

SERFF Tracking Number: CMBD-126288111 State: Arkansas
 Filing Company: Combined Insurance Company of America State Tracking Number: 43496
 Company Tracking Number: 372095-AR-909
 TOI: L071 Individual Life - Whole Sub-TOI: L071.101 Fixed/Indeterminate Premium - Single Life
 Product Name: Application for Whole Life Insurance
 Project Name/Number: 372095-AR-909/372095-AR-909

Filing at a Glance

Company: Combined Insurance Company of America

Product Name: Application for Whole Life Insurance SERFF Tr Num: CMBD-126288111 State: Arkansas

TOI: L071 Individual Life - Whole SERFF Status: Closed-Approved- Closed State Tr Num: 43496

Sub-TOI: L071.101 Fixed/Indeterminate Premium - Single Life Co Tr Num: 372095-AR-909 State Status: Approved-Closed

Filing Type: Form Reviewer(s): Linda Bird
 Author: Anita Sibley Disposition Date: 09/17/2009
 Date Submitted: 09/14/2009 Disposition Status: Approved-Closed

Implementation Date Requested: On Approval Implementation Date:
 State Filing Description:

General Information

Project Name: 372095-AR-909
 Project Number: 372095-AR-909
 Requested Filing Mode: Review & Approval
 Explanation for Combination/Other:
 Submission Type: New Submission
 Overall Rate Impact:
 Filing Status Changed: 09/17/2009

Status of Filing in Domicile:
 Date Approved in Domicile:
 Domicile Status Comments:
 Market Type: Individual
 Group Market Size:
 Group Market Type:
 Explanation for Other Group Market Type:
 State Status Changed: 09/17/2009
 Created By: Anita Sibley
 Corresponding Filing Tracking Number:

Deemer Date:
 Submitted By: Anita Sibley
 Filing Description:
 Application for Life Insurance 372095-AR-909 is being submitted for your review and approval.

Please see the attached Cover Letter in the Supporting Documentation tab for details.

Company and Contact

SERFF Tracking Number: CMBD-126288111 *State:* Arkansas
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Product Name: Application for Whole Life Insurance
Project Name/Number: 372095-AR-909/372095-AR-909

Filing Contact Information

Anita Sibley, Policy Analyst Anita.Sibley@combined.com
 1000 N Milwaukee Avenue 847-953-1526 [Phone]
 6th Floor 847-953-1557 [FAX]
 Glenview, IL 60025

Filing Company Information

Combined Insurance Company of America	CoCode: 62146	State of Domicile: Illinois
1000 Milwaukee Avenue	Group Code: 317	Company Type:
Glenview, IL 60025	Group Name:	State ID Number:
(847) 953-1531 ext. [Phone]	FEIN Number: 36-2136262	

Filing Fees

Fee Required? Yes
 Fee Amount: \$50.00
 Retaliatory? Yes
 Fee Explanation: Retaliatory Fee equals \$50.00 per form
 Per Company: No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Combined Insurance Company of America	\$50.00	09/14/2009	30521261

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Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Linda Bird	09/17/2009	09/17/2009

Amendments

Schedule	Schedule Item Name	Created By	Created On	Date Submitted
Form	Application for Life Insurance	Anita Sibley	09/15/2009	09/15/2009
Supporting Document	Application - Changes Highlighted	Anita Sibley	09/15/2009	09/15/2009
Supporting Document	Memorandum of Variability	Anita Sibley	09/15/2009	09/15/2009

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Disposition

Disposition Date: 09/17/2009

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		No
Supporting Document	Life & Annuity - Actuarial Memo		No
Supporting Document	Cover Letter		Yes
Supporting Document (revised)	Application - Changes Highlighted		Yes
Supporting Document	Application - Changes Highlighted	Replaced	Yes
Supporting Document (revised)	Memorandum of Variability		Yes
Supporting Document	Memorandum of Variability	Replaced	Yes
Supporting Document	Replacement Notices		Yes
Form (revised)	Application for Life Insurance		Yes
Form	Application for Life Insurance	Replaced	Yes

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Amendment Letter

Submitted Date: 09/15/2009

Comments:

I realized after submitting this filing on 9/14/2009 that the bracketing was incomplete. Therefore, at this time, I am submitting updated versions of the bracketed application, the highlight application and the variability memorandum showing all of the variable material in the application.

Thank you for your consideration of this filing submission.

Changed Items:

Form Schedule Item Changes:

Form Schedule Item Changes:

Form Number	Form Type	Form Name	Action	Form Action Other	Previous Filing #	Replaced Form #	Readability Score	Attachments
372095-AR-909	Application/Enrollment Form	EApplication for Life Insurance	Initial				43.200	372095-AR-909(2).pdf

Supporting Document Schedule Item Changes:

User Added -Name: Application - Changes Highlighted

Comment:

372095-AR-909-Highlighted(2).pdf

User Added -Name: Memorandum of Variability

Comment:

372095-AR-909-Variability_2_.pdf

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Form Schedule

Lead Form Number: 372095-AR-909

Schedule Item Status	Form Number	Form Type Form Name	Action	Action Specific Data	Readability	Attachment
	372095-AR-909	Application/ Enrollment Form Application for Life Insurance	Initial		43.200	372095-AR-909(2).pdf

Application for Life Insurance

FORM #[33095]

