

SERFF Tracking Number: AEGB-125986268 State: Arkansas  
Filing Company: Western Reserve Life Assurance Co. of Ohio State Tracking Number: 41390  
Company Tracking Number: IUL03 1208 AR, SAIUL1208W  
TOI: L09I Individual Life - Flexible Premium Sub-TOI: L09I.001 Single Life  
Adjustable Life  
Product Name: Flexible Premium Adjustable Life Insurance Policy with an Index Feature et al  
Project Name/Number: IUL03 1207 AR, SAIUL1208W/IUL03 1207 AR, SAIUL1208W

## Filing at a Glance

Company: Western Reserve Life Assurance Co. of Ohio

Product Name: Flexible Premium Adjustable Life Insurance Policy with an Index Feature et al  
SERFF Tr Num: AEGB-125986268 State: Arkansas

TOI: L09I Individual Life - Flexible Premium Adjustable Life  
SERFF Status: Closed-Approved-Closed State Tr Num: 41390

Sub-TOI: L09I.001 Single Life  
Co Tr Num: IUL03 1208 AR, SAIUL1208W  
State Status: Approved-Closed

Filing Type: Form

Reviewer(s): Linda Bird  
Author: Joanne Nolte  
Disposition Date: 06/04/2009  
Date Submitted: 01/27/2009  
Disposition Status: Approved-Closed

Implementation Date Requested: On Approval  
State Filing Description:

Implementation Date:

## General Information

Project Name: IUL03 1207 AR, SAIUL1208W  
Project Number: IUL03 1207 AR, SAIUL1208W  
Requested Filing Mode: Review & Approval

Status of Filing in Domicile: Pending  
Date Approved in Domicile:  
Domicile Status Comments: Concurrently submitted

Explanation for Combination/Other:  
Submission Type: New Submission  
Overall Rate Impact:  
Filing Status Changed: 06/04/2009

Market Type: Individual  
Group Market Size:  
Group Market Type:  
Explanation for Other Group Market Type:  
State Status Changed: 06/04/2009

Deemer Date:  
Submitted By: Joanne Nolte

Created By: Joanne Nolte  
Corresponding Filing Tracking Number: IUL03 1208 AR, SAIUL1208W

Filing Description:

RE: IUL03 1208 AR - Flexible Premium Adjustable Life Insurance Policy with an Index Feature  
SAIUL1208W - Supplemental Life Application

SERFF Tracking Number: AEGB-125986268 State: Arkansas  
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Dear Sir/Madam:

Please find attached a copy of the above referenced form. This is a new form and is not intended to replace any form previously approved by your Department. This form has been submitted in final printed form in which it will be distributed to Insureds. This form is subject to only minor modifications in paper size and stock, ink, border, Company logo, Company address, adaptation to computer printing, and Officers' signatures. These forms are also being filed on our sister companies of Transamerica Life Insurance Company and Stonebridge Life Insurance Company.

Flexible Premium Adjustable Life Insurance Policy with an Index Feature - The Insurance Benefit is paid at death. This policy contains a built in Index Feature that allows the Owner to elect on the application what portion of the net premiums goes into either the Basic Interest Account or one or more Index Accounts, as elected by the Insured. One Index Account, the Global Index Account, is included in this filing. We may add additional Index accounts in the future. Interest to the Basic Interest Account Segments is credited at rates declared by the Company, but will not be less than the Basic Interest Account Guaranteed Minimum Interest Rate shown on the Policy Specifications Page. Excess Index Interest may be credited on premiums allocated to an Index Account based on the annual growth, if any, in Standard & Poor's 500 Composite Stock Price Index, Dow Jones Euro Stoxx 50 Price Index and Hang Seng Index, excluding dividend income. The annual growth in the Index Account(s) will be limited to a Cap, which is declared by the Company on an annual basis for each segment. Premiums are flexible and are payable while the policy remains in force. Coverage lasts until the Insured's death.

This form is based on the 2001 CSO Mortality Table.

We intend to use applications:

U000310, which was approved by your Department on August 31, 2007;  
L 108 0805 AR, which was approved by your Department on January 12, 2006; and  
6000 R0103 AR, which was approved by your Department on January 15, 2003.

Supplemental Life Application - Application form SAIUL1208W is a supplemental life application for use with this base policy.

We will market these forms to the general public. An actuarial demonstration and supporting documentation are attached for your reference. The policy form will be illustrated.

We would appreciate your review and approval of this form.

Sincerely,  
WESTERN RESERVE LIFE ASSURANCE CO. OF OHIO

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Joanne D. Nolte  
 Policy Analyst

## Company and Contact

### Filing Contact Information

Joanne Nolte, Analyst jnolte@aegonusa.com  
 4333 Edgewood Rd. NE 515-339-7519 [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: \$50.00  
 Retaliatory? No  
 Fee Explanation:  
 Per Company: No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Western Reserve Life Assurance Co. of Ohio	\$50.00	01/27/2009	25290790

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## Correspondence Summary

### Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Linda Bird	06/04/2009	06/04/2009

### Objection Letters and Response Letters

Objection Letters				Response Letters		
Status	Created By	Created On	Date Submitted	Responded By	Created On	Date Submitted
Pending Industry Response	Linda Bird	01/30/2009	01/30/2009	Joanne Nolte	06/04/2009	06/04/2009

### Filing Notes

Subject	Note Type	Created By	Created On	Date Submitted
Request for information	Note To Filer	Linda Bird	04/16/2009	04/16/2009
Request for information	Note To Reviewer	Joanne Nolte	04/15/2009	04/15/2009
Response to letter dated 3/30/09	Note To Filer	Linda Bird	03/31/2009	03/31/2009
Response to letter dated 3/30/09	Note To Reviewer	Joanne Nolte	03/31/2009	03/31/2009
Objection letter dated 1/30/09	Note To Filer	Linda Bird	03/30/2009	03/30/2009

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## **Disposition**

Disposition Date: 06/04/2009

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		Yes
Supporting Document	Health - Actuarial Justification		No
Supporting Document	Outline of Coverage		No
Supporting Document	AR - Cert of Compliance		Yes
Supporting Document	AR - Cert of Regulation 34		Yes
Supporting Document	AR - Bulletin 11-83		Yes
Supporting Document	Sample Specification Page		Yes
Supporting Document	Actuarial materials		No
Supporting Document	External Indexed Guidelines certifications		Yes
Form	Flexible Premium Adjustable Life Insurance Policy with an Index Feature		Yes
Form	Supplemental Life Application		Yes

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## Objection Letter

Objection Letter Status Pending Industry Response  
Objection Letter Date 01/30/2009  
Submitted Date 01/30/2009  
Respond By Date  
Dear Joanne Nolte,

This will acknowledge receipt of the captioned filing.

### Objection 1

- AR - Cert of Compliance (Supporting Document)

Comment: External Indexed contracts are subject to the External Indexed Guidelines. Please furnish certification that this filing is in compliance with these guidelines and certifications required by these guidelines.

Please feel free to contact me if you have questions.

Sincerely,  
Linda Bird

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## Response Letter

Response Letter Status Submitted to State  
Response Letter Date 06/04/2009  
Submitted Date 06/04/2009

Dear Linda Bird,

### Comments:

Thank you for your letter dated January 30, 2009. I apologize that it has taken us so long to respond.

### Response 1

Comments: Please see the attached certifications.

#### Related Objection 1

Applies To:

- AR - Cert of Compliance (Supporting Document)

Comment:

External Indexed contracts are subject to the External Indexed Guidelines. Please furnish certification that this filing is in compliance with these guidelines and certifications required by these guidelines.

### Changed Items:

#### Supporting Document Schedule Item Changes

Satisfied -Name: External Indexed Guidelines certifications

Comment: Please fiind the following certifications and information with regards to the state's External Indexed Guidelines.

No Form Schedule items changed.

No Rate/Rule Schedule items changed.

If you have any questions or concerns regarding this, please feel free to contact me at 515.339.7519 or via e-mail at jnolte@aegonusa.com.

Sincerely,  
Joanne Nolte

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**Note To Filer**

**Created By:**

Linda Bird on 04/16/2009 08:33 AM

**Last Edited By:**

Linda Bird

**Submitted On:**

04/16/2009 08:33 AM

**Subject:**

Request for information

**Comments:**

Dear Ms. Nolte,

Joe Musgrove is the states's Chief Actuary and can be reached at 501-371-2632.

Very truly yours,

Linda Bird

Certified Rate and Form Analyst

Life and Health Division

(501) 371-2769

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**Note To Reviewer**

**Created By:**

Joanne Nolte on 04/15/2009 08:19 PM

**Last Edited By:**

Joanne Nolte

**Submitted On:**

04/15/2009 08:19 PM

**Subject:**

Request for information

**Comments:**

Dear Ms. Bird,

We are working on the objection for this filing and our actuaries have come across a question. They have requested that I contact you and ask for the current AR AOMR requirements.

Also, can I please get the name and phone number of your Chief Actuary. Our actuarial staff may have further questions and they feel that it might be beneficial to speak with the state's actuary.

I appreciate any help you can give me. Thank you in advance.

Sincerely,

Joanne Nolte

Policy Analyst

515-339-7519

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**Note To Filer**

**Created By:**

Linda Bird on 03/31/2009 11:18 AM

**Last Edited By:**

Linda Bird

**Submitted On:**

03/31/2009 11:18 AM

**Subject:**

Response to letter dated 3/30/09

**Comments:**

We have placed a 30 day extension on this objection letter dated 1/30/09 for your response to the state.

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**Note To Reviewer**

**Created By:**

Joanne Nolte on 03/31/2009 08:46 AM

**Last Edited By:**

Joanne Nolte

**Submitted On:**

03/31/2009 08:46 AM

**Subject:**

Response to letter dated 3/30/09

**Comments:**

Dear Ms. Bird,

Thank you for your inquiry regarding this filing. We do plan to respond to the objection, but would like to request an extension. We have all the certifications you requested created and ready to resubmit, however are having a discussion regarding who should be signing the Agent Education Certification. Once we have that issue resolved, we will be able to send the response to the state. I apologize for the length of time this has taken, I hope to have it resolved soon.

I appreciate you patients and support in this matter.

Sincerely,

Joanne Nolte

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**Note To Filer**

**Created By:**

Linda Bird on 03/30/2009 11:27 AM

**Last Edited By:**

Linda Bird

**Submitted On:**

03/30/2009 11:28 AM

**Subject:**

Objection letter dated 1/30/09

**Comments:**

It has come to our attention that you have not responded to our 1/30/09 objection letter regarding this filing.

Please advise the Department if the company would like to withdraw the filing or if additional time is needed to comply?

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## Form Schedule

**Lead Form Number: IUL03 1208 AR**

Schedule Item Status	Form Number	Form Type Form Name	Action	Action Specific Data	Readability	Attachment
	IUL03 1208 AR	Policy/Contract/Fratern al Insurance Policy with Certificate: an Index Feature Amendmen t, Insert Page, Endorseme nt or Rider	Initial		51.300	IUL03 1208 AR - W.pdf
	SAIUL1208 W	Application/Supplemental Life Enrollment Application Form	Initial		51.800	SAIUL1208W.pdf



A Stock Company  
Home Office located at: Columbus, Ohio  
Administrative Office located at: 4333 Edgewood Road NE, Cedar Rapids, Iowa 52499  
(Hereafter called the Company, we, our or us) (319) 355-8511

INSURED: [JOHN DOE] INITIAL SPECIFIED AMOUNT: \$[25,000]  
POLICY NUMBER: [110 01 SAMPLE] POLICY DATE: [JANUARY 1, 2009]  
OWNER(S): [JOHN DOE]

WE AGREE to pay the Net Death Benefit to the Beneficiary(ies) upon receiving due proof of the Insured's death, while this Policy is In Force, and to provide You, the Owner, with the other rights and benefits of this Policy. These agreements are subject to the provisions of this Policy.

This Policy's Policy Value and Cash Surrender Value will be based on the amount, timing and frequency of premiums paid, Monthly Deductions taken and the amount of interest credited. Net Premiums are allocated into the Basic Interest Account and/or one or more Index Accounts, as elected by You. Interest is credited to the Account Options at rates not less than the Guaranteed Minimum Interest Rates shown in the Policy Specifications Pages. Excess interest may be credited to the Basic Interest Account based on rates declared by us. Excess interest may be credited to an Index Account based in part on the growth, if any, of certain securities indexes. Excess Index Interest, if any, for an Index Account Segment will only be credited as of that Segment's Ending Date. Any Excess Index Interest that might otherwise be credited as of a Segment's Ending Date will not be credited if certain activity takes place prior to the Segment's Ending Date. We may make additional Index Accounts available after we issue this Policy.

10 DAY RIGHT TO CANCEL - You may cancel this Policy by delivering or mailing a request to us or to the agent from whom it was purchased. You must return this Policy to us or to the agent before midnight of the tenth (10th) day after the day You receive it. Your request given by mail and return of this Policy by mail are effective on being postmarked, properly addressed and postage prepaid. We must return all payments made for this Policy within thirty (30) days after we receive notice of cancellation and this returned Policy.

Signed for us at our home office.

A handwritten signature in cursive script, appearing to read 'William H. Bergen'.

SECRETARY

A handwritten signature in cursive script, appearing to read 'Brenda Casey'.

PRESIDENT

This Policy is a legal contract between the policyowner and the Company.

READ YOUR POLICY CAREFULLY

FLEXIBLE PREMIUM ADJUSTABLE LIFE INSURANCE POLICY WITH  
AN INDEX FEATURE  
PREMIUMS PAYABLE WHILE THE POLICY IS IN FORCE  
NET DEATH BENEFIT PAYABLE AT DEATH  
NON-PARTICIPATING

## INDEX DISCLOSURES

### The Global Index Account.

Excess interest credited to the Global Index Account value is based on a weighted average of changes in the Standard & Poor's 500<sup>®</sup> Composite Stock Price Index, Dow Jones Euro Stoxx 50<sup>®</sup> Price Index and Hang Seng Index.

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STOXX and Dow Jones have no relationship to the Company, other than the licensing of the Dow Jones Euro Stoxx 50<sup>®</sup> and the related trademarks for use in connection with the plan of insurance offered by this Policy ("Product").

STOXX and Dow Jones do not:

- \* Sponsor, endorse, sell or promote the Product.
- \* Recommend that any person invest in the Product or any securities.
- \* Have any responsibility or liability for or make any decisions about the timing, amount or pricing of the Product.
- \* Have any responsibility or liability for the administration, management or marketing of the Product.
- \* Consider the needs of the Product or the Owners of the Product in determining, composing or calculating the Dow Jones Euro Stoxx 50<sup>®</sup> or have any obligation to do so.

STOXX and Dow Jones will not have any liability in connection with the Product. Specifically,

- \* STOXX and Dow Jones do not make any warranty, express or implied, and disclaim any and all warranty about:
  - \* The results to be obtained by the Product, the Owner of the Product or any other person in connection with the use of and the data included in the Dow Jones Euro Stoxx 50<sup>®</sup>;
  - \* The accuracy or completeness of the Dow Jones Euro Stoxx 50<sup>®</sup> and its data;
  - \* The merchantability and the fitness for a particular purpose or use of the Dow Jones Euro Stoxx 50<sup>®</sup> and its data;
- \* STOXX and Dow Jones will have no liability for any errors, omissions or interruptions in the Dow Jones Euro Stoxx 50<sup>®</sup> or its data;
- \* Under no circumstances will STOXX or Dow Jones be liable for any lost profits or indirect, punitive, special or consequential damages or losses, even if STOXX or Dow Jones knows that they might occur.

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## DEFINITIONS

When we use the following words, this is what we mean:

**ACCOUNT OPTION** - An account to which Net Premiums and/or Transfers may be allocated and the values of which are components of the Policy Value. The Account Options are the Basic Interest Account and the Index Account(s).

**AGE** - A person's age on his or her last birthday, unless otherwise specified.

**BASIC INTEREST ACCOUNT** - An Account Option for which the interest will be based on rates declared by the Company. The Basic Interest Account is comprised of Basic Interest Account Segments. The value of the Basic Interest Account is the sum of the values of those Segments plus any amount(s) pending application to a Basic Interest Account Segment.

**BEGINNING DATE** - The first Monthly Date for a Segment. The Beginning Date is reset on the Segment's Ending Date.

**BENEFICIARY(IES)** - The person(s) designated to receive all or a portion of the Net Death Benefit in the event of the Insured's death.

**CAP** - The maximum Index Change that can be used to determine the Excess Index Interest credited to an Index Account Segment. Each Index Account Segment may have a different Cap. Caps are declared by the Company at its discretion.

**CASH SURRENDER VALUE** - The amount available upon surrender. The Cash Surrender Value equals the Policy Value less any surrender charge and less any Indebtedness.

**CURRENT INTEREST RATE** - The rate at which interest will be credited to a Basic Interest Account Segment. Current Interest Rates are declared by the Company at its discretion. Different Current Interest Rates may apply to different Basic Interest Account Segments.

**DEATH BENEFIT** - An amount used to determine the Net Death Benefit. The Death Benefit section of this Policy explains how the Death Benefit is determined based on which Death Benefit Option is in effect. You may select either the Level or Increasing Death Benefit Option.

**ENDING DATE** - The date used to determine the ending value of a Segment. The Ending Date for a Segment is the last Monthly Date in its Segment Period and is the same date as the next Beginning Date. The Ending Date is reset at that time for the next Segment.

**EXCESS INDEX INTEREST** - Any interest credited to an Index Account Segment in excess of interest credited at the Index Account Guaranteed Minimum Interest Rate. Excess Index Interest, if any, will only be credited as of the Ending Date for the Segment.

**GRACE PERIOD** - The 61-day period within which You may prevent Your policy from Lapsing by paying all amounts due. The Policy will enter its Grace Period if we have not received sufficient premiums. See the Grace Period provision for details.

**IMMEDIATE FAMILY** - A person's spouse, child, brother, sister, parent, grandparent, or grandchild.

**INDEBTEDNESS** - All Policy loans, if any, and accrued loan interest.

**INDEX** - A securities index designated by us for use in calculating Excess Index Interest. This may include the Standard & Poor's 500<sup>®</sup> Composite Stock Price Index, Dow Jones Euro Stoxx 50 Price Index, Hang Seng Index, or other widely published index. The current value of each Index is available by contacting us at our Administrative Office. Should the publication of an Index ever change in frequency or be discontinued, we will replace it with another appropriate widely published index, subject to any necessary prior regulatory approvals. We will notify You of any such changes.

**INDEX ACCOUNT** - An Account Option for which any interest in excess of the minimum guaranteed rate will be based in part on changes in the values of published Indexes. Each Index Account is comprised of Index Account Segments. The value of each Index Account is the sum of the values of those Segments, plus any amounts pending application to a Segment of that Index Account. The Global Index Account is an Index Account. A list of all of the Index Accounts in this Policy on the Policy Date appears in the Policy Specifications Pages. We may make other Index Accounts available in the future.

**INDEX CHANGE** - The percentage change in the applicable Index Values from an Index Account Segment's Beginning Date to its Ending Date. The Index Change will be used to determine the Excess Interest, if any. The Index Change may be determined differently for different Index Accounts.

**INDEX VALUE** - The value of an Index (excluding dividends) as stated by its publisher.

**IN FORCE** - The status of this Policy while the Insured's life remains insured under the terms of this Policy.

**INSURED** - The person whose life is insured under this Policy as shown on the application and on the first page of this Policy.

**LAPSE** - Termination of this Policy at the end of the Grace Period due to nonpayment of sufficient premiums.

**LOAN RESERVE** - The portion of the Policy Value transferred from the Account Options when You borrow from this Policy. The Loan Reserve is credited with interest separately from the Account Options.

**MINIMUM MONTHLY NO LAPSE PREMIUM** - Prior to the No Lapse Ending Date, payment of this amount will prevent the Policy from lapsing in the event the Cash Surrender Value is less than the next Monthly Deduction. The No Lapse Ending Date in effect on the Policy Date is shown in the Policy Specifications Pages. It may be extended in the event of a Reinstatement.

**MONTHLY DATE** - The same day of the month as the Policy Date for each succeeding month this Policy remains In Force.

**MONTHLY DEDUCTION** - Amount taken from the Policy Value each Policy Month equal to the monthly cost of insurance and other charges. All of these terms are explained in the Monthly Deduction provision of the Policy Value section of this Policy.

**NET DEATH BENEFIT** - The amount payable under the terms of this Policy when the Insured dies while it is In Force. The Death Benefit section of this Policy explains how the Net Death Benefit is determined.

**NET PREMIUM** - The part of a premium payment that the Owner may elect to have allocated to the Account Options. It is equal to such premium payment minus the Premium Expense Charge. The Premium Expense Charge is described in the Net Premiums provision of the General Provisions.

**OWNER** - The Owner (also called "You" or "Your") as shown in the application and on the first page of this Policy, unless subsequently changed as provided in this Policy. The Owner is the Insured unless otherwise stated.

**POLICY ANNIVERSARY** - The same day and month as the Policy Date for each succeeding year this Policy remains In Force.

**POLICY DATE** - The date coverage under this Policy becomes effective and the date from which Policy Anniversaries, Policy Years, Monthly Dates and Policy Months are determined.

**POLICY VALUE** - The sum of the values of the Account Options, plus the amount of the Loan Reserve, if any.

**QUALIFIED ADDITIONAL BENEFITS** - Specific benefits defined as such in section 7702 of the Internal Revenue Code.

**RECORD DATE** - The date this Policy is recorded on our books as an In Force Policy. The Record Date is shown in the Policy Specifications Pages.

**REINSTATE** - To restore coverage after this Policy has Lapsed.

**SEGMENT** - A component of the Basic Interest Account or of an Index Account. Premiums and Transfers are applied to Segments with Beginning Dates on the next Monthly Date.

**SEGMENT PERIOD** - The number of Policy Months from a Segment's Beginning Date to its Ending Date. The Segment Period may be different for each Account Option. The Basic Interest Account has a twelve-month Segment Period. The listing of Index Accounts in the Policy Specifications Pages shows the length of their respective Segment Periods. Each Segment is assigned a number corresponding to the Policy Month in which it is created.

**SPECIFIED AMOUNT** - An amount used to determine the Death Benefit. The Initial Specified Amount is shown in the Policy Specifications Pages. When we refer to the Specified Amount, we mean the Initial Specified Amount as increased or decreased in accordance with this Policy.

