

SERFF Tracking Number: CMBD-126288144 State: Arkansas  
 Filing Company: Combined Insurance Company of America State Tracking Number: 43493  
 Company Tracking Number: 362012-AR-909  
 TOI: L09I Individual Life - Flexible Premium Sub-TOI: L09I.001 Single Life  
 Adjustable Life  
 Product Name: Application for Universal Life Insurance  
 Project Name/Number: 362012-AR-909/362012-AR-909

## Filing at a Glance

Company: Combined Insurance Company of America

Product Name: Application for Universal Life Insurance SERFF Tr Num: CMBD-126288144 State: Arkansas

TOI: L09I Individual Life - Flexible Premium Adjustable Life SERFF Status: Closed-Approved- Closed State Tr Num: 43493

Sub-TOI: L09I.001 Single Life Co Tr Num: 362012-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: 362012-AR-909

Project Number: 362012-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 Coverage 362012-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

### Filing Contact Information

SERFF Tracking Number: CMBD-126288144 State: Arkansas  
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 Product Name: Application for Universal Life Insurance  
 Project Name/Number: 362012-AR-909/362012-AR-909

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

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**Filing Fees**

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

| COMPANY                               | AMOUNT  | DATE PROCESSED | TRANSACTION # |
|---------------------------------------|---------|----------------|---------------|
| Combined Insurance Company of America | \$50.00 | 09/14/2009     | 30521120      |

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## Correspondence Summary

### Dispositions

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

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## Disposition

Disposition Date: 09/17/2009

Implementation Date:

Status: Approved-Closed

Comment:

Rate data does NOT apply to filing.

SERFF Tracking Number: CMBD-126288144 State: Arkansas  
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| <b>Schedule</b>            | <b>Schedule Item</b>                    | <b>Schedule Item Status</b> | <b>Public Access</b> |
|----------------------------|---|-----------------------------|----------------------|
| <b>Supporting Document</b> | Flesch Certification                    |                             | Yes                  |
| <b>Supporting Document</b> | Application                             |                             | No                   |
| <b>Supporting Document</b> | Health - Actuarial Justification        |                             | No                   |
| <b>Supporting Document</b> | Outline of Coverage                     |                             | No                   |
| <b>Supporting Document</b> | Cover Letter                            |                             | Yes                  |
| <b>Supporting Document</b> | Application - Changes Highlighted       |                             | Yes                  |
| <b>Supporting Document</b> | Memorandum of Variability               |                             | Yes                  |
| <b>Supporting Document</b> | Replacement Notices                     |                             | Yes                  |
| <b>Form</b>                | Application for Life Insurance Coverage |                             | Yes                  |



**Application for Life Insurance Coverage**

**FORM #[36002]**

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

Application Date: / /

ACTION REQUESTED:  New Enrollment  Add Rider  Benefit Increase

|   |   |  |                      |                     |                |
|---|---|--|----------------------|---------------------|----------------|
| EMPLOYEE'S (Proposed Insured, Owner) NAME (First MI Last) |   | <input type="checkbox"/> Male<br><input type="checkbox"/> Female | Birthdate: Mo/Day/Yr | Age                 | State of Birth |
| EMPLOYEE'S HOME ADDRESS (Street, City, State, Zip)        |   |  |                      |                     | Home Phone No. |
| [Social Security No.]                                     | EMPLOYER  | Hire Date: Mo/Day/Yr   | Employee ID#         | Gross Annual Income |                |
| Occupation  | Has the employee used tobacco in any form in the last 12 mos.? Yes <input type="checkbox"/> No <input type="checkbox"/> |  | Height<br>ft. in.    | Weight<br>lbs.      |                |
| BENEFICIARY'S Full Name                                   | Relationship  | CONTINGENT BENEFICIARY'S Name                                    |                      | Relationship        |                |

