Diabetes
- Hepatitis B or C
- Cirrhosis
- Pancreas disease or disorder
- Emphysema (COLD or COPD) or chronic lung or pulmonary disease
- Alcohol or drug use
- Hemophilia
- Multiple sclerosis or Amyotrophic Lateral Sclerosis (ALS)
- Alzheimer’s disease, dementia or other neurological disorder
- Kidney disease or disorder (excluding kidney stones)

Yes       No

3) Are you currently hospitalized, or in the past 5 years, have you been admitted to a hospital or other medical facility for any of the following?

- Chest pain
- High blood pressure
- Asthma
- Depression
- Manic-depression or bipolar disorder
- Other mental or nervous system disorder
- Connective tissue disease
- Paralysis
- Seizure
- Anemia
- Liver disease or disorder

Yes       No

4) In the past 2 years, have you had your driver's license revoked, suspended or been convicted of reckless driving, driving without a valid license or for driving while under the influence of alcohol or drugs (DWI, DUI)? Or have you had more than 2 moving violations in the past 12 months? [Or have you ever been convicted of a felony?]

Yes       No

5) In the past 12 months, have you, on more than one occasion, engaged in, or do you plan in the next 12 months to engage in, risky activities, extreme sports, or flying a plane other than as a commercial airline pilot? Or are you currently engaged in a hazardous occupation that exposes you to the risk of loss of life?

Yes       No

6) Have you been diagnosed as having AIDS, AIDS Related Complex (ARC), or any other disorder of your immune system or have you had a positive HIV test?

Yes       No

7) Are you currently a patient in a hospital (other than for childbirth), or resident in a nursing home, assisted living facility or other long-term care facility? Or are you currently receiving in-home care by a healthcare professional? Or are you currently receiving disability income benefits or have you submitted a claim for disability income benefits within the past 5 years? Or have you been advised to have or are you awaiting results of non-routine medical tests or procedures?

Yes       No

8) In the past year, have you experienced unexplained weight loss?

Yes       No

**[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.**

**Notice to residents of Arkansas, Kentucky and Ohio:** Any person who knowingly and with intent to defraud any insurance company or other person files a request 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 is a crime and subjects such person to criminal and civil penalties.

**Notice to residents of 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.

**Notice to residents of New Jersey:** Any person who includes any false or misleading information on a request for an insurance policy is subject to criminal and civil penalties.

**Notice to residents of Louisiana, New Mexico and West Virginia:** 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 to residents of Maine, Tennessee and 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 may include imprisonment, fines or a denial for insurance benefits.

**Notice to residents of Maryland:** Any person who knowingly and willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly and willfully presents false information in an application for insurance in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

**Notice to residents of Oklahoma: WARNING:** 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.

**Notice to residents of Pennsylvania:** Any person who knowingly and with 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 is a crime and subjects such person to criminal and civil penalties.]

**[MIB, Inc. (MIB) Pre-Notice:**

Information regarding your insurability will be treated as confidential. Household Life Insurance Company, or its reinsurers may, however, make a brief report thereon to MIB, Inc., 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 in its file.

Upon receipt of a request from you, MIB will arrange disclosure of any information it may have in your file. Please contact MIB at 866 692-6901 (TTY 866 346-3642). If you question the accuracy of information in MIB's file, you may contact MIB and seek 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.

Household Life Insurance Company, or its reinsurers, may also release information in 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](http://www.mib.com)].

**Authorization & Signing:**

I, the Proposed Insured, hereby authorize any health plan, licensed physician, medical practitioner, health care professional, hospital, clinic, laboratory, pharmacy, pharmacist, pharmacy benefit provider, medical facility, VA facility, the MIB, Inc. (MIB), any other health care provider, employer, insurance company, union welfare fund, public or private agency, consumer reporting agency, worker’s compensation carrier, Motor Vehicle Agency, and any other person or organization that has provided payment, treatment or services to me or on my behalf (My Providers) to give any and all information relating to my health (except psycho-therapy notes) and my insurance policies and claims to Household Life Insurance Company and any and all affiliates and subsidiaries, their agents, employees, representatives and any persons providing services to Household Life Insurance Company (the “Company”).