**TRANSFER** - Movement of part or all of the value of a Segment to or from another Account Option.

**UNIT** - \$1,000.00 of Specified Amount.

POLICY SPECIFICATIONS PAGES

POLICY NUMBER:	[110 01 SAMPLE]	INSURED:	[JOHN DOE]
INITIAL SPECIFIED AMOUNT:	[\$25,000]	ISSUE AGE/SEX:	[35/MALE]
MINIMUM SPECIFIED AMOUNT:	[\$25,000]	POLICY DATE:	[JANUARY 1, 2009]
DEATH BENEFIT OPTION:	[LEVEL]	RECORD DATE:	[JANUARY 1, 2009]
PLANNED PREMIUM:	[\$100.00]	NO LAPSE ENDING DATE:	[JANUARY 1, 2029]
PAYMENT FREQUENCY:	[MONTHLY]	INITIAL PREMIUM:	[\$100.00]
RATE CLASS:	[NON-TOBACCO]		
OWNER(S):	[JOHN DOE]		

POLICY CHARGE

GUARANTEED MAXIMUM:	\$12.00 per month
INITIAL:	\$ [10.00] per month

GUARANTEED MINIMUM INTEREST RATE

BASIC INTEREST ACCOUNT:	2.00%
INDEX ACCOUNT:	1.00%

LOAN RESERVE INTEREST CREDITED: [2.50]%

LOAN INTEREST RATES CHARGED:

STANDARD MAXIMUM:	[3.50]%
STANDARD CURRENT:	[3.25]%
PREFERRED MAXIMUM:	[2.75]%
PREFERRED CURRENT:	[2.50]%

PREMIUM EXPENSE CHARGE

GUARANTEED MAXIMUM:	6.0% (years 1-10)
	2.5% (years 11+)
INITIAL:	[6.0]%(years 1-10)
	[2.5]%(years 11+)

PER UNIT CHARGE

GUARANTEED MAXIMUM:	\$ 0.22 per month (years 1-8)
	\$ 0.00 per month (years 9+)
INITIAL:	[\$0.22] per month (years 1-8)
	[\$0.00] per month (years 9+)

LIFE INSURANCE COMPLIANCE TEST: [Guideline Premium Test]

Premiums are payable while the Policy is In Force. It is possible that coverage will expire where either no premiums are paid following payment of the Initial Premium or subsequent premiums are insufficient to continue coverage. Changes in the interest credited to Your Policy or changes in the Policy Charges, Per Unit Charge, or monthly cost of insurance would also affect Your coverage.

THE TAX STATUS OF THIS POLICY MAY CHANGE. WE URGE YOU TO CONSULT YOUR PERSONAL TAX ADVISOR EACH YEAR REGARDING MATTERS OF POSSIBLE TAXATION.

MONTHLY DEDUCTION AND RIDER INFORMATION

TYPE OF COVERAGE	SPECIFIED AMOUNT OR BENEFIT AMOUNT	PAYABLE TO	MONTHLY DEDUCTION
BASIC POLICY	[\$25,000]	WHILE THE POLICY REMAINS IN FORCE	[\$16.51]

The charges in the Monthly Deduction column shown above are only applicable for the first Monthly Deduction taken on the Policy Date. For Monthly Deductions taken after the Policy Date, please refer to the Policy and Rider forms.

**SURRENDER CHARGES PER \$1,000  
OF INITIAL SPECIFIED AMOUNT**

<u>End of Policy Year</u> AT ISSUE	<u>Surrender Charge</u>	<u>End of Policy Year</u>	<u>Surrender Charge</u>
1	\$[22.80]	6	\$[14.36]
2	[21.20]	7	[10.94]
3	[21.20]	8	[7.52]
4	[19.84]	9	[3.42]
5	[18.70]	10+	[0.00]
	[17.78]		

**TABLE OF MINIMUM MONTHLY NO LAPSE PREMIUMS**

<u>Policy Year</u>	<u>Minimum Monthly No Lapse Premiums</u>	<u>End of Year Sum of all Minimum Monthly No Lapse Premiums</u>
1	\$[16.90]	\$[202.80]
2	[16.90]	[405.60]
3	[16.90]	[608.40]
4	[16.90]	[811.20]
5	[16.90]	[1,014.00]
6	[16.90]	[1,216.80]
7	[16.90]	[1,419.60]
8	[16.90]	[1,622.40]
9	[16.90]	[1,825.20]
10	[16.90]	[2,028.00]
11	[16.90]	[2,230.80]
12	[16.90]	[2,433.60]
13	[16.90]	[2,636.40]
14	[16.90]	[2,839.20]
15	[16.90]	[3,042.00]
16	[16.90]	[3,244.80]
17	[16.90]	[3,447.60]
18	[16.90]	[3,650.40]
19	[16.90]	[3,853.20]
20	[16.90]	[4,056.00]

INDEX ACCOUNTS\*

<u>Name of Index Account</u>	<u>Index Segment Period</u>	<u>Index</u>
Global Index Account	12 months	Standard & Poor's 500® Composite Stock Price Index Dow Jones Euro Stoxx 50 Price Index Hang Seng Index

\* The Company may make additional Index Accounts available.

## DEATH BENEFIT RATIOS

For the Guideline Premium Test, the Death Benefit Ratios are as follows:

<u>Age</u>	<u>Death Benefit Ratio</u>	<u>Age</u>	<u>Death Benefit Ratio</u>
0-40	2.50	61	1.28
41	2.43	62	1.26
42	2.36	63	1.24
43	2.29	64	1.22
44	2.22	65	1.20
45	2.15	66	1.19
46	2.09	67	1.18
47	2.03	68	1.17
48	1.97	69	1.16
49	1.91	70	1.15
50	1.85	71	1.13
51	1.78	72	1.11
52	1.71	73	1.09
53	1.64	74	1.07
54	1.57	75-90	1.05
55	1.50	91	1.04
56	1.46	92	1.03
57	1.42	93	1.02
58	1.38	94	1.01
59	1.34	95-99	1.00
60	1.30	100+	1.01

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## GENERAL PROVISIONS

**THE CONTRACT** - This Policy is issued in consideration of the application and the payment of the Initial Premium shown in the Policy Specifications Pages.

This Policy, any endorsement(s) or rider(s), and the copy of the application (including any amendments and questionnaires) attached to it contain the entire contract between You and us. Any statements made in the application (or any amendments and questionnaires) either by You or by the Insured will, in the absence of fraud, be considered representations and not warranties. Also, any written statement made either by You or by the Insured will not be used to void Your Policy nor to defend against a claim under Your Policy unless the statement is contained in the application, in an application for Reinstatement or for an increase in the Specified Amount, or in any amendments or questionnaires attached to Your Policy.

No change or waiver of any of the provisions of this Policy will be valid unless made in writing by us and signed by an officer of the Company. No agent or other person has the authority to change or waive any provision of this Policy.

Any extra benefit rider attached to this Policy will become a part of this Policy and will be subject to all the terms and conditions of this Policy unless we state otherwise in the rider.

**SUICIDE** - If the Insured, whether sane or insane, dies by suicide within two (2) years from the Policy Date, our liability will be limited to an amount equal to the premiums paid for this Policy, less any Indebtedness and any partial withdrawals from this Policy.

If the Insured, whether sane or insane, dies by suicide within two (2) years from the effective date of any increase in the Specified Amount, our liability for the amount of increase will be limited to the Monthly Deductions for the increase.

**INCONTESTABILITY** - We cannot contest this Policy, except for fraud or non-payment of premium, after it has been In Force during the lifetime of the Insured for two (2) years after the later of (1) the Policy Date and (2) the date of any Reinstatement. We may also contest this Policy for two (2) years following the effective date of any increase in the Specified Amount, but only for the amount of the increase.

**ASSIGNMENT** - You may assign this Policy. The assignment must be in writing and filed at our Administrative Office. We assume no responsibility for the validity or effect of any assignment of this Policy or of any interest in it. Any proceeds which become payable to an assignee will be payable in a single sum and will be subject to proof of the assignee's interest and the extent of the assignment.

**MISSTATEMENT OF AGE OR SEX** - If the Age and/or sex of the Insured has been misstated, the Death Benefit will be adjusted to that which would have been purchased by the most recent Monthly Deduction at the correct Age and/or sex.

**BENEFICIARY** - When the Net Death Benefit is payable, we will pay it to the Beneficiary(ies) named by You in accordance with this Policy. If a primary or contingent Beneficiary dies before the Insured, that Beneficiary's interest in this Policy ends with that Beneficiary's death. Only those Beneficiaries who survive the Insured will be eligible to share in the Net Death Benefit. If no Beneficiary survives the Insured, we will pay the Net Death Benefit of this Policy to You, if living, otherwise to Your estate as Beneficiary.

**CHANGE OF OWNER OR BENEFICIARY** - You may change the Owner or a Beneficiary by filing a request with us. If You have designated a Beneficiary irrevocably, the consent of the irrevocable Beneficiary will be required to change Your designation. A request will not be effective until we record it at our Administrative Office. After it has been so recorded, it will take effect as of the date You signed the request. However, if the Insured dies before the request has been so recorded, the request will not be effective as to those proceeds we have paid before Your request was recorded.

**NON-PARTICIPATING** - This Policy will not share in our surplus.

**ILLUSTRATIONS** - Upon request at any time, we will send You an illustration of Your Policy's benefits and values. There will be no charge for the first such illustration in a Policy Year. We reserve the right to charge a fee of \$25.00 or less for any illustration after the first in a Policy Year.

**PREMIUMS** - The Initial Premium is shown in the Policy Specifications Pages and is due on the Policy Date. All premiums are payable to us in advance and must be mailed to our Administrative Office or to an agent authorized by us to collect premiums. A premium receipt signed by a Company officer will be provided upon request.

**PLANNED PREMIUM** - The amount and frequency of the Planned Premiums are shown in the Policy Specifications Pages. However, premium payments are flexible and You may change the amount and frequency of payments. Some changes, including interruption of Planned Premium payments or reduction in the amount of Planned Premium payments, may cause Your Policy to enter the Grace Period and subsequently Lapse.

**UNSCHEDULED PREMIUMS** - Additional premiums may be paid at any time, provided that this Policy is In Force. We reserve the right to limit the amount of premiums that may be paid on this Policy if we determine that:

1. Such amount may exceed the amount allowable if this Policy is to continue to qualify as a life insurance contract under section 7702 of the Internal Revenue Code; or
2. Payment of a greater amount would increase the Death Benefit by more than the amount of the premium being paid (unless we are provided evidence of insurability satisfactory to us); or
3. The premium paid in any twelve-month (12) period exceeds the annual Planned Premium plus \$25,000.00.

The minimum amount of any premium that will be accepted is \$25.00.

**NET PREMIUMS** - A Net Premium is any premium received minus the Premium Expense Charge. The initial Premium Expense Charge applicable to this Policy is shown in the Policy Specifications Pages. We may increase or decrease the Premium Expense Charge, but we will never charge more than the Guaranteed Maximum Premium Expense Charge. Any change in the Premium Expense Charge will be applied uniformly to all members of the same Rate Class.

**ALLOCATION OF PREMIUM PAYMENT** - A Net Premium will be allocated to the Basic Interest Account and/or the Index Account(s) on the day the premium is received at our Administrative Office. We will allocate Net Premiums to the Account Options specified by You. Allocations of Net Premium must total 100% and no fractional percentages will be permitted. Prior to the end of any Policy Month, You may elect to change the allocation of Net Premiums for the following Policy Months. Your request for change must be received in our Administrative Office prior to the first day of the Policy Month for which the change is to become effective. Changes may not be made more than once per Policy Month.

Net Premium allocations are only applied to Account Option Segments on Monthly Dates. Allocations of Net Premiums received on other dates will be credited with interest at the applicable rates until that time. For the Basic Interest Account, the applicable rate is the Current Interest Rate. For the Index Accounts, it is the Index Account Guaranteed Minimum Interest Rate.

**TERMINATION** - Upon termination of this Policy according to its terms, all benefits under it will cease. This Policy will terminate on the earliest of the following:

1. The date of the Insured's death, subject to any right to receive payment of any Net Death Benefit;
2. The date this Policy Lapses; or
3. The date this Policy is surrendered, subject to any right to receive payment of any Policy proceeds.

**NOTICES** - All notices, selections, requests, and elections for the exercise of any right under this Policy must be in a form satisfactory to us. We may require any such notice, selection, request, or election to be in writing and signed by You.

**GRACE PERIOD** - Failure to pay sufficient premiums may cause this Policy to Lapse. If at any time you have not paid sufficient premiums, this Policy will enter a sixty-one (61) day Grace Period. We will send a notice to Your address as shown on our records at least thirty (30) days prior to the end of the Grace Period. If sufficient premiums are not paid by the end of the Grace Period, this Policy will Lapse. If the Insured dies during the Grace

Period, we will pay the Net Death Benefit.

**NO-LAPSE GUARANTEE** - This Policy will enter the Grace Period if the Cash Surrender Value on any Monthly Date is not sufficient to pay the Monthly Deduction then due. However, prior to the No Lapse Ending Date shown in the Policy Specifications Pages, this Policy will not enter the Grace Period if the sum of the premiums that have been paid, less any Indebtedness and partial withdrawals, is greater than or equal to the sum of all Minimum Monthly No Lapse Premiums due on or before that Monthly Date.

**NEGATIVE POLICY VALUES** - As a result of Monthly Deductions, the Policy Value may become negative during a Grace Period or prior to the No Lapse Ending Date. If the Insured dies during the Grace Period while the Policy Value is negative, we will subtract from the Net Death Benefit the amount necessary to make the Policy Value zero (0). No interest will be credited while the Policy Value is negative. Any negative values must be repaid by the Owner on the No Lapse Ending Date or this Policy will enter the Grace Period and may Lapse.

**CHANGES TO THE MINIMUM MONTHLY NO LAPSE PREMIUM** - The Minimum Monthly No Lapse Premiums in effect on the Policy Date are shown in the Policy Specifications Pages. The Minimum Monthly No Lapse Premium will increase for each Policy Month following the date of an increase in the Specified Amount, or when an extra benefit rider is added or increased. It will decrease for each Policy Month following the date of a decrease in the Specified Amount or when an extra benefit rider is decreased or discontinued. We will notify You of the new Minimum Monthly No Lapse Premium. The No Lapse Ending Date will not be extended for any change to this Policy.

**REINSTATEMENT** - If this Policy Lapses, You may Reinstate it during the lifetime of the Insured. Any Reinstatement must be made within five (5) years from the Lapse date. We will require:

1. Your request to Reinstate this Policy,
2. The Insured's consent to Reinstatement,
3. Evidence of insurability satisfactory to us, and
4. Payment of the following:
  - (a) Prior to the No Lapse Ending Date, the lesser of: (i) the total Minimum Monthly No Lapse Premium from issue through the Policy Month of Lapse; plus two (2) Policy Months of Minimum Monthly No Lapse Premium; minus any premiums already paid net of any partial withdrawals and Indebtedness; or (ii) an amount sufficient to provide a Net Premium equal to one (1) Monthly Deduction due at the time of termination; plus two (2) Monthly Deductions due in advance at the time of Reinstatement; plus an amount sufficient to increase the Policy Value above the surrender charge.
  - (b) After the No Lapse Ending Date: an amount sufficient to provide a Net Premium equal to one (1) Monthly Deduction due at the time of termination; plus two (2) Monthly Deductions due in advance at the time of Reinstatement; plus an amount sufficient to increase the Policy Value above the surrender charge.

The date of Reinstatement will be the Monthly Date on or following the date the application for Reinstatement is approved by us, so long as the Insured is still living. If all the conditions for Reinstatement are satisfied, this Policy will be placed In Force again on the following basis:

1. Any unloaned Policy Value on the date of Lapse will be Reinstated.
2. The surrender charge applicable at Reinstatement will be equal to what it was at Lapse, and the surrender charge period will be extended by the length of time between Lapse and Reinstatement.
3. The cost of insurance rates will be based on the Age at Reinstatement.
4. Any Indebtedness as of the date of termination will not be Reinstated.
5. Amounts paid at the time of Reinstatement will be applied as new premiums in accordance with Your most recent premium allocation instructions.
6. The No Lapse Ending Date will be extended by the length of time between Lapse and Reinstatement.
7. Riders may be Reinstated subject to underwriting.

**PARTIAL WITHDRAWALS** - Cash withdrawals may be made from this Policy during the lifetime of the Insured. We must receive a withdrawal request at our Administrative Office. The Policy Value will be reduced by the

withdrawal amount and a \$25.00 fee will also be deducted. The minimum withdrawal amount is \$500.00. There is no surrender charge for a partial withdrawal. If a requested withdrawal would result in the reduction of the Cash Surrender Value to less than \$500.00, the requested transaction will be considered a surrender and the Cash Surrender Value provision will apply.

You may specify in Your request the Account Options from which the withdrawal should be made. If no Account Option is specified, the withdrawal amount and the fee will be withdrawn on a pro-rata basis according to the portion of the unloaned Policy Value in each Account Option. Under each Account Option, the withdrawal amount and fee will be withdrawn from the highest numbered Segment first, and then from the next highest numbered Segment(s).

If the Death Benefit Option as shown in the Policy Specifications Pages is Level, then the Specified Amount will be reduced by the amount of the withdrawal requested. However, no withdrawal will be allowed if the resulting Specified Amount would be less than the Minimum Specified Amount as shown in the Policy Specifications Pages.

Reductions in the Specified Amount due to any partial withdrawals will be in following order:

1. To the most recent increase in the Specified Amount.
2. To the next most recent increase and each preceding increase in the Specified Amount.
3. To the Initial Specified Amount or the current Specified Amount, if less.

We reserve the right to defer a withdrawal for the period allowed by law, but not more than six (6) months.

**ANNUAL REPORT** - This is a statement of the Policy's activities during the Policy Year. We will send You a report at least once a year, or as requested.

#### **DEATH BENEFIT**

**NET DEATH BENEFIT** - We will pay the Net Death Benefit, subject to the terms of this Policy, when the Insured dies while this Policy is In Force. We determine the amount of the Net Death Benefit as of the date of the Insured's death. The Net Death Benefit equals the Death Benefit less any Indebtedness. If the Insured dies during the Grace Period while the Policy Value is negative, we will subtract from the Net Death Benefit the amount necessary to make the Policy Value zero (0). We will pay the Net Death Benefit promptly after we receive due proof at our Administrative Office of the Insured's death. See the Payment of Proceeds provision for payment options.

**DEATH BENEFIT OPTIONS** - The amount of the Death Benefit is determined by which Death Benefit Option is in effect. The Policy Specifications Pages show which Death Benefit Option (Level or Increasing) is in effect as of the Policy Date.

The Level Death Benefit is the greatest of:

1. The Specified Amount; or
2. The Death Benefit determined by the method described below that corresponds to the Life Insurance Compliance Test shown in the Policy Specifications Pages:
  - (a) Guideline Premium Test: The appropriate Death Benefit Ratio, as shown in the Policy Specifications Pages, multiplied by the Policy Value; or
  - (b) Cash Value Accumulation Test: The appropriate Death Benefit Ratio, as shown in the Policy Specifications Pages, multiplied by the difference between the Policy Value and any applicable Net Single Premiums for Riders (which are Qualified Additional Benefits), as shown in the Policy Specifications Pages; or
3. The minimum amount required for this Policy to qualify as a life insurance contract under Section 7702 of the Internal Revenue Code.

The Increasing Death Benefit is the greatest of:

1. The Specified Amount plus the Policy Value; or

2. The Death Benefit determined by the method described below that corresponds to the Life Insurance Compliance Test shown in the Policy Specifications Pages:
  - (a) Guideline Premium Test: The appropriate Death Benefit Ratio, as shown in the Policy Specifications Pages, multiplied by the Policy Value; or
  - (b) Cash Value Accumulation Test: The appropriate Death Benefit Ratio, as shown in the Policy Specifications Pages, multiplied by the difference between the Policy Value and any applicable Net Single Premiums for Riders (which are Qualified Additional Benefits), as shown in the Policy Specifications Pages; or
3. The minimum amount required for this Policy to qualify as a life insurance contract under Section 7702 of the Internal Revenue Code.

**CHANGE OF DEATH BENEFIT OPTION** - After the third Policy Anniversary and before the Insured's Age 95, You may request a change of the Death Benefit Option. You may change the Death Benefit Option no more than once during a twelve-month (12) period. The change will go into effect on the Monthly Date on or following the date we approve the request. If You change from LEVEL to INCREASING, the Specified Amount will be decreased by the Policy Value as of the date of the change. However, no change will be allowed if the resulting Specified Amount would be less than the Minimum Specified Amount shown in the Policy Specifications Pages. If You change from INCREASING to LEVEL, the Specified Amount will be increased by the amount of the Policy Value as of the date of the change.

**SPECIFIED AMOUNT** - The Initial Specified Amount for this Policy is shown in the Policy Specifications Pages. You may increase or decrease the Specified Amount as set forth below by sending a request to our Administrative Office. However, You may change the Specified Amount only once during a twelve-month (12) period. Any change in the Specified Amount will take effect on the first Monthly Date following our approval of Your request. If You request a change in the Specified Amount and if the change is approved by us, we will notify You when the change has been made.

**INCREASE IN THE SPECIFIED AMOUNT** - You may request an increase of the Specified Amount after the first Policy Anniversary and prior to the Insured's Age 86. A new application will be required. The minimum increase is \$10,000.00. Any increase will be subject to our underwriting requirements as well as to this Policy's provisions regarding suicide and incontestability.

**DECREASE IN THE SPECIFIED AMOUNT** - You may request a decrease of the Specified Amount after the third Policy Anniversary. The decrease will be applied against the most recent increase in Specified Amount. It will then be applied to other increases in the reverse order in which they occurred. No decrease of the Specified Amount below the Minimum Specified Amount will be allowed. We may limit decreases to no more than 20% of the Specified Amount prior to the decrease.

**INTEREST FROM DATE OF DEATH** - If the proceeds under this Policy are not paid within 30 days after we receive proof of the death of the Insured, we will pay interest on the proceeds from the date we receive proof of death to the date of payment. Interest will be paid at a rate of 8% per annum on the proceeds.

## **POLICY VALUES**

**POLICY VALUE** - The Policy Value is the sum of the Basic Interest Account value and the Index Account value(s), plus the amount of the Loan Reserve, if any. On the Policy Date, each Account Option's value is equal to the portion of the Net Premium allocated to that Account Option minus the portion of the first Monthly Deduction removed from that Account Option. Thereafter, each Account Option's value will be determined as follows:

The **Basic Interest Account's** value is equal to the sum of the values of the Basic Interest Account Segments, plus any amounts pending application to one of those Segments.

Net Premiums and loan repayments allocated to the Basic Interest Account after a Monthly Date are credited with interest at the applicable Current Interest Rate until the next Monthly Date. At that time, they are placed in a Basic Interest Account Segment corresponding to that Monthly Date, along with any Transfers made to the Basic Interest Account. Each Basic Interest Account Segment may have a different Current Interest Rate and will have its interest calculated separately from other Basic Interest Account Segments. The Current Interest Rate is

declared by the Company at its discretion and is not based on any Index. The Current Interest Rate will never be less than the Basic Interest Account Guaranteed Minimum Interest Rate shown in the Policy Specifications Pages.

We calculate the value of each Basic Interest Account Segment as follows as of each Monthly Date:

1. The value, if any, of the Segment as of the preceding Monthly Date; plus
2. Any portion of a Net Premium or loan repayment that was received since the preceding Monthly Date and is being applied to the Segment as of the current Monthly Date, together with any interest earned thereon; plus
3. Any Transfers being made to that Basic Interest Account Segment as of the current Monthly Date; plus
4. Interest earned on the Segment since the preceding Monthly Date at the Current Interest Rate; minus
5. Any Transfers from the Segment occurring as of the current Monthly Date; minus
6. Any portion(s) of partial withdrawals or loans taken from the Segment since the preceding Monthly Date; minus
7. The portion of any Monthly Deduction taken from the Segment for the current Monthly Date.

An Index Account's value is equal to the sum of the values of the Index Account's Segments plus any amounts pending application to one of those Segments.

Net Premiums and loan repayments allocated to an Index Account after a Monthly Date are credited with interest at the Index Account Guaranteed Minimum Interest Rate shown in the Policy Specifications Pages until the next Monthly Date. At that time, they are placed in an Index Account Segment corresponding to that Monthly Date, along with any Transfers made to that Index Account.

