

SERFF Tracking Number: IHLI-126159482 State: Arkansas
Filing Company: Investors Heritage Life Insurance Company State Tracking Number: 42598
Company Tracking Number: 24900AR
TOI: L08 Life - Other Sub-TOI: L08.000 Life - Other
Product Name: Ordinary App/Riders/Questionnaires
Project Name/Number: Ordinary App/Riders/Questionnaires/ICC09-24900

Filing at a Glance

Company: Investors Heritage Life Insurance Company

Product Name: Ordinary SERFF Tr Num: IHLI-126159482 State: Arkansas

App/Riders/Questionnaires

TOI: L08 Life - Other SERFF Status: Closed-Approved- State Tr Num: 42598
Closed

Sub-TOI: L08.000 Life - Other

Co Tr Num: 24900AR

State Status: Approved-Closed

Filing Type: Form

Reviewer(s): Linda Bird

Authors: Julie Hunsinger, Karen
Jones, Brad Shepherd

Disposition Date: 06/12/2009

Date Submitted: 06/09/2009

Disposition Status: Approved-
Closed

Implementation Date Requested: On Approval

Implementation Date:

State Filing Description:

General Information

Project Name: Ordinary App/Riders/Questionnaires

Status of Filing in Domicile: Pending

Project Number: ICC09-24900

Date Approved in Domicile:

Requested Filing Mode: Review & Approval

Domicile Status Comments: These forms have been filed in Kentucky as part of the Interstate Compact filing which was submitted on May 20, 2009.

Explanation for Combination/Other:

Market Type: Individual

Submission Type: New Submission

Group Market Size:

Overall Rate Impact:

Group Market Type:

Filing Status Changed: 06/12/2009

Explanation for Other Group Market Type:

State Status Changed: 06/12/2009

Deemer Date:

Created By: Karen Jones

Submitted By: Karen Jones

Corresponding Filing Tracking Number:

Filing Description:

We are submitting the attached application form, 2 rider application supplement forms and 4 underwriting questionnaires for review and approval. This application form will be used to apply for whole life and/or term life insurance coverage. Attached is a Term Insurance Rider Application and Child Insurance Rider Application as well as Nicotine Usage, Military Service, Aviation and Avocation Questionnaires which will be used to underwrite the policy being applied for.

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These forms are in final print format, they have not been previously filed in Arkansas. This application form and the associated policy will be marketed without illustrations, as there are no non-guaranteed elements involved. These forms are to be used during the underwriting process and will become a part of the policy.

Company and Contact

Filing Contact Information

Karen Jones, Filing Administrator kjones@ihlic.com
 P.O. Box 717 800-422-2011 [Phone] 1007 [Ext]
 Frankfort, KY 40602-0717 502-875-7084 [FAX]

Filing Company Information

Investors Heritage Life Insurance Company CoCode: 64904 State of Domicile: Kentucky
 P.O. Box 717 Group Code: Company Type: LAH
 200 Capital Avenue Group Name: State ID Number:
 Frankfort, KY 40602-0717 FEIN Number: 61-0574893
 (502) 209-1007 ext. [Phone]

Filing Fees

Fee Required? Yes
 Fee Amount: \$140.00
 Retaliatory? No
 Fee Explanation: \$20 x 7 forms = \$140.00
 Per Company: No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Investors Heritage Life Insurance Company	\$140.00	06/09/2009	28449460

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Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Linda Bird	06/12/2009	06/12/2009

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Disposition

Disposition Date: 06/12/2009

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
Form	Ordinary Application		Yes
Form	Additional Insured Rider Application		Yes
Form	Child Term Rider Application		Yes
Form	Nicotine Usage Questionnaire		Yes
Form	Military Service Questionnaire		Yes
Form	Aviation Questionnaire		Yes
Form	Avocation Questionnaire		Yes

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Form Schedule

Lead Form Number: ICC09-24900 (Rev. 04-2009)

Schedule Item Status	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
	ICC09-24900 (Rev. 04-2009)	Application/Ordinary Enrollment Form	Application/Ordinary Enrollment Form	Initial		50.300	Form ICC09-24900 (Rev. 04-2009).pdf
	ICC09-24900 AIR	Application/Additional Insured Enrollment Form	Application/Additional Insured Rider Application Form	Initial		51.100	ICC09-24900 AIR.pdf
	ICC09-24900 CTR	Application/Child Term Enrollment Form	Application/Child Term Enrollment Application Form	Initial		51.000	ICC09-24900 CTR.pdf
	ICC09-NICQUEST 1 (03-2009)	Other	Nicotine Usage Questionnaire	Initial		58.900	Nicotine Usage Questionnaire .pdf
	ICC09 MSW/UND (5-2009)	Other	Military Service Questionnaire	Initial		60.900	MILITARY QUESTIONN AIRE.pdf
	ICC09 80297 (5-2009)	Other	Aviation Questionnaire	Initial		57.000	AVIATION Questionnaire .pdf
	ICC09 80298 (5-2009)	Other	Avocation Questionnaire	Initial		59.400	AVOCATION QUESTIONN AIRE.pdf

**APPLICATION
FOR LIFE INSURANCE**

INVESTORS HERITAGE *Life Insurance Company*

PO Box 717 • Frankfort, KY 40602-0717 • Phone: 800.422.2011 • Fax: 502.875.7084
E-mail: investorsheritage@ihlic.com • www.investorsheritage.com

PRINT USING BLACK INK. ALL SECTIONS MUST BE COMPLETED.

PROPOSED INSURED							
SECTION 1	1. Name (First, Middle, Last)		2. Birth Date	Month Day Year	3. State/Country of Birth		
	4. Street Address		5. <input type="checkbox"/> Male <input type="checkbox"/> Female		6. Citizenship (Country)		
	7. City, State, Zip		8. Home Phone ()		9. Other Phone ()		
	10. Social Security Number	11. Employer Name & Address		12. Occupation & Duties			
	13. E-mail Address			14. Driver's License Number/State of Issue			
OWNER (If different from Proposed Insured)							
SECTION 2	1. Name (First, Middle, Last)		2. Home Phone ()		3. Other Phone ()		
	4. Mailing Address		5. Birth Date		6. E-mail Address		
	7. Relationship to Proposed Insured		8. Social Security Number or Tax ID Number				
BENEFICIARY							
SECTION 3	1. Primary Beneficiary Name(s)		SSN	Relationship to Proposed Insured		Share % if not equal	
	2. Contingent Beneficiary Name(s)		SSN	Relationship to Proposed Insured		Share % if not equal	
THE POLICY							
SECTION 4	1. Choose Plan of insurance <input type="checkbox"/> Whole Life <input type="checkbox"/> Term						
	1a. If term plan, years of insurance _____		Face Amount / Units	Annual Premium	4. Cash with application \$ _____		
	1b. Insurance Face Amounts/Units & Annual Premium		1b. _____	1b. _____	5. Premium Period		
	2. Benefits (If available) Mark appropriate box and indicate Face Amount or Premium				<input type="checkbox"/> 5 Pay <input type="checkbox"/> 10 Pay		
	2a. <input type="checkbox"/> Additional Insured Rider (If yes, complete AIR Application)		2a. _____	2a. _____	<input type="checkbox"/> 20 Pay <input type="checkbox"/> To Age 65		
	2b. <input type="checkbox"/> Child Rider (If yes, complete CR application)		2b. _____	2b. _____	<input type="checkbox"/> To Age 100		
	2c. <input type="checkbox"/> Accidental Death Benefit Rider on Primary Insured (Maximum Issue Amount—\$150,000)		2c. _____	2c. _____	5. Payment mode		
	2d. <input type="checkbox"/> Waiver of Premium Rider on Primary Insured		2d. _____	2d. _____	<input type="checkbox"/> Annual		
	2e. <input type="checkbox"/> Other Rider _____		2e. _____	2e. _____	<input type="checkbox"/> Semi-Annual		
	3. Automatic Premium Loan Option? <input type="checkbox"/> Yes <input type="checkbox"/> No		Policy Fee \$ _____		<input type="checkbox"/> Quarterly PAT		
		Total Annual Premium \$ _____		<input type="checkbox"/> Monthly PAT			
				6. Planned modal premium \$ _____			
OTHER INSURANCE / REPLACEMENT INFORMATION							
SECTION 5	1. Does Proposed Insured now have any life insurance or annuity (includes personal, business or group life) (a) in force or applications pending with any company? or (b) which will be replaced, changed, or borrowed against because of this application? <input type="checkbox"/> Yes <input type="checkbox"/> No Provide details to "Yes" answers below and submit appropriate replacement forms.						
	2. Name of Company	Date of Issue	Life Amount	Personal/Business	Accidental Death Amount	To be replaced?	
				<input type="checkbox"/> Personal <input type="checkbox"/> Business		<input type="checkbox"/> Yes <input type="checkbox"/> No	
				<input type="checkbox"/> Personal <input type="checkbox"/> Business		<input type="checkbox"/> Yes <input type="checkbox"/> No	
				<input type="checkbox"/> Personal <input type="checkbox"/> Business		<input type="checkbox"/> Yes <input type="checkbox"/> No	
				<input type="checkbox"/> Personal <input type="checkbox"/> Business		<input type="checkbox"/> Yes <input type="checkbox"/> No	
If there is additional insurance beyond those listed, please provide on a separate sheet of paper.							