Proposed Issue Date: _____

I am applying for this coverage based on the following health and employment information:

EMPLOYEE'S (Proposed Insured, Owner) NAME (First MI Last)		<input type="checkbox"/> Male <input type="checkbox"/> Female	Birthdate: Mo/Day/Yr	Age	State of Birth
EMPLOYEE'S HOME ADDRESS (Street, City, State, Zip)					
Home Phone No.	Driver's License No. & State	[Social Security No.]		Height ft. in.	Weight lbs.
EMPLOYER					Hire Date: Mo/Day/Yr
BENEFICIARY'S Name and Relationship Base Plan:		[NBT for the benefit of the designated beneficiaries under a United States Savings Bond Continuation Plan dated]		Phone # to call for Personal History Interview	Best time to call <input type="checkbox"/> a.m. <input type="checkbox"/> p.m.
[Rider:]					

Plan/[Rider]:	Insurance Amount	PREMIUM	MODE
Total:			

Death proceeds of base policy to be paid in equal payments over 10 years (Plan 1 of Settlement Options)? Yes No

1. Are you employed in your primary occupation for less than 30 hours each week? Yes No
2. Within the past 5 years, have you received any ADVICE or TREATMENT for or taken prescription MEDICINE for:
 - a. Stroke, heart attack, coronary artery disease, or other heart condition? Yes No
 - b. Cancer (except basal cell carcinoma), malignant growth, melanoma or Hodgkin's disease? Yes No
 - c. Emphysema, chronic obstructive lung or pulmonary disease, Alzheimer's or Parkinson's disease? Yes No
 - d. Organ transplant, polycystic kidney disease or kidney failure? Yes No
 - e. Cirrhosis of the liver, alcoholism or drug addiction? Yes No
 - f. Down's Syndrome, Cerebral Palsy, Muscular Dystrophy, Multiple Sclerosis, or Cystic Fibrosis? Yes No
3. Have you been diagnosed by a physician as having AIDS (Acquired Immune Deficiency Syndrome) or ARC (AIDS Related Complex) or been tested positive for HIV? Yes No
4. Have you been convicted of reckless driving or driving under the influence of alcohol in the last five years? Yes No
5. Have you had any advice, treatment, or taken any prescription medication for any other sickness, injury or defect, excluding flu, colds, sprains, and routine physicals in the last five years? Yes No

(If "Yes" is answered to question 5, explain below). In any case, please provide information on your physician.

Health Condition & Medication	Date of Diagnosis	Date Last Treated	Surgery?	Receiving Treatment?	Physician's Name, Address, Phone No. (Street, City, State)

Do you currently have any existing life insurance policies or annuity contracts in force? Yes No
(If "Yes", complete Important Notice Form No. 300055)

CONFIDENTIALITY OF MEDICAL INFORMATION

The information disclosed on this application will not be disclosed to the employer or any other person without the authorization of the applicant.

PLEASE READ CAREFULLY

It is very important that you review the application carefully. Misstatements or omissions could cause an otherwise valid claim to be denied. Please check the application carefully and advise your agent if any information is not correct or not complete or if any medical history has not been included. **I understand that any insurance applied for will not take effect unless and until Combined Insurance Company of America approves my application, the contract is issued, and the required premium is received by Combined Insurance Company of America.**

In applying for this coverage, I represent and affirm the following:

1. The information which I have given as recorded on this Application is true and complete to the best of my knowledge and belief.
2. I have received the Medical Information Bureau (MIB) Disclosure Statement, the notice under the Fair Credit Reporting Act, and Notice of Information Practices.

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

I authorize Combined Insurance Company of America or its reinsurers to acquire from and authorize any hospital, physician, medical practitioner, clinic, medically related facility, insurance company, the Medical Information Bureau, Inc. (MIB), Bureau of Motor Vehicles, or consumer reporting agency to release to Combined Insurance Company of America any medical information regarding me or the past or present health of me for the purpose of evaluating this application for insurance. I also authorize Combined Insurance Company of America or its reinsurers to disclose all such information to any physician, the Medical Information Bureau, Inc. or any other insurance company in order to evaluate a claim or an application for insurance.

This authorization shall remain valid for a period of two years from the issue date of the policy. A photocopy of this authorization will be as valid as the original. A copy of the authorization is available upon request to the Company.

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.

I do do not elect the automatic premium loan option.

X _____ City: _____ State: _____ Date: ____/____/____
Signature of Employee

I, the authorized agent, have on the Date of Application recorded the information as given to me by the Employee. To the best of my knowledge and belief the policy being applied for will - will not replace any existing insurance. I have delivered the Notice of Information Practices. I have no knowledge of any unfavorable medical history not recorded on this Application.