|   |                          |  |                      |                   |                |
|---|--------------------------|--|----------------------|-------------------|----------------|
| DEPENDENT'S (Proposed Dependent Insured) NAME (First MI Last) |                          | <input type="checkbox"/> Male<br><input type="checkbox"/> Female   | Birthdate: Mo/Day/Yr | Age               | State of Birth |
| Dependent's Occupation  | Relationship to Employee | Has the dependent used tobacco in any form in the last 12 mos.? Yes <input type="checkbox"/> No <input type="checkbox"/> |                      | Height<br>ft. in. | Weight<br>lbs. |
| BENEFICIARY'S Full Name                                       | Relationship             | CONTINGENT BENEFICIARY'S Name  |                      | Relationship      |                |

|   |                       |
|---|-----------------------|
| <b>AMOUNT OF INSURANCE BEING APPLIED FOR:</b>         | <b>Premium – Mode</b> |
| Employee Universal Life (including the account value) |                       |
| <b>Total Premium:</b>                                 |                       |

Do you elect the Automatic Increase feature (premiums increase \$1 a week for 5 years on policy anniversary)? Yes  No

|   |  |   |
|---|--|---|
| 1. Are you employed in your primary occupation for less than 30 hours each week?  | Yes <input type="checkbox"/> No <input type="checkbox"/> |   |
| <i>Answer questions 2, 3 and 4 if applying on a Non-Guaranteed issue basis.</i>   | <u>Employee</u>  | <u>Dependent</u>                                  |
|   | Yes No   | Yes No  |
| 2. Have you or your Dependent been diagnosed by a physician as having AIDS (Acquired Immune Deficiency Syndrome) or ARC (AIDS Related Complex) or been tested positive for HIV? | <input type="checkbox"/> <input type="checkbox"/>        | <input type="checkbox"/> <input type="checkbox"/> |
| 3. Have you or your Dependent missed more than 5 consecutive days of work due to accident or sickness during the past 6 months?   | <input type="checkbox"/> <input type="checkbox"/>        | <input type="checkbox"/> <input type="checkbox"/> |
| 4. Have you or your Dependent received treatment in an outpatient or emergency facility or been hospitalized during the past 12 months?   | <input type="checkbox"/> <input type="checkbox"/>        | <input type="checkbox"/> <input type="checkbox"/> |

**Answer questions 5 and 6 if "Yes" is answered to question 3 or 4, or if applying on a Non-Express Issue basis.**

|  |   |   |
|--|---|---|
| 5. Have you or your Dependent been convicted of reckless driving or driving under the influence of alcohol or drugs in the last 5 years? List your Driver's license # and state:   | <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> |
| 6. Have you or your Dependent had any advice, treatment, or taken any prescription medication for any heart condition, cancer, stroke or any other sickness, injury or defect, excluding flu, colds and routine physicals in the last 5 years? | <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> |

**If "Yes" is answered to question 6, explain on Page 2. In any case, please provide information on your physician.**

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

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 this 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:

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

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 will  – will not  replace any existing insurance. I have delivered the Notice of Information Practices and Accelerated Benefit Disclosure. I have no knowledge of any unfavorable medical history not recorded on this Application.

Signature of Licensed Agent \_\_\_\_\_ Code # \_\_\_\_\_

**PLEASE READ CAREFULLY  
HEALTH AND MEDICATIONS INFORMATION  
(Explanation to question 6)**

| Health Condition and Medication | Date | Employee/<br>Dependent? | Surgery? | Receiving<br>Treatment? | Physician's Name, Address, Phone No. |
|---------------------------------|------|-------------------------|----------|-------------------------|--------------------------------------|
|                                 |      |                         |          |                         |                                      |
|                                 |      |                         |          |                         |                                      |
|                                 |      |                         |          |                         |                                      |
|                                 |      |                         |          |                         |                                      |
|                                 |      |                         |          |                         |                                      |

**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.

**AUTHORIZATION TO RELEASE 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 information regarding me or my dependent or the past or present health of me or my dependent 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 to you upon request to the Company.

