

SERFF Tracking Number: AGLL-126197037 State: Arkansas
Filing Company: AGL Life Assurance Company State Tracking Number: 42703
Company Tracking Number: APP-0901AR
TOI: L06I Individual Life - Variable Sub-TOI: L06I.002 Single Life - Flexible Premium
Product Name: Application for Life Insurance
Project Name/Number: Application/APP-0901AR

Filing at a Glance

Company: AGL Life Assurance Company

Product Name: Application for Life Insurance

TOI: L06I Individual Life - Variable

Sub-TOI: L06I.002 Single Life - Flexible
Premium

Filing Type: Form

SERFF Tr Num: AGLL-126197037 State: Arkansas

SERFF Status: Closed-Approved-
Closed State Tr Num: 42703

Co Tr Num: APP-0901AR

State Status: Approved-Closed

Author: Harley Misson

Date Submitted: 06/19/2009

Reviewer(s): Linda Bird

Disposition Date: 06/22/2009

Disposition Status: Approved-
Closed

Implementation Date:

Implementation Date Requested: On Approval

State Filing Description:

General Information

Project Name: Application

Project Number: APP-0901AR

Requested Filing Mode:

Status of Filing in Domicile: Authorized

Date Approved in Domicile:

Domicile Status Comments: Variable life forms
are exempt from the form filing requirements of
the Commonwealth of Pennsylvania.

Market Type: Individual

Group Market Size:

Group Market Type:

Explanation for Other Group Market Type:

State Status Changed: 06/22/2009

Created By: Harley Misson

Corresponding Filing Tracking Number:

Explanation for Combination/Other:

Submission Type: New Submission

Overall Rate Impact:

Filing Status Changed: 06/22/2009

Deemer Date:

Submitted By: Harley Misson

Filing Description:

This application, APP-0901AR, will be used with our individual variable life contract (VL-0901AR approved 06/16/08) and joint variable life contract (VJ-0901AR approved 08/04/08).

AGL Life Assurance Company distributes variable annuity and variable life insurance products exclusively in "private placement" offerings that are exempt from registration under the Federal Securities Act of 1933. Pursuant to this exemption from registration, AGL products are offered for sale only to individuals, corporations, partnerships, etc. that

SERFF Tracking Number: AGLL-126197037 State: Arkansas
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 Product Name: Application for Life Insurance
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AGL determines are accredited investors, as defined in Regulation D, promulgated by the U.S. Securities and Exchange Commission.

Please contact me with any questions regarding the filing at 484-530-4805 or hmisson@philafin.com.

Sincerely,

Harley W. Misson
 Director of Compliance

Company and Contact

Filing Contact Information

Harley Misson, hmisson@philafin.com
 610 W. Germantown Pike 484-530-4805 [Phone]
 Suite 460 484-530-0265 [FAX]
 Plymouth Meeting, PA 19462

Filing Company Information

AGL Life Assurance Company CoCode: 60232 State of Domicile: Pennsylvania
 610 W. Germantown Pike Group Code: Company Type: Insurance
 Suite 460 Group Name: State ID Number:
 Plymouth Meeting, PA 19462 FEIN Number: 52-0795747
 (484) 530-4800 ext. [Phone]

Filing Fees

Fee Required? Yes
 Fee Amount: \$40.00
 Retaliatory? No
 Fee Explanation: \$40 per form
 Per Company: No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
AGL Life Assurance Company	\$40.00	06/19/2009	28684271

SERFF Tracking Number: AGLL-126197037

State: Arkansas

Filing Company: AGL Life Assurance Company

State Tracking Number: 42703

Company Tracking Number: APP-0901AR

TOI: L061 Individual Life - Variable

Sub-TOI: L061.002 Single Life - Flexible Premium

Product Name: Application for Life Insurance

Project Name/Number: Application/APP-0901AR

Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Linda Bird	06/22/2009	06/22/2009

SERFF Tracking Number: AGLL-126197037

State: Arkansas

Filing Company: AGL Life Assurance Company

State Tracking Number: 42703

Company Tracking Number: APP-0901AR

TOI: L061 Individual Life - Variable

Sub-TOI: L061.002 Single Life - Flexible Premium

Product Name: Application for Life Insurance

Project Name/Number: Application/APP-0901AR

Disposition

Disposition Date: 06/22/2009

Implementation Date:

Status: Approved-Closed

Comment:

Rate data does NOT apply to filing.