Signature of Licensed Agent _____ Code # _____ % Split _____

Agent Split: Name: _____ Code # _____ % Split _____

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Supporting Document Schedules

	Item Status:	Status Date:
Satisfied - Item: Flesch Certification		
Comments:		
Attachments:		
372095-AR-909-Readability.pdf		
Certification of Compliance.pdf		

	Item Status:	Status Date:
Bypassed - Item: Application		
Bypass Reason: This is an application only filing. The application is included in the Form Schedule.		
Comments:		

	Item Status:	Status Date:
Satisfied - Item: Cover Letter		
Comments:		
Attachment:		
372095-AR-909-Cover.pdf		

	Item Status:	Status Date:
Satisfied - Item: Application - Changes Highlighted		
Comments:		
Attachment:		
372095-AR-909-Highlighted(2).pdf		

	Item Status:	Status Date:
Satisfied - Item: Memorandum of Variability		

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Product Name: Application for Whole Life Insurance
Project Name/Number: 372095-AR-909/372095-AR-909

Comments:

Attachment:

372095-AR-909-Variability_2_.pdf

Item Status:

**Status
Date:**

Satisfied - Item: Replacement Notices

Comments:

Attachments:

300055.pdf

300055RM.pdf



September 11, 2009

READABILITY CERTIFICATION

RE: Form No. 372095-AR-909 – Application for Life Insurance

We hereby certify that the above captioned form has a Flesch Index Score of 43.2 with the deletion of medical terminology and language drafted to conform to the requirements of applicable state and federal laws, regulations, or agency interpretations. The form meets the reading ease requirements.

A handwritten signature in black ink that reads "Michael J. Hollar".

Michael J. Hollar
Assistant Secretary

Certificate of Compliance with Arkansas Rule and Regulation 19

Insurer: Combined Insurance Company of America

Form Number(s): 372095-AR-909 - Application for Life Insurance

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

Michael J. Hollar

Signature of Company Officer

Michael J. Hollar
Name

Assistant Secretary
Title

September 11, 2009
Date



VIA SERFF

September 14, 2009

Honorable Jay Bradford
Arkansas Insurance Department
1200 West 3rd Street
Little Rock, AR 72201-1904

RE: **SERFF Tracking Number: CMBD-1262881111**
Combined Insurance Company of America
FEIN Number: 36-2136262 -- NAIC Number: 317-62146
Form Numbers: 372095-AR-909 -- Application for Whole Life Insurance
Individual Life

Dear Commissioner Bradford:

Attached for your review and approval is Application 372095-AR-909. This is a new form that will replace Application 372095R04, which was previously approved by your department on October 8, 2004 under SERFF Tracking Number USPH-65KR5E319/00. The application is used to market Individual Whole Life Policy 33095-AR, which was approved on June 20, 2003 under SERFF Tracking Number USPH-5NENK5134/00.

The new application was created to incorporate the changes required by Arkansas Life Insurance and Annuities Replacement Rule 97, which becomes effective on January 1, 2010. Specific changes are highlighted on the bracketed version that is attached to the Supporting Documentation tab, along with a Variability Memorandum, Certification of Compliance and the required Readability Certification.

Also attached for your reference, are copies of our Important Notice for Replacement of Life Insurance or Annuities, Form No. 300055 and our Replacement Memorandum 30055RM.

Illinois, our domiciliary state, has not adopted the Life Replacement Model Regulation as yet. Therefore, this form has not been filed in our state of domicile.

Your attention to this filing is very much appreciated. If you have any questions or concerns, please feel free to contact me.

Sincerely,

Anita Sibley
Policy Analyst

Anita Sibley, ACS, AIRC – Policy Analyst – Policy Filings/Government Relations
Toll Free to Product Filings: 888-449-3623 Direct: 847-953-1526 Fax: 847-953-1557 E-Mail: anita.sibley@combined.com

Application for Life Insurance

FORM #[33095]

Proposed Issue Date: _____

I am applying for this coverage based on the following health and employment information:

EMPLOYEE'S (Proposed Insured, Owner) NAME (First MI Last)	<input type="checkbox"/> Male <input type="checkbox"/> Female	Birthdate: Mo/Day/Yr	Age	State of Birth
EMPLOYEE'S HOME ADDRESS (Street, City, State, Zip)				
Home Phone No.	Driver's License No. & State	[Social Security No.]	Height ft. in.	Weight lbs.
EMPLOYER				Hire Date: Mo/Day/Yr
BENEFICIARY'S Name and Relationship Base Plan:		[NBT for the benefit of the designated beneficiaries under a United States Savings Bond Continuation Plan dated]		Phone # to call for Personal History Interview
[Rider:]				Best time to call <input type="checkbox"/> a.m. <input type="checkbox"/> p.m.

Plan/[Rider]:	Insurance Amount	PREMIUM	MODE
Total:			

Death proceeds of base policy to be paid in equal payments over 10 years (Plan 1 of Settlement Options)? Yes No

1. Are you employed in your primary occupation for less than 30 hours each week? Yes No
2. Within the past 5 years, have you received any **ADVICE** or **TREATMENT** for or taken prescription **MEDICINE** for:
 - a. Stroke, heart attack, coronary artery disease, or other heart condition? Yes No
 - b. Cancer (except basal cell carcinoma), malignant growth, melanoma or Hodgkin's disease? Yes No
 - c. Emphysema, chronic obstructive lung or pulmonary disease, Alzheimer's or Parkinson's disease? Yes No
 - d. Organ transplant, polycystic kidney disease or kidney failure? Yes No
 - e. Cirrhosis of the liver, alcoholism or drug addiction? Yes No
 - f. Down's Syndrome, Cerebral Palsy, Muscular Dystrophy, Multiple Sclerosis, or Cystic Fibrosis? Yes No
3. Have you been diagnosed by a physician as having AIDS (Acquired Immune Deficiency Syndrome) or ARC (AIDS Related Complex) or been tested positive for HIV? Yes No
4. Have you been convicted of reckless driving or driving under the influence of alcohol in the last five years? Yes No
5. Have you had any advice, treatment, or taken any prescription medication for any other sickness, injury or defect, excluding flu, colds, sprains, and routine physicals in the last five years? Yes No

(If "Yes" is answered to question 5, explain below). In any case, please provide information on your physician.