X \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_  
Signature of Employee

Employee's Name: \_\_\_\_\_ Social Security # \_\_\_\_\_  
(Print)

**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.**

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## Supporting Document Schedules

|   | <b>Item Status:</b> | <b>Status Date:</b> |
|---|---------------------|---------------------|
| <b>Satisfied - Item:</b> Flesch Certification |                     |                     |
| <b>Comments:</b>                              |                     |                     |
| <b>Attachments:</b>                           |                     |                     |
| 362016-AR-909-Readability.pdf                 |                     |                     |
| Certification of Compliance.pdf               |                     |                     |

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

|   | <b>Item Status:</b> | <b>Status Date:</b> |
|---|---------------------|---------------------|
| <b>Bypassed - Item:</b> Outline of Coverage   |                     |                     |
| <b>Bypass Reason:</b> This is an Life application filing. An Outline of Coverage is not required. |                     |                     |
| <b>Comments:</b>  |                     |                     |

|                                       | <b>Item Status:</b> | <b>Status Date:</b> |
|---------------------------------------|---------------------|---------------------|
| <b>Satisfied - Item:</b> Cover Letter |                     |                     |
| <b>Comments:</b>                      |                     |                     |
| <b>Attachment:</b>                    |                     |                     |
| 362012-AR-909-Cover.pdf               |                     |                     |

|  | <b>Item Status:</b> | <b>Status Date:</b> |
|--|---------------------|---------------------|
| <b>Satisfied - Item:</b> Application - Changes Highlighted |                     |                     |
| <b>Comments:</b>   |                     |                     |

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Product Name: Application for Universal Life Insurance  
Project Name/Number: 362012-AR-909/362012-AR-909

**Attachment:**

362012-AR-909-Highlighted.pdf

**Item Status:**

**Status**

**Date:**

**Satisfied - Item:** Memorandum of Variability

**Comments:**

**Attachment:**

362012-AR-909-Variability.pdf

**Item Status:**

**Status**

**Date:**

**Satisfied - Item:** Replacement Notices

**Comments:**

**Attachments:**

300055.pdf

300055RM.pdf



September 11, 2009

**READABILITY CERTIFICATION**

RE: Form No. 362012-AR-909 – Application for Term Life Insurance

We hereby certify that the above captioned form has a Flesch Index Score of 44.1 and 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): 362012-AR-909 - Application for Life Insurance Coverage

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

*Michael J. Hollar*

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Signature of Company Officer

Michael J. Hollar  
Name

Assistant Secretary  
Title

September 11, 2009  
Date



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**VIA SERFF**

September 14, 2009

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

RE: **SERFF Tracking Number: CMBD-126288144**  
**Combined Insurance Company of America**  
**FEIN Number: 36-2136262 -- NAIC Number: 317-62146**  
Form Numbers: 362012-AR-909 -- Application for Universal Life Insurance  
**Individual Life**

Dear Commissioner Bradford:

Attached for your review and approval is Application 362012-AR-909. This is a new form that will replace Application 362012R-F-02, which was previously approved by your department on June 12, 2002 under SERFF Tracking Number USPH-5AVKAN292/00. The application is used to market Individual Universal Life Policy 36002-AR, which was approved on February 19, 1998.

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](mailto:anita.sibley@combined.com)

**Application for Life Insurance Coverage**

**FORM #[36002]**

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

Application Date: / /

ACTION REQUESTED:  New Enrollment  Add Rider  Benefit Increase

|   |   |  |                      |                     |                |
|---|---|--|----------------------|---------------------|----------------|
| EMPLOYEE'S (Proposed Insured, Owner) NAME (First MI Last) |   | <input type="checkbox"/> Male<br><input type="checkbox"/> Female | Birthdate: Mo/Day/Yr | Age                 | State of Birth |
| EMPLOYEE'S HOME ADDRESS (Street, City, State, Zip)        |   |  |                      |                     | Home Phone No. |
| [Social Security No.]                                     | EMPLOYER  | Hire Date: Mo/Day/Yr   | Employee ID#         | Gross Annual Income |                |
| Occupation  | Has the employee used tobacco in any form in the last 12 mos.? Yes <input type="checkbox"/> No <input type="checkbox"/> |  | Height<br>ft. in.    | Weight<br>lbs.      |                |
| BENEFICIARY'S Full Name                                   | Relationship  | CONTINGENT BENEFICIARY'S Name                                    |                      | Relationship        |                |