GENERAL RISK INFORMATION

1. In the past 3 years, has the Proposed Insured used tobacco or products containing nicotine? Yes No

If yes, check all that apply.	<input type="checkbox"/> Cigarettes	<input type="checkbox"/> Cigar	<input type="checkbox"/> Pipe	<input type="checkbox"/> Chewing Tobacco	<input type="checkbox"/> Snuff	<input type="checkbox"/> Nicotine Substitutes
Date first used (month/year)						
Date last used (month/year)						
Quantity						

2. Within the past 5 years, has the Proposed Insured:
- a. Plead guilty to or been convicted of driving while impaired, intoxicated or under the influence of any drug; plead guilty to or been convicted of any moving violation; or been involved in any accident in which the Proposed Insured was found to be at fault? Yes No
 - b. Flown, other than as a fare paying passenger on a scheduled airline, or intend to do so within the next 2 years? Yes No (If "Yes", complete an Aviation Questionnaire)
 - c. Participated in motor sports events or racing, boat racing, rock or mountain climbing, hang gliding, ballooning, sky diving or scuba diving or intend to do so within the next 2 years? (If "Yes", complete an Avocation Questionnaire) Yes No
 - d. Plead guilty to or been convicted of any felony or misdemeanor, or have any misdemeanor or felony charge currently pending? (If "Yes" provide details including state, county, and city of violations.) Yes No
3. Is the Proposed Insured a member of the military, military reserve, or National Guard, whether active or inactive; or has the Proposed Insured entered into a written agreement to become a member of the military, military reserve, or National Guard, whether active or inactive, at a future date? (If "Yes", complete a Military Service Questionnaire) Yes No
4. Has the Proposed Insured ever had life, health, or disability insurance declined, postponed, modified or rated? Yes No (If "Yes", provide details including company name, date issued, amount, owner and if business or personal.)
5. Within the past 12 months, has the Proposed Insured been unable to work, attend school, been unable to perform normal daily activities, or been confined at home? Yes No

MEDICAL INFORMATION

1. Name and address of usual medical advisor(s) _____
2. Date of last visit: _____ 3. Reason for last visit: _____
4. What treatment was given or medication prescribed? _____
5. Height: _____ ft in. 6. Weight: _____ lbs. 7. Weight change in past year? Gain Loss No Change 8. Cause of weight change: _____
9. Within the past 10 years, has the Proposed Insured been diagnosed, treated, tested positive for, or been given medical advice by a member of the medical profession for:
- a. High blood pressure, stroke, chest pain, coronary artery disease or any other disease of the heart, blood vessels, cerebrovascular system, or cardiovascular system? Yes No
 - b. Cancer, tumor, leukemia, lymphatic cancer or any other growth or malignancy? Yes No
 - c. Diabetes, thyroid disorder, anemia or any blood or glandular disorder? Yes No
 - d. Asthma, shortness of breath, sleep apnea, or any other nose, throat, lung, or respiratory disorder? Yes No
 - e. Any disorder of the stomach, intestines, liver or pancreas, including hepatitis, ulcers or any other disorder of the digestive system? Yes No
 - f. Any injury or disease of the bones, muscles, joints, eyes or skin? Yes No
 - g. Epilepsy, seizures, brain disorder, or any other disease of the nervous system? Yes No
 - h. Anxiety, depression, or an emotional, behavioral, mental or nervous disorder? Yes No
 - i. Any disease or disorder of the kidney, bladder or reproductive system? Yes No
10. Within the past 10 years, has the Proposed Insured used or experimented with barbiturates, amphetamines, hallucinogens, heroin, cocaine, or other habit forming drugs except as prescribed by a physician? Yes No
11. Within the past 10 years, has the Proposed Insured received medical treatment or counseling for, or been advised by a physician to discontinue the use of alcohol or prescribed or non-prescribed drugs? Yes No
12. Has the Proposed Insured ever been diagnosed by a member of the medical profession or tested positive for Human Immunodeficiency Virus (AIDS virus) or Acquired Immune Deficiency Syndrome (AIDS)? Yes No
13. Other than stated above, within the past 5 years has the Proposed Insured been treated, examined or advised by a member of the medical profession to get any specified medical care which was not completed, such as any hospitalization, surgery or diagnostic test, except those tests related to the Human Immunodeficiency Virus (AIDS virus)? Yes No
14. Have the Proposed Insured's parents and / or siblings been diagnosed or treated for heart disease, kidney disease, diabetes, cancer or stroke? (If "Yes", indicate family member, illness, age at onset of illness, and if applicable, age at death.) Yes No

Explanation of all "Yes" answers in Sections 6 & 7. Use additional paper or continue in Special Requests Section, if necessary.

Number	Illness	Date & Duration	Treatment & Results	Doctors & Hospitals

SPECIAL REQUESTS / REMARKS

FRAUD NOTICE

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

PREMIUM PAYOR (if different than Proposed Insured)

1. Name (First, Middle, Last)	2. Home Phone ()	3. Social Security Number
4. Mailing Address	5. City, State Zip	6. Relationship to Proposed Insured

REQUEST FOR PRE-AUTHORIZED TRANSFER (PAT)

I hereby request and authorize Investors Heritage Life Insurance Company, Frankfort, Kentucky ("Investors Heritage") to make preauthorized transfers from my bank account by way of draft, check, or electronic transfer for the payment of premiums for this policy. This authorization shall be subject to the following conditions:

- (1) The preauthorized transfer shall occur on or after the premium due dates unless otherwise specified;
- (2) Investors Heritage shall not incur any liability on any transfer returned by the bank;
- (3) Amounts not honored by the bank after initial deposit shall constitute non-payment of premium and coverage shall lapse subject to all provisions of each policy;
- (4) This authorization may be revoked by either party upon 30 days advance written notice, and Investors Heritage may immediately revoke this request if any preauthorized transfer is dishonored by the bank when presented.

Frequency of Transfer

ANNUALLY SEMI-ANNUALLY QUARTERLY MONTHLY

Renewal premiums will be debited on MONTHLY mode unless a different mode is marked.

Date	Depositor's Printed Name as it appears on bank records	Depositor's Signature
------	--	-----------------------

Name of Bank	Bank or branch address
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Complete the following OR submit a voided check.