SERFF Tracking Number: AGLL-126197037 State: Arkansas
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 TOI: L061 Individual Life - Variable Sub-TOI: L061.002 Single Life - Flexible Premium
 Product Name: Application for Life Insurance
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Form Schedule

Lead Form Number: APP-0901AR

Schedule Item Status	Form Number	Form Type Form Name	Action	Action Specific Data	Readability	Attachment
	APP-0901AR	Application/ Enrollment Form	Initial		48.900	APP-0901AR.pdf

AGL LIFE ASSURANCE COMPANY

610 West Germantown Pike, Suite 460 • Plymouth Meeting, PA 19462

APPLICATION FOR LIFE INSURANCE



THE FOLLOWING NOTICES MUST BE GIVEN TO THE PROPOSED INSURED/OWNER/APPLICANT

INVESTIGATIVE CONSUMER REPORT NOTICE

In compliance with federal and state laws, this is to advise you that an investigative consumer report may be made as a part of our procedure for processing your application for insurance. The information for this report is obtained through personal interviews with your neighbors, friends, or others with whom you are acquainted. The report may include information as to your character, general reputation, personal characteristics, and mode of living. You may request to be interviewed for the consumer report if one is to be done. You may, upon written request, be informed whether or not a report was ordered, and if so, the name and address of the consumer reporting agency which made the report. Upon proper identification, you have the right to inspect and/or receive a copy of the report from that agency. You have the right to make a written request to us within a reasonable period of time to receive additional detailed information about the nature and scope of this investigation. Write to: AGL Life Assurance Company, Underwriting Department, 610 West Germantown Pike, Suite 460, Plymouth Meeting, PA 19462.

MIB, INC. DISCLOSURE NOTICE

Information regarding your insurability will be treated as confidential. AGL Life Assurance Company, or our reinsurers, may however, make a brief report thereon to the MIB, Inc., formerly known as Medial Information Bureau, a not-for-profit membership organization of insurance companies, which operates an information exchange on behalf of its Members. If you apply to another MIB Member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, MIB, upon request, will supply such company with the information about you in its file.

Upon receipt of a request from you, MIB will arrange disclosure of any information it may have in your file. Please contact MIB at 866 692-6901(TYY 866 346-3642.) If you question the accuracy of information in MIB's file, you may contact MIB and seek a correction in accordance with the procedures set forth in the Federal Fair Credit Reporting Act. The address of MIB's information office is 50 Braintree Hill Park, Suite 400, Braintree, Massachusetts 02184-8734.

AGL Life Assurance Company, or our reinsurers, may also release information from its file to other insurance companies to whom you may apply for life or health insurance, or to whom a claim for benefits may be submitted. Information for consumers about MIB may be obtained on its website at www.mib.com.

