

SERFF Tracking Number: CTZN-126245361 State: Arkansas  
Filing Company: Ozark National Life Insurance Company State Tracking Number: 43117  
Company Tracking Number:  
TOI: L08 Life - Other Sub-TOI: L08.000 Life - Other  
Product Name: Policy Owner Change Request Form  
Project Name/Number: Policy Owner Change Request Form/

## Filing at a Glance

Company: Ozark National Life Insurance Company

Product Name: Policy Owner Change Request SERFF Tr Num: CTZN-126245361 State: Arkansas  
Form

TOI: L08 Life - Other

SERFF Status: Closed-Approved-  
Closed

State Tr Num: 43117

Sub-TOI: L08.000 Life - Other

Co Tr Num:

State Status: Approved-Closed

Filing Type: Form

Reviewer(s): Linda Bird

Author: Amy Inman

Disposition Date: 08/12/2009

Date Submitted: 08/04/2009

Disposition Status: Approved-  
Closed

Implementation Date Requested: On Approval

Implementation Date:

State Filing Description:

## General Information

Project Name: Policy Owner Change Request Form

Status of Filing in Domicile: Not Filed

Project Number:

Date Approved in Domicile:

Requested Filing Mode:

Domicile Status Comments: This is the initial  
filing of this form in the domicile state.

Explanation for Combination/Other:

Market Type: Individual

Submission Type: New Submission

Group Market Size:

Overall Rate Impact:

Group Market Type:

Filing Status Changed: 08/12/2009

Explanation for Other Group Market Type:

State Status Changed: 08/12/2009

Deemer Date:

Created By: Amy Inman

Submitted By: Amy Inman

Corresponding Filing Tracking Number:

Filing Description:

Ozark National Life Insurance Company, NAIC# 67385

To Whom It May Concern:

Policy Owner's Change Request Form number H01294E (R0509) is being filed for the first time in this state. This form will be used by a policy owner to make several different administrative changes to a policy.

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## Company and Contact

### Filing Contact Information

Amy Inman, Associate Counsel amy.inman@sbcglobal.net  
400 E. Anderson Lane 512-837-7100 [Phone]  
Austin, TX 78752 512-836-9334 [FAX]

### Filing Company Information

Ozark National Life Insurance Company CoCode: 67385 State of Domicile: Arkansas  
400 E. Anderson Lane Group Code: 612 Company Type: Life  
Austin, TX 78752 Group Name: Citizens, Inc. State ID Number:  
(512) 837-7100 ext. [Phone] FEIN Number: 71-0289536

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## Filing Fees

Fee Required? No  
Retaliatory? No  
Fee Explanation:  
Per Company: No

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## Correspondence Summary

### Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Linda Bird	08/12/2009	08/12/2009

### Objection Letters and Response Letters

Objection Letters				Response Letters		
Status	Created By	Created On	Date Submitted	Responded By	Created On	Date Submitted
Pending Industry Response	Linda Bird	08/05/2009	08/05/2009	Amy Inman	08/05/2009	08/05/2009

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## **Disposition**

Disposition Date: 08/12/2009

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	Policy Owner Change Request		Yes

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## Objection Letter

Objection Letter Status Pending Industry Response  
Objection Letter Date 08/05/2009  
Submitted Date 08/05/2009  
Respond By Date 09/08/2009

Dear Amy Inman,

This will acknowledge receipt of the captioned filing.

Objection 1

No Objections

Comment: The filing fee was not included under EFT on this submission. Please advise if a check for the filing fee will follow by regular mail on this filing? We will hold your filing in a pending status until the fee is received.

Please feel free to contact me if you have questions.

Sincerely,

Linda Bird

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## Response Letter

Response Letter Status Submitted to State  
Response Letter Date 08/05/2009  
Submitted Date 08/05/2009

Dear Linda Bird,

### Comments:

Dear Ms. Bird -

A check in the amount of \$20.00 for the filing fee will be mailed to the Department.

### Response 1

Comments: A check in the amount of \$20.00 for the filing fee will be mailed to the Department.

