

SERFF Tracking Number: SYMX-126236905 State: Arkansas
Filing Company: Symetra Life Insurance Company State Tracking Number: 42990
Company Tracking Number: TL AR0013810F01
TOI: L08 Life - Other Sub-TOI: L08.000 Life - Other
Product Name: LUC-148 7/09 - Individual Life Application
Project Name/Number: IND- Individual/TL AR0013810F01

Filing at a Glance

Company: Symetra Life Insurance Company

Product Name: LUC-148 7/09 - Individual Life Application SERFF Tr Num: SYMX-126236905 State: Arkansas

Application

TOI: L08 Life - Other

SERFF Status: Closed-Approved- Closed State Tr Num: 42990

Sub-TOI: L08.000 Life - Other

Co Tr Num: TL AR0013810F01

State Status: Approved-Closed

Filing Type: Form

Reviewer(s): Linda Bird

Author: Symetra Life

Disposition Date: 07/27/2009

Date Submitted: 07/21/2009

Disposition Status: Approved-Closed

Implementation Date Requested: 08/18/2009

Implementation Date:

State Filing Description:

General Information

Project Name: IND- Individual

Status of Filing in Domicile: Not Filed

Project Number: TL AR0013810F01

Date Approved in Domicile:

Requested Filing Mode: Review & Approval

Domicile Status Comments:

Explanation for Combination/Other:

Market Type: Individual

Submission Type: New Submission

Group Market Size:

Overall Rate Impact:

Group Market Type:

Filing Status Changed: 07/27/2009

Explanation for Other Group Market Type:

State Status Changed: 07/27/2009

Deemer Date:

Created By: Symetra Life

Submitted By: Symetra Life

Corresponding Filing Tracking Number:

Filing Description:

SYMETRA Life Insurance Company

NAIC # 1129-68608 FEIN # 91-0742147

LUC-148 7/09 - Part I Individual Life Application

We are submitting copies of the final version of the above referenced forms for your review. The form is new and does

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not replace any form currently in use in your state. The content does not deviate from normal company or industry standards.

LUC-148 7/09, Part I Individual Life Application, will be used as part of the application process with individual term products approved in your state. It will become a part of the policy at issue.

These products will be sold through agents who are licensed and appointed by Symetra Life Insurance Company.

If you have questions, please contact me at the numbers noted below.

Sincerely,
Elizabeth A. Hampton
Contract Analyst
lisa.hampton@symetra.com
425-256-5468
800-796-3872 ext 65468

Company and Contact

Filing Contact Information

Elizabeth Hampton, Senior Insurance Compliance Analyst
P.O. Box 34690 SC-11
Seattle, WA 98124-1690
Lisa.Hampton@Symetra.com
425-256-8000 [Phone] 65468 [Ext]
425-256-5466 [FAX]

Filing Company Information

Symetra Life Insurance Company
P.O. Box 34690
Seattle, WA 98124-1690
(425) 256-8000 ext. [Phone]
CoCode: 68608
Group Code: 1129
Group Name:
FEIN Number: 91-0742147
State of Domicile: Washington
Company Type:
State ID Number: 667

Filing Fees

Fee Required? Yes
Fee Amount: \$20.00
Retaliatory? No
Fee Explanation: 1 application form.

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Per Company: No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Symetra Life Insurance Company	\$20.00	07/21/2009	29338418

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Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Linda Bird	07/27/2009	07/27/2009

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Disposition

Disposition Date: 07/27/2009

Implementation Date:

Status: Approved-Closed

Comment:

Rate data does NOT apply to filing.

SERFF Tracking Number: SYMX-126236905 *State:* Arkansas
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Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification		Yes
Supporting Document	Application		No
Supporting Document	Statement of Variability		Yes
Form	LUC-148 7/09 - Individual Life Application		Yes

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Form Schedule

Lead Form Number: LUC-148 7/09

Schedule Item Status	Form Number	Form Type Form Name	Action	Action Specific Data	Readability	Attachment
	LUC-148 7/09	Application/ LUC-148 7/09 - Enrollment Form Individual Life Application	Initial		50.400	LUC-148 7_09.PDF