**AGL LIFE ASSURANCE COMPANY
APPLICATION FOR LIFE INSURANCE – PART I**

A. FIRST INSURED						
NAME First	Middle	Last	Birthdate	Birth Place (State or Country)	Citizenship: U.S. <input type="checkbox"/> Other _____	<input type="checkbox"/> Male <input type="checkbox"/> Female
Social Security Number		Driver's License No. and State		Occupation (include duties)		
Residence Address					Residence Phone Number	
Business Address					Business Phone Number	
B. SECOND INSURED						
NAME First	Middle	Last	Birthdate	Birth Place (State or Country)	Citizenship: U.S. <input type="checkbox"/> Other _____	<input type="checkbox"/> Male <input type="checkbox"/> Female
Social Security Number		Driver's License No. and State		Occupation (include duties)		
Residence Address					Residence Phone Number	
Business Address					Business Phone Number	
C. COVERAGE						
Plan of Insurance: <input type="checkbox"/> Variable Life <input type="checkbox"/> Survivorship Variable Life			Death Benefit Option: <input type="checkbox"/> Option 1 – Level <input type="checkbox"/> Option 2 – Face Amount + Account Value <input type="checkbox"/> Option 3 – Face Amount + Lesser of Account Value or Initial Net Premium			
Life Insurance Qualification Test: <input type="checkbox"/> Guideline Premium Test <input type="checkbox"/> Cash Value Accumulation Test			Premium Mode: <input type="checkbox"/> Annual <input type="checkbox"/> Other _____			
Face Amount: \$ _____			Paid with application \$ _____ Planned Premium (only if Universal Life) \$ _____			
D. POLICY OWNER (Complete if other than Proposed Insured)						
FULL NAME				Relationship to Insured		S.S. or Tax ID No.
Owner's Address					Owner's Phone Number	
E. BENEFICIARY						
PRIMARY: Name					Relationship to Insured	
CONTINGENT: Name					Relationship to Insured	
F. LIFE INSURANCE IN FORCE - FIRST INSURED						
Company Name	Policy Number	Year Issued	Face Amount	Policy to be:		
				<input type="checkbox"/> replaced		
				<input type="checkbox"/> replaced		
				<input type="checkbox"/> replaced		
				<input type="checkbox"/> replaced		
				<input type="checkbox"/> replaced		
1.) Is the insurance now applied for intended to replace insurance or annuities in this or any other company? <input type="checkbox"/> Yes <input type="checkbox"/> No (If "Yes," indicate which policies above)						
2.) Are you now applying for Life Insurance with any other company? <input type="checkbox"/> Yes <input type="checkbox"/> No If "Yes," state the company, type of policy, and face amount applied for. _____						

APPLICATION FOR LIFE INSURANCE – PART 1 (Continued)

G. LIFE INSURANCE IN FORCE - SECOND INSURED

Company Name	Policy Number	Year Issued	Face Amount	Policy to be:
				<input type="checkbox"/> replaced
				<input type="checkbox"/> replaced
				<input type="checkbox"/> replaced
				<input type="checkbox"/> replaced
				<input type="checkbox"/> replaced

1.) Is the insurance now applied for intended to replace insurance or annuities in this or any other company? Yes No
(If "Yes," indicate which policies above)

2.) Are you now applying for Life Insurance with any other company? Yes No If "Yes," state the company, type of policy, and face amount applied for. _____

H. NON MEDICAL FACTORS - FIRST INSURED

	Yes	No
1.) Have you ever had any application for life insurance, or reinstatement for life insurance declined, postponed or rated?	<input type="checkbox"/>	<input type="checkbox"/>
2.) Are you a member, or do you intend to become a member of the armed forces, including the reserves?	<input type="checkbox"/>	<input type="checkbox"/>
3.) In the last 3 years have you, or do you have plans to travel, reside, or work outside of the United States?	<input type="checkbox"/>	<input type="checkbox"/>
4.) In the last 3 years have you, or do you intend to take flights other than as a fare paying passenger on a scheduled airline? (If "Yes," complete an Aviation Questionnaire).	<input type="checkbox"/>	<input type="checkbox"/>
5.) In the last 3 years have you, or do you have plans to engage in scuba/skin diving, motor vehicle racing, skydiving, rock climbing, mountaineering, or any other hazardous sporting activity? (If "Yes," provide details below.)	<input type="checkbox"/>	<input type="checkbox"/>
6.) In the last 5 years have you had a driver's license suspended or revoked, been convicted of a moving violation, or charged with driving while impaired or intoxicated?	<input type="checkbox"/>	<input type="checkbox"/>
7.) Have you ever been convicted of a felony? (If "Yes," provide details below including parole and probation status.)	<input type="checkbox"/>	<input type="checkbox"/>