Account Type: Account Number

Checking Routing Number

Savings

The 28th is the last day of the month that a pre-authorized transfer can be made.

TAX CERTIFICATION

Under penalties of perjury, it is certified that (a) the Social Security number(s) or Tax ID number(s) shown in this application are correct, and (b) the holders of said numbers are not subject to any backup withholding of U.S. Federal income tax for failure to report interest or dividends.

ACKNOWLEDGEMENT

I, the Proposed Insured (and any Owner signing below), ACKNOWLEDGE that I have been given a copy of the "Notice of Information Practices" required by Public Law 91-508 and other information practices statutes, and also a copy of the MIB Pre-Notice. I know that this application cannot be processed if I do not sign the authorization below.

AGREEMENT

I, the Proposed Insured (and any Owner signing below) AGREE to the following:

- a. Have read or had read to me the application and all statements and answers in this application as they pertain to me are complete and true to the best of my knowledge and belief.
- b. Insurance will start only as provided in the Conditional Receipt. If no Conditional Receipt is issued or if insurance under it has stopped and not started again, no insurance will start by reason of the application until the policy is delivered and the first premium paid in full. No insurance will start if at that time the health of all proposed insureds is not as described in the application.
- c. Investors Heritage Life Insurance Company, hereinafter called "Insurance Company", does not give any agent or person other than an officer of the Insurance Company authority to waive any answer or otherwise modify this application.
- d. \$ _____ has been deposited toward payment of the first premium on the applied for policy. The terms of the Conditional Receipt for that premium deposit are accepted.

AUTHORIZATION TO OBTAIN AND DISCLOSE INFORMATION

Each of the undersigned declares that:

- a. I understand that the information obtained by use of this authorization will be used to determine eligibility for insurance and/or benefits, or for the Insurance Company to determine its obligations under the policy issued in connection with this application.
- b. The Insurance Company, its reinsurers, insurance support organizations, consumer reporting agencies and their authorized entities may obtain data about my health, prescription medication history, and related information, mode of living (except as may be related directly or indirectly to sexual orientation), avocations, and any other medical or non-medical information.
- c. Any doctor, medical practitioner, medical or medically related facility, laboratory, Pharmacy Benefit Managers, the Veterans Administration, the MIB, viatical settlement company, employer, consumer reporting agency, creditor, government agency, insurance or reinsurance company which has such data about me may give such data to the Insurance Company and its reinsurers when this authorization or a copy of it is shown. All sources but the MIB may give such data to agencies that the Insurance Company has hired to retrieve the information. The information as provided herein pursuant to the authorization will not be redisclosed unless authorized by you or otherwise required by law. Covered Entities, as defined by the Health Insurance Portability and Accountability Act of 1996 (HIPAA), may not condition treatment, payment, enrollment, or eligibility for benefits on whether this Authorization is signed.
- d. Any request by the Insurance Company for medical records is on my behalf and the information must be provided within any requirements imposed by applicable state statutes governing patient access to medical records.
- e. Data about mental illness, alcoholism, sexually transmitted diseases and the use of drugs are to be included, except for psychotherapy notes.
- f. The Insurance Company or its reinsurers may make a brief report about me to the MIB, Inc.
- g. This authorization is good for 24 months after it is signed.
- h. The Insurance Company may obtain an investigative consumer report ("inspection report") on me.
 - Yes, I want to be interviewed if such a report is obtained.
- i. I have read this authorization and know my authorized representative or I may request a copy of it. I may revoke this authorization by writing to the Insurance Company.

SIGNATURES OF PROPOSED INSURED / OWNER

X) _____ Signed at _____ On _____
 Signature of Proposed Insured if age 18 or older (City, State) (Month, Day, Year)
 (15 or older in Kentucky and North Carolina)

X) _____ X) _____
 Signature of Owner if other than Proposed Insured Signature of parent or guardian if Proposed Insured age 17 or younger
 (14 or younger in Kentucky and North Carolina)

AGENT'S STATEMENT AND SIGNATURE

I, the undersigned agent(s), certify that:

- 1. The applicant is either personally known to me or I have seen the applicant's government issued identification;
- 2. I have witnessed the signature of the applicant and/or any proposed insured;
- 3. I have asked each proposed insured each question on the application. The answers have been recorded by me exactly as stated and I know of nothing affecting the insurability of any proposed insured which is not fully recorded in this application.
- 4. Does the Proposed Insured now have any life insurance or annuity in force with any company? Yes No

If "Yes" complete and submit the appropriate replacement forms.

Date: _____

X) _____ IHLIC Agent Code # _____ Name of licensed agent or representative (Please Print)
 Signature of licensed agent 1

X) _____ IHLIC Agent Code # _____ Name of licensed agent or representative (Please Print)
 Signature of licensed agent 2

INVESTORS HERITAGE *Life Insurance Company*
HIPAA COMPLIANT AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

Proposed Insured / Patient	Date of Birth			Social Security Number
	Month	Day	Year	
Proposed Additional Insured	Month	Day	Year	
Children Proposed for Insurance	Month	Day	Year	

I authorize any health plan, physician, health care professional, hospital, Veterans Administration, clinic, laboratory, pharmacy or pharmacy benefit manager, medical facility, insurance company, insurance support organization (such as MIB), or other health care provider that has provided payment, treatment or services to me or on my behalf within the past 10 years (collectively, "My Providers") to disclose my entire medical record, medication history, and any other protected health information concerning me to Investors Heritage Life Insurance Company, or its designee.

Name of designee (if applicable) _____

This includes information on the diagnosis or treatment of Human Immunodeficiency Virus (HIV), Acquired Immune Deficiency Syndrome (AIDS) and Sexually Transmitted Diseases (STDs). This also includes information on the diagnosis and treatment of mental illness and the use of alcohol, drugs, and tobacco, but excludes psychotherapy notes.

By my signature below, I acknowledge that any agreements I have made to restrict my protected health information do not apply to this authorization and I instruct My Providers to release and disclose my entire medical record without restriction.

This protected health information is to be disclosed under this Authorization so that Investors Heritage Life Insurance Company may: (1) underwrite my application for coverage, make eligibility, risk rating, policy issuance and enrollment determinations; (2) obtain reinsurance; (3) administer claims and determine or fulfill responsibility for coverage and provision of benefits; (4) administer coverage; and (5) conduct other legally permissible activities that relate to any coverage I have or have applied for with Investors Heritage Life Insurance Company.

This authorization shall remain in force for 24 months following the date of my signature below, and a copy of this authorization is as valid as the original. I understand that I have the right to revoke this authorization in writing, at any time, by sending a written request for revocation to Investors Heritage Life Insurance Company, P.O. Box 717, Frankfort, KY 40602, Attn: General Counsel. I understand that a revocation is not effective to the extent that any of My Providers has already relied on this Authorization or to the extent that Investors Heritage Life Insurance Company has a legal right to contest a claim under an insurance policy or to contest the policy itself. I understand that any information disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal rules governing privacy and confidentiality of health information. However, Investors Heritage Life Insurance Company will protect the privacy of health information in accordance with other applicable state and federal privacy laws and their own privacy policies.

I understand that My Providers may not refuse to provide treatment or payment for health care services because I refuse to sign this authorization. I further understand that if I refuse to sign this authorization to release my complete medical record, Investors Heritage Life Insurance Company may not be able to process my application, or if coverage has been issued, may not be able to make any benefit payments. I understand that my authorized representative or I am entitled to a copy of this signed authorization.