We calculate the value of each Index Account Segment as follows as of each Monthly Date:

1. The value, if any, of the Segment as of the preceding Monthly Date; plus
2. Any portion of a Net Premium or loan repayment that was received since the preceding Monthly Date and is being applied to the Segment as of the current Monthly Date, together with any interest earned thereon; plus
3. Any Transfers being made to that Index Account Segment as of the current Monthly Date; plus
4. Interest earned on the Segment since the preceding Monthly Date at the Index Account Guaranteed Minimum Interest Rate; plus
5. Excess Index Interest, if any, credited to the Segment as of the Monthly Date if it is the Segment's Ending Date; minus
6. Any Transfers from the Segment occurring as of the current Monthly Date; minus
7. Any portion(s) of partial withdrawals or loans taken from the Segment since the preceding Monthly Date; minus
8. The portion of any Monthly Deduction taken from the Segment for the current Monthly Date.

**ADDITIONAL INDEX ACCOUNTS** - The Index Accounts available as of the Policy Date are shown in the Policy Specifications Pages. We may make additional Index Accounts available to You under this Policy and will notify you if that occurs.

**MONTHLY DEDUCTION** - As of the Policy Date and each Monthly Date thereafter, a Monthly Deduction will be deducted from the Policy Value. The Monthly Deduction will be taken on a pro-rata basis from the Basic Interest Account and the Index Account(s). Within each Account Option, the pro-rata portion of the Monthly Deduction will be deducted from the highest numbered Segment first, and then from the next highest numbered Segment(s) to the extent of their respective values. Each Monthly Deduction consists of:

1. The Monthly Cost of Insurance; plus
2. The Policy Charge; plus
3. Any charge for additional benefits provided by any riders (as shown in the Policy Specifications Pages); plus
4. Any charges for a substandard Rate Class rating; plus
5. The number of this Policy's Units multiplied by the applicable Per Unit Charge.

**MONTHLY COST OF INSURANCE** - The Monthly Cost of Insurance as of each Monthly Date is determined as follows:

1. Determine the Amount at Risk by subtracting the Policy Value from the Death Benefit.
2. Divide the Amount at Risk by 1,000.
3. Multiply the result by the appropriate monthly cost of insurance rate to arrive at the Monthly Cost of Insurance.

In determining the Amount at Risk and the appropriate monthly cost of insurance rates, we first apply the Policy Value to the Initial Specified Amount. If the Policy Value exceeds the Initial Specified Amount, we will then apply the remaining Policy Value to any increases in the Specified Amount in the order of their occurrence. Any remaining Policy Value will then be applied to any additional Death Benefit caused by the application of the Death Benefit Ratio.

**MONTHLY COST OF INSURANCE RATES** - To determine the monthly cost of insurance rates, we will refer to our current monthly cost of insurance rate tables in effect for this Policy using the Insured's Age, sex, any rating, and Rate Class (as shown in the Policy Specifications Pages) and the duration from the Policy Date or from the date of any increase in Specified Amount. Different monthly cost of insurance rates may apply to increases in the Specified Amount following the Policy Date and any additional Death Benefit caused by the application of the Death Benefit Ratio. Monthly cost of insurance rates may be changed by us from time to time. A change in the monthly cost of insurance rates will apply to all persons of the same Age, sex, any rating, and Rate Class and whose policies or increases in the Specified Amount have been in effect for the same length of time. The rates will not exceed those shown in the Table of Guaranteed Maximum Monthly Cost of Insurance Rates using the Insured's Age, sex and Rate Class, adjusted for any rating.

**POLICY CHARGE** - The initial Policy Charge applicable to this Policy is shown in the Policy Specifications Pages. We may increase or decrease the Policy Charge, but we will never charge in excess of the Guaranteed Maximum Policy Charge. Any change in the Policy Charge will be applied uniformly to all members of the same Rate Class.

**PER UNIT CHARGE** - The initial Per Unit Charge applicable to this Policy is shown in the Policy Specifications Pages. We may increase or decrease the Per Unit Charge, but we will never charge in excess of the Guaranteed Maximum Per Unit Charge. Any change in the Per Unit Charge will be applied uniformly to all members of the same Rate Class. Different Per Unit Charges may apply to increases in the Specified Amount.

**CHANGES IN RATES OR CHARGES** - The Company has the right to change the Policy Charge, the Premium Expense Charge, the Per Unit Charge, and the Monthly Cost of Insurance Rates. The Company may not charge more than the guaranteed maximum charges or rates. Any changes to the Policy Charge, the Premium Expense Charge, the Per Unit Charge, or the Monthly Cost of Insurance Rates will be based on our expectations as to future cost factors. Such cost factors may include, but are not limited to, mortality, interest, persistency, expenses, reinsurance costs, and state and federal taxes. We will not change these charges or rates to recoup any prior losses.

**INTEREST CREDITED TO THE BASIC INTEREST ACCOUNT** - Each Basic Interest Account Segment will accumulate interest from its Beginning Date to its Ending Date at the Current Interest Rate in effect on the date the Segment is created or renewed. Interest is credited using the effective annual interest rate method. The Company sets Current Interest Rates from time to time at its discretion and different rates may apply to different Segments. The Current Interest Rate will never be less than the Basic Interest Account Guaranteed Minimum Interest Rate shown in the Policy Specifications Pages. You will only be informed in writing of Your Current Interest Rates when You receive the Annual Report. At any other time, You may contact our Administrative Office to obtain information on the Current Interest Rates in effect for this Policy.

**INTEREST CREDITED TO THE INDEX ACCOUNTS** - Each Index Account Segment will accumulate interest from its Beginning Date to its Ending Date at the Index Account Guaranteed Minimum Interest Rate shown in the Policy Specifications Pages. Interest is credited using the effective annual interest rate method. A Segment may also be credited with Excess Index Interest as of its Ending Date. For the purpose of calculating a Death Benefit, surrender, loan, or partial withdrawal as of a date before the Segment's Ending Date, the Segment's value will only include interest at the Index Account Guaranteed Minimum Interest Rate.

Excess Index Interest for an Index Account Segment as of its Ending Date is calculated as follows:

(a multiplied by b) minus c where:

a is: the Index Change

b is: the Segment's adjusted beginning value

c is: any interest previously credited to the Segment during the Segment Period at the Index Account Guaranteed Minimum Interest Rate.

The Segment's adjusted beginning value is determined as of the Segment's Beginning Date. We start with any value renewing from a prior Segment Period, after we have applied any Excess Index Interest for that period and deducted any Transfers from the Segment occurring at that time. Then we add any Net Premiums, loan repayments and Transfers applied to the Segment on its Beginning Date. Finally, we subtract the following activity occurring in the Segment during the Segment Period:

1. Any amounts deducted on account of partial withdrawals;
2. Any amounts transferred on account of Policy loans; and
3. One half of the amounts taken for Monthly Deductions.

The Excess Index Interest credited to an Index Account Segment will never be less than zero (0).

**GLOBAL INDEX ACCOUNT** - The Index Change for a Segment of the Global Index Account is calculated using the changes in the Index Values of Standard & Poor's 500® Composite Stock Price Index ("S&P 500"), Dow Jones Euro Stoxx 50® Price Index ("ES 50") and Hang Seng Index, excluding dividends.

For each Segment, we determine the Index Values for each of these Indexes as of the Beginning and Ending Dates. If the S&P 500 is published for the applicable date, we use the value for that date. Otherwise, we use the next published value. For each of the ES 50 and the Hang Seng Index, we use the value that is published on the next day after the applicable date on which both that Index and the S&P 500 are published.

The values we use are based on the following currencies:

S&P 500: United States Dollars

ES 50: Euros

Hang Seng Index: Hong Kong Dollars

The Index Change is calculated as follows:

$$\text{Segment Index Change} = 50\% \text{ of A} + 30\% \text{ of B} + 20\% \text{ of C}$$

Where: A = The percentage change in value of the S&P 500 or ES 50, whichever is more favorable to You

B = The percentage change in value of the S&P 500 or ES 50, whichever is less favorable to You

C = The percentage change in value of the Hang Seng Index

The A, B and C components may be positive or negative, but the Index Change for a Global Index Account Segment is adjusted so that it will neither exceed the Cap nor be less than 0%.

**CAP** - A Cap will be declared for each Index Account Segment on or before its Beginning Date and each renewal thereof. The Cap will never be less than the Basic Interest Account Current Interest Rate as of the Beginning Date and as of each renewal. The Cap may change upon the renewal of a Segment and may differ between Index Account Segments. Once a Cap is declared for an Index Account Segment, it applies until its next Ending Date. The Company sets each Cap at its discretion and You will only be informed in writing of Your current Caps when You receive the Annual Report. At any other time, You may contact our Administrative Office to obtain information on the Caps in effect for this Policy.

**TRANSFERS** -You may transfer amounts between Account Options. There is no charge to process Transfers. A Transfer from the Basic Interest Account is only allowed as of a Monthly Date. For Transfers from the Basic Interest Account, the amount will be transferred from the highest numbered Segment first, and then from the next highest numbered Segment(s), to the extent of their respective values. A Transfer from an Index Account Segment is only allowed as of the transferring Segment's Ending Date. You may not request more than one (1) Transfer from the same Account Option in a Policy Month. A Transfer will be made to an Account Option's Segment that begins as of the next Monthly Date following receipt of Your request in our Administrative Office. Transfers may not be made between Segments of the same Account Option.

### **POLICY LOANS**

**POLICY LOANS** - After the first Policy Year and while this Policy is In Force, You may borrow against this Policy an amount which is not greater than 90% of the Cash Surrender Value minus loan interest that will accrue prior to the next Policy Anniversary. This Policy will be the sole security for the loan. We may require a minimum loan amount of \$500.00. The loan date will be the date we process the loan request.

A Policy that becomes overloaned will enter the Grace Period and may Lapse. Your Policy will become overloaned when the Indebtedness equals or exceeds the Policy Value minus the surrender charge.

When a loan is made, an amount equal to the loan will be transferred from the Account Options to a Loan Reserve. We will credit the amount in the Loan Reserve with interest at an effective annual interest rate shown in the Policy Specifications Pages. You may specify the Account Option(s) from which the amount of the loan will be transferred. If the values of the specified Account Option(s) are insufficient or no Account Option is specified, the amount of the loan will be transferred on a pro-rata basis according to the unloaned Policy Value in each remaining Account Option. Under each Account Option, the amount will be transferred from the highest numbered Segment first, and then from the next highest numbered Segment(s), to the extent of their respective values.

**REPAYMENT OF LOANS** - While this Policy is In Force, any loan may be repaid. You may specify the Account Option(s) to which the loan repayment will be applied. If no Account Option is specified, the loan repayment will be applied on a pro-rata basis according to the current premium allocation instructions. You must clearly identify the payment as a loan repayment or it will be treated as a premium.

**INTEREST ON LOANS** - On each Policy Anniversary, we charge interest on each Policy loan. Interest not paid when due will be treated as a new loan and we will charge interest on it up to the maximum Policy loan interest rate. Loan interest rates are stated on an annual basis. The loan interest rates we charge as of the Policy Date are shown in the Policy Specifications Pages. The interest rate is guaranteed not to exceed the maximum standard loan interest rate. From time to time, we may declare various lower Policy loan interest rates. We may also apply different loan interest rates to different parts of the loan.

After the tenth Policy Year, we will from time to time declare an interest rate that we will charge on preferred loans. This rate will not exceed the maximum preferred loan interest rate shown in the Policy Specifications Pages. We will determine the amount eligible for a preferred loan by subtracting the total premiums paid (less withdrawals) from the unloaned Policy Value.

### **NONFORFEITURE OPTIONS**

**CASH SURRENDER VALUE** - You may surrender this Policy for its Cash Surrender Value which may be paid in a lump sum or under a Settlement Option. The Cash Surrender Value is determined as follows:

1. The Policy Value; minus
2. The surrender charge, if any; minus
3. Any Indebtedness.

If You surrender this Policy within thirty (30) days after a Policy Anniversary, the Cash Surrender Value will not be less than the Cash Surrender Value on that Policy Anniversary less any Indebtedness or partial withdrawals occurring on or after that Policy Anniversary. A surrender that occurs between a Segment's Beginning and Ending Dates will not be eligible for any portion of the Excess Index Interest that might otherwise have been payable on the Ending Date had the surrender not occurred.

We may require that this Policy be sent in with Your request. We may defer payment of the Cash Surrender Value for not more than six (6) months.

When You surrender this Policy for its Cash Surrender Value, this Policy will terminate.

**SURRENDER CHARGE** - The Surrender Charges Per \$1,000.00 of Initial Specified Amount are shown in the Policy Specifications Pages.

If an increase in the Specified Amount is requested and approved, additional surrender charges will apply to this Policy. These additional surrender charges are shown in the Surrender Charge Per \$1,000.00 of Increase in Specified Amount tables. They are listed by the Insured's Age and sex at the time of the increase and by duration from the time of the increase.

**REDUCED PAID-UP INSURANCE** - If You elect in writing, we will use the Cash Surrender Value to provide nonparticipating paid-up endowment at Age 120 insurance, payable under the same conditions as this Policy. We will determine the amount of the Reduced Paid-Up Insurance using the net single premium rate for the Insured's Age for an amount equal to or less than the then current Specified Amount of this Policy.

If there is any excess Cash Surrender Value remaining after the paid-up endowment insurance becomes effective, such excess will be returned to You.

If the paid-up endowment insurance is surrendered for its Cash Surrender Value within thirty (30) days after an anniversary of the paid-up endowment insurance, its Cash Surrender Value will be equal to the Cash Surrender Value on that anniversary. Its Cash Surrender Value will be determined by multiplying the Endowment at Age 120 net single premium at the Insured's then attained Age by the amount of Reduced Paid-Up Insurance.

**BASIS USED FOR CALCULATION** - Reserves for this Policy are not less than the required minimum reserves and shall never be less than the Cash Surrender Value.

All of the values of this Policy are equal to or greater than the minimums set by the laws of the state where the Policy is delivered. If required, we have filed a statement about this with Your state insurance department.

**MALE AND FEMALE JUVENILE  
GUARANTEED MAXIMUM MONTHLY COST OF INSURANCE RATES**

See the Monthly Cost of Insurance Rates provision.

<u>AGE</u>	<u>MALE MONTHLY COST OF INSURANCE PER \$1,000</u>	<u>FEMALE MONTHLY COST OF INSURANCE PER \$1,000</u>	<u>AGE</u>	<u>MALE MONTHLY COST OF INSURANCE PER \$1,000</u>	<u>FEMALE MONTHLY COST OF INSURANCE PER \$1,000</u>
0	\$0.06000	\$0.03500	61	\$0.96583	\$0.75250
1	0.03833	0.02583	62	1.08166	0.81333
2	0.02750	0.01916	63	1.20583	0.87916
3	0.02000	0.01666	64	1.33666	0.95000
4	0.01750	0.01583	65	1.47083	1.02750
5	0.01750	0.01500	66	1.60583	1.11250
6	0.01833	0.01583	67	1.74666	1.20666
7	0.01833	0.01750	68	1.89500	1.30916
8	0.01833	0.01750	69	2.05750	1.42333
9	0.01916	0.01750	70	2.24500	1.55250
10	0.02000	0.01833	71	2.47583	1.69833
11	0.02333	0.02083	72	2.74500	1.85750
12	0.02833	0.02250	73	3.02666	2.03250
13	0.03333	0.02583	74	3.33000	2.22333
14	0.04333	0.02833	75	3.66250	2.43333
15	0.05500	0.03000	76	4.03666	2.66250
16	0.06500	0.03250	77	4.47250	2.91416
17	0.07416	0.03416	78	4.97666	3.19000
18	0.07916	0.03666	79	5.54000	3.49333
19	0.08166	0.03833	80	6.16833	3.86916
20	0.08333	0.03916	81	6.85000	4.33000
21	0.08416	0.04083	82	7.56833	4.81666
22	0.08500	0.04166	83	8.35166	5.32833
23	0.08666	0.04250	84	9.22416	5.89500
24	0.08833	0.04416	85	10.19666	6.46583
25	0.09083	0.04583	86	11.26416	7.14000
26	0.09500	0.04833	87	12.41583	7.97416
27	0.09750	0.05083	88	13.63833	8.85416
28	0.09666	0.05333	89	14.91916	9.72333
29	0.09583	0.05583	90	16.19000	10.35166
30	0.09500	0.05833	91	17.43916	10.96083
31	0.09416	0.06250	92	18.74500	11.97666
32	0.09500	0.06583	93	20.12166	13.35083
33	0.09666	0.07083	94	21.57166	15.07500
34	0.09916	0.07666	95	23.01000	16.95666
35	0.10333	0.08333	96	24.41250	18.80750
36	0.10916	0.08916	97	25.90500	20.00583
37	0.11583	0.09500	98	27.49583	20.64916
38	0.12416	0.10000	99	29.19333	21.99833
39	0.13250	0.10500	100	30.81333	23.75166
40	0.14333	0.11166	101	32.24666	25.65750
41	0.15583	0.11916	102	33.77083	27.75500
42	0.17083	0.12750	103	35.39166	30.05916
43	0.18916	0.13750	104	37.11250	32.57166
44	0.21000	0.14916	105	38.94083	35.22666
45	0.23083	0.16333	106	40.88083	37.94416
46	0.25250	0.18000	107	42.94000	40.70666
47	0.27083	0.19833	108	45.12416	43.51666
48	0.28500	0.22000	109	47.43916	46.42000
49	0.30333	0.24416	110	49.89166	49.33000
50	0.32583	0.27000	111	52.49000	52.13500
51	0.35500	0.30000	112	55.23916	54.81416
52	0.39166	0.33250	113	58.14833	57.56583
53	0.43416	0.36750	114	61.22333	61.00500
54	0.48583	0.40500	115	64.47166	64.27916
55	0.54333	0.44666	116	67.89833	67.69666
56	0.60500	0.49250	117	71.51250	71.32500
57	0.66250	0.54083	118	75.31750	74.71500
58	0.71916	0.59083	119	79.30583	78.25500
59	0.78500	0.64166	120+	83.33333	83.33333
60	0.86666	0.69500			

**MALE AND FEMALE NON-TOBACCO (NT)  
 GUARANTEED MAXIMUM MONTHLY COST OF INSURANCE RATES**

See the Monthly Cost of Insurance Rates provision.

<u>AGE</u>	<u>MALE</u>	<u>FEMALE</u>	<u>AGE</u>	<u>MALE</u>	<u>FEMALE</u>
	<u>MONTHLY COST OF INSURANCE PER \$1,000</u>	<u>MONTHLY COST OF INSURANCE PER \$1,000</u>		<u>MONTHLY COST OF INSURANCE PER \$1,000</u>	<u>MONTHLY COST OF INSURANCE PER \$1,000</u>
18	\$0.07666	\$0.03583	70	\$2.10583	\$1.46750
19	0.07833	0.03750	71	2.33250	1.60916
20	0.07916	0.03750	72	2.59750	1.76416
21	0.07916	0.03916	73	2.87666	1.93333
22	0.07916	0.04000	74	3.17666	2.12083
23	0.08000	0.04000	75	3.50333	2.32666
24	0.08083	0.04166	76	3.87166	2.55250
25	0.08333	0.04250	77	4.30000	2.80250
26	0.08666	0.04583	78	4.79750	3.07500
27	0.08833	0.04750	79	5.35500	3.37416
28	0.08666	0.05000	80	5.97666	3.74583
29	0.08583	0.05250	81	6.65250	4.20250
30	0.08500	0.05500	82	7.36833	4.68583
31	0.08416	0.05833	83	8.15000	5.19333
32	0.08500	0.06166	84	9.01916	5.75916
33	0.08750	0.06583	85	9.98583	6.33250
34	0.08916	0.07083	86	11.04916	7.01000
35	0.09333	0.07666	87	12.19833	7.84666
36	0.09750	0.08250	88	13.42000	8.72916
37	0.10333	0.08750	89	14.70166	9.60750
38	0.11083	0.09166	90	15.97833	10.25416
39	0.11750	0.09666	91	17.23500	10.87250
40	0.12666	0.10250	92	18.55166	11.89750
41	0.13750	0.10916	93	19.94000	13.28666
42	0.15083	0.11666	94	21.40250	15.01666
43	0.16666	0.12583	95	22.85083	16.89916
44	0.18416	0.13666	96	24.26500	18.75333
45	0.20333	0.14916	97	25.77166	19.95666
46	0.22250	0.16416	98	27.37833	20.61000
47	0.23833	0.18166	99	29.09250	21.96583
48	0.25083	0.20083	100	30.73000	23.72833
49	0.26666	0.22250	101	32.18250	25.64333
50	0.28750	0.24666	102	33.72750	27.75333
51	0.31416	0.27416	103	35.37000	30.05833
52	0.34666	0.30500	104	37.10583	32.57083
53	0.38416	0.33750	105	38.93416	35.22583
54	0.43166	0.37166	106	40.87500	37.94333
55	0.48500	0.41083	107	42.93416	40.70583
56	0.54000	0.45333	108	45.11916	43.51583
57	0.59333	0.49833	109	47.43500	46.41916
58	0.64666	0.54500	110	49.88750	49.32916
59	0.70916	0.59250	111	52.48583	52.13416
60	0.78500	0.64250	112	55.23583	54.81333
61	0.87750	0.69750	113	58.14583	57.56500
62	0.98500	0.75583	114	61.22083	61.00416
63	1.10250	0.81750	115	64.46916	64.27833
64	1.22500	0.88500	116	67.89666	67.69583
65	1.35250	0.96000	117	71.51083	71.32500
66	1.48166	1.04166	118	75.31666	74.71500
67	1.61666	1.13250	119	79.30583	78.25500
68	1.75916	1.23333	120+	83.33333	83.33333
69	1.91916	1.34333			

**MALE AND FEMALE TOBACCO (T)**  
**GUARANTEED MAXIMUM MONTHLY COST OF INSURANCE RATES**

See the Monthly Cost of Insurance Rates provision.