I hereby acknowledge that the information released will be used and disclosed so the Company may:

- 1) underwrite my insurance application, make eligibility, risk rating, policy issuance, and enrollment determinations;
- 2) obtain reinsurance;
- 3) administer claims and determine or fulfill any coverage obligations and provide any applicable benefits;
- 4) administer coverage; and /or
- 5) conduct other legally permissible activities relating to any coverage I have or have applied for with the Company.

I understand all or part of the information collected may be disclosed to MIB and any reinsurance companies with which the Company does business, and any other insurance company with which the insured may have insurance. Information may also be disclosed to persons performing business or legal functions for the Company. The Company may also disclose information to prevent fraud or misrepresentations or when required by subpoena or by court or governmental order.

I understand that if I refuse to sign this authorization, Household Life Insurance Company will not be able to process my application. I understand that I may revoke this authorization by notifying Household Life Insurance Company in writing of my desire to revoke it. However, I understand that if I revoke this authorization, it will not have any effect on actions already taken by Household Life Insurance Company in reliance on this authorization and may result in application denial *or* a claim being denied. I understand that a copy of this authorization will be included in my policy(ies).

I understand that the information described herein and disclosed to Household Life Insurance Company is protected by certain federal and/or state privacy regulations. Once Household Life Insurance Company discloses this information, as allowed in this Authorization, the information may no longer be subject to such privacy regulations. I understand, however, that Household Life Insurance Company requires the entities listed above with whom it shares this information to enter into confidentiality agreements prohibiting the disclosure of this information except as allowed herein.

**I understand that the coverage shall take effect as of the policy issue date only if the proposed insured is an insurable risk on the date of this application and Household Life Insurance Company receives payment of the first scheduled premium.**

By signing your name and date below, you agree: (1) that you have read and fully understand all of the questions, answers and statements given in this application; (2) that the statements and answers on this application are full, complete and *true* to the best of your knowledge; (3) you intend to form a legally binding contract; (4) this authorization is valid for [two and one-half years] from the date shown below; and (5) a printout of the terms stated above will constitute a "writing" under any applicable law or regulation.

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Proposed Insured’s Signature	Date
[	]
Owner’s Signature (if different from Proposed Insured)	Date
[	]

[Company Representative Replacement Questionnaire: To the best of your knowledge, does the applicant own an existing life insurance policy insuring the proposed insured’s life?

Yes       No

Company Representative Replacement Questionnaire: To the best of your knowledge, will this insurance that is applied for replace or change an existing life insurance or annuity?

Yes       No

(if yes, please complete additional forms as required)

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Authorized Company Representative Signature	Date
[	]

# HOUSEHOLD LIFE INSURANCE COMPANY

[Home Office: 500 Woodward Avenue, Suite 4000, Detroit, MI 48226-3425  
Administrative Office: 200 Somerset Corporate Blvd., P.O. Box 6989, Suite 100, Bridgewater, NJ 08807  
Toll Free 800-443-7187 www.\_\_\_\_\_]

## APPLICATION FOR REINSTATEMENT OF LIFE INSURANCE POLICY

Policy Number: 12345

Name of Owner (if different from Insured): John Doe

Name of Insured: Mary Doe

Height (feet and inches): 5'4 Current Weight (lbs): 135 Date of Birth: 01/23/53

[State or Province/Country of Birth New Jersey][Occupation: Sales Representative]

Application is made for reinstatement of the above numbered policy [and riders, if applicable] [as indicated below] which lapsed by failure to pay premium due

- |  |  |
|--|--|
| <input type="checkbox"/> Return of Premium Benefit Rider | <input type="checkbox"/> Secondary Insured Term Benefit Rider                      |
| <input type="checkbox"/> Accidental Death Benefit Rider  | <input type="checkbox"/> Dependent Child Benefit Rider - list each eligible child: |
| <input type="checkbox"/> Waiver of Premium Benefit Rider | Name _____ Date of Birth _____   |
| <input type="checkbox"/> Accelerated Death Benefit Rider | _____  |

Statement of insurability to be completed by Insured person:

### Underwriting Information:

- 1) In the past 12 months, have you used tobacco or nicotine in any form?  
 Yes  No
- 2) In the past 10 years, have you been advised to have treatment for, or have you been treated for, or consulted a physician or other practitioner for any of the following?
- |  |  |  |
|--|--|--|
| <ul style="list-style-type: none"><li>Heart or coronary artery disease or disorder</li><li>Stroke, transient ischemic attack (TIA), aneurysm, or other blood vessel disease or disorder</li><li>Peripheral vascular disease</li><li>Cancer (other than basal cell carcinoma)</li></ul> | <ul style="list-style-type: none"><li>Diabetes</li><li>Hepatitis B or C</li><li>Cirrhosis</li><li>Pancreas disease or disorder</li><li>Emphysema (COLD or COPD) or chronic lung or pulmonary disease</li><li>Alcohol or drug use</li></ul> | <ul style="list-style-type: none"><li>Hemophilia</li><li>Multiple sclerosis or Amyotrophic Lateral Sclerosis (ALS)</li><li>Alzheimer's disease, dementia or other neurological disorder</li><li>Kidney disease or disorder (excluding kidney stones)</li></ul> |
|--|--|--|
- Yes  No  
If yes, please explain in detail: \_\_\_\_\_

- 3) Are you currently hospitalized, or in the past 5 years, have you been admitted to a hospital or other medical facility for any of the following?
- |  |  |  |
|--|--|--|
| <ul style="list-style-type: none"><li>Chest pain</li><li>High blood pressure</li><li>Asthma</li><li>Depression</li></ul> | <ul style="list-style-type: none"><li>Manic-depression or bipolar disorder</li><li>Other mental or nervous system disorder</li><li>Connective tissue disease</li><li>Paralysis</li></ul> | <ul style="list-style-type: none"><li>Seizure</li><li>Anemia</li><li>Liver disease or disorder</li></ul> |
|--|--|--|
- Yes  No  
If yes, please explain in detail: \_\_\_\_\_

4) In the past 2 years, have you had your driver's license revoked, suspended or been convicted of reckless driving, driving without a valid license or for driving while under the influence of alcohol or drugs (DWI, DUI)? Or have you had more than 2 moving violations in the past 12 months? [Or have you ever been convicted of a felony?]

Yes       No

If yes, please explain in detail: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

5) In the past 12 months, have you, on more than one occasion ,engaged in, or do you plan in the next 12 months to engage in, risky activities, extreme sports, or flying a plane other than as a commercial airline pilot? Or are you currently engaged in a hazardous occupation that exposes you to the risk of loss of life?

Yes       No

If yes, please explain in detail: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

6) Have you been diagnosed as having AIDS, AIDS Related Complex (ARC), or any other disorder of your immune system or have you had a positive HIV test?

Yes       No

If yes, please explain in detail: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

7) Are you currently a patient in a hospital (other than for childbirth), or resident in a nursing home, assisted living facility or other long-term care facility? Or are you currently receiving in-home care by a healthcare professional? Or are you currently receiving disability income benefits or have you submitted a claim for disability income benefits within the past 5 years? Or have you been advised to have or are you awaiting results of non-routine medical tests or procedures?

Yes       No

If yes, please explain in detail: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

8) In the past year, have you experienced unexplained weight loss?

Yes       No

If yes, please explain in detail: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**[Payment Method**

Charge my Credit Card       Visa       MasterCard       Discover       American Express

Account # \_\_\_\_\_ Exp. Date \_\_\_\_\_

Debit my [checking/savings] Account      Bank Name \_\_\_\_\_ Account # \_\_\_\_\_

ABA Number \_\_\_\_\_ Type \_\_\_\_\_  
(first 9 numbers in the lower left-hand corner of your check)

Certified Check/Money Order Enclosed      Total Premium Enclosed/Due \$ \_\_\_\_\_]

**[Fraud Warning:**

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Information regarding your insurability will be treated as confidential. Household Life Insurance Company, or its reinsurers may, however, make a brief report thereon to MIB, Inc., 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 in its file.

Upon receipt of a request from you, MIB will arrange disclosure of any information it may have in your file. Please contact MIB at 866 692-6901 (TTY 866 346-3642). If you question the accuracy of information in MIB's file, you may contact MIB and seek 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.

Household Life Insurance Company, or its reinsurers, may also release information in 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](http://www.mib.com)]

**Authorization & Signing**

I, the Proposed Insured, hereby authorize any health plan, licensed physician, medical practitioner, health care professional, hospital, clinic, laboratory, pharmacy, pharmacist, pharmacy benefit provider, medical facility, VA facility, the MIB, Inc. (MIB), any other health care provider, employer, insurance company, union welfare fund, public or private agency, consumer reporting agency, worker's compensation carrier, Motor Vehicle Agency, and any other person or organization that has provided payment, treatment or services to me or on my behalf (My Providers) to give any and all information relating to my health (except psycho-therapy notes) and my insurance policies and claims to Household Life Insurance Company and any and all affiliates and subsidiaries, their agents, employees, representatives and any persons providing services to Household Life Insurance Company (the "Company").