Date: _____

X) _____
 Signature of Primary Proposed Insured / patient or personal representative

X) _____
 Signature of Additional Proposed Insured / patient or personal representative

	AGENT'S REPORT
SECTION 1	EXAM INFORMATION
	1. If required, have you ordered or obtained: <input type="checkbox"/> Exam <input type="checkbox"/> Blood Profile <input type="checkbox"/> Urine Specimen <input type="checkbox"/> Other _____ 2. Name of paramedical company or examiner _____ 3. Date scheduled or completed _____
SECTION 2	PROPOSED INSURED INFORMATION
	1. Contact Proposed Insured(s) at: <input type="checkbox"/> Home <input type="checkbox"/> Business <input type="checkbox"/> Other Telephone number () _____ 2. Best day(s) to contact Proposed Insured(s) <input type="checkbox"/> Monday <input type="checkbox"/> Tuesday <input type="checkbox"/> Wednesday <input type="checkbox"/> Thursday <input type="checkbox"/> Friday 3. Best time to contact Proposed Insured(s) <input type="checkbox"/> 9 am - 12 pm <input type="checkbox"/> 1 pm - 4 pm <input type="checkbox"/> 5 pm - 8:30 pm 4. How long have you known the Proposed Insured? <input type="checkbox"/> Friend <input type="checkbox"/> Existing Client <input type="checkbox"/> Relative <input type="checkbox"/> Acquaintance <input type="checkbox"/> Just Met 5. Proposed Insured's annual income? _____ 6. Proposed Insured's net worth? _____ 7. Did you personally interview the Proposed Insured(s) and complete the application in his or her presence? <input type="checkbox"/> Yes <input type="checkbox"/> No 8. Prior residence address if current is less than 5 years? _____
	AGENT CHECKLIST
SECTION 3	Explain all "Yes" answers in Section 6 - Agent Remarks / Explanations. 1. Do you know anything not disclosed which affects the underwriting of this risk?..... <input type="checkbox"/> Yes <input type="checkbox"/> No 2. Is there another application currently pending or being submitted to any other life insurance company? <input type="checkbox"/> Yes <input type="checkbox"/> No 3. Has any Proposed Insured applied elsewhere for any insurance coverage within the past 6 months?..... <input type="checkbox"/> Yes <input type="checkbox"/> No
	PROPOSED INSURED UNDER AGE 18 OR FOR CHILD RIDER
SECTION 4	Explain all "No" answers in Section 6 - Agent Remarks / Explanations. 1. Did you see the child(ren) proposed for insurance?..... <input type="checkbox"/> Yes <input type="checkbox"/> No 2. Do all the children proposed for insurance appear to be in good health? <input type="checkbox"/> Yes <input type="checkbox"/> No 3. Are all brothers and sisters insured for equal amounts? <input type="checkbox"/> Yes <input type="checkbox"/> No 4. Are the parents insured for at least as much as that applied for and in force on the child? <input type="checkbox"/> Yes <input type="checkbox"/> No
	PURPOSE OF INSURANCE
SECTION 5	<input type="checkbox"/> Family security <input type="checkbox"/> Business loan <input type="checkbox"/> Buy-sell agreement <input type="checkbox"/> Key Person <input type="checkbox"/> Personal loan or residential mortgage <input type="checkbox"/> Other _____
SECTION 6	AGENT REMARKS / EXPLANATIONS TO ANSWERS ABOVE
SECTION 7	AGENT CERTIFICATION
	I certify that 1. I have asked each question separately, the answers were recorded as given, and they are complete and accurate to the best of my knowledge and belief; 2. I have complied with state and federal laws on disclosure, cost comparison and replacement; and 3. I have given the applicant a copy of the Notice of Information Practices. Date: _____ X) _____ Signature of licensed agent 1 IHLIC Agent Code # Name of licensed agent or representative (Please Print) X) _____ Signature of licensed agent 2 IHLIC Agent Code # Name of licensed agent or representative (Please Print)

INVESTORS HERITAGE LIFE INSURANCE COMPANY
PO Box 717
Frankfort, KY 40602-0717
800.422.2011

CONDITIONAL INSURANCE RECEIPT

This Conditional Receipt provides a limited amount of life insurance coverage, for a limited period of time, subject to the terms of this receipt. This Conditional Receipt may not be given if the age of any proposed insured is under 15 days or over 70 years of age.

AMOUNT LIMITATION

The maximum amount of life insurance, including accidental death, which will become effective under this receipt will be the smaller of the face amount of insurance applied for or \$100,000. This includes any pending and in force insurance.

CONDITIONS

1. A minimum advance payment equal to one month's premium for the insurance applied for must be made.
2. Any check given in payment must be honored when first presented to the bank.
3. All medical examinations and tests required by the Company's initial underwriting requirements must be completed and received at our Home Office during the lifetime of any individual proposed for insurance, and prior to the Company's termination of the application, but in any case within sixty (60) days from the completion of the application.
4. If any person proposed for insurance dies by suicide or if the application contains any material misrepresentations, then the Company's liability under this receipt is limited to a refund of the premium paid.
5. Each person proposed for insurance must be a risk insurable on the application date in accordance with the Company's rules, limits and standards for the plan and the amount applied for without modification either as to plan, amount, riders, supplemental agreements and/or the rate of premium paid.

IHCC09-24900 (Rev. 04-2009)

CONDITIONAL RECEIPT

INVESTORS HERITAGE LIFE INSURANCE COMPANY
PO Box 717
Frankfort, KY 40602-0717
800.422.2011

NOTICE OF INFORMATION PRACTICES *THIS NOTICE MUST BE GIVEN TO PROPOSED INSURED*



INFORMATION INSURANCE PRACTICES

We will rely primarily on the information you give to us. We may also get information from other sources, such as doctors, or other medical professionals who have treated you. In some cases, we may ask a consumer reporting agency to gather information and send us an investigative consumer report as explained in the Fair Credit Reporting Act below. You may ask to be interviewed as part of the preparation of any such report.

MEDICAL INFORMATION BUREAU

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

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

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

FAIR CREDIT REPORTING ACT INVESTIGATIVE CONSUMER REPORTS

In compliance with the Fair Credit Reporting Act, you are hereby notified that an investigative report may be made. Information may be obtained through personal interviews with neighbors, friends, associates or other persons with whom you are acquainted. This inquiry includes information as to the character, general reputation, personal characteristics, and mode of living (except as may be related to sexual orientation) of any person proposed for insurance. You have the right to make a written request to Investors Heritage Life Insurance within a reasonable period of time for a complete and accurate disclosure of additional information concerning the nature and scope of the investigation. Upon your written request, you will be informed whether or not an investigation was made by us. If so, you will receive the name and address of the consumer reporting agency involved. You may receive and inspect a copy of the Investigative Consumer Report by contacting the consumer reporting agency.

ICCC09-24900 (Rev. 04-2009)

INVESTORS HERITAGE LIFE INSURANCE COMPANY

CONDITIONAL INSURANCE RECEIPT (continued from front)

BEGINNING DATE. If all conditions in this receipt have been fulfilled exactly, coverage under the policy applied for, subject to the Amount Limitations, may begin on the later of:

- 1. The date of completion of the application;
2. The date of completion of all medical examinations, tests and other evidence required by the Company; or
3. The policy date, if any, requested in the application.

TERMINATION DATE. Coverage under this receipt, if it has begun, will terminate automatically on the earliest of (1) sixty days from the date of this receipt; or (2) the date the insurance takes effect under the applied for policy.

If the policy is not issued exactly as applied for, it will become effective when it is delivered to and accepted by the applicant. Upon delivery and acceptance, the first full premium must be paid. If the application is declined or not approved within sixty (60) days of its completion, no insurance will have been in force. Any premium paid will be returned. No agent of our Company has the authority to change or modify any of the provisions of this receipt.

ALL PREMIUM CHECKS MUST BE PAYABLE TO THE COMPANY. DO NOT MAKE CHECK PAYABLE TO THE AGENT OR LEAVE THE PAYEE BLANK. THIS RECEIPT IS NOT VALID UNLESS SIGNED BY A LICENSED AGENT OF INVESTORS HERITAGE LIFE INSURANCE COMPANY.