Health Condition & Medication	Date of Diagnosis	Date Last Treated	Surgery?	Receiving Treatment?	Physician's Name, Address, Phone No. (Street, City, State)

Do you currently have any existing life insurance policies or annuity contracts in force? Yes No
 (If "Yes", complete Important Notice Form No. 300055)

CONFIDENTIALITY OF MEDICAL INFORMATION

The information disclosed on this application will not be disclosed to the employer or any other person without the authorization of the applicant.

PLEASE READ CAREFULLY

It is very important that you review the application carefully. Misstatements or omissions could cause an otherwise valid claim to be denied. Please check the application carefully and advise your agent if any information is not correct or not complete or if any medical history has not been included. **I understand that any insurance applied for will not take effect unless and until Combined Insurance Company of America approves my application, the contract is issued, and the required premium is received by Combined Insurance Company of America.**

In applying for this coverage, I represent and affirm the following:

1. The information which I have given as recorded on this Application is true and complete to the best of my knowledge and belief.
2. I have received the Medical Information Bureau (MIB) Disclosure Statement, the notice under the Fair Credit Reporting Act, and Notice of Information Practices.

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

I authorize Combined Insurance Company of America or its reinsurers to acquire from and authorize any hospital, physician, medical practitioner, clinic, medically related facility, insurance company, the Medical Information Bureau, Inc. (MIB), Bureau of Motor Vehicles, or consumer reporting agency to release to Combined Insurance Company of America any medical information regarding me or the past or present health of me for the purpose of evaluating this application for insurance. I also authorize Combined Insurance Company of America or its reinsurers to disclose all such information to any physician, the Medical Information Bureau, Inc. or any other insurance company in order to evaluate a claim or an application for insurance.

This authorization shall remain valid for a period of two years from the issue date of the policy. A photocopy of this authorization will be as valid as the original. A copy of the authorization is available upon request to the Company.

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.

I do do not elect the automatic premium loan option.

X _____ City: _____ State: _____ Date: ____/____/____
Signature of Employee

I, the authorized agent, have on the Date of Application recorded the information as given to me by the Employee. **To the best of my knowledge and belief the policy being applied for will - will not replace any existing insurance.** I have delivered the Notice of Information Practices. I have no knowledge of any unfavorable medical history not recorded on this Application.

Signature of Licensed Agent _____ Code # _____ % Split _____

Agent Split: Name: _____ Code # _____ % Split _____



VARIABILITY MEMORANDUM
Application for Term Life Insurance
Form No. 372095-AR-909

Bracketed Information	Options/Reasons
Home Office Address	Bracketed to alleviate a future filing if the address changes.
Form Number	Bracketed to allow for a future change in the form number of the policy being marketed.
Social Security Number	Bracketed to allow us the flexibility to remove if we decide not to use this field.
NBT for the benefit of the designated beneficiaries under a United States Savings Bond Continuation Plan dated	Bracketed to allow us the flexibility to remove if not used for NBT bond program.
Rider:	All inclusive. Bracketed to allow us the flexibility to remove if we decide not to market a rider with this policy.

**COMBINED INSURANCE COMPANY OF AMERICA
5050 Broadway, Chicago, Illinois 60640**

IMPORTANT NOTICE:

REPLACEMENT OF LIFE INSURANCE OR ANNUITIES

You are contemplating the purchase of a life insurance policy or annuity contract. In some cases this purchase may involve discontinuing or changing an existing policy or contract. If so, a replacement is occurring. Financed purchases are also considered replacements.

A replacement occurs when a new policy or contract is purchased and, in connection with the sale, you discontinue making premium payments on an existing policy or contract, or an existing policy or contract is surrendered, forfeited, assigned to the replacing insurer, or otherwise terminated or used in a financed purchase.

A financed purchase occurs when the purchase of a new life insurance policy involves the use of funds obtained by the withdrawal or surrender of or by borrowing some or all of the policy values, including accumulated dividends, of an existing policy to pay all or part of premium or payment due on the new policy. A financed purchase is a replacement.

You should carefully consider whether a replacement is in your best interest. You will pay acquisition costs and there may be surrender costs deducted from your policy or contract. You may be able to make changes to your existing policy or contract to meet your insurance needs at less cost. A financed purchase will reduce the value of your existing policy and may reduce the amount paid upon the death of the insured.

We want you to understand the effects of replacements before you make your purchase decision and ask that you answer the following questions and consider the questions on the back of this form.

1. Are you considering discontinuing making premium payments, surrendering, forfeiting, assigning to the insurer, or otherwise terminating your existing policy or contract? YES NO
2. Are you considering using funds from your existing policies or contracts to pay premiums due on the new policy or contract? YES NO

If you answered "yes" to either of the above questions, list each existing policy or contract you are contemplating replacing (include the name of the insurer, the insured or annuitant, and the policy or contract number if available) and whether each policy or contract will be replaced or used as a source of financing:

	INSURER NAME	CONTRACT OR POLICY #	INSURED OR ANNUITANT	REPLACED (R) OR FINANCING (F)
1.	_____	_____	_____	_____
2.	_____	_____	_____	_____
3.	_____	_____	_____	_____

Make sure you know the facts. Contact your existing company or its agent for information about the old policy or contract. If you request one, an in force illustration, policy summary or available disclosure documents must be sent to you by the existing insurer. Ask for and retain sales material used by the agent in the sales presentation. Be sure that you are making an informed decision.