I hereby acknowledge that the information released will be used and disclosed so the Company may:

- 1) underwrite my insurance reinstatement application, make eligibility, risk rating, policy reinstatement, and enrollment determinations;
- 2) obtain reinsurance;
- 3) administer claims and determine or fulfill any coverage obligations and provide any applicable benefits;
- 4) administer coverage; and/or
- 5) conduct other legally permissible activities relating to any coverage I have or have applied for with the Company.

I understand all or part of the information collected may be disclosed to MIB and any reinsurance companies with which the Company does business, and any other insurance company with which the insured may have insurance. Information may also be disclosed to persons performing business or legal functions for the Company. The Company may also disclose information to prevent fraud or misrepresentations or when required by subpoena or by court or governmental order.

I understand that if I refuse to sign this authorization, Household Life Insurance Company will not be able to process my application. I understand that I may revoke this authorization by notifying Household Life Insurance Company in writing of my desire to revoke it. However, I understand that if I revoke this authorization, it will not have any affect on actions already taken by Household Life Insurance Company in reliance on this authorization and may result in this application or a claim being denied. I understand that a copy of this authorization will be included in my policy.

I understand that the information described herein and disclosed to Household Life Insurance Company is protected by certain federal and/or state privacy regulations. Once Household Life Insurance Company discloses this information, as allowed in this Authorization, the information may no longer be subject to such privacy regulations. I understand, however, that Household Life Insurance Company requires the entities listed above with whom it shares this information to enter into confidentiality agreements prohibiting the disclosure of this information except as allowed herein.

I understand that the coverage shall be in effect as of the date of this reinstatement if and only if the proposed insured is accepted as an insurable risk by the Company for reinstatement purposes at this time, and all overdue premiums are paid with interest as stated in the policy. For purposes of this reinstatement, the reinstated policy will be incontestable after it has been in force during the Insured's lifetime for two years from the date of reinstatement, except for non-payment of premiums.

By signing your name and date below, you agree: (1) that you have read and fully understand all of the questions, answers and statements given in this application; (2) that the statements and answers on this application are full, complete and true to the best of your knowledge; (3) you intend to form a legally binding contract; (4) this authorization is valid for [two and one-half years] from this application date; and (5) a printout of the terms stated above will constitute a "writing" under any applicable law or regulation.

\_\_\_\_\_  
Insured's Signature

\_\_\_\_\_  
Date

[\_\_\_\_\_  
Owner's Signature (if different from Insured)

\_\_\_\_\_  
Date ]

**[Notice Regarding Information Practices**

To issue an insurance policy, we need to obtain information about you and any other persons proposed for insurance. Some of that information will come from you. Some will come from other sources. That information and any information collected by us later may, in certain circumstances, be disclosed to third parties without your specific permission. You have a right to access and correction with respect to the information collected about you.]

SERFF Tracking Number: HHRN-126152709 State: Arkansas  
 Filing Company: Household Life Insurance Company State Tracking Number: 42494  
 Company Tracking Number: 09-019-AR  
 TOI: L08 Life - Other Sub-TOI: L08.000 Life - Other  
 Product Name: Life Application Filing  
 Project Name/Number: /09-019-AR

## Supporting Document Schedules

	<b>Item Status:</b>	<b>Status Date:</b>
<b>Satisfied - Item:</b> Flesch Certification		
<b>Comments:</b> Readability Certification, Certification of Compliance and GAD Notice attached.		
<b>Attachments:</b> Readability Certification.pdf GAD Notice C-6-026 Ed. 03_04.pdf STATE OF AR CERTIFICATION.pdf		

	<b>Item Status:</b>	<b>Status Date:</b>
<b>Bypassed - Item:</b> Application		
<b>Bypass Reason:</b> Applications are attached to the Form Schedule Tab.		
<b>Comments:</b>		

	<b>Item Status:</b>	<b>Status Date:</b>
<b>Satisfied - Item:</b> Statement of Variability		
<b>Comments:</b> Statement of Variability attached for application form HLI-1-203-0409		
<b>Attachment:</b> Application EOV.pdf		

## HOUSEHOLD LIFE INSURANCE COMPANY

Home office: 500 Woodward Avenue, Suite 4000, Detroit, MI 48226-3425  
Administrative Office: 200 Somerset Corporate Blvd., Suite 100, Bridgewater, NJ 08807

### READABILITY CERTIFICATION

**Company Name:** Household Life Insurance Company

I hereby certify, that the form(s) listed below has (have) the following readability score(s) as calculated by the Flesch Reading Ease Test.