<u>AGE</u>	<u>MALE</u>	<u>FEMALE</u>	<u>AGE</u>	<u>MALE</u>	<u>FEMALE</u>
	<u>MONTHLY COST OF INSURANCE PER \$1,000</u>	<u>MONTHLY COST OF INSURANCE PER \$1,000</u>		<u>MONTHLY COST OF INSURANCE PER \$1,000</u>	<u>MONTHLY COST OF INSURANCE PER \$1,000</u>
18	\$0.09500	\$0.04250	70	\$3.27583	\$2.59250
19	0.10250	0.04666	71	3.55833	2.82083
20	0.10833	0.04916	72	3.88666	3.06916
21	0.11333	0.05250	73	4.21750	3.34000
22	0.11916	0.05500	74	4.57583	3.62333
23	0.12500	0.05750	75	4.97416	3.92083
24	0.13166	0.06083	76	5.41583	4.24250
25	0.13916	0.06583	77	5.92666	4.58916
26	0.14666	0.07000	78	6.51250	4.96333
27	0.15083	0.07416	79	7.15750	5.36583
28	0.15166	0.07916	80	7.86250	5.86750
29	0.15083	0.08416	81	8.61166	6.48083
30	0.15000	0.08916	82	9.38250	7.11250
31	0.15083	0.09583	83	10.20416	7.75750
32	0.15333	0.10250	84	11.13333	8.42916
33	0.15833	0.11083	85	12.18666	9.05000
34	0.16416	0.12166	86	13.32916	9.76750
35	0.17083	0.13250	87	14.54333	10.65750
36	0.18083	0.14333	88	15.80916	11.54833
37	0.19250	0.15250	89	17.11083	12.36333
38	0.20666	0.16166	90	18.36833	12.82666
39	0.22250	0.17166	91	19.56500	13.20666
40	0.24166	0.18250	92	20.79333	14.02750
41	0.26500	0.19500	93	22.06333	15.18916
42	0.29250	0.21083	94	23.41833	16.80833
43	0.32500	0.22833	95	24.78250	18.71833
44	0.36166	0.24916	96	26.07750	20.53750
45	0.39833	0.27333	97	27.44250	21.61666
46	0.43500	0.30166	98	28.88333	22.04916
47	0.46583	0.33666	99	30.40416	23.21416
48	0.48916	0.37833	100	31.82666	24.79000
49	0.51916	0.42500	101	33.04250	26.49333
50	0.55833	0.47500	102	34.32083	28.34416
51	0.60916	0.53000	103	35.66333	30.33666
52	0.67083	0.58916	104	37.19416	32.63583
53	0.74500	0.65333	105	39.01666	35.28666
54	0.83333	0.72166	106	40.95166	37.99916
55	0.92750	0.79416	107	43.00583	40.75833
56	1.02500	0.87166	108	45.18416	43.56416
57	1.11500	0.95000	109	47.49500	46.46333
58	1.20083	1.03166	110	49.94166	49.36916
59	1.30166	1.11916	111	52.53416	52.17083
60	1.42583	1.21000	112	55.27916	54.84583
61	1.57750	1.30833	113	58.18250	57.59333
62	1.75166	1.41250	114	61.25250	61.02833
63	1.93833	1.51916	115	64.49583	64.29916
64	2.12500	1.63416	116	67.91833	67.71166
65	2.30750	1.75833	117	71.52666	71.33666
66	2.48416	1.89333	118	75.32666	74.72333
67	2.66250	2.04333	119	79.31166	78.25916
68	2.84500	2.20750	120+	83.33333	83.33333
69	3.04583	2.38833			

## PAYMENT OF PROCEEDS

**POLICY PROCEEDS** - The amount of the Net Death Benefit payable upon the death of the Insured or the amount of the Cash Surrender Value payable upon surrender of this Policy.

**LUMP SUM PAYMENT** - We will pay the Policy proceeds in a lump sum payment, unless a settlement option is elected.

**SETTLEMENT OPTIONS** - During the Insured's lifetime, you may request that we pay the Policy proceeds under one of the following settlement options. We will also use any other method of payment that is agreeable to You and us. After the Insured's death, a Beneficiary may elect to receive such Beneficiary's share of the Net Death Benefit under a settlement option. However, You may provide that the Beneficiary will not be permitted to change the settlement option You have selected. If a settlement option is requested, we will prepare an agreement to be signed which will state the terms and conditions under which the payments will be made. This agreement will include a statement regarding the withdrawal value, if any, and to whom any remaining proceeds will be paid following the death of the person receiving the payments.

**OPTION 1 - Interest Payments -**

(Payment of interest on the Policy proceeds at such times and for such period as is agreeable to You and us.) During the period, withdrawals of remaining proceeds may be made in amounts of at least \$100.00. At the end of the period, any remaining proceeds will be paid in either a single sum or under any other method we approve.

**OPTION 2 - Payments for a Specified Period -**

(Monthly payments for a specified number of years.) The amount of each monthly payment for each \$1,000.00 of proceeds applied under this option is shown in the Option 2 Table. The monthly payments for any period not shown will be furnished upon request.

Option 2 Table

PAYMENTS FOR A SPECIFIED PERIOD	
Number of Years Payable	Amount of Monthly Payments
5	\$17.49
10	9.18
15	6.42
20	5.04
25	4.22
30	3.68

**OPTION 3 - Life Income -**

(Monthly payments for the life of the person who is to receive the income.) We will require satisfactory proof of the person's Age and sex. Payments can be guaranteed for ten (10) or twenty (20) years, or until an amount equal to the Policy proceeds has been paid. The amount of each monthly payment for each \$1,000.00 of proceeds applied under this option is shown in the Option 3 Table. The monthly payments for any ages not shown will be furnished upon request.

Option 3 Table

LIFE INCOME					
MONTHLY INCOME PAYMENTS					
Guaranteed For Life			Guaranteed For 10 Years		
M	Adjusted AGE	F	M	Adjusted AGE	F
\$3.25	50	\$3.13	\$3.23	50	\$3.12
3.60	55	3.45	3.57	55	3.43
4.07	60	3.87	4.01	60	3.83
4.72	65	4.43	4.59	65	4.35
5.63	70	5.22	5.32	70	5.05
Guaranteed Return of Policy Proceeds			Guaranteed For 20 Years		
M	Adjusted AGE	F	M	Adjusted AGE	F
\$3.09	50	\$3.03	\$3.17	50	\$3.09
3.37	55	3.29	3.46	55	3.36
3.72	60	3.62	3.80	60	3.69
4.16	65	4.05	4.16	65	4.07
4.72	70	4.59	4.51	70	4.45

OPTION 4 - Payments of a Specified Amount -

(Monthly payments of a Specified Amount until the proceeds and interest are fully paid.)

OPTION 5 - Joint and Survivor Life Income -

(Monthly payments during the joint lifetime of two (2) persons and continued during the lifetime of the survivor.) We will pay the amount retained, with interest, in equal monthly payments, as shown in the Option 5 Table. The monthly payment for other Age or sex combinations will be furnished upon request.

Option 5 Table

JOINT AND SURVIVOR LIFE INCOME				
MONTHLY PAYMENTS FOR EACH \$1,000.00 OF PROCEEDS APPLIED				
ADJUSTED AGE OF ONE PAYEE (MALE)*	ADJUSTED AGE OF OTHER PAYEE* (FEMALE)			
	15 Years Less than Male Payee's	10 Years Less than Male Payee's	5 Years Less than Male Payee's	Same as Male Payee's
50	\$2.47	\$2.59	\$2.70	\$2.81
55	2.62	2.76	2.91	3.06
60	2.80	2.98	3.17	3.37
65	3.04	3.27	3.52	3.79
70	3.34	3.65	3.99	4.37

\* Age nearest birthday

FOR OPTIONS 3 and 5 - An adjustment will be made in determining the Age(s) of the payee(s) when using the above charts to obtain the amount of each monthly payment for each \$1,000.00 of proceeds applied under these options as shown in the following table. The monthly payment for other Age or sex combinations will be furnished upon request.

Options 3 & 5 - AGE ADJUSTMENT TABLE	
PAYMENT COMMENCEMENT DATE	ADJUSTED AGE
BEFORE 2010	Actual AGE
2010-2019	Actual Age minus 1
2020-2026	Actual Age minus 2
2027-2033	Actual Age minus 3
2034-2040	Actual Age minus 4
After 2040	Determined by us

**CONDITIONS** - Proceeds of less than \$1,000.00 may not be applied under any settlement option and will be paid in a lump sum. We may change the payment frequency if payments under an option become less than \$20.00.

A corporation may receive payments under a life income option only if the payments are based on the life of the Insured, or a surviving spouse or a dependent of the Insured.

**PROCEEDS EXEMPT FROM THE CLAIMS OF CREDITORS** - To the extent permitted by law, each settlement option payment and any withdrawal shall be free from legal process and the claim of any creditor of the person entitled to them.

**RATE OF INTEREST AND MORTALITY** - Options 1 through 5 are based on a guaranteed interest rate of 2.0% using the "2000 Annuity Mortality Table" with projections.

SURRENDER CHARGES PER \$1,000 OF  
INCREASES IN SPECIFIED AMOUNTS  
MALE TOBACCO

Duration

<u>Age</u>	<u>0</u>	<u>1</u>	<u>2</u>	<u>3</u>	<u>4</u>	<u>5</u>	<u>6</u>	<u>7</u>	<u>8</u>	<u>9</u>	<u>10+</u>
18	19.00	17.67	17.67	16.53	15.58	14.82	11.97	9.12	6.27	2.85	0.00
19	19.95	18.55	18.55	17.36	16.36	15.56	12.57	9.58	6.58	2.99	0.00
20	19.95	18.55	18.55	17.36	16.36	15.56	12.57	9.58	6.58	2.99	0.00
21	19.95	18.55	18.55	17.36	16.36	15.56	12.57	9.58	6.58	2.99	0.00
22	20.90	19.44	19.44	18.18	17.14	16.30	13.17	10.03	6.90	3.14	0.00
23	20.90	19.44	19.44	18.18	17.14	16.30	13.17	10.03	6.90	3.14	0.00
24	20.90	19.44	19.44	18.18	17.14	16.30	13.17	10.03	6.90	3.14	0.00
25	21.85	20.32	20.32	19.01	17.92	17.04	13.77	10.49	7.21	3.28	0.00
26	21.85	20.32	20.32	19.01	17.92	17.04	13.77	10.49	7.21	3.28	0.00
27	22.80	21.20	21.20	19.84	18.70	17.78	14.36	10.94	7.52	3.42	0.00
28	22.80	21.20	21.20	19.84	18.70	17.78	14.36	10.94	7.52	3.42	0.00
29	23.75	22.09	22.09	20.66	19.48	18.53	14.96	11.40	7.84	3.56	0.00
30	23.75	22.09	22.09	20.66	19.48	18.53	14.96	11.40	7.84	3.56	0.00
31	24.70	22.97	22.97	21.49	20.25	19.27	15.56	11.86	8.15	3.71	0.00
32	24.70	22.97	22.97	21.49	20.25	19.27	15.56	11.86	8.15	3.71	0.00
33	25.65	23.85	23.85	22.32	21.03	20.01	16.16	12.31	8.46	3.85	0.00
34	25.65	23.85	23.85	22.32	21.03	20.01	16.16	12.31	8.46	3.85	0.00
35	26.60	24.74	24.74	23.14	21.81	20.75	16.76	12.77	8.78	3.99	0.00
36	27.55	25.62	25.62	23.97	22.59	21.49	17.36	13.22	9.09	4.13	0.00
37	27.55	25.62	25.62	23.97	22.59	21.49	17.36	13.22	9.09	4.13	0.00
38	28.50	26.51	26.51	24.80	23.37	22.23	17.96	13.68	9.41	4.28	0.00
39	29.45	27.39	27.39	25.62	24.15	22.97	18.55	14.14	9.72	4.42	0.00
40	30.40	29.18	28.27	26.45	24.93	23.71	19.15	14.59	10.03	4.56	0.00
41	30.40	29.18	28.27	26.45	24.93	23.71	19.15	14.59	10.03	4.56	0.00
42	31.35	30.10	29.16	27.27	25.71	24.45	19.75	15.05	10.35	4.70	0.00
43	32.30	31.01	30.04	28.10	26.49	25.19	20.35	15.50	10.66	4.85	0.00
44	33.25	31.92	30.92	28.93	27.27	25.94	20.95	15.96	10.97	4.99	0.00

Ages 45-85 are shown on the following page.

**SURRENDER CHARGES PER \$1,000 OF  
INCREASES IN SPECIFIED AMOUNTS  
MALE TOBACCO**

**Duration**

<u>Age</u>	<u>0</u>	<u>1</u>	<u>2</u>	<u>3</u>	<u>4</u>	<u>5</u>	<u>6</u>	<u>7</u>	<u>8</u>	<u>9</u>	<u>10+</u>
45	34.20	32.83	31.81	29.75	28.04	26.68	21.55	16.42	11.29	5.13	0.00
46	35.15	33.74	32.69	30.58	28.82	27.42	22.14	16.87	11.60	5.27	0.00
47	36.10	34.66	33.57	31.41	29.60	28.16	22.74	17.33	11.91	5.42	0.00
48	38.00	36.48	35.34	33.06	31.16	29.64	23.94	18.24	12.54	5.70	0.00
49	38.95	37.39	36.22	33.89	31.94	30.38	24.54	18.70	12.85	5.84	0.00
50	39.90	37.91	37.11	34.71	32.72	31.12	25.14	19.15	13.17	5.99	0.00
51	40.85	38.81	37.99	35.54	33.50	31.86	25.74	19.61	13.48	6.13	0.00
52	42.75	40.61	39.76	37.19	35.06	33.35	26.93	20.52	14.11	6.41	0.00
53	44.65	42.42	41.52	38.85	36.61	34.83	28.13	21.43	14.73	6.70	0.00
54	45.60	43.32	42.41	39.67	37.39	35.57	28.73	21.89	15.05	6.84	0.00
55	47.50	45.13	43.70	41.33	38.95	37.05	29.93	22.80	15.68	7.13	0.00
56	49.40	46.93	45.45	42.98	40.51	38.53	31.12	23.71	16.30	7.41	0.00
57	50.35	47.83	46.32	43.80	41.29	39.27	31.72	24.17	16.62	7.55	0.00
58	49.40	46.93	45.45	42.98	40.51	38.53	31.12	23.71	16.30	7.41	0.00
59	49.40	46.93	45.45	42.98	40.51	38.53	31.12	23.71	16.30	7.41	0.00
60	48.45	46.03	44.57	42.15	39.73	37.79	30.52	23.26	15.99	7.27	0.00
61	48.45	46.03	44.57	42.15	39.73	37.79	30.52	23.26	15.99	7.27	0.00
62	47.50	45.13	43.70	41.33	38.95	37.05	29.93	22.80	15.68	7.13	0.00
63	47.50	45.13	43.70	41.33	38.95	37.05	29.93	22.80	15.68	7.13	0.00
64	46.55	44.22	42.83	40.50	38.17	36.31	29.33	22.34	15.36	6.98	0.00
65	46.55	44.22	42.36	40.50	38.17	36.31	29.33	22.34	15.36	6.98	0.00
66	46.55	44.22	42.36	40.50	38.17	36.31	29.33	22.34	15.36	6.98	0.00
67	46.55	44.22	42.36	40.50	38.17	36.31	29.33	22.34	15.36	6.98	0.00
68	45.60	43.32	41.50	39.67	37.39	35.57	28.73	21.89	15.05	6.84	0.00
69	45.60	43.32	41.50	39.67	37.39	35.57	28.73	21.89	15.05	6.84	0.00
70	45.60	43.32	40.58	38.76	36.48	34.20	28.73	21.89	15.05	6.84	0.00
71	45.60	43.32	40.58	38.76	36.48	34.20	28.73	21.89	15.05	6.84	0.00
72	45.60	43.32	40.58	38.76	36.48	34.20	28.73	21.89	15.05	6.84	0.00
73	44.65	42.42	39.74	37.95	35.72	33.49	28.13	21.43	14.73	6.70	0.00
74	44.65	42.42	39.74	37.95	35.72	33.49	28.13	21.43	14.73	6.70	0.00
75	44.65	41.08	38.85	36.61	34.83	32.59	28.13	21.43	14.73	6.70	0.00
76	43.70	40.20	38.02	35.83	34.09	31.90	27.53	20.98	14.42	6.56	0.00
77	43.70	40.20	38.02	35.83	34.09	31.90	27.53	20.98	14.42	6.56	0.00
78	42.75	39.33	37.19	35.06	33.35	31.21	26.93	20.52	14.11	6.41	0.00
79	41.80	38.46	36.37	34.28	32.60	30.51	26.33	20.06	13.79	6.27	0.00
80	40.85	37.58	35.54	33.50	31.86	29.82	25.74	19.61	13.48	6.13	0.00
81	40.85	37.58	35.54	33.50	31.86	29.82	25.74	19.61	13.48	6.13	0.00
82	39.90	36.71	34.71	32.72	31.12	29.13	25.14	19.15	13.17	5.99	0.00
83	38.95	35.83	33.89	31.94	30.38	28.43	24.54	18.70	12.85	5.84	0.00
84	38.95	35.83	33.89	31.94	30.38	28.43	24.54	18.70	12.85	5.84	0.00
85	38.00	34.96	33.06	31.16	29.64	27.74	23.94	18.24	12.54	5.70	0.00

SURRENDER CHARGES PER \$1,000 OF  
INCREASES IN SPECIFIED AMOUNTS  
MALE JUVENILE (AGES 0-17)  
MALE NON-TOBACCO (AGES 18-85)

Age	Duration										
	<u>0</u>	<u>1</u>	<u>2</u>	<u>3</u>	<u>4</u>	<u>5</u>	<u>6</u>	<u>7</u>	<u>8</u>	<u>9</u>	<u>10+</u>
0	13.30	12.37	12.37	11.57	10.91	10.37	8.38	6.38	4.39	2.00	0.00
1	14.25	13.25	13.25	12.40	11.69	11.12	8.98	6.84	4.70	2.14	0.00
2	14.25	13.25	13.25	12.40	11.69	11.12	8.98	6.84	4.70	2.14	0.00
3	14.25	13.25	13.25	12.40	11.69	11.12	8.98	6.84	4.70	2.14	0.00
4	14.25	13.25	13.25	12.40	11.69	11.12	8.98	6.84	4.70	2.14	0.00
5	14.25	13.25	13.25	12.40	11.69	11.12	8.98	6.84	4.70	2.14	0.00
6	15.20	14.14	14.14	13.22	12.46	11.86	9.58	7.30	5.02	2.28	0.00
7	15.20	14.14	14.14	13.22	12.46	11.86	9.58	7.30	5.02	2.28	0.00
8	15.20	14.14	14.14	13.22	12.46	11.86	9.58	7.30	5.02	2.28	0.00
9	15.20	14.14	14.14	13.22	12.46	11.86	9.58	7.30	5.02	2.28	0.00
10	15.20	14.14	14.14	13.22	12.46	11.86	9.58	7.30	5.02	2.28	0.00
11	16.15	15.02	15.02	14.05	13.24	12.60	10.17	7.75	5.33	2.42	0.00
12	16.15	15.02	15.02	14.05	13.24	12.60	10.17	7.75	5.33	2.42	0.00
13	16.15	15.02	15.02	14.05	13.24	12.60	10.17	7.75	5.33	2.42	0.00
14	16.15	15.02	15.02	14.05	13.24	12.60	10.17	7.75	5.33	2.42	0.00
15	17.10	15.90	15.90	14.88	14.02	13.34	10.77	8.21	5.64	2.57	0.00
16	17.10	15.90	15.90	14.88	14.02	13.34	10.77	8.21	5.64	2.57	0.00
17	17.10	15.90	15.90	14.88	14.02	13.34	10.77	8.21	5.64	2.57	0.00
18	17.10	15.90	15.90	14.88	14.02	13.34	10.77	8.21	5.64	2.57	0.00
19	18.05	16.79	16.79	15.70	14.80	14.08	11.37	8.66	5.96	2.71	0.00
20	18.05	16.79	16.79	15.70	14.80	14.08	11.37	8.66	5.96	2.71	0.00
21	18.05	16.79	16.79	15.70	14.80	14.08	11.37	8.66	5.96	2.71	0.00
22	18.05	16.79	16.79	15.70	14.80	14.08	11.37	8.66	5.96	2.71	0.00
23	19.00	17.67	17.67	16.53	15.58	14.82	11.97	9.12	6.27	2.85	0.00
24	19.00	17.67	17.67	16.53	15.58	14.82	11.97	9.12	6.27	2.85	0.00
25	19.00	17.67	17.67	16.53	15.58	14.82	11.97	9.12	6.27	2.85	0.00
26	19.95	18.55	18.55	17.36	16.36	15.56	12.57	9.58	6.58	2.99	0.00
27	19.95	18.55	18.55	17.36	16.36	15.56	12.57	9.58	6.58	2.99	0.00
28	19.95	18.55	18.55	17.36	16.36	15.56	12.57	9.58	6.58	2.99	0.00
29	20.90	19.44	19.44	18.18	17.14	16.30	13.17	10.03	6.90	3.14	0.00
30	20.90	19.44	19.44	18.18	17.14	16.30	13.17	10.03	6.90	3.14	0.00
31	21.85	20.32	20.32	19.01	17.92	17.04	13.77	10.49	7.21	3.28	0.00
32	21.85	20.32	20.32	19.01	17.92	17.04	13.77	10.49	7.21	3.28	0.00
33	21.85	20.32	20.32	19.01	17.92	17.04	13.77	10.49	7.21	3.28	0.00
34	22.80	21.20	21.20	19.84	18.70	17.78	14.36	10.94	7.52	3.42	0.00
35	22.80	21.20	21.20	19.84	18.70	17.78	14.36	10.94	7.52	3.42	0.00
36	23.75	22.09	22.09	20.66	19.48	18.53	14.96	11.40	7.84	3.56	0.00
37	23.75	22.09	22.09	20.66	19.48	18.53	14.96	11.40	7.84	3.56	0.00
38	24.70	22.97	22.97	21.49	20.25	19.27	15.56	11.86	8.15	3.71	0.00
39	25.65	23.85	23.85	22.32	21.03	20.01	16.16	12.31	8.46	3.85	0.00
40	25.65	24.62	23.85	22.32	21.03	20.01	16.16	12.31	8.46	3.85	0.00
41	26.60	25.54	24.74	23.14	21.81	20.75	16.76	12.77	8.78	3.99	0.00
42	27.55	26.45	25.62	23.97	22.59	21.49	17.36	13.22	9.09	4.13	0.00
43	27.55	26.45	25.62	23.97	22.59	21.49	17.36	13.22	9.09	4.13	0.00
44	28.50	27.36	26.51	24.80	23.37	22.23	17.96	13.68	9.41	4.28	0.00

Ages 45-85 are shown on the following page.