The existing policy or contract is being replaced because

I certify that the responses herein are, to the best of my knowledge, accurate:

Applicant's Signature and Printed Name Date

Agent's Signature and Printed Name Date

I do not want this notice read aloud to me. _____ (Applicants must initial only if they do not want the notice read aloud.)

A replacement may not be in your best interest, or your decision could be a good one. You should make a careful comparison of the costs and benefits of your existing policy or contract and the proposed policy or contract. One way to do this is to ask the company or agent that sold you your existing policy or contract to provide you with information concerning your existing policy or contract. This may include an illustration of how your existing policy or contract is working now and how it would perform in the future based on certain assumptions. Illustrations should not, however, be used as a sole basis to compare policies or contracts. You should discuss the following with your agent to determine whether replacement or financing your purchase makes sense:

PREMIUMS:

- Are they affordable?
- Could they change?
- You're older - are premiums higher for the proposed new policy?
- How long will you have to pay premiums on the new policy? On the old policy?

POLICY VALUES:

- New policies usually take longer to build cash values and to pay dividends.
- Acquisition costs for the old policy may have been paid; you will incur costs for the new one.
- What surrender charges do the policies have?
- What expense and sales charges will you pay on the new policy?
- Does the new policy provide more insurance coverage?

INSURABILITY:

- If your health has changed since you brought your old policy, the new one could cost you more, or you could be turned down.
- You may need a medical exam for a new policy.
- Claims on most new policies for up to the first two years can be denied based on inaccurate statements.
- Suicide limitations may begin anew on the new coverage.

IF YOU ARE KEEPING THE OLD POLICY AS WELL AS THE NEW POLICY:

- How are premiums for both policies being paid?
- How will the premiums on your existing policy be affected?
- Will a loan be deducted from death benefits?
- What values from the old policy are being used to pay premiums?

IF YOU ARE SURRENDERING AN ANNUITY OR INTEREST SENSITIVE LIFE PRODUCT:

- Will you pay surrender charges on your old contract?
- What are the interest rate guarantees for the new contract?
- Have you compared the contract charges or other policy expenses?

OTHER ISSUES TO CONSIDER FOR ALL TRANSACTIONS:

- What are the tax consequences of buying the new policy?
- Is this a tax free exchange? (See your tax advisor).
- Is there a benefit from favorable "grand-fathered" treatment of the old policy under the federal tax code?
- Will the existing insurer be willing to modify the old policy?
- How does the quality and financial stability of the new company compare with your existing company?

**COMBINED INSURANCE COMPANY OF AMERICA
5050 Broadway, Chicago, Illinois 60640**

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A replacement occurs when a new policy or contract is purchased and, in connection with the sale, you discontinue making premium payments on an existing policy or contract, or an existing policy or contract is surrendered, forfeited, assigned to the replacing insurer, or otherwise terminated or used in a financed purchase.

A financed purchase occurs when the purchase of a new life insurance policy involves the use of funds obtained by the withdrawal or surrender of or by borrowing some or all of the policy values, including accumulated dividends, of an existing policy to pay all or part of premium or payment due on the new policy. A financed purchase is a replacement.

You should carefully consider whether a replacement is in your best interest. You will pay acquisition costs and there may be surrender costs deducted from your policy or contract. You may be able to make changes to your existing policy or contract to meet your insurance needs at less cost. A financed purchase will reduce the value of your existing policy and may reduce the amount paid upon the death of the insured.

We want you to understand the effects of replacements before you make your purchase decision and ask that you answer the following questions and consider the questions on the back of this form.

1. Are you considering discontinuing making premium payments, surrendering, forfeiting, assigning to the insurer, or otherwise terminating your existing policy or contract? YES NO
2. Are you considering using funds from your existing policies or contract to pay premiums due on the new policy or contract? YES NO

If you answered "yes" to either of the above questions, list each existing policy or contract you are contemplating replacing (include the name of the insurer, the insured or annuitant, and the policy or contract number if available) and whether each policy or contract will be replaced or used as a source of financing:

	INSURER NAME	CONTRACT OR POLICY #	INSURED OR ANNUITANT	REPLACED (R) OR FINANCING (F)
1.	_____	_____	_____	_____
2.	_____	_____	_____	_____
3.	_____	_____	_____	_____

Make sure you know the facts. Contact your existing company or its agent for information about the old policy or contract. If you request one, an in force illustration, policy summary or available disclosure documents must be sent to you by the existing insurer. Ask for and retain sales material used by the agent in the sales presentation. Be sure that you are making an informed decision.

The existing policy or contract is being replaced because

I certify that the responses herein are, to the best of my knowledge, accurate:

Applicant's Signature and Printed Name Date

Agent's Signature and Printed Name Date

I do not want this notice read aloud to me. _____ (Applicants must initial only if they do not want the notice read aloud.)