<b>Form Number</b>	<b>Score</b>
HLI-1-203-0409	47.3
HLI-1-205-0409	47.0

*Michael Palace*

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Michael Palace ASA, MAAA- Assistant Vice President / Product Design and Pricing

May 26, 2009  
Date

**LIMITATIONS AND EXCLUSIONS UNDER THE  
ARKANSAS LIFE AND HEALTH INSURANCE  
GUARANTY ASSOCIATION ACT**

Residents of this state who purchase life insurance, annuities or health and accident insurance should know that the insurance companies licensed in this state to write these types of insurance are members of the Arkansas Life and Health Insurance Guaranty Association (“Guaranty Association”). The purpose of the Guaranty Association is to assure that policy and contract owners will be protected, within limits, in the unlikely event that a member insurer becomes financially unable to meet its obligations. If this should happen, the Guaranty Association will assess its other member insurance companies for the money to pay the claims of policy owners who live in this state and, in some cases, to keep coverage in force. The valuable extra protection provided by the member insurers through the Guaranty Association is not unlimited, however. And, as noted in the box below, this protection is not a substitute for consumers' care in selecting insurance companies that are well managed and financially stable.

**DISCLAIMER**

The Arkansas Life and Health Insurance Guaranty Association (“Guaranty Association”) may not provide coverage for this policy. If coverage is provided, it may be subject to substantial limitations or exclusions, and require continued residency in this state. You should not rely on coverage by the Guaranty Association in purchasing an insurance policy or contract.

Coverage is NOT provided for your policy or contract or any portion of it that is not guaranteed by the insurer or for which you have assumed the risk, such as non-guaranteed amounts held in a separate account under a variable life or variable annuity contract.

Insurance companies or their agents are required by law to provide you with this notice. However, insurance companies and their agents are prohibited by law from using the existence of the Guaranty Association to induce you to purchase any kind of insurance policy.

**The Arkansas Life and Health Insurance Guaranty Association**

c/o The Liquidation Division  
1023 West Capitol  
Little Rock, Arkansas 72201

**Arkansas Insurance Department**

1200 West Third Street  
Little Rock, Arkansas 72201-1904

The state law that provides for this safety-net is called the Arkansas Life and Health Insurance Guaranty Association Act (“Act”). Below is a brief summary of the Act’s coverages, exclusions and limits. This summary does not cover all provisions of the Act; nor does it in any way change anyone’s rights or obligations under the Act or the rights or obligations of the Guaranty Association.

**COVERAGE**

Generally, individuals will be protected by the Guaranty Association if they live in this state and hold a life, annuity or health insurance contract or policy, or if they are insured under a group insurance contract issued by a member insurer. The beneficiaries, payees or assignees of policy or contract owners are protected as well, even if they live in another state.

**EXCLUSIONS FROM COVERAGE**

However, persons owning such policies are NOT protected by the Guaranty Association if:

- They are eligible for protection under the laws of another state (this may occur when the insolvent insurer was incorporated in another state whose guaranty association protects insureds who live outside that state);
- The insurer was not authorized to do business in this state;
- Their policy or contract was issued by a nonprofit hospital or medical service organization, an HMO, a fraternal benefit society, a mandatory state pooling plan, a mutual assessment company or similar plan in which the policy or contract owner is subject to future assessments, or by an insurance exchange.