### Related Objection 1

Comment:

The filing fee was not included under EFT on this submission. Please advise if a check for the filing fee will follow by regular mail on this filing? We will hold your filing in a pending status until the fee is received.

### Changed Items:

No Supporting Documents changed.

No Form Schedule items changed.

No Rate/Rule Schedule items changed.

Thank you.

Sincerely,  
Amy Inman

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## Form Schedule

**Lead Form Number: H01294E (R0509)**

Schedule Item Status	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
	H01294E (R0509)	Other	Policy Owner Change Request	Initial		43.900	Policy Owner Change Request Form.pdf

**Ozark National Life Insurance Company**  
 Telephone: (800) 880-5044 • E-mail: [pos@citizensinc.com](mailto:pos@citizensinc.com)

**POLICY OWNER'S CHANGE REQUEST (See Reverse Side for Service Request)**

Policy Number (10-digits)	Insured	Owner (If other than Insured)	Date July 28, 2009
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**INSTRUCTIONS:** Mark and complete any section(s) of the form to indicate your request. Date and sign each side of this form for which you have made a request. Mail this completed form to:  
 Policy Service Department  
 P.O. Box 149151  
 Austin TX 78714-9151

Upon receipt at the home office, the requested changes will be processed subject to the policy provisions. Any request received by the Company more than 60 days after the date the request was signed may be returned to you for a current date and signature.

<input type="checkbox"/> 1. BENEFICIARY	I hereby revoke all prior designations of beneficiary and request the designation below:	
	PRINT FULL GIVEN NAME AND SURNAME	RELATIONSHIP TO INSURED
	Primary Beneficiary	
	Address of Beneficiary	
	Contingent Beneficiary	
	Address of Contingent Beneficiary	

Unless otherwise directed, proceeds will be paid in equal shares to any primary beneficiary(ies) who survive the insured; however, if none survive, proceeds will be paid in equal shares to any contingent beneficiary(ies) who survive the insured.

<input type="checkbox"/> 2. OWNER	I hereby request that all benefits, rights and privileges incident to ownership of the policy be vested in the new owner below:	
	PRINT FULL GIVEN NAME AND SURNAME	RELATIONSHIP TO INSURED
	New Owner	SSN or Tax ID
	Address of New Owner	
	Contingent Owner	
	Address of Contingent Owner	

<input type="checkbox"/> 3. NAME	Change Name of: <input type="checkbox"/> Insured <input type="checkbox"/> Owner <input type="checkbox"/> Payor <input type="checkbox"/> Beneficiary	
	From (Print Former Name)	To (Print New Name)
	Reason for name change. If reason is other than Marriage, attach copy of Legal Evidence.	

<input type="checkbox"/> 4. NON-FORFEITURE	I hereby request the cash value of the policy, less any existing indebtedness to the company, be applied to:			
	<input type="checkbox"/> Extended Term Insurance		<input type="checkbox"/> Paid Up Insurance	
	Supplemental benefits are to be cancelled in accordance with the policy. Pure endowment, if any available, matures if the insured is living on the maturity date.			
	HOME OFFICE USE ONLY:			
	Effective Date	Amount of Insurance	Expiry Date	Pure Endowment
				Maturity Date

I direct any endorsement of the policy requested above be effected upon the Company's acceptance and acknowledgement evidenced below. I understand a change of beneficiary designation or transfer of ownership shall take effect as of the Acknowledgement of Request for Change date and I agree the Company may waive any policy provision requiring return of the policy for endorsement, but at its discretion may require its return.