A replacement may not be in your best interest, or your decision could be a good one. You should make a careful comparison of the costs and benefits of your existing policy or contract and the proposed policy or contract. One way to do this is to ask the company or agent that sold you your existing policy or contract to provide you with information concerning your existing policy or contract. This may include an illustration of how your existing policy or contract is working now and how it would perform in the future based on certain assumptions. Illustrations should not, however, be used as a sole basis to compare policies or contracts. You should discuss the following with your agent to determine whether replacement or financing your purchase makes sense:

PREMIUMS:

- Are they affordable?
- Could they change?
- You're older - are premiums higher for the proposed new policy?
- How long will you have to pay premiums on the new policy? On the old policy?

POLICY VALUES:

- New policies usually take longer to build cash values and to pay dividends.
- Acquisition costs for the old policy may have been paid; you will incur costs for the new one.
- What surrender charges do the policies have?
- What expense and sales charges will you pay on the new policy?
- Does the new policy provide more insurance coverage?

INSURABILITY:

- If your health has changed since you brought your old policy, the new one could cost you more, or you could be turned down.
- You may need a medical exam for a new policy.
- Claims on most new policies for up to the first two years can be denied based on inaccurate statements.
- Suicide limitations may begin anew on the new coverage.

IF YOU ARE KEEPING THE OLD POLICY AS WELL AS THE NEW POLICY:

- How are premiums for both policies being paid?
- How will the premiums on your existing policy be affected?
- Will a loan be deducted from death benefits?
- What values from the old policy are being used to pay premiums?

IF YOU ARE SURRENDERING AN ANNUITY OR INTEREST SENSITIVE LIFE PRODUCT:

- Will you pay surrender charges on your old contract?
- What are the interest rate guarantees for the new contract?
- Have you compared the contract charges or other policy expenses?

OTHER ISSUES TO CONSIDER FOR ALL TRANSACTIONS:

- What are the tax consequences of buying the new policy?
- Is this a tax free exchange? (See your tax advisor).
- Is there a benefit from favorable "grand-fathered" treatment of the old policy under the federal tax code?
- Will the existing insurer be willing to modify the old policy?
- How does the quality and financial stability of the new company compare with your existing company?

COMBINED INSURANCE COMPANY OF AMERICA
 5050 Broadway, Chicago, Illinois 60640

LIFE INSURANCE AND ANNUITIES

REPLACEMENT MEMORANDUM

EXISTING CONTRACT/POLICY

PROPOSED CONTRACT/POLICY

Owner / Annuitant(s) _____

Owner / Annuitant(s) _____

Insurer _____

Insurer _____

Contract # _____

Application # _____

Product Type * _____

Product Type * _____

Product Name _____

Product Name _____

FOR BOTH LIFE INSURANCE AND ANNUITIES
(Complete all that is applicable)

CONTRACT OR POLICY PROVISION	EXISTING CONTRACT/POLICY	REPLACEMENT CONTRACT/POLICY
Current Proposed Premium / Annual Consideration		
Current Contract Value		
Current Surrender Value		
Death Benefit Amount		
Current Interest Rate & Guarantee Period		
Guaranteed Minimum Accumulation/Interest Rate		

* Deferred Fixed Annuity, Deferred Variable Annuity, Deferred Indexed Fixed Annuity, Immediate Annuity, Indexed Life Insurance, Variable Life Insurance, Whole Life Insurance, Universal Life Insurance, Term Life Insurance and Endowment

COMBINED INSURANCE COMPANY OF AMERICA
5050 Broadway, Chicago, Illinois 60640

LIFE INSURANCE AND ANNUITIES

REPLACEMENT MEMORANDUM

EXISTING CONTRACT/POLICY

PROPOSED CONTRACT/POLICY

Owner / Annuitant(s) _____

Owner / Annuitant(s) _____

Insurer _____

Insurer _____

Contract # _____

Application # _____

Product Type * _____

Product Type * _____

Product Name _____

Product Name _____

FOR BOTH LIFE INSURANCE AND ANNUITIES
(Complete all that is applicable)

CONTRACT OR POLICY PROVISION	EXISTING CONTRACT/POLICY	REPLACEMENT CONTRACT/POLICY
Current Proposed Premium / Annual Consideration		
Current Contract Value		
Current Surrender Value		
Death Benefit Amount		
Current Interest Rate & Guarantee Period		
Guaranteed Minimum Accumulation/Interest Rate		

* Deferred Fixed Annuity, Deferred Variable Annuity, Deferred Indexed Fixed Annuity, Immediate Annuity, Indexed Life Insurance, Variable Life Insurance, Whole Life Insurance, Universal Life Insurance, Term Life Insurance and Endowment

SERFF Tracking Number: CMBD-126288111 State: Arkansas
 Filing Company: Combined Insurance Company of America State Tracking Number: 43496
 Company Tracking Number: 372095-AR-909
 TOI: L071 Individual Life - Whole Sub-TOI: L071.101 Fixed/Indeterminate Premium - Single Life
 Product Name: Application for Whole Life Insurance
 Project Name/Number: 372095-AR-909/372095-AR-909

Superseded Schedule Items

Please note that all items on the following pages are items, which have been replaced by a newer version. The newest version is located with the appropriate schedule on previous pages. These items are in date order with most recent first.