Amount Received: \$ _____ From: _____ Date: _____
month day year

Agent's Signature _____ Agent's Address _____

Agent's Phone Number _____

NOTICE OF INFORMATION PRACTICES (continued)

PERSONAL HISTORY INTERVIEW

We may also conduct a personal history interview. This is a phone call placed from our underwriting office. Its purpose is to make sure that the information regarding the insured on the application is correct. Our interviewers are trained to conduct their calls in a friendly, professional manner. The nature of the information discussed is always treated as personal and confidential and will only be used to help determine your eligibility for insurance.

MEDICAL EXAMS

As part of the underwriting process we may ask for medical tests or exams to be completed at our expense. Common tests include a paramedical exam, which will consist of questions about your medical history and measurement of your body height, weight, blood pressure, and pulse. Blood tests, and in some instances, an EKG (electrocardiogram) may be required. If you have any questions about the specific tests that will be required of you, please feel free to contact your agent.

CONTESTABILITY

You are strongly urged to review the completed application for accuracy. A claim may be denied if the application contains false statements or misrepresentations or fails to disclose material facts. In such a case, the policy could be void and coverage could be lost or denied.

YOUR RIGHTS TO ACCESS AND CORRECTION

You can obtain access to personal information about you contained in our policy files by sending us a written request. You may also request any necessary corrections, amendments or deletion of any information in our files which you believe to be inaccurate or irrelevant.

FRAUD NOTICE

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

INVESTORS HERITAGE LIFE INSURANCE COMPANY

INVESTORS HERITAGE LIFE INSURANCE COMPANY
200 CAPITAL AVENUE
PO BOX 717
FRANKFORT KY 40602-0717

PHONE: 800.422.2011
FAX: 502.875.7084
EMAIL: ihlic@ihlic.com
WEBSITE: www.investorsheritage.com

ADDITIONAL INSURED INSURANCE RIDER APPLICATION SUPPLEMENT

SECTION 1	PRINT USING BLACK INK. COVERAGE INFORMATION		ALL SECTIONS MUST BE COMPLETED.		
	Application for the addition of an Additional Insured Insurance Rider to application or policy: Application on: (Proposed Insured's full name) _____ Application date: _____ Insured's Name: _____ Policy number: _____			Amount of Additional Insured Rider _____	
SECTION 2	ADDITIONAL PROPOSED INSURED				
	1. Name (First, Middle, Last)		2. Birth Date	3. State/Country of Birth	
	4. Street Address		5. <input type="checkbox"/> Male <input type="checkbox"/> Female	6. Citizenship (Country)	
	7. City, State, Zip		8. Home Phone ()	9. Other Phone ()	
	10. Social Security Number	11. Employer Name & Address		12. Occupation & Duties	
	13. E-mail Address			14. Driver's License Number/State of Issue	
SECTION 3	OTHER INSURANCE / REPLACEMENT INFORMATION				
	1. Does the Additional Proposed Insured now have any life insurance or annuity (includes personal, business or group life) (a) in force or applications pending with any company? or (b) which will be replaced, changed, or borrowed against because of this application? <input type="checkbox"/> Yes <input type="checkbox"/> No Provide details to "Yes" answers below and submit appropriate replacement forms.				
	2. Name of Company	Date of Issue	Life Amount	Personal/Business <input type="checkbox"/> Personal <input type="checkbox"/> Business	Accidental Death Amount <input type="checkbox"/> Yes <input type="checkbox"/> No
				<input type="checkbox"/> Personal <input type="checkbox"/> Business	<input type="checkbox"/> Yes <input type="checkbox"/> No
If there is additional insurance beyond those listed, please provide on a separate sheet of paper.					
SECTION 4	BENEFICIARY INFORMATION				
	1. Primary Beneficiary Name(s)	SSN	Relationship to Additional Proposed Insured	Share % if not equal	
	2. Contingent Beneficiary Name(s)	SSN	Relationship to Additional Proposed Insured	Share % if not equal	
SECTION 5	GENERAL RISK INFORMATION				
	1. In the past 3 years, has the Additional Proposed Insured used tobacco or products containing nicotine? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, check all that apply.				
		<input type="checkbox"/> Cigarettes	<input type="checkbox"/> Cigar	<input type="checkbox"/> Pipe	<input type="checkbox"/> Chewing Tobacco
	Date first used (month/year)				<input type="checkbox"/> Snuff
	Date last used (month/year)				<input type="checkbox"/> Nicotine Substitutes
	Quantity				
2. Within the past 5 years, has the Additional Proposed Insured:					
a. Plead guilty to or been convicted of driving while impaired, intoxicated or under the influence of any drug; plead guilty to or been convicted of any moving violation; or been involved in any accident in which the Additional Proposed Insured was found to be at fault? <input type="checkbox"/> Yes <input type="checkbox"/> No					
b. Flown, other than as a fare paying passenger on a scheduled airline, or intend to do so within the next 2 years? <input type="checkbox"/> Yes <input type="checkbox"/> No (If "Yes", complete an Aviation Questionnaire)					
c. Participated in motor sports events or racing, boat racing, rock or mountain climbing, hang gliding, ballooning, sky diving or scuba diving or intend to do so within the next 2 years? (If "Yes", complete an Avocation Questionnaire) <input type="checkbox"/> Yes <input type="checkbox"/> No					
d. Plead guilty to or been convicted of any felony or misdemeanor, or have any misdemeanor or felony charge currently pending? (If "Yes" provide details including state, county, and city of violations.) <input type="checkbox"/> Yes <input type="checkbox"/> No					
3. Is the Additional Proposed Insured a member of the military, military reserve, or National Guard, whether active or inactive; or has the Additional Proposed Insured entered into a written agreement to become a member of the military, military reserve, or National Guard, whether active or inactive, at a future date? (If "Yes", complete a Military Service Questionnaire) <input type="checkbox"/> Yes <input type="checkbox"/> No					
4. Has the Additional Proposed Insured ever had life, health, or disability insurance declined, postponed, modified or rated? <input type="checkbox"/> Yes <input type="checkbox"/> No (If "Yes", provide details including company name, date issued, amount, owner and if business or personal.)					
5. Within the past 12 months, has the Additional Proposed Insured been unable to work, attend school, been unable to perform normal daily activities, or been confined at home? <input type="checkbox"/> Yes <input type="checkbox"/> No					

MEDICAL INFORMATION

1. Name and address of usual medical advisor(s) _____
2. Date of last visit: _____ 3. Reason for last visit: _____
4. What treatment was given or medication prescribed? _____
5. Height: _____ ft _____ in. 6. Weight: _____ lbs. 7. Weight change in past year? Gain Loss No Change 8. Cause of weight change: _____
9. Within the past 10 years, has the Additional Proposed Insured been diagnosed, treated, tested positive for, or been given medical advice by a member of the medical profession for:
 - a. High blood pressure, stroke, chest pain, coronary artery disease or any other disease of the heart, blood vessels, cerebrovascular system, or cardiovascular system? Yes No
 - b. Cancer, tumor, leukemia, lymphatic cancer or any other growth or malignancy? Yes No
 - c. Diabetes, thyroid disorder, anemia or any blood or glandular disorder? Yes No
 - d. Asthma, shortness of breath, sleep apnea, or any other nose, throat, lung, or respiratory disorder? Yes No
 - e. Any disorder of the stomach, intestines, liver or pancreas, including hepatitis, ulcers or any other disorder of the digestive system? Yes No
 - f. Any injury or disease of the bones, muscles, joints, eyes or skin? Yes No
 - g. Epilepsy, seizures, brain disorder, or any other disease of the nervous system? Yes No
 - h. Anxiety, depression, or an emotional, behavioral, mental or nervous disorder? Yes No
 - i. Any disease or disorder of the kidney, bladder or reproductive system? Yes No
10. Within the past 10 years, has the Additional Proposed Insured used or experimented with barbiturates, amphetamines, hallucinogens, heroin, cocaine, or other habit forming drugs except as prescribed by a physician? Yes No
11. Within the past 10 years, has the Additional Proposed Insured received medical treatment or counseling for, or been advised by a physician to discontinue the use of alcohol or prescribed or non-prescribed drugs? Yes No
12. Has the Additional Proposed Insured ever been diagnosed by a member of the medical profession or tested positive for Human Immunodeficiency Virus (AIDS virus) or Acquired Immune Deficiency Syndrome (AIDS)? Yes No
13. Other than stated above, within the past 5 years has the Additional Proposed Insured been treated, examined or advised by a member of the medical profession to get any specified medical care which was not completed, such as any hospitalization, surgery or diagnostic test, except those tests related to the Human Immunodeficiency Virus (AIDS virus)? Yes No
14. Have the Additional Proposed Insured's parents and / or siblings been diagnosed or treated for heart disease, kidney disease, diabetes, cancer or stroke? (If "Yes", indicate family member, illness, age at onset of illness, and if applicable, age at death.) Yes No

Explanation of all "Yes" answers above. Use additional paper, if necessary.