-----SIGN BELOW FOR THE ABOVE REQUEST(S)-----

\_\_\_\_\_  
Signature of Witness

\_\_\_\_\_  
Signature of Insured or Owner, if other than Insured

\_\_\_\_\_  
Printed Witness Name

\_\_\_\_\_  
Date

**THE UNDERSIGNED ASSIGNEE AND IRREVOCABLE BENEFICIARY AGREE(S) TO THE ABOVE REQUEST(S) AND CHANGE(S).**

\_\_\_\_\_  
Signature of Assignee (If Any)

\_\_\_\_\_  
Signature of Irrevocable Beneficiary (If Any)

<b>HOME OFFICE USE ONLY</b>	
<b>ACKNOWLEDGEMENT OF REQUEST FOR CHANGE - PLEASE ATTACH TO POLICY</b>	
Dated at Austin, Texas on _____, 20____ by _____	Print Company officer's name and title
Company Name: _____	Company Officer Signature: _____



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## Supporting Document Schedules

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

**Satisfied - Item:** Flesch Certification

**Comments:**

**Attachment:**

Flesch Cert. - Policy Owner form.pdf

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

**Satisfied - Item:** Application

**Comments:**

The Policy Owner Change Request Form will be used with policies that were sold using the attached applications.

**Attachments:**

App - UPR-1-7-84.pdf

FAM-APP.pdf

GDB-APP.pdf

PRE-APP.pdf

CERTIFICATION

I, Amy S. Inman, Associate Counsel, hereby certify that the following forms submitted by Ozark National Life Insurance Company meet the minimum readability requirements of the State of Indiana.

<u>FORM DESCRIPTION</u>	<u>FLESCH SCORE</u>
H01294E (R0509) Policy Owner Change Request	43.9



Amy S. Inman,  
Associate Counsel

**OZARK NATIONAL LIFE INSURANCE COMPANY**

**APPLICATION  
PART ONE**

Home Office: Little Rock, Arkansas

Policy No. \_\_\_\_\_  
Date of Policy \_\_\_\_\_

1. Print full name of Proposed Insured \_\_\_\_\_  
2. Soc. Sec. Number \_\_\_\_\_

3. Date of Birth \_\_\_\_\_ Mo. \_\_\_\_\_ Day \_\_\_\_\_ Year \_\_\_\_\_  
Place of Birth \_\_\_\_\_ (State) \_\_\_\_\_ Age \_\_\_\_\_ Last Birthday \_\_\_\_\_  
4. Height \_\_\_\_\_ ft. \_\_\_\_\_ in. \_\_\_\_\_ Weight \_\_\_\_\_ lbs.  
5.  Male  Female  Married  Single  
6. Residence No. & Street \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
7. Previous Address During Past Two Years Present Tel. No. \_\_\_\_\_  
No. & Street \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ ( ) \_\_\_\_\_

12. (a)  Life Insurance-Amt. \$ \_\_\_\_\_  
Base Plan  
 Waiver of Life Policy Premium on Disability Rider  
 Accidental Death Benefit Rider \$ \_\_\_\_\_  
 Term Ins. Rider (Plan \_\_\_\_\_ Term \_\_\_\_\_ Yrs; Initial Amt. \$ \_\_\_\_\_)  
 PBP Rider  
 Flex. Prem. Annuity Rider -- Prem. \$ \_\_\_\_\_ Ann.  
 GDA Rider -- Ann. Deposit \$ \_\_\_\_\_  
 Other \_\_\_\_\_

8. Occupation(s) \_\_\_\_\_  
Duties \_\_\_\_\_  
Employer \_\_\_\_\_ Tel. No. \_\_\_\_\_  
No. & Street \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
City \_\_\_\_\_

9. Owner, if other than the Proposed Insured  
Name \_\_\_\_\_ Relationship \_\_\_\_\_  
Age \_\_\_\_\_  
No. & Street \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
City \_\_\_\_\_  
Soc. Sec. or Tax ID No. of Owner \_\_\_\_\_

10. Life Ins. in Force or Applied for on Proposed Insured  
Company \_\_\_\_\_ Plan \_\_\_\_\_ Amt. \_\_\_\_\_ Issued Yr. \_\_\_\_\_ ADB \_\_\_\_\_

13. Annuity Policy (If Annuity Policy is applied for omit Questions 10, 11, 12, 16, 17, 21, 22, 23, 24, 25 & 26)  
Plan of Annuity \_\_\_\_\_  
(a)  IRA  TSA  KEOGH  Non-Qualified  
(b) Amt. of Monthly Annuity \$ \_\_\_\_\_ Prem. \$ \_\_\_\_\_  
Age at Maturity: \_\_\_\_\_ years

11. Other Persons Proposed For Insurance  
Name \_\_\_\_\_ Relation \_\_\_\_\_ D of B \_\_\_\_\_ State \_\_\_\_\_ Ht. \_\_\_\_\_ Wt. \_\_\_\_\_  
\_\_\_\_\_

14. Premiums Payable  Annually  Semi-Annually  
 Quarterly  Monthly  PAC  MDO  
 Salary Deduction  Military Allotment  Weekly  
Any Premium Notices will be sent to Insured at Residence Address unless otherwise requested.