Creation Date:	Schedule	Schedule Item Name	Replacement Creation Date	Attached Document(s)
09/11/2009	Form	Application for Life Insurance	09/15/2009	372095-AR-909.pdf (Superseded)
09/11/2009	Supporting Document	Memorandum of Variability	09/15/2009	372095-AR-909-Variability.pdf (Superseded)
09/11/2009	Supporting Document	Application - Changes Highlighted	09/15/2009	372095-AR-909-Highlighted.pdf (Superseded)

Application for Life Insurance

FORM #[33095]

Proposed Issue Date: _____

I am applying for this coverage based on the following health and employment information:

EMPLOYEE'S (Proposed Insured, Owner) NAME (First MI Last)	<input type="checkbox"/> Male <input type="checkbox"/> Female	Birthdate: Mo/Day/Yr	Age	State of Birth
EMPLOYEE'S HOME ADDRESS (Street, City, State, Zip)				
Home Phone No.	Driver's License No. & State	[Social Security No.]	Height ft. in.	Weight lbs.
EMPLOYER				Hire Date: Mo/Day/Yr
BENEFICIARY'S Name and Relationship Base Plan:	NBT for the benefit of the designated beneficiaries under a United States Savings Bond Continuation Plan dated		Phone # to call for Personal History Interview	Best time to call <input type="checkbox"/> a.m. <input type="checkbox"/> p.m.
[Rider:]				

Plan/[Rider]:	Insurance Amount	PREMIUM	MODE
Total:			

Death proceeds of base policy to be paid in equal payments over 10 years (Plan 1 of Settlement Options)? Yes No

1. Are you employed in your primary occupation for less than 30 hours each week? Yes No
2. Within the past 5 years, have you received any **ADVICE** or **TREATMENT** for or taken prescription **MEDICINE** for:
 - a. Stroke, heart attack, coronary artery disease, or other heart condition? Yes No
 - b. Cancer (except basal cell carcinoma), malignant growth, melanoma or Hodgkin's disease? Yes No
 - c. Emphysema, chronic obstructive lung or pulmonary disease, Alzheimer's or Parkinson's disease? Yes No
 - d. Organ transplant, polycystic kidney disease or kidney failure? Yes No
 - e. Cirrhosis of the liver, alcoholism or drug addiction? Yes No
 - f. Down's Syndrome, Cerebral Palsy, Muscular Dystrophy, Multiple Sclerosis, or Cystic Fibrosis? Yes No
3. Have you been diagnosed by a physician as having AIDS (Acquired Immune Deficiency Syndrome) or ARC (AIDS Related Complex) or been tested positive for HIV? Yes No
4. Have you been convicted of reckless driving or driving under the influence of alcohol in the last five years? Yes No
5. Have you had any advice, treatment, or taken any prescription medication for any other sickness, injury or defect, excluding flu, colds, sprains, and routine physicals in the last five years? Yes No

(If "Yes" is answered to question 5, explain below). In any case, please provide information on your physician.

Health Condition & Medication	Date of Diagnosis	Date Last Treated	Surgery?	Receiving Treatment?	Physician's Name, Address, Phone No. (Street, City, State)

Do you currently have any existing life insurance policies or annuity contracts in force? Yes No
(If "Yes", complete Important Notice Form No. 300055)

CONFIDENTIALITY OF MEDICAL INFORMATION

The information disclosed on this application will not be disclosed to the employer or any other person without the authorization of the applicant.

PLEASE READ CAREFULLY

It is very important that you review the application carefully. Misstatements or omissions could cause an otherwise valid claim to be denied. Please check the application carefully and advise your agent if any information is not correct or not complete or if any medical history has not been included. **I understand that any insurance applied for will not take effect unless and until Combined Insurance Company of America approves my application, the contract is issued, and the required premium is received by Combined Insurance Company of America.**

In applying for this coverage, I represent and affirm the following:

1. The information which I have given as recorded on this Application is true and complete to the best of my knowledge and belief.
2. I have received the Medical Information Bureau (MIB) Disclosure Statement, the notice under the Fair Credit Reporting Act, and Notice of Information Practices.

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

I authorize Combined Insurance Company of America or its reinsurers to acquire from and authorize any hospital, physician, medical practitioner, clinic, medically related facility, insurance company, the Medical Information Bureau, Inc. (MIB), Bureau of Motor Vehicles, or consumer reporting agency to release to Combined Insurance Company of America any medical information regarding me or the past or present health of me for the purpose of evaluating this application for insurance. I also authorize Combined Insurance Company of America or its reinsurers to disclose all such information to any physician, the Medical Information Bureau, Inc. or any other insurance company in order to evaluate a claim or an application for insurance.

This authorization shall remain valid for a period of two years from the issue date of the policy. A photocopy of this authorization will be as valid as the original. A copy of the authorization is available upon request to the Company.

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.

I do do not elect the automatic premium loan option.

X _____ City: _____ State: _____ Date: ____/____/____
Signature of Employee

I, the authorized agent, have on the Date of Application recorded the information as given to me by the Employee. To the best of my knowledge and belief the policy being applied for will - will not replace any existing insurance. I have delivered the Notice of Information Practices. I have no knowledge of any unfavorable medical history not recorded on this Application.