Proposed Primary Insured Information

Primary Insured Name _____ Male Female SS# _____
First Middle Last

State or Foreign Country of Birth _____ Date of Birth _____ Height _____ Weight _____

Home Address _____
Street/PO Box City State Zip

Daytime Phone _____ Evening Phone _____ Driver's License # _____

Employer _____ Occupation _____ Annual Income _____

Proposed Other Insured Information

Other Insured Name _____ Male Female SS# _____
First Middle Last

State or Foreign Country of Birth _____ Date of Birth _____ Height _____ Weight _____

Home Address _____
Street/PO Box City State Zip

Daytime Phone _____ Evening Phone _____ Driver's License # _____

Employer _____ Occupation _____ Annual Income _____

Relationship to Proposed Primary Insured _____

Applicant/Owner Information (If other than Proposed Primary Insured or Proposed Other Insured)

Applicant/Owner Name _____ SS#/Tax ID _____

Applicant/Owner Address _____
Street/PO Box City State Zip

Insurance Needed For Mortgage Protection Income Replacement Debt Protection Other _____

Proposed Primary Insured Beneficiary Information

Beneficiary Name	Relationship	Primary	Contingent	%
_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	_____
_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	_____
_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	_____
The Proposed Primary Insured's living children, natural and adopted, to share equally.		<input type="checkbox"/>	<input type="checkbox"/>	_____

Proposed Other Insured Beneficiary Information

Beneficiary Name	Relationship	Primary	Contingent	%
_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	_____
_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	_____
_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	_____
The Proposed Other Insured's living children, natural and adopted, to share equally		<input type="checkbox"/>	<input type="checkbox"/>	_____

Complete for Simplified Issue Only

Amount of Financed/Refinanced Mortgage \$ _____ Mortgage Start Date _____

Co-Mortgagee Name (if any) _____

Financial Institution Name _____

By my signature on this application, I understand that the life policy applied for is only available on a Simplified Issue basis to homeowners who have secured a mortgage in the last [24] months.

Rate Class Applied For (Check one only for each Proposed Insured)

	Standard Non-Nicotine	Standard Nicotine	Preferred Non-Nicotine (Fully Underwritten Only)	Preferred Nicotine (Fully Underwritten Only)
Proposed Primary Insured	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Proposed Other Insured	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Product Information

Face Amount For Proposed Primary Insured Only (Not including riders) \$ _____

Issue Type (Check only one box)

- Fully-Underwritten Simplified Issue

Select only one of the three products and one term period.

- | | |
|--|---|
| <input type="checkbox"/> [Symetra Protector Term] – Initial Term Period
15 Year Term <input type="checkbox"/> Level Premium Guaranteed 15 Years
<input type="checkbox"/> Level Premium Guaranteed 5 Years (Simplified Issue)
<input type="checkbox"/> Level Premium Guaranteed 10 Years (Fully-Underwritten)

20 Year Term <input type="checkbox"/> Level Premium Guaranteed 20 Years
<input type="checkbox"/> Level Premium Guaranteed 5 Years (Simplified Issue)
<input type="checkbox"/> Level Premium Guaranteed 10 Years (Fully-Underwritten)

30 Year Term <input type="checkbox"/> Level Premium Guaranteed 30 Years
<input type="checkbox"/> Level Premium Guaranteed 15 Years (Simplified Issue)
<input type="checkbox"/> Level Premium Guaranteed 10 Years (Fully-Underwritten) | <input type="checkbox"/> [Symetra Protector Term Plus] (Includes Return of Premium)
20 Year Term <input type="checkbox"/> Level Premium Guaranteed 20 Years (Fully-Underwritten)
30 Year Term <input type="checkbox"/> Level Premium Guaranteed 30 Years (Fully-Underwritten)

<input type="checkbox"/> [Symetra Mortgage Protector Term Plus] (Includes Return of Premium)

20 Year Term <input type="checkbox"/> Level Premium Guaranteed 20 Years (Simplified Issue)
30 Year Term <input type="checkbox"/> Level Premium Guaranteed 30 Years (Simplified Issue) |
|--|---|