15. \$ \_\_\_\_\_ has been paid to Agent under the terms of the receipt given me, bearing the same date as this application.  
16. Is Automatic Premium Loan Option to Apply?  Yes  No  
17. If participating, indicate dividend option desired  
 Purchase Paid-up Additions  Paid in Cash  
 To Reduce Premiums  Left at interest with Company

18. Do you intend the replacement or change of any existing life insurance or annuities in connection with this application for insurance?  Yes  No If "yes" furnish particulars.

19. Beneficiary (a) Primary Beneficiary, with right of revocation, to whom proceeds will be payable at death of Proposed Insured:  
Designation \_\_\_\_\_ Name \_\_\_\_\_ Date of Birth \_\_\_\_\_ Relationship to Proposed Insured \_\_\_\_\_  
(b) Contingent Beneficiary, if any \_\_\_\_\_

20. Special Requests: \_\_\_\_\_  
For Home Office Endorsement \_\_\_\_\_

21. Has any person proposed for insurance (Give details of any "yes" answer below, identifying person to which it applies.)  
(a) Had any application for life or health insurance rejected, rated up, postponed, modified or cancelled?  Yes  No  
(b) An application for life or health insurance now pending with another insurer?  Yes  No  
(c) Made claim for insurance benefits or disability compensation for illness, injury or military service?  Yes  No  
(d) Ever been rejected, deferred or discharged by military service for physical or mental condition?  Yes  No  
(e) Any intention of occupation change or travel or residence outside of the United States or Canada?  Yes  No

(f) Ever engaged in or contemplates engaging in any type of flying as a pilot or crew member, skin or sky diving, racing or other hazardous activities? (If "yes" complete appropriate questionnaire)  Yes  No  
(g) Ever had their driver's license revoked or suspended?  Yes  No  
(h) Been convicted of or awaiting trial for a felony?  Yes  No  
Date & Details \_\_\_\_\_  
Person \_\_\_\_\_  
Item \_\_\_\_\_

Form LA-1-7-84 Application Part One Continued On Reverse Side

**AUTHORIZATION**

I hereby authorize any licensed physician, medical practitioner, hospital, clinic or other medical or medically related facility, insurance or reinsuring company, the Medical Information Bureau or other organization, institution or person, that has any records or knowledge of me or my health, to give to the Ozark National Life Insurance Company any such information.

To facilitate rapid submission of such information, I authorize all said sources, except the Medical Information Bureau, to give such records or knowledge to any agency employed by the insurance company to collect and transmit such information.

I agree that a photographic copy of this Authorization shall be as valid as the original. I acknowledge receipt of the Medical Information Bureau, Inc. Disclosure Notice. I agree this authorization shall be valid for two and one-half years from the date shown below.

Date \_\_\_\_\_ Signature of Proposed Insured or Applicant \_\_\_\_\_

**OZARK NATIONAL LIFE INSURANCE COMPANY**

Home Office: Little Rock, Arkansas

ALL PREMIUM CHECKS MUST BE MADE PAYABLE TO THE COMPANY. DO NOT MAKE CHECK PAYABLE TO THE AGENT OR LEAVE THE PAYEE BLANK.