Signature of Licensed Agent _____ Code # _____ % Split _____

Agent Split: Name: _____ Code # _____ % Split _____



VARIABILITY MEMORANDUM
Application for Term Life Insurance
Form No. 372095-AR-909

Bracketed Information	Options/Reasons
Home Office Address	Bracketed to alleviate a future filing if the address changes.
Form Number	Bracketed to allow for a future change in the form number of the policy being marketed.
Social Security Number	Bracketed to allow us the flexibility to remove if we decide not to use this field.
Rider:	All inclusive. Bracketed to allow us the flexibility to remove if we decide not to market a rider with this policy.

Application for Life Insurance

FORM #[33095]

Proposed Issue Date: _____

I am applying for this coverage based on the following health and employment information:

EMPLOYEE'S (Proposed Insured, Owner) NAME (First MI Last)		<input type="checkbox"/> Male <input type="checkbox"/> Female	Birthdate: Mo/Day/Yr	Age	State of Birth
EMPLOYEE'S HOME ADDRESS (Street, City, State, Zip)					
Home Phone No.	Driver's License No. & State	[Social Security No.]		Height ft. in.	Weight lbs.
EMPLOYER					Hire Date: Mo/Day/Yr
BENEFICIARY'S Name and Relationship Base Plan:		NBT for the benefit of the designated beneficiaries under a United States Savings Bond Continuation Plan dated		Phone # to call for Personal History Interview	Best time to call <input type="checkbox"/> a.m. <input type="checkbox"/> p.m.
[Rider:]					

Plan/[Rider]:	Insurance Amount	PREMIUM	MODE
Total:			

Death proceeds of base policy to be paid in equal payments over 10 years (Plan 1 of Settlement Options)? Yes No

1. Are you employed in your primary occupation for less than 30 hours each week? Yes No
2. Within the past 5 years, have you received any ADVICE or TREATMENT for or taken prescription MEDICINE for:
 - a. Stroke, heart attack, coronary artery disease, or other heart condition? Yes No
 - b. Cancer (except basal cell carcinoma), malignant growth, melanoma or Hodgkin's disease? Yes No
 - c. Emphysema, chronic obstructive lung or pulmonary disease, Alzheimer's or Parkinson's disease? Yes No
 - d. Organ transplant, polycystic kidney disease or kidney failure? Yes No
 - e. Cirrhosis of the liver, alcoholism or drug addiction? Yes No
 - f. Down's Syndrome, Cerebral Palsy, Muscular Dystrophy, Multiple Sclerosis, or Cystic Fibrosis? Yes No
3. Have you been diagnosed by a physician as having AIDS (Acquired Immune Deficiency Syndrome) or ARC (AIDS Related Complex) or been tested positive for HIV? Yes No
4. Have you been convicted of reckless driving or driving under the influence of alcohol in the last five years? Yes No
5. Have you had any advice, treatment, or taken any prescription medication for any other sickness, injury or defect, excluding flu, colds, sprains, and routine physicals in the last five years? Yes No

(If "Yes" is answered to question 5, explain below). In any case, please provide information on your physician.

Health Condition & Medication	Date of Diagnosis	Date Last Treated	Surgery?	Receiving Treatment?	Physician's Name, Address, Phone No. (Street, City, State)

Do you currently have any existing life insurance policies or annuity contracts in force? Yes No
 (If "Yes", complete Important Notice Form No. 300055)

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The information disclosed on this application will not be disclosed to the employer or any other person without the authorization of the applicant.

PLEASE READ CAREFULLY

It is very important that you review the application carefully. Misstatements or omissions could cause an otherwise valid claim to be denied. Please check the application carefully and advise your agent if any information is not correct or not complete or if any medical history has not been included. **I understand that any insurance applied for will not take effect unless and until Combined Insurance Company of America approves my application, the contract is issued, and the required premium is received by Combined Insurance Company of America.**

In applying for this coverage, I represent and affirm the following:

1. The information which I have given as recorded on this Application is true and complete to the best of my knowledge and belief.
2. I have received the Medical Information Bureau (MIB) Disclosure Statement, the notice under the Fair Credit Reporting Act, and Notice of Information Practices.

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

I authorize Combined Insurance Company of America or its reinsurers to acquire from and authorize any hospital, physician, medical practitioner, clinic, medically related facility, insurance company, the Medical Information Bureau, Inc. (MIB), Bureau of Motor Vehicles, or consumer reporting agency to release to Combined Insurance Company of America any medical information regarding me or the past or present health of me for the purpose of evaluating this application for insurance. I also authorize Combined Insurance Company of America or its reinsurers to disclose all such information to any physician, the Medical Information Bureau, Inc. or any other insurance company in order to evaluate a claim or an application for insurance.

This authorization shall remain valid for a period of two years from the issue date of the policy. A photocopy of this authorization will be as valid as the original. A copy of the authorization is available upon request to the Company.

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.

I do do not elect the automatic premium loan option.

X _____ City: _____ State: _____ Date: ____/____/____
Signature of Employee

I, the authorized agent, have on the Date of Application recorded the information as given to me by the Employee. **To the best of my knowledge and belief the policy being applied for will - will not replace any existing insurance.** I have delivered the Notice of Information Practices. I have no knowledge of any unfavorable medical history not recorded on this Application.

Signature of Licensed Agent _____ Code # _____ % Split _____

Agent Split: Name: _____ Code # _____ % Split _____