Supplemental Benefits and Riders

- Waiver of Premium Rider

Proposed Primary Insured

- Disability Income Rider for Accidental Injury \$ _____
 Monthly benefit min \$50 max \$3,000 not to exceed 1.5% of face amount
- Accidental Death Benefit \$ _____
 Min \$5,000, Max 3 X the face amount up to \$250,000
- Insured Children's Benefit (\$10,000 max per child)
 \$5,000 \$10,000
 (Complete Insured Children's Benefit Application)
- Other _____ \$ _____

Proposed Other Insured

- Other Insured Term Rider \$ _____
- Disability Income Rider for Accidental Injury \$ _____
 Monthly benefit min \$50 max \$3,000 not to exceed 1.5% of the Other Insured face amount
- Accidental Death Benefit \$ _____
 Min \$5,000, Max 3 X the other insured face amount up to \$250,000.
- Other _____ \$ _____

Name and Address of Personal Physician for the Proposed Primary Insured

Name _____

Address _____

Date & reason last consulted _____

What treatment was given or medication prescribed? _____

Name and Address of Personal Physician for the Proposed Other Insured

Name _____

Address _____

Date & reason last consulted _____

What treatment was given or medication prescribed? _____

Temporary Life Insurance Agreement (TIA) questions

	Proposed Primary Insured		Proposed Other Insured	
	Yes	No	Yes	No
1. Within the last 90 days, have you been admitted to, or been advised to be admitted to a hospital?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. In the last two years have you been treated for or been advised to be treated for: heart disease, stroke, tumor, mass, cancer, alcohol, drugs, or Acquired Immunodeficiency Syndrome (AIDS)/Aids Related Complex (ARC) by a medical professional?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

If your face amount is \$1,000,000 or less and you answered NO to the TIA questions above, you will be covered under the TIA if a check is collected for the initial payment or you sign up for the initial payment by EFT (maximum coverage is \$250,000).

NOTE TO AGENT/INSURANCE PRODUCER: For any Yes answers to questions 1 or 2 or if the face amount is greater than \$1,000,000, do not collect premium. No TIA coverage will be in effect.

Personal History

	Proposed Primary Insured		Proposed Other Insured	
	Yes	No	Yes	No
1. Have you:				
a. In the last 12 months, used tobacco or nicotine products in any form?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
If no, have you in the last 36 months, used tobacco or nicotine products in any form?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
If yes for either question, please list frequency and type (cigars, cigarettes, chewing tobacco, nicotine gum, patch, or other) and when last used (MO/YR). _____				
b. In the last 10 years, had a motor vehicle violation for driving under the influence of alcohol or drugs, had your license revoked or suspended, or been convicted of reckless driving?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. In the last 10 years, participated in aviation activities as a pilot or crew member, or engaged in parachuting, mountain and/or rock or ice climbing, hang-gliding, scuba diving, or racing of any motor driven vehicle or craft?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d. In the last 10 years, made a claim or received benefits for disability or worker's compensation as a result of a sickness or injury?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e. Ever had any Life or Disability insurance application declined or extra rated?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
f. Except for traffic violations, ever been convicted in a criminal proceeding?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
g. Ever received advice, counseling or treatment as the result of the use of alcohol or drugs?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
h. Ever used any drug except as legally prescribed by a health care provider? (such as but not limited to: ecstasy, marijuana, cocaine, heroin, methamphetamine, hallucinogenic agents, narcotics, etc.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
i. Ever declared bankruptcy? If yes, include the chapter and discharge date in Personal History Details.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Are you a U.S citizen or permanent legal U.S. resident ("Green Card" holder)? If no, how long have you continuously lived in the U.S. and what is your visa type?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Do you have any plans to travel or live outside of the U.S. or Canada in the next two years?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Are you a member of the armed forces, including the Reserves or National Guard, or do you intend to become one? If yes, please complete the Military Personnel disclosure form.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Personal History Details

For any "Yes" answer to questions 1 & 2 in the Temporary Life Insurance section or questions 1 - 4 in the Personal History section please provide details below. If you need additional space, please use the Additional Details section on page 5.

Question	Person	Explanation
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Medical History

Give complete detail for all yes answers in Medical History Details below. Identify question number and include diagnosis, dates, duration, treatments and medications prescribed; and names/addresses of all physicians and hospitals.