Number	Illness	Date & Duration	Treatment & Results	Doctors & Hospitals

AGREEMENT

Each of the undersigned declares that:
 I have read or have had read to me the completed Additional Insured Insurance Rider Application Supplement before signing below. All statements and answers in this Supplement are correctly recorded and are full, complete, and true. I agree that this Additional Insured Insurance Rider Application Supplement constitutes a part of the application for insurance. I understand that any false statements or material misrepresentations may result in the loss of coverage under the policy or this rider.

SIGNATURES OF ADDITIONAL PROPOSED INSURED / OWNER

X) _____ Signed at _____ (City, State) On _____ (Month, Day, Year)
 Signature of Additional Proposed Insured (if age 18 or older)

X) _____ X) _____
 Signature of Owner if different than Additional Proposed Insured Signature of parent or guardian if Additional Proposed Insured age 17 or younger

AGENT'S SIGNATURE

Date: _____

X) _____
 Signature of licensed agent 1 Agent Code # _____ Name of licensed agent or representative (please print) _____

X) _____
 Signature of licensed agent 2 Agent Code # _____ Name of licensed agent or representative (please print) _____

SECTION 6

SECTION 1	PRINT USING BLACK INK.		COVERAGE INFORMATION				ALL SECTIONS MUST BE COMPLETED.			
	Application for the addition of a Children's Term Insurance Rider to application or policy: Application on: (Proposed Insured's full name) _____ Application date: _____ Insured's Name: _____ Policy number: _____							Amount of Child Rider Insurance: _____		
SECTION 2	CHILDREN PROPOSED FOR INSURANCE UNDER CHILDREN'S RIDER									
	Give information on all unmarried children, adopted children, or stepchildren of the Insured age 18 or less.									
	Name	SSN	Relationship	Date of Birth (mm/dd/yyyy)	State / Country of Birth	Country of citizenship	Height	Weight		
SECTION 3	OTHER INSURANCE / REPLACEMENT INFORMATION									
	1. Does any Proposed Insured now have any life insurance or annuity (includes personal, business or group life) (a) in force or applications pending with any company? or (b) which will be replaced, changed, or borrowed against because of this application? <input type="checkbox"/> Yes <input type="checkbox"/> No Provide details to "Yes" answers below and submit appropriate replacement forms.									
	2. Name of Company	Date of Issue	Life Amount	Personal/Business	Accidental Death Amount	To be replaced?				
				<input type="checkbox"/> Personal <input type="checkbox"/> Business		<input type="checkbox"/> Yes <input type="checkbox"/> No				
				<input type="checkbox"/> Personal <input type="checkbox"/> Business		<input type="checkbox"/> Yes <input type="checkbox"/> No				
If there is additional insurance beyond those listed, please provide on a separate sheet of paper.										
SECTION 4	BENEFICIARY INFORMATION									
	1. Primary Beneficiary Name(s)	SSN	Relationship to Proposed Insured(s)							Share % if not equal
2. Contingent Beneficiary Name(s)	SSN	Relationship to Proposed Insured(s)							Share % if not equal	
SECTION 5	GENERAL RISK INFORMATION									
	1. In the past 3 years, has any child proposed for insurance used tobacco or products containing nicotine? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, check all that apply.									
		<input type="checkbox"/> Cigarettes	<input type="checkbox"/> Cigar	<input type="checkbox"/> Pipe	<input type="checkbox"/> Chewing Tobacco	<input type="checkbox"/> Snuff	<input type="checkbox"/> Nicotine Substitutes			
	Date first used (month/year)									
	Date last used (month/year)									
	Quantity									
	2. Within the past 5 years, has any child proposed for insurance:									
	a. Plead guilty to or been convicted of driving while impaired, intoxicated or under the influence of any drug; plead guilty to or been convicted of any moving violation; or been involved in any accident in which the child proposed for insurance was found to be at fault? <input type="checkbox"/> Yes <input type="checkbox"/> No									
	b. Flown, other than as a fare paying passenger on a scheduled airline, or intend to do so within the next 2 years? <input type="checkbox"/> Yes <input type="checkbox"/> No (If "Yes", complete an Aviation Questionnaire)									
	c. Participated in motor sports events or racing, boat racing, rock or mountain climbing, hang gliding, ballooning, sky diving or scuba diving or intend to do so within the next 2 years? (If "Yes", complete an Avocation Questionnaire) <input type="checkbox"/> Yes <input type="checkbox"/> No									
d. Plead guilty to or been convicted of any felony or misdemeanor, or have any misdemeanor or felony charge currently pending? (If "Yes" provide details including state, county, and city of violations.) <input type="checkbox"/> Yes <input type="checkbox"/> No										
3. Is any child proposed for insurance a member of the military, military reserve, or National Guard, whether active or inactive; or has any child proposed for insurance entered into a written agreement to become a member of the military, military reserve, or National Guard, whether active or inactive, at a future date? (If "Yes", complete a Military Service Questionnaire) <input type="checkbox"/> Yes <input type="checkbox"/> No										
4. Has any child proposed for insurance ever had life, health, or disability insurance declined, postponed, modified or rated? <input type="checkbox"/> Yes <input type="checkbox"/> No (If "Yes", provide details including company name, date issued, amount, owner and if business or personal.)										
5. Within the past 12 months, has any child proposed for insurance been unable to work, attend school, been unable to perform normal daily activities, or been confined at home? <input type="checkbox"/> Yes <input type="checkbox"/> No										