The Guaranty Association also does NOT provide coverage for:

- Any policy or contract or portion thereof which is not guaranteed by the insurer or for which the owner has assumed the risk, such as non-guaranteed amounts held in a separate account under a variable life or variable annuity contract;
- Any policy of reinsurance (unless an assumption certificate was issued);
- Interest rate yields that exceed an average rate;
- Dividends and voting rights and experience rating credits;
- Credits given in connection with the administration of a policy by a group contract holder;
- Employers' plans to the extent they are self-funded (that is, not insured by an insurance company, even if an insurance company administers them);
- Unallocated annuity contracts (which give rights to group contract holders, not individuals);
- Unallocated annuity contracts issued to/in connection with benefit plans protected under Federal Pension Benefit Corporation ("FPBC") (whether the FPBC is yet liable or not);
- Portions of an unallocated annuity contract not owned by a benefit plan or a government lottery (unless the owner is a resident) or issued to a collective investment trust or similar pooled fund offered by a bank or other financial institution;
- Portions of a policy or contract to the extent assessments required by law for the Guaranty Association are preempted by State or Federal law;
- Obligations that do not arise under the policy or contract, including claims based on marketing materials or side letters, riders, or other documents which do not meet filing requirements, or claims for policy misrepresentations, or extra-contractual or penalty claims;
- Contractual agreements establishing the member insurer's obligations to provide book value accounting guarantees for defined contribution benefit plan participants (by reference to a portfolio of assets owned by a nonaffiliate benefit plan or its trustees).

#### **LIMITS ON AMOUNT OF COVERAGE**

The Act also limits the amount the Guaranty Association is obligated to cover: The Guaranty Association cannot pay more than what the insurance company would owe under a policy or contract. Also, for any one insured life, the Guaranty Association will pay a maximum of \$300,000 no matter how many policies and contracts there were with the same company, even if they provided different types of coverages. Within this overall \$300,000 limit, the Association will not pay more than \$300,000 in health insurance benefits, \$300,000 in present value of annuity benefits, or \$300,000 in life insurance death benefits or net cash surrender values - again, no matter how many policies and contracts there were with the same company, and no matter how many different types of coverages. There is a \$1,000,000 limit with respect to any contract holder for unallocated annuity benefits, irrespective of the number of contracts held by the contract holder. These are limitations for which the Guaranty Association is obligated before taking into account either its subrogation and assignment rights or the extent to which those benefits could be provided out of the assets of the impaired or insolvent insurer.

**STATE OF ARKANSAS**  
**CERTIFICATION OF COMPLIANCE**

**Company Name:** HOUSEHOLD LIFE INSURANCE COMPANY

**Form Numbers:** HLI-1-203-0409, HLI-1-205-0409

I hereby certify that to the best of my knowledge and belief, the above form(s) and submission complies with Reg. 19, as well as the other laws and regulations of the State of Arkansas.

*Michael Palace*

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Michael Palace ASA, MAAA- Assistant Vice President / Product Design and Pricing

May 27, 2009

Date

**INDIVIDUAL LIFE**  
**Explanation of Variable Areas**

**Application Form HLI-1-203-0409**

**Heading:**

The Company's address, phone number and website may be changed as required.

**Title**

Title "APPLICATION FOR INDIVIDUAL [TERM LIFE/TERM LIFE WITH ENDOWMENT/WHOLE LIFE] INSURANCE" will show either term life, term life with endowment, or whole life depending upon which is applied for or will show or include another marketing name. Any title will make clear to the applicant that he or she is applying for life insurance.

**Insured Information:**

- "State or Province/Country of Birth" will be included or omitted depending on plan design and underwriting considerations.
- "Home Phone Number" will be included or omitted depending on plan design and underwriting considerations. "Optional" will be included or omitted depending on plan design.
- "Driver's License Number & State of Issue" will be included or omitted depending on plan design and underwriting considerations.
- "Occupation" will be included or omitted depending on plan design and underwriting considerations.
- "Annual Income of Proposed Insured \$" will be included or omitted depending on plan design and underwriting considerations.
- Question regarding citizenship will be included or omitted depending on plan design and underwriting considerations.

**Owner Information**

- Owner information may appear when the owner is someone other than the Insured. The Owner fields may or may not appear when the application is presented through our agent channels depending on plan design.
- "State or Province/Country of Birth" will be included or omitted depending on plan design and underwriting considerations.

**Beneficiary:**

Information for one Primary Beneficiary will be included. If the Company is able to display fields for additional primary and/or contingent beneficiaries, the applicable fields will be displayed depending on plan design.

**Plan Applied For:**

- The terms currently available for term life insurance will be included or omitted at the option of the Company. Additional terms may be added in the future depending on plan design.
- The terms currently available for term life with endowment insurance will be included or omitted at the option of the Company. Additional terms may be added in the future depending on plan design.
- Whole Life plan will be included or omitted at the option of the Company.
- The Automatic Premium Loan election will be included if required by State law and/or in accordance with the Policy and will appear only when applicable.