	Proposed Primary Insured		Proposed Other Insured	
	Yes	No	Yes	No
1. In the last 10 years have you had or been treated or diagnosed for any disorder or disease of:				
a. Respiratory system (lungs, bronchi, trachea, etc.) such as tuberculosis, asthma, emphysema, bronchitis or shortness of breath?.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. Circulatory system (heart, blood, arteries, etc.) such as chest pain, high blood pressure, heart disease or murmur?.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. Digestive system (esophagus, stomach, intestines, pancreas, liver, etc.) such as ulcer, cirrhosis, hepatitis, Crohn's disease, ulcerative colitis, or bleeding?.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d. Nervous system (brain, nerves, etc.) such as paralysis, fainting, seizure, stroke, transient ischemic attack, brain attack, or ALS?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e. Mental health such as depression, anxiety, bipolar, or suicide attempt?.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
f. Genitourinary system (kidney, bladder, reproductive organs, etc.) such as infection, bleeding, male or female disorder, or sexually transmitted diseases (not including HIV)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
g. Musculoskeletal system (muscles, spine, bones, joints, etc.) such as arthritis, back or joint problems?.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
h. Eyes, ears or skin?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
i. Either a benign or malignant growth, cancer, tumor or mass?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
j. Diabetes, hypoglycemia or impaired glucose tolerance?.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
k. Glandular disease or disorder (thyroid, adrenal, lymph glands, etc.)?.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
l. Blood or spleen such as anemia, clotting disorder or lymph node enlargement?.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Within the last 5 years have you:				
a. Been treated or diagnosed for Acquired Immunodeficiency Syndrome (AIDS), AIDS Related Complex (ARC), or tested positive for Human Immunodeficiency Virus (HIV) antibodies?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. Had any other impairment, sickness or diagnostic procedures such as X-ray, EKG, laboratory tests?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. Been hospitalized or had surgery performed, advised or contemplated?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d. Consulted, been examined or treated by any physician, psychiatrist, or medical practitioner not named above or for any cause not mentioned?.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Are you receiving or have you been advised to receive any treatment or diagnostic tests?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Are you taking or have you been advised to take medications, supplements, or herbs of any kind?.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Have you lost 10 or more pounds other than due to diet or exercise during the past 12 months? If yes, give amount and cause of weight loss and number of months at present weight in Medical History Details below.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Medical History Details

For any "Yes" answer to questions 1 – 5 in the Medical History section, please provide details below. If you need additional space, please use the Additional Details section on page 5.

Question	Person	Condition/Diagnosis	Dates/Durations of Condition/Treatment	Doctor's Name and Address
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

Family History

Proposed Primary Insured	Age if Living	Age at Death	Present Health or Cause of Death	Proposed Other Insured	Age if Living	Age at Death	Present Health or Cause of Death
Father	_____	_____	_____	Father	_____	_____	_____
Mother	_____	_____	_____	Mother	_____	_____	_____
Brother(s)	_____	_____	_____	Brother(s)	_____	_____	_____
Sister(s)	_____	_____	_____	Sister(s)	_____	_____	_____

If you need additional space, please use the Additional Details section below.

Additional Details

If you need additional space, please attach a separate piece of paper to this application and have the owner/applicant sign and date it.

Replacement

	Proposed Primary Insured		Proposed Other Insured		*Proposed Applicant/Owner	
	Yes	No	Yes	No	Yes	No
1. Do you have any other existing life insurance policies or annuity contracts in force or applied for with this or any other company?	<input type="checkbox"/>	<input type="checkbox"/>				
Person _____						
Company _____						
Face Amount _____						
Policy Type _____						
Annual Premium _____						

	Proposed Primary Insured		Proposed Other Insured		*Proposed Applicant/Owner	
	Yes	No	Yes	No	Yes	No
2. To the best of your knowledge, will the policy applied for replace any existing life insurance policy or annuity, or is any part of the premium to be paid by policy loan, or cash value on insurance presently in force? (If yes, attach state replacement disclosure.)	<input type="checkbox"/>	<input type="checkbox"/>				
a. Does the policy being replaced have cash value or surrender charges?	<input type="checkbox"/>	<input type="checkbox"/>				
If "YES" then complete as appropriate:						
Cash Value \$ _____ Surrender Charge \$ _____						
Cash Value \$ _____ Surrender Charge \$ _____						
Cash Value \$ _____ Surrender Charge \$ _____						
b. Will the new policy have surrender charges?	<input type="checkbox"/>	<input type="checkbox"/>				

*If different than the Proposed Primary Insured or Proposed Other Insured.