MEDICAL INFORMATION

1. Name and address of usual medical advisor(s) _____ 2. Date of last visit _____
3. Reason for last visit _____ 4. What treatment was given or medication prescribed? _____
5. Has any child proposed for insurance had a weight change of more than 10 pounds during the past 12 months? Yes No
 If "Yes", child _____ lbs. Gain Loss Cause _____
 If "Yes", child _____ lbs. Gain Loss Cause _____
6. Within the past 10 years, has any child proposed for insurance been diagnosed, treated, tested positive for, or been given medical advice by a member of the medical profession for:
- a. High blood pressure, stroke, chest pain, coronary artery disease or any other disease of the heart, blood vessels, cerebrovascular system, or cardiovascular system? Yes No
 - b. Cancer, tumor, leukemia, lymphatic cancer or any other growth or malignancy? Yes No
 - c. Diabetes, thyroid disorder, anemia or any blood or glandular disorder? Yes No
 - d. Asthma, shortness of breath, sleep apnea, or any other nose, throat, lung, or respiratory disorder? Yes No
 - e. Any disorder of the stomach, intestines, liver or pancreas, including hepatitis, ulcers or any other disorder of the digestive system? Yes No
 - f. Any injury or disease of the bones, muscles, joints, eyes or skin? Yes No
 - g. Epilepsy, seizures, brain disorder, or any other disease of the nervous system? Yes No
 - h. Anxiety, depression, or an emotional, behavioral, mental or nervous disorder? Yes No
 - i. Any disease or disorder of the kidney, bladder or reproductive system? Yes No
7. Within the past 10 years, has any child proposed for insurance used or experimented with barbiturates, amphetamines, hallucinogens, heroin, cocaine, or other habit forming drugs except as prescribed by a physician? Yes No
8. Within the past 10 years, has any child proposed for insurance received medical treatment or counseling for, or been advised by a physician to discontinue the use of alcohol or prescribed or non-prescribed drugs? Yes No
9. Has any child proposed for insurance ever been diagnosed by a member of the medical profession or tested positive for Human Immunodeficiency Virus (AIDS virus) or Acquired Immune Deficiency Syndrome (AIDS)? Yes No
10. Other than stated above, within the past 5 years has any child proposed for insurance been treated, examined or advised by a member of the medical profession to get any specified medical care which was not completed, such as any hospitalization, surgery or diagnostic test, except those tests related to the Human Immunodeficiency Virus (AIDS virus)? Yes No
11. Has any child's parents or siblings been diagnosed or treated for heart disease, kidney disease, diabetes, cancer or stroke? Yes No
 (If "Yes", indicate family member, illness, age at onset of illness, and if applicable, age at death.)

Explanation of all "Yes" answers above. Use additional paper, if necessary.

Child	Question	Illness	Date & Duration	Treatment & Results	Doctors & Hospitals

AGREEMENT

Each of the undersigned declares that:
 I have read or have had read to me the completed Children's Term Insurance Application Supplement before signing below. All statements and answers in this Supplement are correctly recorded and are full, complete, and true. I agree that this Children's Term Insurance Rider Application Supplement constitutes a part of the application for insurance. I understand that any false statements or material misrepresentations may result in the loss of coverage under the policy or this rider.

SIGNATURES OF PROPOSED INSURED(S) / OWNER

X) _____ Signed at _____ (City, State) On _____ (Month, Day, Year)
 Signature of Owner

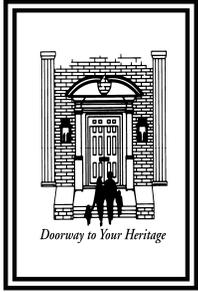
X) _____ Signed at _____ (City, State) On _____ (Month, Day, Year)
 Signature of parent if other than Owner

AGENT'S SIGNATURE

Date: _____

X) _____
 Signature of licensed agent 1 Agent Code # Name of licensed agent or representative (please print)

X) _____
 Signature of licensed agent 2 Agent Code # Name of licensed agent or representative (please print)



INVESTORS HERITAGE

Life Insurance Company

Harry Lee Waterfield II, President

Post Office Box 717 | 200 Capital Avenue | Frankfort, Kentucky 40602-0717

Phone: 800.422.2011 | Fax: 502.875.7084 | Email: ihlic@ihlic.com

NICOTINE USAGE QUESTIONNAIRE

POLICY NUMBER: _____

INSURED

BIRTH DATE

(Check all that apply)

1. Are you currently using tobacco or products containing nicotine (including cigarettes, cigars, pipe, chewing tobacco, snuff, gum, lozenge or patch)?

YES NO

2. Have you ever used tobacco or products containing nicotine (including cigarettes, cigars, pipe, chewing tobacco, snuff, gum, lozenge or patch)?

YES NO

3. If yes, when did you quit?

Month

Day

Year

I hereby represent, to the best of my knowledge and belief, that all answers to the above questions are complete and true.

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

Signed in City and State

Date

X

Insured's Signature

X

Owner's Signature (if different than Insured)

Insured's email address

()

Insured's Daytime phone:

Home Cell Work

Owner's email address (if different than Insured)

()

Owner's Daytime phone:

Home Cell Work

INVESTORS HERITAGE *Life Insurance Company*

200 CAPITAL AVENUE • PO Box 717 • FRANKFORT KY 40602-0717

PHONE: 800.422.2011 • FAX: 502.875.7084 EMAIL: IHLIC@IHLIC.COM • WWW.INVESTORSHERITAGE.COM

AVIATION QUESTIONNAIRE

PRINT USING BLACK INK.
ALL SECTIONS MUST BE COMPLETED.

Name of Proposed Insured: _____ Date of Birth: _____

SECTION 1 HOURS FLOWN	For Pilots, Students and Crew Members: Total of Solo Hours Flown _____ Total Hours Flown _____ Estimated Hours Flying _____ as Pilot or Crew Member: _____ In Past 12 Months: _____ In Next 12 Months: _____
SECTION 2 PILOT LICENSE	Pilot Certificate currently held: <input type="checkbox"/> Private <input type="checkbox"/> Instrument Flight Rating (IFR) <input type="checkbox"/> Student <input type="checkbox"/> Commercial <input type="checkbox"/> Airline Transport Rating (ATR) <input type="checkbox"/> Flight Instructor In the past 10 years have you been grounded or had your license revoked? <input type="checkbox"/> Yes <input type="checkbox"/> No (If "Yes", give details in Remarks Section below.)
SECTION 3 TYPE FLYING	Type of Flying: <input type="checkbox"/> Pleasure <input type="checkbox"/> Freight Carrying or Passenger Service <input type="checkbox"/> Personal Business <input type="checkbox"/> Employer Aircraft or Employee Transportation <input type="checkbox"/> Crop Dusting <input type="checkbox"/> Other (Give details in Remarks Section below.) <input type="checkbox"/> Instructor
SECTION 4 MEDICAL CERTIFICATE	a. Medical Certificate currently held: <input type="checkbox"/> Class III <input type="checkbox"/> Class II <input type="checkbox"/> Class I b. Date of last renewal: Month _____ Day _____ Year _____ c. Was it denied by the Aviation Medical Examiner but eventually issued? <input type="checkbox"/> Yes <input type="checkbox"/> No d. Was it necessary to appeal before Certificate was eventually issued? <input type="checkbox"/> Yes <input type="checkbox"/> No e. Was Medical Certificate granted subject to limitation(s) or physical waiver(s)? <input type="checkbox"/> Yes <input type="checkbox"/> No (If any of the above questions is answered "Yes", please give details in Remarks below.)
SECTION 5 MILITARY FLYING	a. Military Branch or Organization: _____ b. Type Aircraft: _____ Date of Last Flight: _____ c. If not pilot, specify capacity in which you fly: _____
SECTION 6 OTHER FLYING	Other Type of Flying: a. Have you, in the past 10 years, flown or do you intend to fly in the next 2 years: Ultralight, Biplane, Prototype, experimental or personally built or assembled aircraft? <input type="checkbox"/> Yes <input type="checkbox"/> No (If "Yes", complete Avocation Questionnaire.) b. Have you flown in the Civil Air Patrol in the last 12 months or do you intend to do so in the next 2 years? ... <input type="checkbox"/> Yes <input type="checkbox"/> No c. Do you intend to change your present flying to commercial or military flying in the next 2 years? <input type="checkbox"/> Yes <input type="checkbox"/> No (If any of the above questions is answered "Yes", please give details in Remarks below.)
SECTION 7 AVIATION RATES	Should you not qualify for full coverage at standard rates, do you desire: a. Full coverage with extra premium, if available? <input type="checkbox"/> Yes <input type="checkbox"/> No b. Restricted aviation coverage without extra premium, if available? <input type="checkbox"/> Yes <input type="checkbox"/> No
REMARKS:	

The above statements and answers are complete and true to the best of my knowledge and belief and will be the basis for and a part of any policy issued based on them.