I. DETAILS - FOR SECTION H "YES" ANSWERS ABOVE

Question	

J. NON MEDICAL FACTORS - SECOND INSURED

	Yes	No
1.) Have you ever had any application for life insurance, or reinstatement for life insurance declined, postponed or rated?	<input type="checkbox"/>	<input type="checkbox"/>
2.) Are you a member, or do you intend to become a member of the armed forces, including the reserves?	<input type="checkbox"/>	<input type="checkbox"/>
3.) In the last 3 years have you, or do you have plans to travel, reside, or work outside of the United States?	<input type="checkbox"/>	<input type="checkbox"/>
4.) In the last 3 years have you, or do you intend to take flights other than as a fare paying passenger on a scheduled airline? (If "Yes," complete an Aviation Questionnaire).	<input type="checkbox"/>	<input type="checkbox"/>
5.) In the last 3 years have you, or do you have plans to engage in scuba/skin diving, motor vehicle racing, skydiving, rock climbing, mountaineering, or any other hazardous sporting activity? (If "Yes," provide details below.)	<input type="checkbox"/>	<input type="checkbox"/>
6.) In the last 5 years have you had a driver's license suspended or revoked, been convicted of a moving violation, or charged with driving while impaired or intoxicated?	<input type="checkbox"/>	<input type="checkbox"/>
7.) Have you ever been convicted of a felony? (If "Yes," provide details below including parole and probation status.)	<input type="checkbox"/>	<input type="checkbox"/>

K. DETAILS - FOR SECTION J "YES" ANSWERS ABOVE

Question	

APPLICATION FOR LIFE INSURANCE – PART 1 (Continued)