For Agent or Insurance Producer Use Only

- | | |
|---|---|
| | Yes No |
| 1. Does the Applicant/Owner have any existing life insurance policies or annuity contracts with this or any other company?..... | <input type="checkbox"/> <input type="checkbox"/> |
| 2. To the best of your knowledge, will this insurance replace or change any of the applicant/owner's existing life insurance policies or annuity contracts? | <input type="checkbox"/> <input type="checkbox"/> |
| 3. If replacing, how does this policy better serve the Applicant/Owner needs? | |

Additional Information

- | | |
|---|---|
| | Proposed Applicant/Owner |
| | Yes No |
| 1. Do you intend to assign or sell, or have you been involved in any discussion about the possible sale or assignment, of the life insurance policy for which you are applying? | <input type="checkbox"/> <input type="checkbox"/> |
| 2. Have you ever sold a policy to a life settlement, viatical or other secondary market provider, or are you in the process of selling a policy? | <input type="checkbox"/> <input type="checkbox"/> |
| 3. Is this policy being funded via a premium financing loan or with funds borrowed, advanced or paid from another person or entity? | <input type="checkbox"/> <input type="checkbox"/> |

For any "Yes" responses to questions 1 - 3 in the Additional Information section, please provide details in the Remarks section below.

Remarks

Payment Options

Payment Method Check Automatic EFT* Payment With Application \$ _____

Payment Frequency Annually Semiannually Quarterly Monthly EFT*

For all payments (initial and future) to be taken by EFT, please complete the following:

Name On Account _____ Checking Savings Bank Name _____

Routing Number _____ Account Number _____ Draft date (not the 29th, 30th, 31st) _____

*Marking this box authorizes us to automatically deduct from your checking or savings account by electronic funds transfer (EFT).

Conditional Amendment

- | | |
|---|---|
| | Proposed Applicant/Owner |
| | Yes No |
| If coverage is not issued as applied for, excluding substandard ratings, I hereby authorize Symetra to decrease or increase the premium amount stated on this application to cover the benefits issued to the persons insured. | <input type="checkbox"/> <input type="checkbox"/> |

Authorization to Release Personal Information

I hereby authorize and request any medical care provider, pharmacy, pharmacy benefits manager, individual employer, insurance company, reinsuring company, medical examiners, government unit, consumer reporting agency, or other person or organization, and MIB, Inc., to disclose any and all medical information, non-medical information, employment information, and insurance information they hold concerning me, to the employees, agents, or attorneys of Symetra Life Insurance Company. This disclosure Authorization will permit employees, agents or reinsurers of Symetra Life Insurance Company to view, copy, be furnished copies, share, or be given details of all such information described above including, but not limited to, mental and physical condition, evaluation, diagnoses, treatment, prognoses, prescription records, and/or toxicology results; specifically to include drug or alcohol use, mental illness, psychiatric treatment or diagnosis, testing and/or treatment of HIV (AIDS virus) and/or other sexually-transmitted diseases. Symetra Life Insurance Company obtains medical information only in connection with specific products or claims. Symetra Life Insurance Company will not use or share personally identifiable medical information for any purpose other than the underwriting or administration of your policy, claim or account. I understand that the information obtained pursuant to this Authorization will be used for the purpose of verifying, evaluating, negotiating, and other pertinent legal uses, with respect to my application for insurance, or claim under a policy of insurance. This Authorization will expire at the end of the contestability period of any insurance policy issued in reliance on the records obtained through this Authorization or twenty-four (24) months after the date of signing this Authorization. The individual signing this Authorization has the right to revoke Authorization in writing, except to the extent that action has been taken in reliance on the Authorization, or during a contestability period. Revocation may be a basis for denying insurance benefits. A written statement revoking this Authorization delivered to Symetra Life Insurance Company at its usual business address will revoke this Authorization. Any copy of this Authorization shall have the same authority as the original. I also understand that I or my representative have a right to receive a copy of this Authorization upon request.