SURRENDER CHARGES PER \$1,000 OF  
INCREASES IN SPECIFIED AMOUNTS  
MALE JUVENILE (AGES 0-17)  
MALE NON-TOBACCO (AGES 18-85)

Age	Duration										
	<u>0</u>	<u>1</u>	<u>2</u>	<u>3</u>	<u>4</u>	<u>5</u>	<u>6</u>	<u>7</u>	<u>8</u>	<u>9</u>	<u>10+</u>
45	29.45	28.27	27.39	25.62	24.15	22.97	18.55	14.14	9.72	4.42	0.00
46	30.40	29.18	28.27	26.45	24.93	23.71	19.15	14.59	10.03	4.56	0.00
47	30.40	29.18	28.27	26.45	24.93	23.71	19.15	14.59	10.03	4.56	0.00
48	31.35	30.10	29.16	27.27	25.71	24.45	19.75	15.05	10.35	4.70	0.00
49	32.30	31.01	30.04	28.10	26.49	25.19	20.35	15.50	10.66	4.85	0.00
50	33.25	31.59	30.92	28.93	27.27	25.94	20.95	15.96	10.97	4.99	0.00
51	35.15	33.39	32.69	30.58	28.82	27.42	22.14	16.87	11.60	5.27	0.00
52	36.10	34.30	33.57	31.41	29.60	28.16	22.74	17.33	11.91	5.42	0.00
53	37.05	35.20	34.46	32.23	30.38	28.90	23.34	17.78	12.23	5.56	0.00
54	38.00	36.10	35.34	33.06	31.16	29.64	23.94	18.24	12.54	5.70	0.00
55	39.90	37.91	36.71	34.71	32.72	31.12	25.14	19.15	13.17	5.99	0.00
56	40.85	38.81	37.58	35.54	33.50	31.86	25.74	19.61	13.48	6.13	0.00
57	41.80	39.71	38.46	36.37	34.28	32.60	26.33	20.06	13.79	6.27	0.00
58	43.70	41.52	40.20	38.02	35.83	34.09	27.53	20.98	14.42	6.56	0.00
59	45.60	43.32	41.95	39.67	37.39	35.57	28.73	21.89	15.05	6.84	0.00
60	46.55	44.22	42.83	40.50	38.17	36.31	29.33	22.34	15.36	6.98	0.00
61	48.45	46.03	44.57	42.15	39.73	37.79	30.52	23.26	15.99	7.27	0.00
62	47.50	45.13	43.70	41.33	38.95	37.05	29.93	22.80	15.68	7.13	0.00
63	47.50	45.13	43.70	41.33	38.95	37.05	29.93	22.80	15.68	7.13	0.00
64	46.55	44.22	42.83	40.50	38.17	36.31	29.33	22.34	15.36	6.98	0.00
65	46.55	44.22	42.36	40.50	38.17	36.31	29.33	22.34	15.36	6.98	0.00
66	46.55	44.22	42.36	40.50	38.17	36.31	29.33	22.34	15.36	6.98	0.00
67	46.55	44.22	42.36	40.50	38.17	36.31	29.33	22.34	15.36	6.98	0.00
68	45.60	43.32	41.50	39.67	37.39	35.57	28.73	21.89	15.05	6.84	0.00
69	45.60	43.32	41.50	39.67	37.39	35.57	28.73	21.89	15.05	6.84	0.00
70	45.60	43.32	40.58	38.76	36.48	34.20	28.73	21.89	15.05	6.84	0.00
71	45.60	43.32	40.58	38.76	36.48	34.20	28.73	21.89	15.05	6.84	0.00
72	45.60	43.32	40.58	38.76	36.48	34.20	28.73	21.89	15.05	6.84	0.00
73	44.65	42.42	39.74	37.95	35.72	33.49	28.13	21.43	14.73	6.70	0.00
74	44.65	42.42	39.74	37.95	35.72	33.49	28.13	21.43	14.73	6.70	0.00
75	44.65	41.08	38.85	36.61	34.83	32.59	28.13	21.43	14.73	6.70	0.00
76	43.70	40.20	38.02	35.83	34.09	31.90	27.53	20.98	14.42	6.56	0.00
77	43.70	40.20	38.02	35.83	34.09	31.90	27.53	20.98	14.42	6.56	0.00
78	42.75	39.33	37.19	35.06	33.35	31.21	26.93	20.52	14.11	6.41	0.00
79	41.80	38.46	36.37	34.28	32.60	30.51	26.33	20.06	13.79	6.27	0.00
80	40.85	37.58	35.54	33.50	31.86	29.82	25.74	19.61	13.48	6.13	0.00
81	40.85	37.58	35.54	33.50	31.86	29.82	25.74	19.61	13.48	6.13	0.00
82	39.90	36.71	34.71	32.72	31.12	29.13	25.14	19.15	13.17	5.99	0.00
83	38.95	35.83	33.89	31.94	30.38	28.43	24.54	18.70	12.85	5.84	0.00
84	38.95	35.83	33.89	31.94	30.38	28.43	24.54	18.70	12.85	5.84	0.00
85	38.00	34.96	33.06	31.16	29.64	27.74	23.94	18.24	12.54	5.70	0.00

**SURRENDER CHARGES PER \$1,000 OF  
INCREASES IN SPECIFIED AMOUNTS  
FEMALE TOBACCO**

**Duration**

<u>Age</u>	<u>0</u>	<u>1</u>	<u>2</u>	<u>3</u>	<u>4</u>	<u>5</u>	<u>6</u>	<u>7</u>	<u>8</u>	<u>9</u>	<u>10+</u>
18	18.05	16.79	16.79	15.70	14.80	14.08	11.37	8.66	5.96	2.71	0.00
19	18.05	16.79	16.79	15.70	14.80	14.08	11.37	8.66	5.96	2.71	0.00
20	19.00	17.67	17.67	16.53	15.58	14.82	11.97	9.12	6.27	2.85	0.00
21	19.00	17.67	17.67	16.53	15.58	14.82	11.97	9.12	6.27	2.85	0.00
22	19.00	17.67	17.67	16.53	15.58	14.82	11.97	9.12	6.27	2.85	0.00
23	19.95	18.55	18.55	17.36	16.36	15.56	12.57	9.58	6.58	2.99	0.00
24	19.95	18.55	18.55	17.36	16.36	15.56	12.57	9.58	6.58	2.99	0.00
25	19.95	18.55	18.55	17.36	16.36	15.56	12.57	9.58	6.58	2.99	0.00
26	20.90	19.44	19.44	18.18	17.14	16.30	13.17	10.03	6.90	3.14	0.00
27	20.90	19.44	19.44	18.18	17.14	16.30	13.17	10.03	6.90	3.14	0.00
28	21.85	20.32	20.32	19.01	17.92	17.04	13.77	10.49	7.21	3.28	0.00
29	21.85	20.32	20.32	19.01	17.92	17.04	13.77	10.49	7.21	3.28	0.00
30	21.85	20.32	20.32	19.01	17.92	17.04	13.77	10.49	7.21	3.28	0.00
31	22.80	21.20	21.20	19.84	18.70	17.78	14.36	10.94	7.52	3.42	0.00
32	22.80	21.20	21.20	19.84	18.70	17.78	14.36	10.94	7.52	3.42	0.00
33	23.75	22.09	22.09	20.66	19.48	18.53	14.96	11.40	7.84	3.56	0.00
34	23.75	22.09	22.09	20.66	19.48	18.53	14.96	11.40	7.84	3.56	0.00
35	24.70	22.97	22.97	21.49	20.25	19.27	15.56	11.86	8.15	3.71	0.00
36	25.65	23.85	23.85	22.32	21.03	20.01	16.16	12.31	8.46	3.85	0.00
37	25.65	23.85	23.85	22.32	21.03	20.01	16.16	12.31	8.46	3.85	0.00
38	26.60	24.74	24.74	23.14	21.81	20.75	16.76	12.77	8.78	3.99	0.00
39	26.60	24.74	24.74	23.14	21.81	20.75	16.76	12.77	8.78	3.99	0.00
40	27.55	26.45	25.62	23.97	22.59	21.49	17.36	13.22	9.09	4.13	0.00
41	28.50	27.36	26.51	24.80	23.37	22.23	17.96	13.68	9.41	4.28	0.00
42	29.45	28.27	27.39	25.62	24.15	22.97	18.55	14.14	9.72	4.42	0.00
43	30.40	29.18	28.27	26.45	24.93	23.71	19.15	14.59	10.03	4.56	0.00
44	30.40	29.18	28.27	26.45	24.93	23.71	19.15	14.59	10.03	4.56	0.00

Ages 45-85 are shown on the following page.

SURRENDER CHARGES PER \$1,000 OF  
INCREASES IN SPECIFIED AMOUNTS  
FEMALE TOBACCO

Duration

<u>Age</u>	<u>0</u>	<u>1</u>	<u>2</u>	<u>3</u>	<u>4</u>	<u>5</u>	<u>6</u>	<u>7</u>	<u>8</u>	<u>9</u>	<u>10+</u>
45	31.35	30.10	29.16	27.27	25.71	24.45	19.75	15.05	10.35	4.70	0.00
46	32.30	31.01	30.04	28.10	26.49	25.19	20.35	15.50	10.66	4.85	0.00
47	33.25	31.92	30.92	28.93	27.27	25.94	20.95	15.96	10.97	4.99	0.00
48	34.20	32.83	31.81	29.75	28.04	26.68	21.55	16.42	11.29	5.13	0.00
49	35.15	33.74	32.69	30.58	28.82	27.42	22.14	16.87	11.60	5.27	0.00
50	36.10	34.30	33.57	31.41	29.60	28.16	22.74	17.33	11.91	5.42	0.00
51	37.05	35.20	34.46	32.23	30.38	28.90	23.34	17.78	12.23	5.56	0.00
52	38.95	37.00	36.22	33.89	31.94	30.38	24.54	18.70	12.85	5.84	0.00
53	39.90	37.91	37.11	34.71	32.72	31.12	25.14	19.15	13.17	5.99	0.00
54	40.85	38.81	37.99	35.54	33.50	31.86	25.74	19.61	13.48	6.13	0.00
55	42.75	40.61	39.33	37.19	35.06	33.35	26.93	20.52	14.11	6.41	0.00
56	43.70	41.52	40.20	38.02	35.83	34.09	27.53	20.98	14.42	6.56	0.00
57	44.65	42.42	41.08	38.85	36.61	34.83	28.13	21.43	14.73	6.70	0.00
58	46.55	44.22	42.83	40.50	38.17	36.31	29.33	22.34	15.36	6.98	0.00
59	47.50	45.13	43.70	41.33	38.95	37.05	29.93	22.80	15.68	7.13	0.00
60	48.45	46.03	44.57	42.15	39.73	37.79	30.52	23.26	15.99	7.27	0.00
61	48.45	46.03	44.57	42.15	39.73	37.79	30.52	23.26	15.99	7.27	0.00
62	47.50	45.13	43.70	41.33	38.95	37.05	29.93	22.80	15.68	7.13	0.00
63	47.50	45.13	43.70	41.33	38.95	37.05	29.93	22.80	15.68	7.13	0.00
64	46.55	44.22	42.83	40.50	38.17	36.31	29.33	22.34	15.36	6.98	0.00
65	46.55	44.22	42.36	40.50	38.17	36.31	29.33	22.34	15.36	6.98	0.00
66	46.55	44.22	42.36	40.50	38.17	36.31	29.33	22.34	15.36	6.98	0.00
67	46.55	44.22	42.36	40.50	38.17	36.31	29.33	22.34	15.36	6.98	0.00
68	45.60	43.32	41.50	39.67	37.39	35.57	28.73	21.89	15.05	6.84	0.00
69	45.60	43.32	41.50	39.67	37.39	35.57	28.73	21.89	15.05	6.84	0.00
70	45.60	43.32	40.58	38.76	36.48	34.20	28.73	21.89	15.05	6.84	0.00
71	45.60	43.32	40.58	38.76	36.48	34.20	28.73	21.89	15.05	6.84	0.00
72	45.60	43.32	40.58	38.76	36.48	34.20	28.73	21.89	15.05	6.84	0.00
73	44.65	42.42	39.74	37.95	35.72	33.49	28.13	21.43	14.73	6.70	0.00
74	44.65	42.42	39.74	37.95	35.72	33.49	28.13	21.43	14.73	6.70	0.00
75	44.65	41.08	38.85	36.61	34.83	32.59	28.13	21.43	14.73	6.70	0.00
76	43.70	40.20	38.02	35.83	34.09	31.90	27.53	20.98	14.42	6.56	0.00
77	43.70	40.20	38.02	35.83	34.09	31.90	27.53	20.98	14.42	6.56	0.00
78	42.75	39.33	37.19	35.06	33.35	31.21	26.93	20.52	14.11	6.41	0.00
79	41.80	38.46	36.37	34.28	32.60	30.51	26.33	20.06	13.79	6.27	0.00
80	40.85	37.58	35.54	33.50	31.86	29.82	25.74	19.61	13.48	6.13	0.00
81	40.85	37.58	35.54	33.50	31.86	29.82	25.74	19.61	13.48	6.13	0.00
82	39.90	36.71	34.71	32.72	31.12	29.13	25.14	19.15	13.17	5.99	0.00
83	38.95	35.83	33.89	31.94	30.38	28.43	24.54	18.70	12.85	5.84	0.00
84	38.95	35.83	33.89	31.94	30.38	28.43	24.54	18.70	12.85	5.84	0.00
85	38.00	34.96	33.06	31.16	29.64	27.74	23.94	18.24	12.54	5.70	0.00

SURRENDER CHARGES PER \$1,000 OF  
INCREASES IN SPECIFIED AMOUNTS  
FEMALE JUVENILE (AGES 0-17)  
FEMALE NON-TOBACCO (AGES 18-85)

Age	Duration										
	<u>0</u>	<u>1</u>	<u>2</u>	<u>3</u>	<u>4</u>	<u>5</u>	<u>6</u>	<u>7</u>	<u>8</u>	<u>9</u>	<u>10+</u>
0	13.30	12.37	12.37	11.57	10.91	10.37	8.38	6.38	4.39	2.00	0.00
1	13.30	12.37	12.37	11.57	10.91	10.37	8.38	6.38	4.39	2.00	0.00
2	13.30	12.37	12.37	11.57	10.91	10.37	8.38	6.38	4.39	2.00	0.00
3	13.30	12.37	12.37	11.57	10.91	10.37	8.38	6.38	4.39	2.00	0.00
4	13.30	12.37	12.37	11.57	10.91	10.37	8.38	6.38	4.39	2.00	0.00
5	14.25	13.25	13.25	12.40	11.69	11.12	8.98	6.84	4.70	2.14	0.00
6	14.25	13.25	13.25	12.40	11.69	11.12	8.98	6.84	4.70	2.14	0.00
7	14.25	13.25	13.25	12.40	11.69	11.12	8.98	6.84	4.70	2.14	0.00
8	14.25	13.25	13.25	12.40	11.69	11.12	8.98	6.84	4.70	2.14	0.00
9	14.25	13.25	13.25	12.40	11.69	11.12	8.98	6.84	4.70	2.14	0.00
10	15.20	14.14	14.14	13.22	12.46	11.86	9.58	7.30	5.02	2.28	0.00
11	15.20	14.14	14.14	13.22	12.46	11.86	9.58	7.30	5.02	2.28	0.00
12	15.20	14.14	14.14	13.22	12.46	11.86	9.58	7.30	5.02	2.28	0.00
13	15.20	14.14	14.14	13.22	12.46	11.86	9.58	7.30	5.02	2.28	0.00
14	15.20	14.14	14.14	13.22	12.46	11.86	9.58	7.30	5.02	2.28	0.00
15	16.15	15.02	15.02	14.05	13.24	12.60	10.17	7.75	5.33	2.42	0.00
16	16.15	15.02	15.02	14.05	13.24	12.60	10.17	7.75	5.33	2.42	0.00
17	16.15	15.02	15.02	14.05	13.24	12.60	10.17	7.75	5.33	2.42	0.00
18	16.15	15.02	15.02	14.05	13.24	12.60	10.17	7.75	5.33	2.42	0.00
19	16.15	15.02	15.02	14.05	13.24	12.60	10.17	7.75	5.33	2.42	0.00
20	17.10	15.90	15.90	14.88	14.02	13.34	10.77	8.21	5.64	2.57	0.00
21	17.10	15.90	15.90	14.88	14.02	13.34	10.77	8.21	5.64	2.57	0.00
22	17.10	15.90	15.90	14.88	14.02	13.34	10.77	8.21	5.64	2.57	0.00
23	17.10	15.90	15.90	14.88	14.02	13.34	10.77	8.21	5.64	2.57	0.00
24	18.05	16.79	16.79	15.70	14.80	14.08	11.37	8.66	5.96	2.71	0.00
25	18.05	16.79	16.79	15.70	14.80	14.08	11.37	8.66	5.96	2.71	0.00
26	18.05	16.79	16.79	15.70	14.80	14.08	11.37	8.66	5.96	2.71	0.00
27	19.00	17.67	17.67	16.53	15.58	14.82	11.97	9.12	6.27	2.85	0.00
28	19.00	17.67	17.67	16.53	15.58	14.82	11.97	9.12	6.27	2.85	0.00
29	19.00	17.67	17.67	16.53	15.58	14.82	11.97	9.12	6.27	2.85	0.00
30	19.95	18.55	18.55	17.36	16.36	15.56	12.57	9.58	6.58	2.99	0.00
31	19.95	18.55	18.55	17.36	16.36	15.56	12.57	9.58	6.58	2.99	0.00
32	19.95	18.55	18.55	17.36	16.36	15.56	12.57	9.58	6.58	2.99	0.00
33	20.90	19.44	19.44	18.18	17.14	16.30	13.17	10.03	6.90	3.14	0.00
34	20.90	19.44	19.44	18.18	17.14	16.30	13.17	10.03	6.90	3.14	0.00
35	21.85	20.32	20.32	19.01	17.92	17.04	13.77	10.49	7.21	3.28	0.00
36	21.85	20.32	20.32	19.01	17.92	17.04	13.77	10.49	7.21	3.28	0.00
37	21.85	20.32	20.32	19.01	17.92	17.04	13.77	10.49	7.21	3.28	0.00
38	22.80	21.20	21.20	19.84	18.70	17.78	14.36	10.94	7.52	3.42	0.00
39	22.80	21.20	21.20	19.84	18.70	17.78	14.36	10.94	7.52	3.42	0.00
40	23.75	22.80	22.09	20.66	19.48	18.53	14.96	11.40	7.84	3.56	0.00
41	23.75	22.80	22.09	20.66	19.48	18.53	14.96	11.40	7.84	3.56	0.00
42	24.70	23.71	22.97	21.49	20.25	19.27	15.56	11.86	8.15	3.71	0.00
43	24.70	23.71	22.97	21.49	20.25	19.27	15.56	11.86	8.15	3.71	0.00
44	25.65	24.62	23.85	22.32	21.03	20.01	16.16	12.31	8.46	3.85	0.00

Ages 45-85 are shown on the following page.

SURRENDER CHARGES PER \$1,000 OF  
INCREASES IN SPECIFIED AMOUNTS  
FEMALE JUVENILE (AGES 0-17)  
FEMALE NON-TOBACCO (AGES 18-85)

Age	Duration										
	<u>0</u>	<u>1</u>	<u>2</u>	<u>3</u>	<u>4</u>	<u>5</u>	<u>6</u>	<u>7</u>	<u>8</u>	<u>9</u>	<u>10+</u>
45	26.60	25.54	24.74	23.14	21.81	20.75	16.76	12.77	8.78	3.99	0.00
46	26.60	25.54	24.74	23.14	21.81	20.75	16.76	12.77	8.78	3.99	0.00
47	27.55	26.45	25.62	23.97	22.59	21.49	17.36	13.22	9.09	4.13	0.00
48	28.50	27.36	26.51	24.80	23.37	22.23	17.96	13.68	9.41	4.28	0.00
49	29.45	28.27	27.39	25.62	24.15	22.97	18.55	14.14	9.72	4.42	0.00
50	29.45	27.98	27.39	25.62	24.15	22.97	18.55	14.14	9.72	4.42	0.00
51	30.40	28.88	28.27	26.45	24.93	23.71	19.15	14.59	10.03	4.56	0.00
52	31.35	29.78	29.16	27.27	25.71	24.45	19.75	15.05	10.35	4.70	0.00
53	32.30	30.69	30.04	28.10	26.49	25.19	20.35	15.50	10.66	4.85	0.00
54	33.25	31.59	30.92	28.93	27.27	25.94	20.95	15.96	10.97	4.99	0.00
55	34.20	32.49	31.46	29.75	28.04	26.68	21.55	16.42	11.29	5.13	0.00
56	35.15	33.39	32.34	30.58	28.82	27.42	22.14	16.87	11.60	5.27	0.00
57	36.10	34.30	33.21	31.41	29.60	28.16	22.74	17.33	11.91	5.42	0.00
58	37.05	35.20	34.09	32.23	30.38	28.90	23.34	17.78	12.23	5.56	0.00
59	38.00	36.10	34.96	33.06	31.16	29.64	23.94	18.24	12.54	5.70	0.00
60	38.95	37.00	35.83	33.89	31.94	30.38	24.54	18.70	12.85	5.84	0.00
61	40.85	38.81	37.58	35.54	33.50	31.86	25.74	19.61	13.48	6.13	0.00
62	41.80	39.71	38.46	36.37	34.28	32.60	26.33	20.06	13.79	6.27	0.00
63	43.70	41.52	40.20	38.02	35.83	34.09	27.53	20.98	14.42	6.56	0.00
64	44.65	42.42	41.08	38.85	36.61	34.83	28.13	21.43	14.73	6.70	0.00
65	46.55	44.22	42.36	40.50	38.17	36.31	29.33	22.34	15.36	6.98	0.00
66	46.55	44.22	42.36	40.50	38.17	36.31	29.33	22.34	15.36	6.98	0.00
67	46.55	44.22	42.36	40.50	38.17	36.31	29.33	22.34	15.36	6.98	0.00
68	45.60	43.32	41.50	39.67	37.39	35.57	28.73	21.89	15.05	6.84	0.00
69	45.60	43.32	41.50	39.67	37.39	35.57	28.73	21.89	15.05	6.84	0.00
70	45.60	43.32	40.58	38.76	36.48	34.20	28.73	21.89	15.05	6.84	0.00
71	45.60	43.32	40.58	38.76	36.48	34.20	28.73	21.89	15.05	6.84	0.00
72	45.60	43.32	40.58	38.76	36.48	34.20	28.73	21.89	15.05	6.84	0.00
73	44.65	42.42	39.74	37.95	35.72	33.49	28.13	21.43	14.73	6.70	0.00
74	44.65	42.42	39.74	37.95	35.72	33.49	28.13	21.43	14.73	6.70	0.00
75	44.65	41.08	38.85	36.61	34.83	32.59	28.13	21.43	14.73	6.70	0.00
76	43.70	40.20	38.02	35.83	34.09	31.90	27.53	20.98	14.42	6.56	0.00
77	43.70	40.20	38.02	35.83	34.09	31.90	27.53	20.98	14.42	6.56	0.00
78	42.75	39.33	37.19	35.06	33.35	31.21	26.93	20.52	14.11	6.41	0.00
79	41.80	38.46	36.37	34.28	32.60	30.51	26.33	20.06	13.79	6.27	0.00
80	40.85	37.58	35.54	33.50	31.86	29.82	25.74	19.61	13.48	6.13	0.00
81	40.85	37.58	35.54	33.50	31.86	29.82	25.74	19.61	13.48	6.13	0.00
82	39.90	36.71	34.71	32.72	31.12	29.13	25.14	19.15	13.17	5.99	0.00
83	38.95	35.83	33.89	31.94	30.38	28.43	24.54	18.70	12.85	5.84	0.00
84	38.95	35.83	33.89	31.94	30.38	28.43	24.54	18.70	12.85	5.84	0.00
85	38.00	34.96	33.06	31.16	29.64	27.74	23.94	18.24	12.54	5.70	0.00

## SUMMARY OF POLICY BENEFITS

**LIVING BENEFITS** - This Policy has certain values which are available to You during Your lifetime. These values consist of the cash or loan values. You may use these values:

1. To provide supplemental income.
2. As collateral for a loan or as the basis for a Policy loan.
3. To continue some insurance protection if You cannot or do not wish to continue paying premiums.
4. To obtain cash by surrendering this Policy.
5. To obtain cash by partial withdrawal.

**DEATH PROCEEDS** - The amount payable to the Beneficiary is the total of the following amounts determined on the date of the Insured's death:

1. The Death Benefit amount of this Policy; plus
2. Any additional insurance on the Insured's life provided by an extra benefit rider; minus
3. Any Indebtedness; minus
4. Any Monthly Deductions due.

**EXTRA BENEFIT RIDERS** - The extra benefits, if any, shown in the Policy Specifications Pages are fully described in the extra benefit riders that are attached to this Policy.