Received of \_\_\_\_\_ an application for a policy to be issued by the OZARK NATIONAL LIFE INSURANCE COMPANY and the deposit of \_\_\_\_\_ dollars. This receipt is given and the deposit accepted by the Company with the express understanding that the insurance applied for will not become effective until this application has been approved by the Company and the policy actually issued and the first premium paid, as provided in the policy. Insurance, if any, will be effective on the Date of Issue shown in the Policy Benefits Schedule at 12:01 A.M., Standard Time at the place the Proposed Insured(s) resides. Should this application be declined, the Company will return to the applicant the above paid deposit in full.

**NOTICE TO PROPOSED INSURED(S) -- PART ONE**

Federal law requires that notice of investigation be given to persons applying for insurance. In making this application for insurance to Ozark National Life Insurance Company or its reinsurers, it is understood that an investigative consumer report may be prepared whereby information is obtained through personal interviews with your neighbors, friends, or others with whom you are acquainted. This inquiry includes information as to your character, general reputation, personal characteristics and mode of living. You have the right to make a written request within a reasonable period of time to receive additional, detailed information about the nature and scope of this investigation. (See Notice to Proposed Insured(s) -- Part Two on reverse side.)

**NOTICE TO PROPOSED INSURED(S) — PART TWO**

Information regarding your insurability will be treated as confidential. Ozark National Life Insurance Company or its reinsurers may, however, make a brief report thereon to the Medical Information Bureau, a non-profit membership organization of life insurance companies, which operates an information exchange on behalf of its members. If you apply to another Bureau member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, the Bureau, upon request, will supply such company with the information in its file.

Upon receipt of a request from you, the Bureau will arrange disclosure of any information it may have in your file. (Medical information will be disclosed only to your attending physician.) If you question the accuracy of information in the Bureau's file, you may contact the Bureau and seek a correction in accordance with the procedures set forth in the Federal Fair Credit Reporting Act. The address of the Bureau's information office is Post Office Box 105, Essex Station, Boston, Massachusetts 02112, telephone number (617) 426-3660.

Ozark National Life Insurance Company or its reinsurers may also release information in its file to other life insurance companies to whom you may apply for life or health insurance, or to whom a claim for benefits may be submitted. (See Notice to Proposed Insured(s) — Part One, on reverse side.)

**If you do not hear from the Company in relation to the proposed insurance within 30 days, notify the Company stating the name of the Agent, date of the receipt, and the amount paid.**

**NOTICE: ANY PERSON WHO KNOWINGLY PRESENTS A FALSE OR FRAUDULENT CLAIM FOR PAYMENT OF A LOSS OR BENEFIT OR KNOWINGLY PRESENTS FALSE INFORMATION IN AN APPLICATION FOR INSURANCE IS GUILTY OF A CRIME AND MAY BE SUBJECT TO FINES AND CONFINEMENT IN PRISON.**

**PART ONE Application To OZARK NATIONAL LIFE INSURANCE COMPANY (Continued).**

22. Is any person proposed for insurance to be medically examined?  Yes  No. If "yes" give name and with respect to such person. Questions 23, 24 and 25 need not be answered.