L. INSURABILITY DATA – FIRST INSURED	
1. (a) Personal Physician(s) (If "None," list physician last consulted. Provide full name and address.)	
(b) Date last consulted, reason and results.	
(c) What treatment was given or medication prescribed?	
2. Height ___ ft. ___ in. Weight ___ lbs. Has your weight changed 10 pounds or more in the last year? Yes <input type="checkbox"/> No <input type="checkbox"/> If "Yes," how much? ___ lbs. (Provide Explanation in Section N Details)	
3. To the best of your knowledge and belief, have you ever been treated for or been diagnosed as having:	
(a) Any disorder or disease of the eyes, ears, nose, mouth or throat?	Yes <input type="checkbox"/> No <input type="checkbox"/>
(b) Dizziness, headache, fainting, seizures, epilepsy, dementia, paralysis, stroke or any other disorder of the brain or nervous system?	<input type="checkbox"/> <input type="checkbox"/>
(c) Stress, depression, anxiety or any other emotional or psychological disorder?	<input type="checkbox"/> <input type="checkbox"/>
(d) Shortness of breath, chronic cough, bronchitis, asthma, emphysema, tuberculosis, or any other disorder or disease of the lungs or respiratory system?	<input type="checkbox"/> <input type="checkbox"/>
(e) Chest pain, angina, palpitation, irregular or rapid pulse, high blood pressure, elevated cholesterol, rheumatic fever, heart murmur, heart attack or other disorder of the heart or blood vessels?	<input type="checkbox"/> <input type="checkbox"/>
(f) Cirrhosis, hepatitis, intestinal bleeding, ulcer, hernia, colitis, rectal bleeding, recurrent indigestion, reflux, abdominal pain, or any other disease or disorder of the stomach, intestines, rectum, liver or gallbladder?	<input type="checkbox"/> <input type="checkbox"/>
(g) Protein or blood in the urine, nephritis, stone, or other disorder of the kidney, bladder or urinary system?	<input type="checkbox"/> <input type="checkbox"/>
(h) Diabetes; thyroid, pancreas or other endocrine disorder?	<input type="checkbox"/> <input type="checkbox"/>
(i) Neuritis, sciatica, arthritis, gout, or disorder or disease of the muscles, bone, spine, back or joints?	<input type="checkbox"/> <input type="checkbox"/>
(j) Amputation, phlebitis or swelling of legs or ankles?	<input type="checkbox"/> <input type="checkbox"/>
(k) Cancer, polyp, benign or malignant tumor or cyst, or any disease of the skin or lymph glands?	<input type="checkbox"/> <input type="checkbox"/>
(l) Anemia, or any disease or disorder of the blood?	<input type="checkbox"/> <input type="checkbox"/>
(m) Acquired Immune Deficiency Syndrome (AIDS), or any other immunological disease or disorder?	<input type="checkbox"/> <input type="checkbox"/>
(n) Sexually transmitted disease, or any disease or disorder of the uterus, ovaries, breasts, prostate, testes, or any other part of the reproductive system?	<input type="checkbox"/> <input type="checkbox"/>
(o) Any physical or mental disorder, operation, or injury not previously mentioned?	<input type="checkbox"/> <input type="checkbox"/>
4. Do you use alcohol? If "Yes," how many drinks per week? _____	
5. Have you:	
(a) Ever sought or received treatment because of your alcohol use or drug use; or been medically advised to have treatment for the use of alcohol or drugs?	Yes <input type="checkbox"/> No <input type="checkbox"/>
(b) Ever used marijuana, barbiturates, amphetamines, hallucinogens, narcotics or any prescription drug except in accordance with a physician's instructions?	<input type="checkbox"/> <input type="checkbox"/>
(c) Used any tobacco or nicotine products in any form in the last 10 years? If "Yes," circle the product(s) used: cigarettes, cigars, pipe, gum, other _____ If "Yes," check one: <input type="checkbox"/> Use currently <input type="checkbox"/> Date quit _____	<input type="checkbox"/> <input type="checkbox"/>
6. Within the last five years, have you:	
(a) Had an examination, checkup or consultation with any physician or medical facility not previously mentioned?	Yes <input type="checkbox"/> No <input type="checkbox"/>
(b) Had any medical tests, including X-rays, electrocardiograms, and blood studies that were not previously mentioned?	<input type="checkbox"/> <input type="checkbox"/>
(c) Been advised to have surgery, hospitalization, or a test that has not been completed?	<input type="checkbox"/> <input type="checkbox"/>
(d) Taken any drug or medicine prescribed by a physician or other medical practitioner?	<input type="checkbox"/> <input type="checkbox"/>
7. Are you now under observation or taking any treatment or medication?	
8. Has any member of your immediate family been diagnosed or treated for heart disease or cancer?	

APPLICATION FOR LIFE INSURANCE – PART 1 (Continued)