## YOUR RIGHTS

During the Insured's lifetime and while this Policy is In Force, and unless otherwise provided in the Policy, You have the exclusive right to assign this Policy, to receive every benefit and to exercise every right, privilege and option this Policy grants or that we allow. Some of Your rights are:

1. To change the Owner or Beneficiary.
2. To withdraw cash.
3. To surrender this Policy.
4. To stop premium payments.
5. To change the frequency of premium payments.
6. To change the Specified Amount.
7. To change the Death Benefit Option.
8. To borrow on this Policy.
9. To Reinstate this Policy after Lapse.
10. To receive Policy benefits as income.

To exercise any of these rights, or to apply for the proceeds or any benefits under this Policy, communicate with our nearest representative or directly with our Administrative Office. Please notify us promptly of any change of address.

- Please examine Your Policy and the attached copy of the application carefully. Contact Your agent if You desire additional services or information.
- If You change Your address, please notify us at the Administrative Office giving Your full name and Policy number.
- Your Policy is a valuable asset. For Your own protection, let us advise You regarding any suggestion to terminate or replace this Policy.



WESTERN RESERVE LIFE ASSURANCE CO. OF OHIO

A Stock Company

Home Office located at: Columbus, Ohio

Administrative Office located at: 4333 Edgewood Road N.E., Cedar Rapids, Iowa 52499  
 (Hereafter called the Company, we, our or us) (319) 355-8511

FLEXIBLE PREMIUM ADJUSTABLE LIFE  
 INSURANCE POLICY WITH  
 AN INDEX FEATURE  
 PREMIUMS PAYABLE WHILE THE POLICY IS IN FORCE  
 NET DEATH BENEFIT PAYABLE AT DEATH  
 NON-PARTICIPATING

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**WESTERN RESERVE LIFE ASSURANCE CO. OF OHIO**

Administrative Office: 4333 Edgewood Road NE, Cedar Rapids, IA 52499

**Supplemental Application for Index Universal Life Policy**

Supplement to Application Dated: \_\_\_\_\_

Premium Amount: \$ \_\_\_\_\_

Indicate your premium allocation percentages below. Total must equal 100%.

_____	.0%	Global Index Account
_____	.0%	Index Account
_____	.0%	Basic Interest Account
_____	<b>100%</b>	<b>Total</b>

Each of the undersigned hereby certifies and represents as follows:

The statements and answers given on this application are true and correct. I acknowledge and agree that this Supplemental Application together with the original application and any amendments thereto shall be the basis for any insurance issued. This Supplemental Application shall form a part of the original application and of the policy issued thereunder, if any, and they shall be binding on any person who shall have or claim any interest under such policy.

Dated at \_\_\_\_\_ this \_\_\_\_\_ day of \_\_\_\_\_, \_\_\_\_\_

\_\_\_\_\_  
Signature Of Owner if other than Proposed Insured

\_\_\_\_\_  
Signature Of Proposed Insured

SERFF Tracking Number: AEGB-125986268 State: Arkansas  
 Filing Company: Western Reserve Life Assurance Co. of Ohio State Tracking Number: 41390  
 Company Tracking Number: IUL03 1208 AR, SAIUL1208W  
 TOI: L09I Individual Life - Flexible Premium Sub-TOI: L09I.001 Single Life  
 Adjustable Life  
 Product Name: Flexible Premium Adjustable Life Insurance Policy with an Index Feature et al  
 Project Name/Number: IUL03 1207 AR, SAIUL1208W/IUL03 1207 AR, SAIUL1208W

## Supporting Document Schedules

	<b>Item Status:</b>	<b>Status Date:</b>
<b>Satisfied - Item:</b> Flesch Certification		
<b>Comments:</b>		
<b>Attachments:</b>		
Flesch Score Cert WRL.pdf		
AR - Rule and Regulation 19.pdf		
AR - Cert of Regulation 49.pdf		

	<b>Item Status:</b>	<b>Status Date:</b>
<b>Satisfied - Item:</b> Application		
<b>Comments:</b>		
Attached please find specimen copies of the following applications which will be used with this policy:		
L 108 0805 AR - approved 1/12/2006		
U000310 - approved 8/31/2007		
6000 R0103 AR - approved 1/15/2003		
<b>Attachments:</b>		
Specimen copy of L 108 0805 AR.pdf		
Specimen copy of U000310.pdf		
Specimen copy of 6000 R0103 AR.pdf		

	<b>Item Status:</b>	<b>Status Date:</b>
<b>Bypassed - Item:</b> Health - Actuarial Justification		
<b>Bypass Reason:</b> Not applicable.		
<b>Comments:</b>		

	<b>Item Status:</b>	<b>Status Date:</b>
<b>Bypassed - Item:</b> Outline of Coverage		

SERFF Tracking Number: AEGB-125986268 State: Arkansas  
 Filing Company: Western Reserve Life Assurance Co. of Ohio State Tracking Number: 41390  
 Company Tracking Number: IUL03 1208 AR, SAIUL1208W  
 TOI: L09I Individual Life - Flexible Premium Sub-TOI: L09I.001 Single Life  
 Adjustable Life  
 Product Name: Flexible Premium Adjustable Life Insurance Policy with an Index Feature et al  
 Project Name/Number: IUL03 1207 AR, SAIUL1208W/IUL03 1207 AR, SAIUL1208W  
**Bypass Reason:** Not applicable.  
**Comments:**

**Item Status:** **Status Date:**

**Satisfied - Item:** AR - Cert of Compliance  
**Comments:**  
**Attachment:**  
 AR - Cert of Compliance 23-79-138.pdf

**Item Status:** **Status Date:**

**Satisfied - Item:** AR - Cert of Regulation 34  
**Comments:**  
**Attachment:**  
 AR - Cert of Regulation 34.pdf

**Item Status:** **Status Date:**

**Satisfied - Item:** AR - Bulletin 11-83  
**Comments:**  
**Attachment:**  
 AR Western Reserve Bulletin 11-83 Consent Form.pdf

**Item Status:** **Status Date:**

**Satisfied - Item:** Sample Specification Page  
**Comments:**  
**Attachment:**  
 Spec Page - CVAT.pdf

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

**Form Number (may vary by state)**

**Flesch Score**

IUL03 1208  
SAIUL1208W

51.3  
51.8

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

**RULE AND REGULATION 19  
STATE OF ARKANSAS**

Form Number:

Date:

I hereby certify that the accompanying life product is in compliance with Rule and Regulation 19.

---

CERTIFICATION OF REGULATION 49  
STATE OF ARKANSAS

Form Number:

Date:

This is submitted in Compliance with Regulation 49 of the Arkansas Insurance Code.

I hereby certify that the accompanying life product is in compliance with Regulation 49 in that a Life and Health Guaranty Association notice will be given to each policy owner at the time of issue.

---

**APPLICATION FOR INSURANCE**

*Western Reserve Life Assurance Co. of Ohio*

[Administrative Office, 4333 Edgewood Road NE, Cedar Rapids, IA 52499]

[ ]

**PROPOSED INSURED INFORMATION**

1. Name (First, M.I., Last)				2. Mailing Address			
3. Home Telephone No. ( )		4. Work Telephone No. ( )		5. Birth Date		6. Birth State / Country	7. E-mail Address (optional)
8. Height	9. Weight	10. Marital Status		11. Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	12. U.S. Citizen <input type="checkbox"/> Yes <input type="checkbox"/> No	13. If no, give immigration status/type of visa:	
14. Occupation & Duties							
15. Annual Income Current Year			16. Social Security No. or Tax I.D. No.			17. Drivers License No. and State	
18. Have you used any tobacco or nicotine products within the last 5 years? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, list type and when used last							

**BENEFICIARY AND RELATIONSHIP TO PROPOSED INSURED** (Unless otherwise noted, the beneficiary of other persons proposed for Coverage will be the proposed insured.)

19. Primary Relationship		20. Contingent Relationship	
--------------------------	--	-----------------------------	--

**OWNER** (Unless otherwise noted, the Owner will be the Insured.)

21. Name		a. Relationship to Proposed Insured		b. Social Security Number	
c. Address			d. Birth Date		e. Phone ( )

**POLICY INFORMATION**

22. Plan: _____		23. Amount of Insurance		24. Planned Premium \$	
<input type="checkbox"/> Level <input type="checkbox"/> Increasing Term Period _____					
25. Mode of Payment (for bank draft, complete Check-O-Matic authorization, and collect initial payment.)					
<input type="checkbox"/> Monthly Bank Draft <input type="checkbox"/> Annual <input type="checkbox"/> Other _____					

**26. ADDITIONAL BENEFITS and AMOUNTS**

<input type="checkbox"/> Additional Insured Rider (AIR) \$ _____		<input type="checkbox"/> Waiver of Premium Benefit (WP)	
<input type="checkbox"/> Base Insured Rider (BIR) \$ _____		<input type="checkbox"/> Monthly Disability Income Rider (DIR)	
<input type="checkbox"/> Children's Benefit Rider (CBR) \$ _____		<input type="checkbox"/> 2 Year <input type="checkbox"/> 5 Year \$ _____	
<input type="checkbox"/> Guaranteed Insurability Rider (GIR) \$ _____		<input type="checkbox"/> Other _____ \$ _____	
<input type="checkbox"/> Accidental Death Benefit (ADB) \$ _____		<input type="checkbox"/> Other _____ \$ _____	

27. Name of Proposed Additional Insured(s) including any children applying	Birth Date	Sex	Height	Weight	Social Security Number	Relationship to Insured	Used Tobacco or nicotine products in last 5 years? If yes, list type and when used last
							<input type="checkbox"/> No <input type="checkbox"/> Yes _____
							<input type="checkbox"/> No <input type="checkbox"/> Yes _____
							<input type="checkbox"/> No <input type="checkbox"/> Yes _____
							<input type="checkbox"/> No <input type="checkbox"/> Yes _____

**28. LIFE INSURANCE IN FORCE** If none check this box

Insured's Name	Company (only need if replacing)	Policy Number (only need if replacing)	Face Amount
			\$
			\$

**29. DISABILITY INCOME - INSURANCE IN FORCE** If none check this box  Complete if applying for disability income and have current coverage. Please include any salary continuation program or employer paid benefits you may be eligible for should you become ill or injured over an extended period of time.

Insured's Name	Company	Policy Number	Monthly Amount	Benefit Period	Elimination Period

**GENERAL QUESTIONS** Complete the following. For YES answers, give full details in the space provided in Section 52.

30. Will the insurance applied for replace or change any existing insurance or annuity? .....  Yes  No
- Have you or any Proposed Additional Insured (including any children applying),**
31. Been declined, postponed, offered a rated or modified life, health or disability policy or been denied reinstatement? .....  Yes  No
32. Within the past 5 years,
- a. Been cited or convicted of a moving violation, including DUI, or had a driver's license suspended or revoked? .....  Yes  No  
(If yes, provide state and drivers license number.) \_\_\_\_\_
- b. Been or is now fully or partially disabled? .....  Yes  No
- c. Been charged with or convicted of any felony or has been or is currently on probation or parole? .....  Yes  No
33. Within the past 2 years, (If any YES answer, complete the Avocation, Aviation, Foreign Travel Questionnaire.)
- a. Taken part in any type of racing, mountain climbing, underwater or sky diving, hang gliding or plan to? .....  Yes  No
- b. Flown other than as a passenger, or plan to? .....  Yes  No
- c. Had a foreign residence, traveled to a foreign country or are you planning to travel to a foreign country in the next two years? .....  Yes  No
34. Within the past 10 years, used drugs (such as: hallucinogens, barbiturates, excitants or narcotics) except as medication prescribed by a physician, or been treated or counseled for drug or alcohol use? .....  Yes  No
- Questions 35 to 38 apply to you or any Proposed Additional Insured:
35. Family History: Is there a history of cardiovascular disease or cancer in parents/siblings prior to age 60? .....  Yes  No
36. Do you exercise? If yes, describe type, how often per week and how long per session. ....  Yes  No
37. Do you drink alcoholic beverages? If yes, please provide type of drinks, number of occasions per year and the number of drinks consumed on those occasions. ....  Yes  No
38. Have you had any weight change in the past year? .....  Yes  No
39. Do you or any Proposed Additional Insured (including any children applying) have any health, disability or life insurance pending or contemplated with another company? .....  Yes  No

**MEDICAL QUESTIONS** Each question must be individually asked and answered. For YES answers, give full details in the space provided in Section 52.

40. Have you or any Proposed Additional Insured (including any children applying) EVER been diagnosed as having or been treated for AIDS, or AIDS Related Complex (ARC) or tested positive for the AIDS virus? .....  Yes  No
- (Questions 41 to 51) Within the past 10 years, have you or any Proposed Additional Insured (including any children applying) been treated or diagnosed by a health care professional as having:**
41. A heart attack, heart disease, palpitations, heart murmur, chest pain, high blood pressure, stroke, anemia or any other disease or disorder of the blood or circulatory system? .....  Yes  No
42. Emphysema, asthma, shortness of breath, chronic cough, sleep apnea or any other disease or disorder of the respiratory system? .....  Yes  No
43. Seizures, epilepsy, multiple sclerosis, mental illness, depression, suicide attempt, eating disorder, dementia, Alzheimer's disease or any other disease or disorder of the brain or nervous system? .....  Yes  No
44. Sugar, albumin, blood in urine, or any other disease or disorder of the kidneys, bladder, or urinary system? .....  Yes  No
45. Prostate problems, breast problems, a sexually transmitted disease or any other disease or disorder of the reproductive system? .....  Yes  No
46. Stomach, intestine, liver disorder or any other disease or disorder of the gastrointestinal system (such as: ulcer, colitis, Crohn's disease or hepatitis)? .....  Yes  No
47. Diabetes, thyroid disorder or any other disease or disorder of the endocrine system? .....  Yes  No
48. Lupus, arthritis, back, bone, joint, or any other disease or disorder of the muscle or bone? .....  Yes  No
49. Tumor(s), polyp(s), cancer, melanoma or other malignancy? .....  Yes  No
50. Or been advised to have a check-up, consultation, lab test, EKG, X-ray or other diagnostic test? .....  Yes  No
51. Or are you currently under the observation of a physician or taking medication? .....  Yes  No

**52. ADDITIONAL INFORMATION** If additional space required, use Supplemental Form SA-ADINFO.

Question Number	Name of Proposed Insured	Details to General and Medical Questions (Diagnosis, Dates, Durations, and Medications, Dosages, Frequency) Medical Facilities & Physicians Names, Addresses, Phone Numbers

**53. PERSONAL PHYSICIAN(S)** If additional space required, use Supplemental Form SA-ADINFO.

Name of Proposed Insured	Personal Physician(s) Name, Address, Phone Number	Date Last Visited, Reason, Result

**ILLUSTRATION CERTIFICATION** The box below **MUST** be checked if a signed illustration of the policy applied for is **NOT** enclosed with this application.

The Applicant/Owner and the Licensed Agent certify that they have each read and agree with their respective statements below regarding the policy applied for:  
**Applicant's/Owner's statement:** By signing this application, I, the Applicant/Owner acknowledge that I have NOT received an illustration of the policy applied for and understand that an illustration of the policy as issued will be provided no later than the policy delivery date. **Licensed Agent's statement:** By signing this application, I, the Licensed Agent certify that I have NOT presented an illustration of the policy applied for or discussed any non-guaranteed elements of the policy with the Applicant/Owner. Upon or prior to delivery, I will provide an illustration and explain any non-guaranteed elements of the policy.

**ACKNOWLEDGMENT OF PROPOSED OWNER AND INSURED(S)** – Each of the undersigned hereby certifies and represents as follows: The statements and answers given on this application are true and correct. I acknowledge and agree (A) that this application and any amendments shall be the basis for any insurance issued; (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, only a writing signed by an officer of the Company can change the terms of this application or the terms of any insurance issued by the Company; (C) no policy applied for shall take effect until all of the following conditions have been met: 1) the first full premium must be received by the Company; 2) during the lifetime of any proposed insured, the proposed owner must have personally received and accepted the policy which was applied for; 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, and there must have been no change in the insurability of any proposed insured. Unless otherwise stated the undersigned applicant is the premium payor and owner of the policy applied for.

I authorize MIB Group, Inc., my employer or former employer, any consumer reporting agency or governmental agency, or any insurer or reinsurer to provide medical or non-medical information about me to Western Reserve Life Assurance Co. of Ohio, its administrators, representatives or its reinsurers. I understand that this information is to be used by the Company to determine eligibility for insurance and/or eligibility for benefits under an existing policy. This authorization will expire 30 months 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.

**FRAUD WARNING:** 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 a person to criminal and civil penalties.

Please make checks payable to Western Reserve Life Assurance Co. of Ohio. Do not make checks payable to the agent or leave the payee space blank on your check.

Amount paid with application: \$ \_\_\_\_\_ Best time to call for a personal history interview: \_\_\_\_\_ a.m. / p.m. Okay to contact at work?  Yes  No

Dated at \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ this \_\_\_\_\_ day of \_\_\_\_\_ Month \_\_\_\_\_, \_\_\_\_\_ Year

Signature of Proposed Insured \_\_\_\_\_ Signature of Proposed Owner (if other than Proposed Insured) \_\_\_\_\_

Signature of Parent or Legal Guardian (if Proposed Insured is under 18 years of age) \_\_\_\_\_ Signature of Additional Insured \_\_\_\_\_

**TAX NOTICE AND TAXPAYER IDENTIFICATION NUMBER 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 Proposed Owner \_\_\_\_\_ Date \_\_\_\_\_

**AGENT INFORMATION & SIGNATURE**

Signature of Agent \_\_\_\_\_ (Print First and Last Name) \_\_\_\_\_ Agent # \_\_\_\_\_

( ) \_\_\_\_\_ ( ) \_\_\_\_\_

Telephone Number \_\_\_\_\_ Agent Fax # \_\_\_\_\_ Agent E-mail Address \_\_\_\_\_

Split Agent Signature (If Applicable) \_\_\_\_\_ (Print First and Last Name) \_\_\_\_\_ Agent # \_\_\_\_\_

( ) \_\_\_\_\_ ( ) \_\_\_\_\_

Telephone Number \_\_\_\_\_ Agent Fax # \_\_\_\_\_ Agent E-mail Address \_\_\_\_\_

• Did you ask all questions on the application in the presence of all proposed insureds, record the answers as given, and witness all signatures?  Yes  No

If not, please provide details. \_\_\_\_\_

• Do you have any knowledge or reason to believe that the insurance applied for will replace or change any existing insurance or annuity?  Yes  No

(If yes, submit the state required forms.)

# CONDITIONAL RECEIPT

(Detach and leave with applicant if money is submitted with application. If within the past 12 months the proposed insured has been treated for or experienced heart trouble, stroke or cancer, no payment may be accepted with the application.)

## PLEASE READ THIS CAREFULLY

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 or annuity application dated \_\_\_\_\_, with \_\_\_\_\_ as the proposed insured(s) or annuitant. 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 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. Each person proposed to be 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 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 Home Office within the lifetime of the proposed insured;
4. All medical examinations, tests, and other screenings required of any proposed insured by the Company are completed and the results received at our Home Office within 60 days of the date the application was completed; and
5. All parts of the application, any supplemental application, questionnaires, addendum and/or amendments to the application are signed and received at our Home Office.

Any conditional coverage provided by this Receipt will terminate on the earliest of: (a) 90 days from the date 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.

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 additional benefits, if any, for which you have applied.

If one or more of this Receipt's conditions have not been met exactly, or if a 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 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.

This Receipt is not valid unless all blanks are completed above and this Receipt is signed by an agent or authorized Company representative. This Receipt does not provide any conditional insurance until all of the conditions and requirements are met as outlined above.

Dated at \_\_\_\_\_ this \_\_\_\_\_ day of \_\_\_\_\_, \_\_\_\_\_  
City State Month Year

\_\_\_\_\_  
Signature of Agent

## **DETACH AND LEAVE THIS PAGE WITH APPLICANT**

### **NOTICE TO PERSONS APPLYING FOR INSURANCE REGARDING INVESTIGATIVE REPORT**

To proposed insureds: 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.**

### **NOTICE OF DISCLOSURE OF INFORMATION**

**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: Post Office Box 105, Essex Station, Boston, Massachusetts 02122; and telephone number is 866-692-6901 (TTY 866-346-3642 for hearing impaired).

### **NOTICE OF INSURANCE INFORMATION PRACTICES**

To proposed insureds: 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.