23. Has any person proposed for insurance ever had any symptoms of or been afflicted with:	Yes	No	24. Has any person proposed for insurance:	Yes	No
(a) Defect of eyes, ears, nose or throat?	<input type="checkbox"/>	<input type="checkbox"/>	(a) Ever applied for or received a pension or disability benefits?	<input type="checkbox"/>	<input type="checkbox"/>
(b) Disease or disorder of the brain or nervous system?	<input type="checkbox"/>	<input type="checkbox"/>	(b) Used alcoholic beverages to excess or intoxication?	<input type="checkbox"/>	<input type="checkbox"/>
(c) Fainting spells, epilepsy or convulsions, paralysis?	<input type="checkbox"/>	<input type="checkbox"/>	(c) Used or taken to excess narcotics, LSD, amphetamines, barbiturates, marijuana or any habit forming drugs?	<input type="checkbox"/>	<input type="checkbox"/>
(d) Disease or disorder of the heart or blood vessels or circulatory system?	<input type="checkbox"/>	<input type="checkbox"/>	(d) Lost or gained weight during the past 2 years?	<input type="checkbox"/>	<input type="checkbox"/>
(e) Pain or discomfort in chest, high or low blood pressure, shortness of breath, rheumatic fever?	<input type="checkbox"/>	<input type="checkbox"/>	(e) Consulted a physician during the past 5 years?	<input type="checkbox"/>	<input type="checkbox"/>
(f) Disease or disorder of lungs or respiratory system, asthma, emphysema, tuberculosis?	<input type="checkbox"/>	<input type="checkbox"/>	(f) Had an electrocardiogram, x-ray, blood study, urinalysis or any other diagnostic study in the last 5 years?	<input type="checkbox"/>	<input type="checkbox"/>
(g) Disease or disorder of stomach, intestines, rectum, liver or gallbladder, an ulcer or hernia?	<input type="checkbox"/>	<input type="checkbox"/>	(g) Been hospitalized in the last 5 years?	<input type="checkbox"/>	<input type="checkbox"/>
(h) Disease or disorder of the kidney, bladder, prostate?	<input type="checkbox"/>	<input type="checkbox"/>	(h) Been advised to have or contemplated surgery?	<input type="checkbox"/>	<input type="checkbox"/>
(i) Sugar or albumin in urine?	<input type="checkbox"/>	<input type="checkbox"/>	(i) Been advised within the past 5 years to take or is now taking treatment or medication?	<input type="checkbox"/>	<input type="checkbox"/>
(j) Disease or disorder of bone, joints, muscle, back or spine?	<input type="checkbox"/>	<input type="checkbox"/>	(j) Had a parent, child, or spouse with histories of tuberculosis, diabetes, mental, nervous, heart or circulatory disorders?	<input type="checkbox"/>	<input type="checkbox"/>
(k) Rheumatism, arthritis, gout, loss of limb or deformity?	<input type="checkbox"/>	<input type="checkbox"/>	(k) Been told within the past 10 years that he/she had Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC)?	<input type="checkbox"/>	<input type="checkbox"/>
(l) Cancer, tumor, syphilis, diabetes, glands or blood disorder?	<input type="checkbox"/>	<input type="checkbox"/>	(l) Received advice or treatment in connection with any of the categories mentioned in (k) above?	<input type="checkbox"/>	<input type="checkbox"/>
(m) Disease or disorder of breast, womb, ovaries or pelvis?	<input type="checkbox"/>	<input type="checkbox"/>	25. Does any person proposed for insurance now have abnormality, deformity, disease or disorder, or is he or she receiving treatment or taking medication of any kind, to the best of your knowledge and belief?	<input type="checkbox"/>	<input type="checkbox"/>
(n) Any serious illness, disease or injury within the last five years not listed above to the best of your knowledge and belief?	<input type="checkbox"/>	<input type="checkbox"/>			

26. Give complete details of any "yes" answers to Questions 23, 24 and 25.  
 No. Name Disease, Injury or Reason Date Details, Physician, Hospitals, Addresses

The statements and answers on both the front and back of this Application Part One are true and complete to the best of my knowledge and belief. It is agreed that (a) this application and any amendments hereto, with the answers made to the medical examiner and recorded on Part Two, if a medical examination is required by the Company, shall be the basis of any insurance granted; (b) no agent or medical examiner has authority to waive the answer to any question in the application, to pass on insurability, to waive any of the Company's rights or requirements or to make or alter any contract; (c) acceptance of any policy issued shall constitute ratification of any endorsements in the space entitled "For Home Office Endorsement," except that no change in the amount, classification, plan of insurance or annuity, or benefits shall be effective unless agreed to in writing by the Applicant, and (d) no insurance or annuity shall be considered in force unless and until a policy shall have been issued by the Company and said policy manually received and accepted by the Applicant and the full first premium paid thereon, all during the lifetime and before any change in the insurability of any and all persons proposed for insurance from that stated herein.

The Company shall have sixty days from the date hereof within which to consider and act on this application and if within such period a policy has not been received by the Applicant or if notice of approval or rejection has not been given, then this application shall be deemed to have been declined by the Company.