I, the Owner, certify under the penalties of perjury that (1) the number shown in Proposed Insured Information section is my correct taxpayer identification number, and (2) I am not subject to backup withholding.

I (we) agree that all statements and answers recorded on this application are true and complete to the best of my/our knowledge and belief, and shall form a part of any policy issued. I have also read the Temporary Life Insurance Agreement. (Maximum Coverage is \$250,000.)

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

I acknowledge this insurance policy was not a prerequisite to receiving credit, property or services from any bank and that the amount of insurance I am applying for may not meet my complete financial needs. I have received information both orally and in writing stating that this insurance product is not a deposit or other obligation of, or guaranteed by, any bank or an affiliate of a bank and that the insurance product is not insured by the Federal Deposit Insurance Corporation (FDIC) or any other agency of the United States, or an affiliate of a bank.

Signed this _____, at _____, State of _____
Date City State

Printed Name of Proposed Primary Insured

Print Name of Writing Agent or Insurance Producer

Signature of Proposed Primary Insured (Age 15 or older)

Signature of Writing Agent or Insurance Producer

Printed Name of Applicant/Owner

Agent or Insurance Producer Phone

Signature of Applicant/Owner* if other than Proposed Insured

Agent or Insurance Producer Email

Printed Name of Proposed Other Insured

Agent or Insurance Producer Symetra Stat Number

Signature of Proposed Other Insured (Age 15 or older)

Branch Name _____ Branch # _____ 7-Digit Cost Center# _____ Rep ID # _____

* If Applicant is corporation/partnership, a corporate officer/partner other than Proposed Insured must sign.

NOTICE OF INSURANCE INFORMATION PRACTICES

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

Upon receipt of a request from you, MIB will arrange disclosure of any information it may have in your file. 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. Information for consumers about MIB may be obtained on its website at www.mib.com. The address of MIB's information office is 50 Braintree Hill Park, Suite 400, Braintree, MA 02184-8734. MIB may also be contacted at 1-866-692-6901 (TTY 1-866-346-3642).

Symetra Life 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.

Investigative Consumer Report – As a part of our underwriting procedure, we may request an investigative consumer report from a consumer reporting agency. A consumer report confirms and supplements the information on your application about your employment, residence, finances, smoking habits, marital status, occupation, hazardous avocations and general health. This report may also include information concerning your general reputation, personal characteristics and mode of living except as may be related directly or indirectly to your sexual orientation, including drug and alcohol use, motor vehicle driving record and any criminal activity. This information may be obtained through personal interviews with you, your family, friends, neighbors and business associates. If a report is required, you may request to be personally interviewed. If you wish to be personally interviewed, request this in the remarks section on the reverse side of this application and we will notify the consumer reporting agency.

The information contained in the report may be retained by the consumer reporting agency and later disclosed to other companies to the extent permitted by the Fair Credit Reporting Act. We hold investigative consumer reports in strict confidence, and we use them only to evaluate your application on a fair and equitable basis. You have a right to inspect and obtain a copy of this report from the consumer reporting agency. Such a report rarely has an adverse effect on an individual's eligibility for insurance. If it should, however, we will notify you in writing, and identify the reporting agency. You, or your authorized representative, are entitled to a copy of this Notice.

Disclosure to Others – Personal information we obtain about you during the underwriting process is confidential, and we will not disclose it to other persons or organizations without your written authorization, except to the extent necessary for the conduct of our business. Examples of situations where we may share information about you follow:

1. The agent may retain a copy of your application. If reinsurance is required, the reinsurance company will have access to our application file. We give the consumer reporting agency enough identity information about you so that it may initiate a consumer report investigation.
2. We may release information to another life insurance company to whom you have applied for life or health insurance, or to whom you have submitted a claim for benefits, if you have authorized that company to obtain such information, and it submits your authorization to us with its request for information.
3. As stated earlier, we may report information to MIB.
4. We may release information to persons or organizations conducting bona fide actuarial or scientific research studies, audits or evaluations, or to our affiliates who may wish to market products or services.
5. We will disclose information to government regulatory officials, law enforcement authorities, and others where required by law.