**Additional Coverage Applied For:**

This section will be included when riders are offered to the Insured; each rider will be included or omitted according to plan design. Additional approved riders may be displayed and titles of riders may be revised as applicable.

**Coverage Amount:**

The amount of coverage on the policy will be included in this area.

**Payment Frequency:**

Depending on plan design, the applicant may choose to pay premiums annually, semiannually, quarterly, or monthly.

**Payment Method:**

The following Payment captions may be available to applicants and bracketed information will either be displayed, rearranged or deleted depending upon plan design.

• **Option #1**

Charge my Credit Card    Visa    MasterCard    Discover    American Express  
Account # \_\_\_\_\_ Exp. Date \_\_\_\_\_

Debit my [checking/savings] account [Bank Name \_\_\_\_\_] Account # \_\_\_\_\_  
ABA Number \_\_\_\_\_ Type \_\_\_\_\_  
(First 9 numbers in the lower left-hand corner of your check)

• **Option #2**

Charge my Credit Card/Debit Card    Visa    MasterCard    Discover [ Type of Card]  
Account # \_\_\_\_\_ Exp. Date \_\_\_\_\_

Debit my [checking/savings] account [Bank Name \_\_\_\_\_] Account # \_\_\_\_\_  
ABA Number \_\_\_\_\_ Type \_\_\_\_\_  
(First 9 numbers in the lower left-hand corner of your check)

• **Option #3**

Charge my Credit Card/Debit Card    Visa    MasterCard    Discover [ Type of Card]  
Account # \_\_\_\_\_ Exp. Date \_\_\_\_\_

Debit my [checking/savings] account [Bank Name \_\_\_\_\_] Account # \_\_\_\_\_  
ABA Number \_\_\_\_\_ Type \_\_\_\_\_  
(First 9 numbers in the lower left-hand corner of your check)

[Or enclose a voided check from the [checking] account from which you want to make a payment]

• **Option #4**

Charge my Credit Card/Debit Card    Visa    MasterCard    Discover [ Type of Card]  
Account # \_\_\_\_\_ Exp. Date \_\_\_\_\_

Debit my [checking/savings] account [Bank Name \_\_\_\_\_] Account # \_\_\_\_\_  
ABA Number \_\_\_\_\_ Type \_\_\_\_\_  
(First 9 numbers in the lower left-hand corner of your check)

[Or enclose a voided check from the [checking] account from which you want to make a payment]

Bill me directly for the premiums

• **Option #5**

Charge my Credit Card/Debit Card     Visa    MasterCard    Discover [ Type of Card]

Account # \_\_\_\_\_ Exp. Date \_\_\_\_\_

• **Option #6**

Charge my Credit Card     Visa    MasterCard    Discover    American Express

Account # \_\_\_\_\_ Exp. Date \_\_\_\_\_

• **Option #7**

Debit my [checking/savings] account [Bank Name \_\_\_\_\_] Account # \_\_\_\_\_

ABA Number \_\_\_\_\_ Type \_\_\_\_\_

(First 9 numbers in the lower left-hand corner of your check)

• **Option #8**

Bill me directly for the premiums

• **Option #9**

Charge the premium for the coverage to my [Bank Name] credit card account.

• **Option #10**

Debit the premium for the coverage to [Bank Name] [type of] account

• **Option #11**

Bill me for my coverage on my mortgage bill with [Mortgage Company Name].

• **Option #12**

Bill me for my coverage on my [consumer loan/equity] bill with [Lending Institution Name].

• **Option #13**

Bill me later

Check enclosed – start coverage faster

I am enclosing a Check for my first payment of \$\_\_\_\_\_. Please make check payable to [Name of Company]. Write billing frequency selected on the check. You will be billed for future payments.

• **Option #14**

Bill me later

Check enclosed – start coverage faster

I am enclosing a Check for my first payment of \$\_\_\_\_\_. Please make check payable to [Name of Company]. Write billing frequency selected on the check. You will be billed for future payments.

Debit my [checking/savings] account                      [Bank Name \_\_\_\_\_] Account # \_\_\_\_\_

ABA Number \_\_\_\_\_ Type \_\_\_\_\_

(First 9 numbers in the lower left-hand corner of your check)

[Or enclose a voided check from the [checking] account from which you want to make a payment]

• **Option #15**

Check enclosed – start coverage faster

I am enclosing a Check for my first payment of \$\_\_\_\_\_. Please make check payable to [Name of Company]. Write billing frequency selected on the check. You will be billed for future payments.