Dated at \_\_\_\_\_ Signature of Proposed Insured, if 15 years or older  
 this \_\_\_\_\_ day of \_\_\_\_\_, 19\_\_\_\_ Signature of Spouse, if proposed for insurance

Signature of Witness (Agent must witness when required by law) Signature of Payor or Applicant, if other than Proposed Insured (if a corporation, show name of firm and title of officer signing)

AGENT'S REPORT  
 1. Did you personally see each person proposed for insurance and are the answers in this application complete and true insofar as you are able to determine through your own knowledge or inquiry?  Yes  No  
 2. Do you have any knowledge or reason to believe that the insurance or annuity applied for will replace or change any existing insurance or annuity?  Yes  No  
 3.  Commission and/or  volume to be shared with Agent No. \_\_\_\_\_ %

SETTLEMENT ATTACHED  
 Cash  Check   
 \$ \_\_\_\_\_  
 Insert only actual amount sent to Company.

4. Do you know of any condition affecting the reliability or insurability of any person proposed for insurance not fully set forth herein?  
 5. Name and address of physician requested to make examination, (if non-medical - so state) I hereby certify that any information supplied me by the applicant has been truly and accurately recorded on this application.

# OZARK NATIONAL LIFE INSURANCE COMPANY

10201 WEST MARKHAM STREET, LITTLE ROCK, ARKANSAS 72205

## APPLICATION FOR LIFE INSURANCE OR ANNUITY

Application is hereby made to the OZARK NATIONAL LIFE INSURANCE COMPANY for life insurance or an annuity, as indicated below, on the life of the Proposed Insured named below. It is understood and agreed that no insurance coverage shall be effective unless and until this Application is approved by the Company and the policy is delivered during the continued good health of the Proposed Insured.

Proposed Insured or Annuitant \_\_\_\_\_ Social Security No. \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_

State \_\_\_\_\_ Arkansas \_\_\_\_\_ Zip \_\_\_\_\_ Telephone Number \_\_\_\_\_ Sex \_\_\_\_\_

Height \_\_\_\_\_ Weight \_\_\_\_\_ Occupation and Exact Duties \_\_\_\_\_

Date of Birth \_\_\_\_\_ Age Last Birthday \_\_\_\_\_ Amount of Insurance or Annuity \$ \_\_\_\_\_

Plan \_\_\_\_\_ Mode \_\_\_\_\_ Modal Premium \$ \_\_\_\_\_ Premium Collected \$ \_\_\_\_\_

Owner \_\_\_\_\_ Age \_\_\_\_\_ Relationship \_\_\_\_\_

Primary Beneficiary \_\_\_\_\_ Age \_\_\_\_\_ Relationship \_\_\_\_\_

Secondary Beneficiary \_\_\_\_\_ Age \_\_\_\_\_ Relationship \_\_\_\_\_

Is this policy to be used to fund a pre-paid funeral contract? \_\_\_\_\_ Gross Contract Amount \$ \_\_\_\_\_

Assignable Allowed Credits \$ \_\_\_\_\_

### THE FOLLOWING HEALTH QUESTIONS NEED NOT BE ANSWERED IF APPLYING FOR AN ANNUITY

- |   | Yes   | No    |
|---|-------|-------|
| 1. Has the Proposed Insured:  |       |       |
| a. been hospitalized, home confined or in a nursing facility during the past two (2) years?   | _____ | _____ |
| b. ever had any symptoms of or been afflicted with diabetes, cancer, leukemia, tumor, abnormal blood pressure, heart disease, kidney disease, lung disease or breathing disorder, Alzheimer's disease, stroke, alcoholism, or any disorder of the central nervous system? | _____ | _____ |
| c. ever had symptoms of or been afflicted with any serious illness or injury not mentioned above?   | _____ | _____ |
| d. ever been declined, postponed or offered a policy other than as applied for?   | _____ | _____ |
| 2. Have you ever had or been told you had Acquired Immune Deficiency Syndrome (AIDS), Aids-Related Complex (ARC) or had a positive test for antibodies to AIDS?   | _____ | _____ |
| 3. Gained or lost weight during the past year?  | _____ | _____ |
| 4. Will this insurance replace any existing insurance?  | _____ | _____ |

If any question above is answered "Yes," give full details as to dates, names of physicians and hospitals, illness or injury and results in the space provided below. Attach additional sheets if necessary.