Access and Correction – In general, you have a right to learn the nature and substance of any personal information about you in our file, upon your written request. Whenever we make an adverse underwriting decision, we will notify you of the reasons for the decision and the source of the information on which we based our decision. Please refer to the section on MIB, Inc., for that organization's disclosure procedure. There are procedures by which you can obtain access to personal information about you appearing in our policy files, including information contained in investigative consumer reports. We have also established procedures by which you may request correction, amendment or deletion of any information in our files which you believe to be inaccurate or irrelevant. A description of these procedures will also be sent to you upon request. If you feel that any information we have is inaccurate or incomplete, please write to the Individual Underwriting & Issue Department of Symetra Life, PO Box 84068, Seattle, Washington 98124-9918. Your comments will be carefully considered and corrections made where justified.

TEMPORARY LIFE INSURANCE AGREEMENT

AMOUNT OF COVERAGE: If the Temporary Life Insurance questions (questions 2-6 in personal history section) have been answered "no" and if money has been accepted as advance payment for life insurance and the proposed insured dies while this temporary insurance is in effect, we will pay the beneficiary an amount equal to the lesser of:

- (a) the amount of all death benefits applied for with this application, including any accidental death benefits, if applicable; or
- (b) a maximum amount under all Temporary Life Insurance Agreements with Symetra Life of \$250,000.

COVERAGE BEGINS: Life insurance under this Agreement will begin on the date of this application, if the Temporary Life Insurance questions have been completed and answered "no" and money equal to the first full premium has been accepted as advance payment for life insurance.

COVERAGE ENDS: Life insurance under this Agreement will terminate on the earliest of:

- (a) 90 days from the date of this Agreement; or
- (b) the date that insurance takes effect under the policy applied for; or
- (c) the date a policy, other than as applied for, is offered to the applicant; or
- (d) the date the Company mails notice of termination of coverage and a return of the payment to the applicant.

LIMITATIONS:

- (a) This Agreement does not provide benefits for disability.
- (b) Fraud or material misrepresentation in the application or in the answers to the questions of this Agreement invalidate this Agreement and the Company's only liability is for refund of the payment made.
- (c) If the proposed insured is less than 15 days old or more than 80 years old, the Company's liability under this Agreement is limited to a refund of the payment made.
- (d) If the proposed insured commits suicide, the Company's liability under this Agreement is limited to a refund of the payment made.
- (e) If the check or draft submitted as payment is not honored by the bank, there is no coverage under this Agreement.
- (f) No one is authorized to waive or modify the terms of this Agreement.

SERFF Tracking Number: SYMX-126236905 State: Arkansas
Filing Company: Symetra Life Insurance Company State Tracking Number: 42990
Company Tracking Number: TL AR0013810F01
TOI: L08 Life - Other Sub-TOI: L08.000 Life - Other
Product Name: LUC-148 7/09 - Individual Life Application
Project Name/Number: IND- Individual/TL AR0013810F01

Supporting Document Schedules

	Item Status:	Status Date:
Satisfied - Item: Flesch Certification Comments: Attachment: Certificate of Readability.PDF		

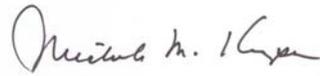
	Item Status:	Status Date:
Bypassed - Item: Application Bypass Reason: Application filing - form is attached to the Forms tab. Comments:		

	Item Status:	Status Date:
Satisfied - Item: Statement of Variability Comments: Attachment: Statement of Variability.PDF		

CERTIFICATION OF READABILITY

To the best of my knowledge, these forms meet all applicable statutes and regulations for readability standards. The Flesch score is:

LUC-148 7/09 – 50.4

A handwritten signature in black ink, appearing to read "Michele M. Kemper". The signature is written in a cursive style with a large initial 'M'.

Michele Kemper, V.P.
Symetra Life Insurance Company

LUC-148 7/09 - Statement of Variability

The following items are being filed in brackets in the contract.

Marketing Name

Symetra Protector Term

Symetra Protector Term Plus

Symetra Mortgage Protector Term

The marketing name may change in the future if our marketing direction changes. No product features will change.