O. INSURABILITY DATA – SECOND INSURED	
1. (a) Personal Physician(s) (If "None," list physician last consulted, provide full name and address.)	
(b) Date last consulted, reason and results.	
(c) What treatment was given or medication prescribed?	
2. Height ___ ft. ___ in. Weight ___ lbs. Has your weight changed 10 pounds or more in the last year? Yes <input type="checkbox"/> No <input type="checkbox"/> If "Yes," how much? ___ lbs. (Provide Explanation in Section Q Details)	
3. To the best of your knowledge and belief, have you ever been treated for or been diagnosed as having:	
	Yes No
(a) Any disorder or disease of the eyes, ears, nose, mouth or throat?	<input type="checkbox"/> <input type="checkbox"/>
(b) Dizziness, headache, fainting, seizures, epilepsy, dementia, paralysis, stroke or any other disorder of the brain or nervous system?	<input type="checkbox"/> <input type="checkbox"/>
(c) Stress, depression, anxiety or any other emotional or psychological disorder?	<input type="checkbox"/> <input type="checkbox"/>
(d) Shortness of breath, chronic cough, bronchitis, asthma, emphysema, tuberculosis, or any other disorder or disease of the lungs or respiratory system?	<input type="checkbox"/> <input type="checkbox"/>
(e) Chest pain, angina, palpitation, irregular or rapid pulse, high blood pressure, elevated cholesterol, rheumatic fever, heart murmur, heart attack or other disorder of the heart or blood vessels?	<input type="checkbox"/> <input type="checkbox"/>
(f) Cirrhosis, hepatitis, intestinal bleeding ulcer, hernia, colitis, rectal bleeding, recurrent indigestion, reflux, abdominal pain, or any other disease or disorder of the stomach, intestines, rectum, liver or gallbladder?	<input type="checkbox"/> <input type="checkbox"/>
(g) Protein or blood in the urine, nephritis, stone, or other disorder of the kidney, bladder or urinary system?	<input type="checkbox"/> <input type="checkbox"/>
(h) Diabetes; thyroid, pancreas or other endocrine disorder?	<input type="checkbox"/> <input type="checkbox"/>
(i) Neuritis, sciatica, arthritis, gout, or disorder or disease of the muscles, bone, spine, back or joints?	<input type="checkbox"/> <input type="checkbox"/>
(j) Amputation, phlebitis or swelling of legs or ankles?	<input type="checkbox"/> <input type="checkbox"/>
(k) Cancer, polyp, benign or malignant tumor or cyst, or any disease of the skin or lymph glands?	<input type="checkbox"/> <input type="checkbox"/>
(l) Anemia, or any disease or disorder of the blood?	<input type="checkbox"/> <input type="checkbox"/>
(m) Acquired Immune Deficiency Syndrome (AIDS), or any other immunological disease or disorder?	<input type="checkbox"/> <input type="checkbox"/>
(n) Sexually transmitted disease, or any disease or disorder of the uterus, ovaries, breasts, prostate, testes, or any other part of the reproductive system?	<input type="checkbox"/> <input type="checkbox"/>
(o) Any physical or mental disorder, operation, or injury not previously mentioned?	<input type="checkbox"/> <input type="checkbox"/>
4. Do you use alcohol? If "Yes," how many drinks per week? _____.	
	<input type="checkbox"/> <input type="checkbox"/>
5. Have you:	
	Yes No
(a) Ever sought or received treatment because of your alcohol use or drug use; or been medically advised to have treatment for the use of alcohol or drugs?	<input type="checkbox"/> <input type="checkbox"/>
(b) Ever used marijuana, barbiturates, amphetamines, hallucinogens, narcotics or any prescription drug except in accordance with a physician's instructions?	<input type="checkbox"/> <input type="checkbox"/>
(c) Used any tobacco or nicotine products in any form in the last 10 years? If "Yes," circle the product(s) used: cigarettes, cigars, pipe, gum, other _____ If "Yes," check one: <input type="checkbox"/> Use currently <input type="checkbox"/> Date quit _____	<input type="checkbox"/> <input type="checkbox"/>
6. Within the last five years, have you:	
	Yes No
(a) Had an examination, checkup or consultation, with any physician or medical facility not previously mentioned?	<input type="checkbox"/> <input type="checkbox"/>
(b) Had any medical tests, including X-rays, electrocardiograms, and blood studies that were not previously mentioned?	<input type="checkbox"/> <input type="checkbox"/>
(c) Been advised to have surgery, hospitalization, or a test that has not been completed?	<input type="checkbox"/> <input type="checkbox"/>
(d) Taken any drug or medicine prescribed by a physician or other medical practitioner?	<input type="checkbox"/> <input type="checkbox"/>
7. Are you now under observation or taking any treatment or medication?	
	<input type="checkbox"/> <input type="checkbox"/>
8. Has any member of your immediate family been diagnosed or treated for heart disease or cancer?	
	<input type="checkbox"/> <input type="checkbox"/>

R. NET PREMIUM ALLOCATION

Allocate the payment to the following account(s) by checking the box(es) and indicating the percentage(s).