<b>SECTION 1. PROPOSED PRIMARY INSURED/OWNER</b>										Specified Amount \$ _____	
1. Last Name					First Name			M.I.			
2. Address (Cannot be a P.O. Box)					Apt#		City				
State	Zip Code	3. Years at Address		4. Home Phone ( )			5. Driver License Number			State	
6. Sex	<input type="checkbox"/> Male <input type="checkbox"/> Female	7. Date of Birth MM-DD-YYYY		8. Age	9. Place of Birth – State/Country			10. Social Security Number			
11. Height ft in	12. Weight lbs	13. Marital Status		14. Employer					Years		
15. Employer's Address and Phone Number											
16. Occupation & Duties											
17. Have you used <b>TOBACCO</b> or any other product containing <b>NICOTINE</b> in the last 5 years? <input type="checkbox"/> Yes <input type="checkbox"/> No Date last used _____											
18. Rate Class Quoted: <input type="checkbox"/> Preferred Elite <input type="checkbox"/> Preferred Plus <input type="checkbox"/> Preferred <input type="checkbox"/> Non-Tobacco <input type="checkbox"/> Preferred Tobacco <input type="checkbox"/> Tobacco <input type="checkbox"/> Juvenile											
<b>SECTION 2. PROPOSED ADDITIONAL INSURED</b>										Specified Amount \$ _____	
If more than one Additional Insured, please use Additional Insured Supplemental Form. We will allow the AIR death benefit recipient to be a choice of: <input type="checkbox"/> Owner <input type="checkbox"/> Primary Insured <input type="checkbox"/> Same beneficiary as the base policy											
1. Last Name					First Name			M.I.			
2. Address (Cannot be a P.O. Box)					Apt#		City				
State	Zip Code	3. Years at Address		4. Home Phone ( )			5. Driver License Number			State	
6. Sex	<input type="checkbox"/> Male <input type="checkbox"/> Female	7. Date of Birth MM-DD-YYYY		8. Age	9. Place of Birth – State/Country			10. Social Security Number			
11. Height ft in	12. Weight lbs	13. Marital Status		14. Relationship to proposed Primary Insured							
15. Employer's Name, Address and Phone Number											
16. Occupation & Duties # Years											
17. Have you used <b>TOBACCO</b> or any other product containing <b>NICOTINE</b> in the last 5 years? <input type="checkbox"/> Yes <input type="checkbox"/> No Date last used _____											
18. Rate Class Quoted: <input type="checkbox"/> Preferred Elite <input type="checkbox"/> Preferred Plus <input type="checkbox"/> Preferred <input type="checkbox"/> Non-Tobacco <input type="checkbox"/> Preferred Tobacco <input type="checkbox"/> Tobacco <input type="checkbox"/> Juvenile											
<b>SECTION 3. APPLICANT/OWNER IF OTHER THAN THE PROPOSED PRIMARY INSURED</b>											
If ownership is 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.											
1. Last Name					First Name			M.I.			
2. Address (Cannot be a P.O. Box)					Apt#		City				
State	Zip Code	3. Home Phone ( )			4. Social Security Number / Tax ID #						
5. Sex	<input type="checkbox"/> Male <input type="checkbox"/> Female	6. Date of Birth/Trust Date MM-DD-YYYY		7. Relationship to the proposed Primary Insured							
8. Are you a citizen of <input type="checkbox"/> USA <input type="checkbox"/> Other Country _____ Type of VISA _____											
<b>SECTION 4. CHILDREN'S BENEFIT RIDER</b>										Specified Amount \$ _____	
Name		Relationship			Date of Birth			Height		Weight	
					MM-DD-YYYY			ft in		lbs	
					MM-DD-YYYY			ft in		lbs	
					MM-DD-YYYY			ft in		lbs	
Are all children listed? <input type="checkbox"/> Yes <input type="checkbox"/> No Are children living with proposed Primary Insured? <input type="checkbox"/> Yes <input type="checkbox"/> No											
If not, explain why: _____											

**SECTION 5. PRIMARY BENEFICIARY – If percentage shares are not listed below, they will be divided equally among the beneficiaries. If ownership or beneficiary is a corporation, partnership or institutional body, please complete the Entity Certification of Authority form. If ownership or beneficiary is a trust, please complete the Trustee Certification Trust form. Attach a copy of the first page and the signature page of the Trust.**

Name	Percent	Relationship	Social Security Number/Tax ID#
<b>Total</b>			<b>1 0 0</b>

**SECTION 6. CONTINGENT BENEFICIARY – If percentage shares are not listed below, they will be divided equally among the beneficiaries.**

Name	Percent	Relationship	Social Security Number/Tax ID#
<b>Total</b>			<b>1 0 0</b>

**SECTION 7. PROPOSED PLAN OF INSURANCE**

WRL Freedom Index UL  
 WRL Freedom Choice Term II     10    15    20    30

**SECTION 9. LIFE INSURANCE COMPLIANCE TEST (if applicable)**

Guideline Premium Test  
 Cash Value Accumulation Test (CVAT)

**SECTION 8. DEATH BENEFIT OPTION (if applicable)**

Level Benefit                       Increasing Benefit

**SECTION 10. ADDITIONAL BENEFITS—PRIMARY INSURED ONLY Not all applicable with all products.**

Base Insured Rider ..... \$ \_\_\_\_\_, \_\_\_\_\_ . \_\_\_\_\_     Disability Waiver of Premium Rider  
 Accidental Death Benefit Rider ..... \$ \_\_\_\_\_, \_\_\_\_\_ . \_\_\_\_\_     Critical Illness Rider  
 Disability Income Rider ..... Other \_\_\_\_\_  
     (monthly benefit) ..... \$ \_\_\_\_\_, \_\_\_\_\_ . \_\_\_\_\_     Other \_\_\_\_\_  
 Disability Waiver of Monthly Deductions Rider     Other \_\_\_\_\_

**SECTION 11. PREMIUMS PAYABLE**

Initial Planned Premium..... \$ \_\_\_\_\_, \_\_\_\_\_ . \_\_\_\_\_  
 Single Premium     Annually     Semiannually     Quarterly     Monthly     Other \_\_\_\_\_  
 Electronic (bank draft) \_\_\_\_\_ Draft Date (1st thru 28th)  
 Direct Bill

**SECTION 12. PREMIUM ALLOCATIONS (Only for IUL)**

Indicate your premium allocation percentages below. Total must equal 100%.

_____ .0%	Index Account
_____ .0%	Basic Interest Account
<b>100%</b>	<b>Total</b>

**SECTION 13. OTHER INSURANCE IN FORCE FOR ALL PROPOSED INSUREDS**

Does the proposed Insured have existing life insurance, disability policies, critical illness or annuity contracts?  Yes  No

Proposed Insured Name	Company	Product Type	Amount of insurance	Year issued	Replacement?
					Yes No
					Yes No
					Yes No

**IS THIS INTENDED TO BE A 1035 EXCHANGE?**  Yes  No

Anticipated Cash Value Transfer \$ \_\_\_\_\_, \_\_\_\_\_ . \_\_\_\_\_

- A) Has any proposed Insured ever had life, disability or health insurance declined, rated, modified, issued with an exclusion rider, canceled, or not renewed? If yes, please explain. \_\_\_\_\_  Yes  No
- B) Will the insurance applied for on any proposed Insured discontinue, replace or change any existing life or annuity policy? If yes, complete replacement forms, if appropriate.  Yes  No
- C) Is there an application for life, accident or sickness insurance now pending or contemplated on any proposed Insured in this or any other company? If yes, give details in Agent's Report.  Yes  No



**SECTION 18. PERSONAL PHYSICIAN (if none, so state)**

Proposed Insured's Name	Date Last Seen, Reason and Results	Name, Address and Phone # of Attending Doctor and Hospital

**SECTION 19. RESIDENCY – Each question must be individually asked and answered for each proposed Insured.**

A) The proposed Insured is a citizen of  USA  Other Country \_\_\_\_\_ Type of VISA \_\_\_\_\_  
B) How many years has the proposed Insured resided in the USA? \_\_\_\_\_  
C) Does any proposed Insured travel outside the USA?  Yes  No  
If yes, provide details: include name of proposed Insured, destination, number of trips, duration of each trip, purpose of trip, plans for the next year. \_\_\_\_\_

**SECTION 20. DRIVING AND PUBLIC RECORDS – Each question must be individually asked and answered for each proposed Insured.**

A) Has any proposed Insured had their driver's license suspended, restricted, revoked, or been cited for a moving violation in the last 5 years?  Yes  No If yes, include name of proposed Insured and give reason: \_\_\_\_\_  
B) Has any proposed Insured in the last ten years been convicted of a misdemeanor (other than a minor traffic violation) or felony?  Yes  No If yes, include name of proposed Insured and give reason: \_\_\_\_\_

**SECTION 21. SPECIAL ACTIVITIES – Each question must be individually asked and answered for each proposed Insured.**

A) Except as a passenger on a regularly scheduled flight, has any proposed Insured flown within the past 2 years, or does any proposed Insured have plans to fly in the future? If yes, complete the Avocation and Aviation Questionnaire.  Yes  No  
B) In the past 2 years has any proposed Insured participated in organized racing (automobile, motorcycle, or boat), underwater or scuba diving, hang gliding, canyoneering, mountain or rock climbing? If yes, complete the Avocation and Aviation Questionnaire.  Yes  No

**SECTION 22. TRANSFER AUTHORIZATION – TO BE COMPLETED BY APPLICANT/OWNER (only for IUL)**

Transfer Authorization:  
Your policy applied for, if issued, will automatically receive transfer privileges, unless declined below. These privileges only allow the Owner and agent of record to change premium allocations and transfer between the Basic Interest Account and the Index Account. Transfers are subject to the restrictions/guidelines outlined in the Statement of Understanding.  
Western Reserve Life Assurance Co. of Ohio will not be liable for complying with transfer instructions it reasonably believes to be authentic, nor for any loss, damage, costs or expense in acting on such instructions, and Policy Owners will bear the risk of any such loss. Western Reserve Life Assurance Co. of Ohio will employ reasonable procedures to confirm that transfer instructions are genuine. If Western Reserve Life Assurance Co. of Ohio does not employ such procedures, it may be liable for losses due to unauthorized or fraudulent instructions. These procedures include but are not limited to requiring forms of personal identification prior to acting upon such transfer instruction, providing written confirmation of such transactions to the Owner and/or tape recording of telephone transfer request instructions received.  
 The agent does **not** have authority to make transfers or change payment allocations on my behalf.

**SECTION 23. OTHER INSURANCE – TO BE COMPLETED BY THE AGENT**

A) Will the policy applied for discontinue, replace or change any existing life insurance policy or annuity?  Yes  No  
B) If mandated by your state, did you present, read and leave a copy of the Replacement Notice with the Applicant/Owner at time of application?  Yes  No  
(In some states the Replacement Notice must be completed and sent in with the application whether or not the Applicant/Owner intends to replace existing coverage.)  
C) Did you present and leave the Applicant/Owner approved sales material?  Yes  No

**SECTION 24. ILLUSTRATION CERTIFICATION (if applicable)**      **The box below MUST be checked if a signed illustration of the policy applied for is NOT enclosed with this application.**

The Applicant/Owner and the Licensed Agent certify that they have each read and agree with their respective statements below regarding the policy applied for:  
**Applicant's/Owner's statement:** By signing this application, I, the Applicant/Owner acknowledge that I have NOT received an illustration of the policy applied for and understand that an illustration of the policy as issued will be provided no later than the policy delivery date. **Licensed Agent's statement:** By signing this application, I, the Licensed Agent certify that I have NOT provided an illustration of the policy as applied for. However, I will provide an illustration conforming to the policy as issued upon or prior to delivery of the policy.

**SECTION 25. 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 \_\_\_\_\_

**SECTION 26. AUTHORIZATION TO OBTAIN AND DISCLOSE INFORMATION**

Each of the undersigned hereby certifies and represents as follows: The statements and answers given on this application are true and correct. I acknowledge and agree (A) that this application and any amendments shall be the basis for any insurance issued; (B) that the agent does not have the authority to waive any question on this application, to deny if insurance will be issued, or to modify any term or provision of any insurance which may be issued based on this application, only a writing signed by an officer of the Company can change the terms of this application or the terms of any insurance issued by the Company; (C) except as provided in the Conditional Receipt, if issued with the same proposed Insured(s) as on this application, no policy applied for shall take effect until after all of the following conditions have been met: 1) the minimum initial premium must be received by the Company; 2) the proposed Owner must have personally received and accepted the policy during the lifetime of all proposed Insured(s) and while all proposed Insured(s) are 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, and the insurance will not take effect if the facts have changed. Unless otherwise stated the undersigned applicant is the premium payor and Owner of the policy applied for.

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 and 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.**

Signed at \_\_\_\_\_ (city) \_\_\_\_\_ (state) on MM - DD - YYYY (date)

Signature of proposed Primary Insured/Owner (Child over age 15 must sign)

Print Agent Name

Signature of parent or legal guardian for Insured(s) 15 and under

Agent #

Signature of proposed Additional Insured

Signature of Applicant/Owner if other than the proposed Primary Insured (If business insurance, show title of officer and name of firm. If trust, show trustee's name)

Signature of Agent/Licensed Rep.

Signature of Split Agent/Licensed Rep.

**Specimen**

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# FRAUD WARNING

The following state(s) and U.S. territories require that insurance applicants acknowledge a fraud warning statement. Please refer to the fraud warning statement for your state or U.S. territory as indicated below.

## For applicants in **ARKANSAS, LOUISIANA 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.

Applicant's Signature \_\_\_\_\_ Date \_\_\_\_\_

## For applicants in **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.

Applicant's Signature \_\_\_\_\_ Date \_\_\_\_\_

## For applicants in **DISTRICT OF COLUMBIA**

It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.

Applicant's Signature \_\_\_\_\_ Date \_\_\_\_\_

## For applicants in **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.

Applicant's Signature \_\_\_\_\_ Date \_\_\_\_\_

## For applicants in **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.

Applicant's Signature \_\_\_\_\_ Date \_\_\_\_\_

## For applicants in **MAINE and TENNESSEE**

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.

Applicant's Signature \_\_\_\_\_ Date \_\_\_\_\_

## For applicants in **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.

Applicant's Signature \_\_\_\_\_ Date \_\_\_\_\_

## For applicants in **NEW MEXICO**

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 civil fines and criminal penalties.

Applicant's Signature \_\_\_\_\_ Date \_\_\_\_\_

## For applicants in **OHIO**

Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

Applicant's Signature \_\_\_\_\_ Date \_\_\_\_\_

## For applicants in **OKLAHOMA**

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.

Applicant's Signature \_\_\_\_\_ Date \_\_\_\_\_

## For applicants in **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.

Applicant's Signature \_\_\_\_\_ Date \_\_\_\_\_

## For applicants in **PUERTO RICO**

Any person who knowingly, and with the intention to defraud, includes false information in an application for insurance or files, assists or abets in the filing of a fraudulent claim to obtain payment of a loss or other benefit, or files more than one claim for the same loss or damage, commits a felony, and if found guilty, shall be punished for each violation with a fine of no less than five thousand dollars (\$5000), not to exceed ten thousand dollars (\$10,000); or imprisoned for a fixed term of three (3) years, or both. If aggravating circumstances exist, the fixed jail term may be increased to a maximum of five (5) years; and if mitigating circumstances are present, the jail term may be reduced to a minimum of two (2) years.

Applicant's Signature \_\_\_\_\_ Date \_\_\_\_\_

## For applicants in **VIRGINIA 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 include imprisonment, fines and denial of insurance benefits.

Applicant's Signature \_\_\_\_\_ Date \_\_\_\_\_

**Specimen**

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## CONDITIONAL RECEIPT

(Detach and leave with applicant only if money is submitted with application. **If within the past 12 months any proposed Insured has been treated for or experienced 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 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. Each person proposed to be 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 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, must be received at our Administrative Office within the lifetime of the proposed Insured to whom the conditional coverage would apply and, 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 parts 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 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 a 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 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 (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 Agent or Authorized Company Rep

\_\_\_\_\_  
Signature of proposed Insured

\_\_\_\_\_  
Signature of Applicant (if other than proposed Insured)

**Specimen**

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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: Post Office Box 105, Essex Station, Boston, Massachusetts 02122; and telephone number is 866-692-1901 (TOLL FREE 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, 1033 Edgewood Road NE, Cedar Rapids, Iowa 52499].

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

**Specimen**

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left blank**

# Additional Insured Supplement

SECTION 1. PROPOSED ADDITIONAL INSURED										SPECIFIED AMOUNT \$ _____
We will allow the AIR death benefit recipient to be a choice of: <input type="checkbox"/> Owner <input type="checkbox"/> Primary Insured <input type="checkbox"/> Same beneficiary as the base policy										
1. Last Name					First Name				M.I.	
2. Address (Cannot be a P.O. Box)							Apt#		City	
State		Zip Code		3. Years at Address		4. Home Phone ( )		5. Driver License Number		State
6. Sex <input type="checkbox"/> Male <input type="checkbox"/> Female		7. Date of Birth MM-DD-YYYY		8. Age		9. Place of Birth – State/Country		10. Social Security Number		
11. Height ft in		12. Weight lbs		13. Marital Status		14. Relationship to proposed Primary Insured				
15. Employer's Name, Address and Phone Number										
16. Occupation & Duties										# Years
17. Have you used <b>TOBACCO</b> or any other product containing <b>NICOTINE</b> in the last 5 years? <input type="checkbox"/> Yes <input type="checkbox"/> No Date last used _____										
18. Rate Class Quoted: <input type="checkbox"/> Preferred Elite <input type="checkbox"/> Preferred Plus <input type="checkbox"/> Preferred <input type="checkbox"/> Non-Tobacco <input type="checkbox"/> Preferred Tobacco <input type="checkbox"/> Tobacco <input type="checkbox"/> Juvenile										
SECTION 2. PROPOSED ADDITIONAL INSURED										SPECIFIED AMOUNT \$ _____
We will allow the AIR death benefit recipient to be a choice of: <input type="checkbox"/> Owner <input type="checkbox"/> Primary Insured <input type="checkbox"/> Same beneficiary as the base policy										
1. Last Name					First Name				M.I.	
2. Address (Cannot be a P.O. Box)							Apt#		City	
State		Zip Code		3. Years at Address		4. Home Phone ( )		5. Driver License Number		State
6. Sex <input type="checkbox"/> Male <input type="checkbox"/> Female		7. Date of Birth MM-DD-YYYY		8. Age		9. Place of Birth – State/Country		10. Social Security Number		
11. Height ft in		12. Weight lbs		13. Marital Status		14. Relationship to proposed Primary Insured				
15. Employer's Name, Address and Phone Number										
16. Occupation & Duties										# Years
17. Have you used <b>TOBACCO</b> or any other product containing <b>NICOTINE</b> in the last 5 years? <input type="checkbox"/> Yes <input type="checkbox"/> No Date last used _____										
18. Rate Class Quoted: <input type="checkbox"/> Preferred Elite <input type="checkbox"/> Preferred Plus <input type="checkbox"/> Preferred <input type="checkbox"/> Non-Tobacco <input type="checkbox"/> Preferred Tobacco <input type="checkbox"/> Tobacco <input type="checkbox"/> Juvenile										
SECTION 3. PROPOSED ADDITIONAL INSURED										SPECIFIED AMOUNT \$ _____
We will allow the AIR death benefit recipient to be a choice of: <input type="checkbox"/> Owner <input type="checkbox"/> Primary Insured <input type="checkbox"/> Same beneficiary as the base policy										
1. Last Name					First Name				M.I.	
2. Address (Cannot be a P.O. Box)							Apt#		City	
State		Zip Code		3. Years at Address		4. Home Phone ( )		5. Driver License Number		State
6. Sex <input type="checkbox"/> Male <input type="checkbox"/> Female		7. Date of Birth MM-DD-YYYY		8. Age		9. Place of Birth – State/Country		10. Social Security Number		
11. Height ft in		12. Weight lbs		13. Marital Status		14. Relationship to proposed Primary Insured				
15. Employer's Name, Address and Phone Number										
16. Occupation & Duties										# Years
17. Have you used <b>TOBACCO</b> or any other product containing <b>NICOTINE</b> in the last 5 years? <input type="checkbox"/> Yes <input type="checkbox"/> No Date last used _____										
18. Rate Class Quoted: <input type="checkbox"/> Preferred Elite <input type="checkbox"/> Preferred Plus <input type="checkbox"/> Preferred <input type="checkbox"/> Non-Tobacco <input type="checkbox"/> Preferred Tobacco <input type="checkbox"/> Tobacco <input type="checkbox"/> Juvenile										

**SECTION 4. PROPOSED ADDITIONAL INSURED** **SPECIFIED AMOUNT \$ \_\_\_\_\_**

We will allow the AIR death benefit recipient to be a choice of:  Owner  Primary Insured  Same beneficiary as the base policy

1. Last Name		First Name			M.I.
2. Address (Cannot be a P.O. Box)				Apt#	City
State	Zip Code	3. Years at Address	4. Home Phone ( )	5. Driver License Number	State
6. Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	7. Date of Birth MM - DD - YYYY	8. Age	9. Place of Birth – State/Country	10. Social Security Number	
11. Height ft in	12. Weight lbs	13. Marital Status	14. Relationship to proposed Primary Insured		
15. Employer's Name, Address and Phone Number					
16. Occupation & Duties					# Years
17. Have you used <b>TOBACCO</b> or any other product containing <b>NICOTINE</b> in the last 5 years? <input type="checkbox"/> Yes <input type="checkbox"/> No Date last used _____					
18. Rate Class Quoted: <input type="checkbox"/> Preferred Elite <input type="checkbox"/> Preferred Plus <input type="checkbox"/> Preferred <input type="checkbox"/> Non-Tobacco <input type="checkbox"/> Preferred Tobacco <input type="checkbox"/> Tobacco <input type="checkbox"/> Juvenile					

**SECTION 5. DECLARATIONS**

I (We) represent that all statements and answers made in this supplement are full, complete and true to the best of my (our) knowledge and belief. It is agreed that this statement shall be made part of the application, and is subject to all terms and conditions contained in the application.

Signed at \_\_\_\_\_ (city) \_\_\_\_\_ (state) on MM - DD - YYYY (date)

sec. 1 _____ Signature of proposed Additional Insured (Child over 15 must sign)	sec. 3 _____ Signature of proposed Additional Insured (Child over 15 must sign)
sec. 2 _____ Signature of proposed Additional Insured (Child over 15 must sign)	sec. 4 _____ Signature of proposed Additional Insured (Child over 15 must sign)
_____ Signature of Parent or Legal Guardian for Insured(s) 15 and under	_____ Signature of Applicant/Owner, if other than the proposed Primary Insured (If business insurance, show title of officer and name of firm. If trust, show trustee's name)
_____ Witness (Registered Representative)	

**APPLICATION FOR INSURANCE**

Western Reserve Life Assurance Co. of Ohio  
 Administrative Office, 4333 Edgewood Road NE, Cedar Rapids, IA 52499

[ ]

PROPOSED INSURED INFORMATION							
Name (First, M.I., Last)				Mailing Address			
Home Telephone No. ( )		Work Telephone No. ( )		Birth Date	Birth Place (State or Country)		E-Mail Address
Height	Weight	Marital Status		Sex	U.S. Citizen <input type="checkbox"/> Yes <input type="checkbox"/> No		If no, give immigration status/type of visa:
Occupation & Duties			Annual Income Current Year _____		Social Security No. or Tax I.D. No.		
			Annual Income Previous Year _____		Drivers License No./ State		
			Net Worth _____				

Have you used any tobacco within the last 5 years?  Yes  No If yes, list type and when used last \_\_\_\_\_

BENEFICIARY AND RELATIONSHIP TO PROPOSED INSURED	
<i>(Unless otherwise noted, the beneficiary of other persons proposed for Coverage will be the proposed insured.)</i>	
Primary	Contingent

OWNER(S)		
<i>(Unless otherwise noted, the Owner will be the Insured. For Florida applicants, you may name a secondary addressee to receive notice of possible lapse in coverage - complete the Additional information section.)</i>		
Name	Relationship to Proposed Insured	Social Security Number
Address	Birth Date	Phone ( )

POLICY INFORMATION		
Plan: _____	Amount of Insurance	Planned Premium
<input type="checkbox"/> Level <input type="checkbox"/> Increasing Guarantee Period _____	\$ _____	\$ _____

DISABILITY INCOME		
PLAN _____	AMOUNT: BASE _____ SIR _____	
BENEFIT PERIOD _____	ELIM. PER _____	OCCUPATIONAL CLASS _____
OPTIONAL RIDERS (SPECIFY RIDER, AMOUNT, ETC.) _____		
TOTAL INITIAL DISABILITY INC. PREM. \$ _____		

Mode of Payment (for bank draft, complete Check-O-Matic authorization, and initial payment required.)		
<input type="checkbox"/> Monthly Bank Draft	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Semi-Annual <input type="checkbox"/> Annual

BENEFIT/RIDERS					
	Benefit Units Monthly \$ Amount			Benefit Units Monthly \$ Amount	
<input type="checkbox"/> Waiver of Premium Benefit (WP)	_____		<input type="checkbox"/> Guaranteed Insurability Rider (GIR)	_____	
<input type="checkbox"/> Waiver of Monthly Deduction	_____		<input type="checkbox"/> Return of Premium Rider	_____	
<input type="checkbox"/> Children's Rider	_____		<input type="checkbox"/> Monthly Disability Income Rider	_____	
<input type="checkbox"/> Additional Insured Rider (AIR)	_____		<input type="checkbox"/> Other _____	_____	
<input type="checkbox"/> Base Insured Rider (BIR)	_____		<input type="checkbox"/> Other _____	_____	
<input type="checkbox"/> Accidental Death Benefit (ADB)	_____		<input type="checkbox"/> Other _____	_____	

Name of Other Proposed Insured(s)	Birth Date	Sex	Height	Weight	Social Security Number	Relationship to Insured	Amount of Insurance	Used Tobacco in last 5 years? If yes, list type and when used last
								<input type="checkbox"/> Yes <input type="checkbox"/> No
								<input type="checkbox"/> Yes <input type="checkbox"/> No
								<input type="checkbox"/> Yes <input type="checkbox"/> No
								<input type="checkbox"/> Yes <input type="checkbox"/> No

LIFE INSURANCE IN FORCE		
Insured's Name	Company/ Policy Number	Face Amount
		\$
		\$
		\$
		\$
		\$
		\$

DISABILITY INCOME - INSURANCE IN FORCE (Complete only if Disability Coverage is being applied for)				
Insured's Name	Company/ Policy Number	Monthly Amount	Benefit Period	Elimination Period

PERSONAL PHYSICIAN(S)		
Name of Proposed Insured	Personal Physician(s) Name, Address, Phone Number	Date Last Visited, Reason, Result

**GENERAL QUESTIONS** Complete the following. For YES answers, give full details in the space provided on the next page.

1. Will the insurance applied for replace or change an existing insurance or annuity?  Yes  No
- Have you or any proposed insured,**
2. Had any health, disability or life insurance pending or contemplated with another company?  Yes  No
  3. Been declined, postponed, offered a new or modified life, health or disability policy or been denied reinstatement?  Yes  No
  4. Within the past 5 years,
    - a. Been cited or convicted of a moving violation, including DUI, or had a driver's license suspended or revoked?  Yes  No  
(If yes, provide state and drivers license number.)
    - b. Been or is now fully or partially disabled?  Yes  No
    - c. Been charged with or convicted of any felony or been on probation?  Yes  No
  5. Within the past 2 years,
    - a. Taken part in any type of racing, mountain climbing, underwater or sky diving, hang gliding or plan to?  Yes  No
    - b. Flown other than a passenger, or plan to? (If yes, complete the Aviation Supplement.)  Yes  No
    - c. Foreign residence or travel contemplated?  Yes  No
  6. Within the past 10 years, used drugs (such as: hallucinogens, barbiturates, excitants or narcotics) except as medication prescribed by a physician, or been treated or counseled for drug or alcohol use?  Yes  No
  7. Family History: Is there a history of cardiovascular disease or cancer in parents/siblings prior to age 60?  Yes  No
  8. Do you exercise? If yes, describe type, how often per week and how long per session.  Yes  No
  9. Do you drink alcoholic beverages? If yes, please provide type of drinks, number of occasions per year and the number of drinks consumed on those occasions.  Yes  No
  10. Have you had any weight change in the past year?  Yes  No



**TAXPAYER IDENTIFICATION AND BACKUP WITHHOLDING CERTIFICATION** – Under penalties of perjury, each of the undersigned hereby certifies (1) that the Social Security or Taxpayer Identification Number set forth on this application is correct and (2) that I am currently not subject to backup withholding. [Cross out (2) if not 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.