Signed at: _____ (X) _____
City and State Signature of Proposed Insured

Date: _____

INVESTORS HERITAGE *Life Insurance Company*

200 CAPITAL AVENUE • PO Box 717 • FRANKFORT KY 40602-0717

PHONE: 800.422.2011 • FAX: 502.875.7084 EMAIL: IHLIC@IHLIC.COM • WWW.INVESTORSHERITAGE.COM

AVOCATION QUESTIONNAIRE

PRINT USING BLACK INK.
ALL SECTIONS MUST BE COMPLETED.

Name of Proposed Insured: _____ Date of Birth: _____

SECTION 1 RACING SPORTS	Racing, Auto, Motorcycle, Snowmobile, Motorboat <input type="checkbox"/> I do not participate in Racing Sports. (Skip to next section.)
	Type: <input type="checkbox"/> Midget <input type="checkbox"/> Hotrod <input type="checkbox"/> Sportscar <input type="checkbox"/> Cycle <input type="checkbox"/> Other <input type="checkbox"/> Stock <input type="checkbox"/> Drag <input type="checkbox"/> Snowmobile <input type="checkbox"/> Boat
	Vehicle or boat: <u>Make & Model:</u> _____ Class & category _____
	Displacement: _____ Horsepower _____
	Timing: <input type="checkbox"/> Vehicle vs. Vehicle <input type="checkbox"/> Vehicle vs. Clock Maximum speed attained: _____ mph
	Location: <input type="checkbox"/> Oval Track <input type="checkbox"/> Closed Circuit <input type="checkbox"/> Drag Strip <input type="checkbox"/> Hill Climb <input type="checkbox"/> Other : _____
	In the past 10 years have you had a racing accident?..... <input type="checkbox"/> Yes <input type="checkbox"/> No (If "Yes", explain details in Remarks Section below.)
	Racing organizations affiliated with? _____ Races supervised by? _____
Frequency (# Races) Last 12 Months _____ 12-24 Months Ago _____ Estimated Next 12 Months _____	

SECTION 2 UNDERWATER SPORTS	<input type="checkbox"/> I do not participate in Underwater Sports. (Skip to next section.)
	Type: <input type="checkbox"/> Scuba <input type="checkbox"/> Skin <input type="checkbox"/> Snorkel Purpose: <input type="checkbox"/> Recreation <input type="checkbox"/> Rescue <input type="checkbox"/> Salvage
	Locations: <input type="checkbox"/> Oceans <input type="checkbox"/> Lakes <input type="checkbox"/> Rivers <input type="checkbox"/> Pools <input type="checkbox"/> Quarries <input type="checkbox"/> Caves <input type="checkbox"/> Other _____
	Have you received formal diving training? <input type="checkbox"/> Yes <input type="checkbox"/> No (If "Yes", give details in Remarks Section below.)
	Do you use the "buddy system"? <input type="checkbox"/> Yes <input type="checkbox"/> No
Average Time at each depth? 0-75 Ft _____ 75-125 Ft _____ Over 125 Ft _____	
# of Dives: Last 12 Months _____ 12 - 24 Months Ago _____ Estimated Next 12 Months _____	

SECTION 3 SKY SPORTS	Please identify which activities you participate in: <input type="checkbox"/> I do not participate in Sky Sports. (Skip to next section.)
	<input type="checkbox"/> Sky Diving <input type="checkbox"/> Hang Gliding <input type="checkbox"/> Ultralights <input type="checkbox"/> Biplaning <input type="checkbox"/> Parachuting <input type="checkbox"/> Ballooning <input type="checkbox"/> Other _____
	If sky diving: Delayed jumping done?..... <input type="checkbox"/> Yes <input type="checkbox"/> No If ballooning: Gas ballooning <input type="checkbox"/> Yes <input type="checkbox"/> No
	Any stunting or baton passing? <input type="checkbox"/> Yes <input type="checkbox"/> No
	Are you a member of a club? <input type="checkbox"/> Yes <input type="checkbox"/> No Hot air ballooning <input type="checkbox"/> Yes <input type="checkbox"/> No
	What class of license do you hold? _____ Usual location or type of terrain? _____
	In the past 10 years have you been in an accident connected with this avocation(s)? <input type="checkbox"/> Yes <input type="checkbox"/> No (If "Yes", give details in Remarks Section below.)
	# Flights or Jumps: Last 12 Months _____ 12 - 24 Months Ago _____ Estimated Next 12 Months _____ Average Height _____ Average Distance _____ Average Duration _____ Maximum Height _____ Maximum Distance _____ Maximum Duration _____

Remarks or Other Avocations (Include details regarding nature, locations, frequency, and degree of participation.)
--

The above statements and answers are complete and true to the best of my knowledge and belief and will be the basis for and a part of any policy issued based on them.

Signed at: _____ (X) _____
City and State Signature of Proposed Insured

Date: _____

SERFF Tracking Number: IHLI-126159482 State: Arkansas
Filing Company: Investors Heritage Life Insurance Company State Tracking Number: 42598
Company Tracking Number: 24900AR
TOI: L08 Life - Other Sub-TOI: L08.000 Life - Other
Product Name: Ordinary App/Riders/Questionnaires
Project Name/Number: Ordinary App/Riders/Questionnaires/ICC09-24900

Supporting Document Schedules

Item Status:

Status

Date:

Satisfied - Item: Flesch Certification

Comments:

Readability Certification and Certificate of Compliance with Arkansas Rule & Regulation 19 are attached.

Attachments:

Readability Certification.pdf
Certificate of Compliance.pdf

Item Status:

Status

Date:

Satisfied - Item: Application

Comments:

This is a new application filing.

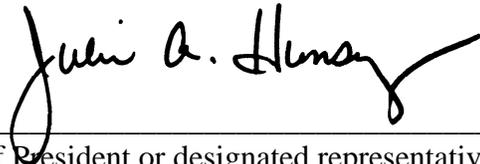
**APPLICATION FORM, 2 RIDER & 4 UNDERWRITING QUESTIONNAIRS
FILING
READABILITY CERTIFICATION**

**INVESTORS HERITAGE LIFE INSURANCE COMPANY
NAIC No. 64904**

I have reviewed or supervised the preparation of the forms listed below and certify that the forms comply with the applicable readability requirements of the Arkansas Code.

Form Number	Description	Flesch Score
ICC09-24900 (Rev. 04-2009)	Ordinary Whole Life and/or Term Life Insurance Policy Application	50.3
ICC09-24900 AIR	Term Insurance Rider	51.1
ICC09-24900 CTR	Child Insurance Rider	51
ICC09-NICQUEST1 (03-2009)	Nicotine Usage Questionnaire	58.9
ICC09 MSW/UND (5-2009)	Military Service Questionnaire	60.9
ICC09 80297 (5-2009)	Aviation Questionnaire	57
ICC09 80297 (5-2009)	Avocation Questionnaire	59.4

June 9, 2009
Date



Signature of President or designated representative

Julie Hunsinger, FSA, MAAA
Name of Person signing above

Vice President & Chief Actuary
Title of person signing above

Certificate of Compliance with Arkansas Rule and Regulation 19

Insurer: Investors Heritage Life Insurance Company

Form Number(s): Form : ICC09-24900 (Rev. 04-2009) - Ordinary Application
Form : ICC09-24900 AIR - Additional Insured Insurance Rider Application
Form : ICC09-24900 CTR - Children's Term Life Insurance Rider Application
Form : ICC09 MSW/UND (502009) - Military Service Questionnaire
Form : ICC09 80297 (5-2009) - Aviation Questionnaire
Form : ICC09 80298 (5-2009) - Avocation Questionnaire
Form : ICC09-NICQUEST1 (03-2009) - Nicotine Usage Questionnaire

I hereby certify that the filing above meets all applicable Arkansas requirements including the requirements of Rule and Regulation 19.



Signature of Company Officer

Julie A. Hunsinger, FSA, MAAA

Name

Vice President & Chief Actuary

Title

June 9, 2009

Date

Date