Investment Account	Percent
<input type="checkbox"/> _____	_____ %
Total	100 %

S. SUITABILITY

I understand that I have applied to purchase a Variable Life Insurance Policy and that the death benefit and cash values of such a policy may increase or decrease in amount or duration based on the investment experience of the underlying subaccounts. No minimum cash surrender value is guaranteed. All surrender values under the contract are variable and are not guaranteed as to fixed dollar amounts. The death benefit may be variable or fixed under specified conditions.

I believe that the Variable Life Insurance Policy for which I am applying is suitable to meet my financial objectives in light of my age and financial experience, and the assets available to me other than the Policy. I am not dependent upon the Variable Life Policy for which I am applying to satisfy my daily living expenses or other expenses that I reasonably expect to incur.

I have received a Private Placement Memorandum for the Variable Life Policy for which I am applying describing the Policy and the investment options available within the Policy.

T. AGREEMENT

I understand the Net Premium I allocate to the Variable Account will be invested in the Money Market subaccount for a time period not less than the Free Look period, unless otherwise permitted by the governing jurisdiction.

I recognize that AGL Life Assurance Company is not a bank and shares of the subaccounts are not backed or guaranteed by any bank or insured by the FDIC.

U. SPECIAL REMARKS

V. REPRESENTATIONS, CONDITIONS AND AUTHORIZATION

I represent that all answers to the questions in this application and any medical examinations required, are complete and true to the best of my knowledge and belief, and I agree that:

- (1) The answers to those questions, together with this agreement, are the basis for issuing any policy;
- (2) Only the President or a Vice President of the Company can make or change any contract or waive any of the Company's rights or requirements;
- (3) No insurance will take effect until the Initial premium is paid and the Policy is delivered to the Owner while there has been no change, from the date of application, in the insurability of all persons proposed for insurance.

I authorize any physician, medical practitioner, hospital, clinic, other medical or medically related facility; Veterans Administration; insurance or reinsurance company; the Medical Information Bureau; consumer reporting agency; other organization; institution; employer; relative; friend; or neighbor to disclose to AGL Life Assurance Company and/or its reinsurers, medical and any other information pertaining to me or any of my minor children who are proposed for insurance. The information that may be disclosed includes information about employment, other insurance, physical, mental, drug and/or alcohol conditions, character, habits, avocations, finances, general reputation, credit and other personal characteristics. I understand that the information obtained is for the purpose of determining eligibility for insurance and that this information may be reviewed in connection with claims that are later submitted. I agree that this authorization will be valid for two years from the date signed and that a photographic copy of this authorization is as valid as the original. I may request a copy of this authorization.

Under penalty of perjury, I confirm that (a) the Social Security or Tax Identification Number shown above is correct, and (b) that I am not subject to back-up withholding. (Strike this out and initial if not true).

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 is guilty of a crime and may be subject to fines and confinement in prison.

I have read and understand these representations, conditions and authorization and acknowledge receipt of notices regarding disclosure and the underwriting process.

Signed at (City, State) _____ on (Month, Day) _____, 20 ____

First Proposed Insured's Signature
(parent or guardian if minor)

Second Proposed Insured's Signature
(parent or guardian if minor)

Owner's Signature (if other than Proposed Insured)

Additional Signature

Agent's Signature

SERFF Tracking Number: AGLL-126197037

State: Arkansas

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TOI: L061 Individual Life - Variable

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Product Name: Application for Life Insurance

Project Name/Number: Application/APP-0901AR

Supporting Document Schedules

Item Status:

**Status
Date:**

Satisfied - Item: Flesch Certification

Comments:

Attachment:

Flesch Certification.pdf

Item Status:

**Status
Date:**

Bypassed - Item: Application

Bypass Reason: The application is in the Form Schedule

Comments:

Item Status:

**Status
Date:**

Bypassed - Item: Life & Annuity - Acturial Memo

Bypass Reason: Not applicable

Comments:

AGL LIFE ASSURANCE COMPANY

Flesch Readability Certification

APP-0901AR.....48.9

I hereby certify that each Flesch Readability score listed above is correct and true.



Harley W. Misson
Compliance Analyst

June 19, 2009
Date