I DECLARE that all answers to the questions above and the appropriate details on any additional sheet accompanying this application are complete, true and accurately recorded. I understand and agree that no one has authority to permit me to withhold information or to answer any question falsely and that any policy which may be issued by the Company on this Application shall be accepted subject to its terms. I expressly authorize any physician or hospital to disclose any information acquired by examination or treatment of me or any member of my family. A copy of this authorization shall be as valid as the original. I expressly waive all statutory rights governing such disclosure. I also understand that premiums will be paid by Automatic Premium Loan in the event any premium is not paid before the end of its Grace Period.

Signed at \_\_\_\_\_

\_\_\_\_\_ Arkansas, this \_\_\_\_\_ day of \_\_\_\_\_

20 \_\_\_\_\_

# OZARK NATIONAL LIFE INSURANCE COMPANY

10201 WEST MARKHAM STREET, LITTLE ROCK, ARKANSAS 72205

## APPLICATION FOR LIMITED BENEFIT LIFE INSURANCE

Application is hereby made to the OZARK NATIONAL LIFE INSURANCE COMPANY for limited benefit life insurance on the life of the Proposed Insured named below. It is understood and agreed that no insurance coverage shall be effective unless and until this Application is approved by the Company and the policy is delivered during the lifetime of the Proposed Insured.

Proposed Insured \_\_\_\_\_ Social Security No. \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_

State Arkansas Zip \_\_\_\_\_ Telephone Number \_\_\_\_\_ Sex \_\_\_\_\_

Date of Birth \_\_\_\_\_ Age Last Birthday \_\_\_\_\_ Amount of Insurance \$ \_\_\_\_\_

Plan \_\_\_\_\_ Mode \_\_\_\_\_ Modal Premium \$ \_\_\_\_\_ Premium Collected \$ \_\_\_\_\_

Owner \_\_\_\_\_ Age \_\_\_\_\_ Relationship \_\_\_\_\_

Primary Beneficiary \_\_\_\_\_ Age \_\_\_\_\_ Relationship \_\_\_\_\_

Secondary Beneficiary \_\_\_\_\_ Age \_\_\_\_\_ Relationship \_\_\_\_\_

Is this policy to be used to fund a pre-paid funeral contract? \_\_\_\_\_ Gross Contract Amount \$ \_\_\_\_\_

Assignable Allowed Credits \$ \_\_\_\_\_

Benefits for death due to natural causes are limited as follows, depending on the plan chosen. **All percentages are of the Amount of Insurance shown on this Application.**

### 3% Increasing Graded Death Benefit Plans:

3-Year Pay — 50% 1st Year, Full Benefit 2nd Year and Thereafter.

5-Year Pay — 30% 1st Year, 65% 2nd Year and Full Benefit 3rd Year and Thereafter.

### Level Graded Death Benefit Plans:

Whole Life — 25% 1st Year, 50% 2nd Year, 75% 3rd Year and Full Benefit 4th Year and Thereafter.

Within the past 12 months, have you, the Proposed Insured, been advised by any physician or other medical practitioner that you have a terminal illness or disease, or that you should receive hospital, nursing home or hospice care? Yes \_\_\_\_\_ No \_\_\_\_\_  
If the answer is "Yes," the Proposed Insured is not eligible for life insurance, and this application will not be processed.

Will this insurance replace any existing insurance? Yes \_\_\_\_\_ No \_\_\_\_\_

I understand that premiums will be paid by Automatic Premium Loan in the event any premium is not paid before the end of its Grace Period.

Signed at \_\_\_\_\_, Arkansas, this \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_.

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

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

Agent \_\_\_\_\_ Code \_\_\_\_\_

### FOR HOME OFFICE USE ONLY

POLICY NUMBER \_\_\_\_\_ ISSUE DATE \_\_\_\_\_ PLAN \_\_\_\_\_

**ENDORSEMENTS:** \_\_\_\_\_