**ACKNOWLEDGMENT OF APPLICANT AND PROPOSED INSURED** – Each of the undersigned hereby certifies and represents as follows: The statements and answers given on this application are true and correct. I acknowledge and agree (A) that this application and any amendments shall be the basis for any insurance issued; (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, only a writing signed by an officer of the Company can change the terms of this application or the terms of any insurance issued by the Company; (C) no policy applied for shall take effect until all of the following conditions have been met: 1) the first full premium must be received by the Company; 2) during the lifetime of any proposed insured, the proposed owner must have personally received and accepted the policy which was applied for and all answers on this application must be true and correct on the date such policy is received and accepted; 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, and there must have been no change in the insurability of any proposed insured. Unless otherwise stated the undersigned applicant is the premium payor and owner of the policy applied for.

I authorize Medical Information Bureau, Inc., my employer, any consumer reporting agency or insurance company, or any other individual or entity that possesses information concerning me to provide such information about me to Western Reserve Life Assurance Co. of Ohio, its representative or its reinsurers.

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 objection 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) Notice of Disclosure of Information, 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.**

Please make checks payable to Western Reserve Life Assurance Co. of Ohio.  
Do not make checks payable to the agent or leave the payee space blank on your check.

Amount paid with 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.**

**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.

Dated at \_\_\_\_\_ this \_\_\_\_\_ day of \_\_\_\_\_, \_\_\_\_\_ Year  
City State Month Year

Signature of Proposed Insured \_\_\_\_\_

Signature of Proposed Owner (if other than Proposed Insured) \_\_\_\_\_

Signature of Parent or Legal Guardian  
(if Proposed Insured is Under 18 years of age) \_\_\_\_\_

Signature of Additional Insured \_\_\_\_\_

Best time to call for a personal history interview: \_\_\_\_\_ a.m. \_\_\_\_\_ p.m. Okay to contact at work? Yes  No

AGENT INFORMATION & SIGNATURE		
Signature of Agent (_____)	(Print First and Last Name) (_____)	Agent # _____
Telephone Number _____	Agent Fax # _____	Agent E-mail Address _____
Split Agent Signature (If Applicable) (_____)	(Print First and Last Name) (_____)	Agent # _____
Telephone Number _____	Agent Fax # _____	Agent E-mail Address _____
<ul style="list-style-type: none"> <li>• Did you ask all questions on the application in the presence of the Proposed Insured, record the answers as given, and witness all signatures? Yes <input type="checkbox"/> No <input type="checkbox"/> If not, please provide details. _____</li> <li>• Do you have any knowledge or reason to believe that the insurance applied for will replace or change any existing insurance or annuity? Yes <input type="checkbox"/> No <input type="checkbox"/> If yes, what company? _____ Policy # _____</li> </ul>		

**ILLUSTRATION CERTIFICATION**

I certify that no illustration was used by me or any other authorized agent of Western Reserve Life Assurance Co. of Ohio in the sale of the life insurance to \_\_\_\_\_ APPLICANT on this date. An illustration conforming to the requirements of the \_\_\_\_\_ STATE state regulation on illustrations will be delivered to this applicant no later than the policy delivery date.

\_\_\_\_\_  
DATE AGENT

I acknowledge that no illustration conforming to the policy applied for was provided to me at the point of sale. I understand an illustration conforming to the policy as issued will be provided to me no later than at the time of policy delivery.

\_\_\_\_\_  
DATE APPLICANT

**AGENT'S REPORT**

How well do you know proposed insured? \_\_\_\_\_  
Yes No

Do you know of any information not given in the application which might affect the insurability of any person proposed for insurance?  
*(If "yes", explain in Remarks Section)*

Is this case personal business? (Is it written on your life, spouse, child, grandchild, parent, or spouse's parent?)  
*(If "yes", explain in Remarks Section)*

Did you see all of those to be insured on the date the application was written?  
*(If "no", explain in Remarks Section)*

Is insurance being applied for with any other company?  
*(If "yes", give details in Remarks Section)*

Did you witness the signing of the application?  
*(If "no", explain in Remarks Section)*

Did you ask each question in this application exactly as printed?  
*(If "no", explain in Remarks Section)*

If application is approved other than as requested:  
 Adjust to premium

Issue face amount as shown

Is applicant being examined by a medical doctor?

Is an EKG being arranged?

Is an exercise EKG being arranged?

Is a blood profile being arranged?

**COMPLETE ONLY IF OWNER IS OTHER THAN INSURED**

OWNER IS:  Corporation  Partnership  
 Individual  Sole Proprietorship  Trust

Purpose of Policy  
 Personal Needs Analysis  Estate Liquidity  
 Mortgage  Buy-Sell  
 Retirement  Key Employee  
 Education  Other

If application is for key-man insurance, on what basis was the applicant's value to the business determined?  
\_\_\_\_\_

Who will pay the premium? \_\_\_\_\_

Total of other insurance on proposed insured payable to business. \_\_\_\_\_

If partnership, give names of all partners. \_\_\_\_\_

Are all other partners insured? If not, explain. \_\_\_\_\_

Relationship of owner to Insured? \_\_\_\_\_

How much life insurance is carried by  
(a) Father \_\_\_\_\_ b) Mother \_\_\_\_\_

(c) If this application is greater than a or b above  
*(Explain in Remarks Section)*

If the Proposed Insured is under age 15, list age of brothers and sisters and amount of insurance on each of their lives  
*(in Remarks Section)*

1. Agent's Name	Account No.	% if Split
2. Agent's Name	Account No.	% if Split

Rate Class:	
<u>Universal</u>	<u>Term</u>
<input type="checkbox"/> Preferred Plus	<input type="checkbox"/> Preferred Elite
<input type="checkbox"/> Preferred	<input type="checkbox"/> Preferred Plus
<input type="checkbox"/> Non-Tobacco	<input type="checkbox"/> Preferred
<input type="checkbox"/> Preferred Tobacco	<input type="checkbox"/> Non-Tobacco
<input type="checkbox"/> Tobacco	<input type="checkbox"/> Preferred Tobacco
	<input type="checkbox"/> Tobacco

**ADDITIONAL REMARKS/AND OR SPECIAL INSTRUCTIONS**

I submit this application assuming full responsibility for delivery of any policy issued and for payment to the company of the first premium, when collected. I know of no condition affecting the insurability of the proposed insured not fully set forth herein. I will not deliver the policy, if the health of the insured has changed.

\_\_\_\_\_  
Signature of Writing Agent  
Print name and account number of, and percentages for agent or agents who are to receive credit and commission.

**PAYOR'S CHECK-O-MATIC PREMIUM PAYMENT PLAN**

**Authorization to Insurance Company**

The Premium Payor hereby authorizes Western Reserve Life Assurance Co. of Ohio to debit his/her account or accounts by means of check or draft drawn or other order made whether by electronic or paper means at the below named financial institution for premiums that may become due under the policy as a result of this application. This authorization is to remain in effect until written notice of revocation is received at the Home Office of the Company or until the Check-O-Matic Premium Payment Plan is terminated in a manner provided below. I (We) expressly agree to all conditions applicable to the Check-O-Matic Premium Payment Plan including those appearing below.

Please attach a voided check.

Bank Name and Address (Name, Office or Branch, Street Address, City, State, Zip Code)		
Policy Number	Check-O-Matic Premium	Date of First Withdrawal

**Authorization to Financial Institution**

As a convenience to me, I hereby request and authorize you to pay and charge to my account checks, drafts and other order's whether by electronic or paper means, with such debits made to my account and drawn or directed by Western Reserve Life Assurance Co. of Ohio to its own order, provided there are sufficient collected funds in said account to pay the same upon presentation. Until you receive written cancellation of this authorization by me (or either of us), you are fully protected when you honor any of those orders. You may, however, discontinue this arrangement by giving 30 days written notice to me (or either of us) and the insurance company. Your treatment of and your rights regarding those orders shall be the same as if I signed or initiated them. If any of those orders are not honored, whether with or without cause and whether intentionally or inadvertently, you shall be under no liability if insurance is forfeited as a result. Notice of charge for debit is hereby waived.

Transit Routing Number	Account Number
Payor Name(s)	Payor Signature(s) <i>Your signature as on financial institution's records. A copy is valid as the original</i>

In consideration of your compliance with the request and authorization above, and of your participation in the Check-O-Matic Premium Payment Plan with Western Reserve Life Assurance Co. of Ohio, incorporated under the laws of the State of Iowa, (hereinafter called the Company), it is hereby agreed that:

The Company will indemnify you and hold you harmless from any loss you may suffer as a consequence of your actions resulting from or in connection with the execution and issuance of any debit by check, draft, or other order, whether by electronic or paper means, whether or not genuine, purporting to be executed and received by you in the regular course of business for the purpose of payment, including any cost or expenses reasonably incurred in connection therewith.

The Company will refund to you any amount you have paid to it in error upon receipt of a claim which you may submit at any time up to twelve months after the date of such payment.

The Company will defend, at its expense, any action which might be brought by any depositor, beneficiary, or assignee or any other person because of your actions taken pursuant to the depositor's or the Company's request or in any manner arising by reason of your participation in the Company's Check-O-Matic Premium Payment Plan.

In the event that any such debit shall be dishonored, whether with or without cause, and whether intentionally or inadvertently, the Company will indemnify you for any loss even though dishonor results in a forfeiture of insurance.

*William H. Bergin*  
Secretary

*James C. Vahl*  
President

**Conditions Applicable to Check-O-Matic Premium Payment Plan**

No check, draft or any other orders, either by electronic or paper means, shall constitute payment until the Company actually receives payment thereof within the period provided in the policy.

The Check-O-Matic Premium Payment Plan may be terminated by either party by giving written notice to the other.

The Check-O-Matic Premium Payment Plan does not in any manner amend or alter the terms and provisions of any policy, contract or agreement except as may be specifically stated in a policy endorsement or properly executed contract amendment.

For changes or questions call: Toll Free 1-800-625-4213

Or Write: Western Reserve Life Assurance Co. of Ohio, 4333 Edgewood Road N.E., Cedar Rapids, IA 52499

## CONDITIONAL RECEIPT

*(Detach and leave with application if money is submitted with application)*

### PLEASE READ THIS CAREFULLY

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 or annuity applied for with \_\_\_\_\_ as the proposed insured. The policy you applied for will not become effective unless and until a policy contract is delivered to you and all other conditions to coverage are met. Subject to the conditions and limitations of this Receipt, conditional insurance under the terms of the policy applied for may become effective prior to policy delivery. Such conditional insurance will take effect when, but not until, all of the following requirements are met during the lifetime of each proposed insured:

1. As of the Effective Date (as defined below), each person proposed to be insured is found to be insurable 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. The payment made with the application must not be less than the full initial premium for the mode of payment chosen in the application;
3. All medical examinations, tests, and other screenings required by the Company are completed and the results received at our Home Office within 60 days of the date the application was completed; and
4. As of the Effective Date, all statements and answers given in the application must still be true, and the insurability of any proposed insured must not have changed.

If these requirements are not met, or if a proposed insured dies by suicide, the Company's liability will be limited to a refund of any money paid with the application.

This receipt will provide insurance starting on the Effective Date. The effective date of the policy applied for may be different than the Effective Date under this receipt. The Effective Date for conditional insurance under this receipt is the date on which the last of the following occurs:

- A. All parts of the application, any supplemental application, or addendum or amendment to the application are signed;
- B. The last required tests and/or medical examinations are completed;
- C. The full initial premium for the mode of payment chosen is received at our Home Office; and
- D. Any additional information required by us is received at our Home Office.

Any conditional coverage provided by this receipt will terminate on the earliest of: (a) 60 days from the date this Receipt 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) the day before the date 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 applied for.

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 applied for.

If one or more of this Receipt's conditions have not been met exactly, 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 the application was signed by you, the application will be deemed to be rejected by the Company and there will be no insurance. 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.**

## **DETACH AND LEAVE THIS PAGE WITH APPLICANT**

### **NOTICE TO PERSONS APPLYING FOR INSURANCE REGARDING INVESTIGATIVE REPORT**

To Proposed Insureds: 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.**

### **NOTICE OF DISCLOSURE OF INFORMATION**

To Proposed Insureds: Information regarding your insurability will be treated as confidential. We or our reinsurer(s) may, however, make a brief report about it to the Medical Information Bureau, Inc. ("MIB"). MIB is a non-profit membership organization of life 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 you submit a claim for benefits to another MIB member company, then MIB, if requested, will supply such company with the information it has on file.

Upon your request, MIB will disclose to you any information it has about you. 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 Post Office Box 105, Essex Station, Boston, Massachusetts 02122. MIB's telephone number is (617) 426-3600.

### **NOTICE OF INSURANCE INFORMATION PRACTICES**

To Proposed Insureds: 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.

**CERTIFICATION OF  
ARKANSAS INSURANCE CODE  
23-79-138**

Policy Number:

Date:

I hereby certify that the accompanying life product is in compliance with Arkansas Insurance Code 23-79-138.

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**STATE OF ARKANSAS  
REGULATION 34**

Form Number:

Date:

We certify that to the best of our knowledge and belief, we are in compliance with Arkansas Rule and Regulation 34 regarding Universal Life products.

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CONSENT TO SUBMIT RATES AND/OR  
COST BASES FOR APPROVAL

Western Reserve Life Assurance Co. of Ohio (“Company”) of Columbus, Ohio does hereby consent and agree that since policy form number IUL03 1208 AR is a flexible premium whole life (universal life) policy which provides for frequent changes in interest rates based on financial market conditions, the company is filing a range of rates it will stay within and will notify the Department at least sixty (60) days prior to any change in the range of rates. The company must also document the method used to calculate its premium and range of rates.

WESTERN RESERVE LIFE ASSURANCE CO. OF OHIO

By \_\_\_\_\_

Cheryl Bock

Assistant Vice President of Contract Development

POLICY SPECIFICATIONS PAGES

POLICY NUMBER:	[110 01 SAMPLE]	INSURED:	[JOHN DOE]
INITIAL SPECIFIED AMOUNT:	[\$25,000]	ISSUE AGE/SEX:	[35/MALE]
MINIMUM SPECIFIED AMOUNT:	[\$25,000]	POLICY DATE:	[JANUARY 1, 2009]
DEATH BENEFIT OPTION:	[LEVEL]	RECORD DATE:	[JANUARY 1, 2009]
PLANNED PREMIUM:	[\$100.00]	NO LAPSE ENDING DATE:	[JANUARY 1, 2029]
PAYMENT FREQUENCY:	[MONTHLY]	INITIAL PREMIUM:	[\$100.00]
RATE CLASS:	[NON-TOBACCO]		
OWNER(S):	[JOHN DOE]		

POLICY CHARGE

GUARANTEED MAXIMUM:	\$12.00 per month
INITIAL:	\$ [10.00] per month

GUARANTEED MINIMUM INTEREST RATE

BASIC INTEREST ACCOUNT:	2.00%
INDEX ACCOUNT:	1.00%

LOAN RESERVE INTEREST CREDITED: [2.50]%

LOAN INTEREST RATES CHARGED:

STANDARD MAXIMUM:	[3.50]%
STANDARD CURRENT:	[3.25]%
PREFERRED MAXIMUM:	[2.75]%
PREFERRED CURRENT:	[2.50]%

PREMIUM EXPENSE CHARGE

GUARANTEED MAXIMUM:	6.0% (years 1-10)
	2.5% (years 11+)
INITIAL:	[6.0]%(years 1-10)
	[2.5]%(years 11+)

PER UNIT CHARGE

GUARANTEED MAXIMUM:	\$ 0.22 per month (years 1-8)
	\$ 0.00 per month (years 9+)
INITIAL:	[\$0.22] per month (years 1-8)
	[\$0.00] per month (years 9+)

LIFE INSURANCE COMPLIANCE TEST: [Cash Value Accumulation Test]

Premiums are payable while the Policy is In Force. It is possible that coverage will expire where either no premiums are paid following payment of the Initial Premium or subsequent premiums are insufficient to continue coverage. Changes in the interest credited to Your Policy or changes in the Policy Charges, Per Unit Charge, or monthly cost of insurance would also affect Your coverage.

THE TAX STATUS OF THIS POLICY MAY CHANGE. WE URGE YOU TO CONSULT YOUR PERSONAL TAX ADVISOR EACH YEAR REGARDING MATTERS OF POSSIBLE TAXATION.

MONTHLY DEDUCTION AND RIDER INFORMATION

TYPE OF COVERAGE	SPECIFIED AMOUNT OR BENEFIT AMOUNT	PAYABLE TO	MONTHLY DEDUCTION
BASIC POLICY	[\$25,000]	WHILE THE POLICY REMAINS IN FORCE	[\$16.51]

The charges in the Monthly Deduction column shown above are only applicable for the first Monthly Deduction taken on the Policy Date. For Monthly Deductions taken after the Policy Date, please refer to the Policy and Rider forms.

**SURRENDER CHARGES PER \$1,000  
OF INITIAL SPECIFIED AMOUNT**

<u>End of Policy Year</u> <u>AT ISSUE</u>	<u>Surrender Charge</u>	<u>End of Policy Year</u>	<u>Surrender Charge</u>
1	\$[22.80]	6	\$[14.36]
2	[21.20]	7	[10.94]
3	[21.20]	8	[7.52]
4	[19.84]	9	[3.42]
5	[18.70]	10+	[0.00]
	[17.78]		

**TABLE OF MINIMUM MONTHLY NO LAPSE PREMIUMS**

<u>Policy Year</u>	<u>Minimum Monthly No Lapse Premiums</u>	<u>End of Year Sum of all Minimum Monthly No Lapse Premiums</u>
1	\$[16.90]	\$[202.80]
2	[16.90]	[405.60]
3	[16.90]	[608.40]
4	[16.90]	[811.20]
5	[16.90]	[1,014.00]
6	[16.90]	[1,216.80]
7	[16.90]	[1,419.60]
8	[16.90]	[1,622.40]
9	[16.90]	[1,825.20]
10	[16.90]	[2,028.00]
11	[16.90]	[2,230.80]
12	[16.90]	[2,433.60]
13	[16.90]	[2,636.40]
14	[16.90]	[2,839.20]
15	[16.90]	[3,042.00]
16	[16.90]	[3,244.80]
17	[16.90]	[3,447.60]
18	[16.90]	[3,650.40]
19	[16.90]	[3,853.20]
20	[16.90]	[4,056.00]

INDEX ACCOUNTS\*

<u>Name of Index Account</u>	<u>Index Segment Period</u>	<u>Index</u>
Global Index Account	12 months	Standard & Poor's 500® Composite Stock Price Index Dow Jones Euro Stoxx 50 Price Index Hang Seng Index

\* The Company may make additional Index Accounts available.

## DEATH BENEFIT RATIOS

For the Cash Value Accumulation Test, the Death Benefit Ratios are as follows:

<u>Age</u>	<u>Death Benefit Ratio</u>	<u>Age</u>	<u>Death Benefit Ratio</u>
35	[4.84521]	70	[1.63489]
36	[4.67848]	71	[1.59653]
37	[4.51747]	72	[1.56003]
38	[4.36225]	73	[1.52547]
39	[4.21281]	74	[1.49265]
40	[4.06871]	75	[1.46140]
41	[3.93006]	76	[1.43164]
42	[3.79676]	77	[1.40334]
43	[3.66878]	78	[1.37658]
44	[3.54608]	79	[1.35143]
45	[3.42843]	80	[1.32788]
46	[3.31566]	81	[1.30588]
47	[3.20739]	82	[1.28533]
48	[3.10305]	83	[1.26607]
49	[3.00214]	84	[1.24801]
50	[2.90473]	85	[1.23114]
51	[2.81092]	86	[1.21546]
52	[2.72081]	87	[1.20096]
53	[2.63443]	88	[1.18757]
54	[2.55172]	89	[1.17518]
55	[2.47282]	90	[1.16366]
56	[2.39759]	91	[1.15271]
57	[2.32574]	92	[1.14199]
58	[2.25688]	93	[1.13125]
59	[2.19071]	94	[1.12020]
60	[2.12726]	95	[1.10842]
61	[2.06661]	96	[1.09517]
62	[2.00888]	97	[1.07939]
63	[1.95407]	98	[1.05976]
64	[1.90203]	99	[1.03430]
65	[1.85251]	100+	[1.01000]
66	[1.80529]		
67	[1.76007]		
68	[1.71668]		
69	[1.67496]		

NET SINGLE PREMIUMS FOR RIDERS TABLE

For the Cash Value Accumulation Test, the Net Single Premium for Riders are as follows:

NO APPLICABLE RIDERS ELECTED AT TIME OF POLICY DATE.

The Net Single Premium for Riders is based on the Insured's sex, any rating, Rate Class, Rider Benefits or Specified Amounts, and Age at the beginning of each Policy Year for Riders that are Qualified Additional Benefits. The Net Single Premium for Riders is used in calculating the Death Benefit as shown in the Death Benefit Option provision.