- **Option #16**

Charge my Debit Card  Visa  MasterCard  Discover  Other

Account # \_\_\_\_\_ Exp. Date \_\_\_\_\_

- **Option #17**

Please [charge/debit] [to] my existing [Financial Institution Name] [Card/Bank Account] on file.

**Replacement:**

Replacement questions will show as required by state law and will conform to model law requirements if/when adopted by state. Company may revise wording within the questions but will comply with state law. Company may remove the following statement if additional forms are not required: (If yes, additional forms may be required, depending upon your state)?

**Underwriting Information:**

The following question may be removed if the Company becomes able to check criminal record without asking: "Or have you ever been convicted of a felony?"

**Fraud Warnings:**

The NAIC model fraud warning language will be added, deleted or revised as required according to model law regulations and will appear in states that do not have state mandated fraud warning language, where allowed. The fraud notice applicable to the state will appear on the application. The state fraud warning language will be added, deleted or revised as required according to state law. The fraud warning may be moved and appear above the signature lines.

**MIB Notice:**

The MIB notice is bracketed to allow for revision without refilling due to mandated changes by MIB. The MIB notice may appear as shown or as a separate document.

**Authorization:**

The authorization will be valid for two and one-half years or will be revised to conform to the time period required by state law.

**Owner Signature and date**

This signature and date block will be included when the Owner of the policy is someone other than the applicant.

**Company Representative Replacement Questionnaire**

These questions will be included when coverage is effectuated by a company representative. Company may revise wording within the questions but will comply with state law.

All page numbering may be subject to change.

**Application Form HLI-1-205-0409**

**Heading:**

Company addresses, website and phone number may be changed as required.

**Insured Information:**

- John Doe information is included in the form. The following customer information may be pre-populated: Insured's name, policy number, date of birth, and name of owner (if different than the Insured). If any information has changed prior to reinstatement, we will provide the Insured with the appropriate mechanisms to allow for change at the time of reinstatement.
- "State or Province/Country of Birth" will be included or omitted depending on plan design and underwriting considerations.
- "Occupation" will be included or omitted depending on plan design and underwriting considerations.
- "and riders, if applicable" will be included or omitted depending if rider elections will be reinstated with the Policy or/ are available for election at the time of reinstatement. The inclusion or omission of this language will depend on plan design.
- "as indicated below" will be included or omitted if rider elections are available at the time of reinstatement.
- All, none, or only applicable rider elections will appear at the time of reinstatement. Additional approved riders will be displayed and titles of riders may be revised as applicable.

**Underwriting Information**

The following question may be removed if the Company becomes able to check criminal record without asking: "Or have you ever been convicted of a felony?"

**Payment Method Information:**

The following Payment captions may be available to applicants and bracketed information will either be displayed, rearranged or deleted depending upon plan design.

Charge my Credit Card     Visa     MasterCard     Discover     American Express  
Account # \_\_\_\_\_ Exp. Date \_\_\_\_\_

Debit my [checking/savings] account                      Bank Name \_\_\_\_\_ Account # \_\_\_\_\_  
ABA Number \_\_\_\_\_ Type \_\_\_\_\_  
(first 9 numbers in the lower left-hand corner of your check)

Certified Check/Money Order Enclosed                      Total Premium Enclosed/Due \$\_\_\_\_\_]

**Fraud Warnings:**

The NAIC model fraud warning language will be added, deleted or revised as required according to model law regulations and will appear in states that do not have state mandated fraud warning language, where allowed. The fraud notice applicable to the state will appear on the application. The state fraud warning language will be added, deleted or revised as required according to state law. The fraud warning may be moved and appear above the signature lines.

**MIB Notice:**

The MIB notice is bracketed to allow for revision without refiling due to mandated changes by MIB. The MIB notice may appear as shown or as a separate document.

**Authorization:**

The authorization will be valid for two and one-half years or will be revised to conform to the time period required by state law.

**Owner Signature and date**

This signature and date block will be included when the Owner of the policy is someone other than the applicant.

**Notice of Information Practices**

Notice language is not part of the application and may be shown at the bottom of the application or as a separate document. Notice may be revised without refiling, but will always conform to state law.

All page numbering may be subject to change.

The Policy number on each page may be subject to change.