|   |                          |  |                      |                   |                |
|---|--------------------------|--|----------------------|-------------------|----------------|
| DEPENDENT'S (Proposed Dependent Insured) NAME (First MI Last) |                          | <input type="checkbox"/> Male<br><input type="checkbox"/> Female   | Birthdate: Mo/Day/Yr | Age               | State of Birth |
| Dependent's Occupation  | Relationship to Employee | Has the dependent used tobacco in any form in the last 12 mos.? Yes <input type="checkbox"/> No <input type="checkbox"/> |                      | Height<br>ft. in. | Weight<br>lbs. |
| BENEFICIARY'S Full Name                                       | Relationship             | CONTINGENT BENEFICIARY'S Name  |                      | Relationship      |                |

|   |                       |
|---|-----------------------|
| <b>AMOUNT OF INSURANCE BEING APPLIED FOR:</b>         | <b>Premium – Mode</b> |
| Employee Universal Life (including the account value) |                       |
| <b>Total Premium:</b>                                 |                       |

Do you elect the Automatic Increase feature (premiums increase \$1 a week for 5 years on policy anniversary)? Yes  No

|   |  |   |
|---|--|---|
| 1. Are you employed in your primary occupation for less than 30 hours each week?  | Yes <input type="checkbox"/> No <input type="checkbox"/> |   |
| <i>Answer questions 2, 3 and 4 if applying on a Non-Guaranteed issue basis.</i>   | <b>Employee</b>  | <b>Dependent</b>                                  |
|   | Yes No   | Yes No  |
| 2. Have you or your Dependent been diagnosed by a physician as having AIDS (Acquired Immune Deficiency Syndrome) or ARC (AIDS Related Complex) or been tested positive for HIV? | <input type="checkbox"/> <input type="checkbox"/>        | <input type="checkbox"/> <input type="checkbox"/> |
| 3. Have you or your Dependent missed more than 5 consecutive days of work due to accident or sickness during the past 6 months?   | <input type="checkbox"/> <input type="checkbox"/>        | <input type="checkbox"/> <input type="checkbox"/> |
| 4. Have you or your Dependent received treatment in an outpatient or emergency facility or been hospitalized during the past 12 months?   | <input type="checkbox"/> <input type="checkbox"/>        | <input type="checkbox"/> <input type="checkbox"/> |

**Answer questions 5 and 6 if "Yes" is answered to question 3 or 4, or if applying on a Non-Express Issue basis.**

|  |   |   |
|--|---|---|
| 5. Have you or your Dependent been convicted of reckless driving or driving under the influence of alcohol or drugs in the last 5 years? List your Driver's license # and state:   | <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> |
| 6. Have you or your Dependent had any advice, treatment, or taken any prescription medication for any heart condition, cancer, stroke or any other sickness, injury or defect, excluding flu, colds and routine physicals in the last 5 years? | <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> |

**If "Yes" is answered to question 6, explain on Page 2. In any case, please provide information on your physician.**

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

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 this 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:

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

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 will  - will not  replace any existing insurance.** I have delivered the Notice of Information Practices and Accelerated Benefit Disclosure. I have no knowledge of any unfavorable medical history not recorded on this Application.

Signature of Licensed Agent \_\_\_\_\_ Code # \_\_\_\_\_

**PLEASE READ CAREFULLY**  
**HEALTH AND MEDICATIONS INFORMATION**  
 (Explanation to question 6)

| Health Condition and Medication | Date | Employee/Dependent? | Surgery? | Receiving Treatment? | Physician's Name, Address, Phone No. |
|---------------------------------|------|---------------------|----------|----------------------|--------------------------------------|
|                                 |      |                     |          |                      |                                      |
|                                 |      |                     |          |                      |                                      |
|                                 |      |                     |          |                      |                                      |
|                                 |      |                     |          |                      |                                      |
|                                 |      |                     |          |                      |                                      |

**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.

**AUTHORIZATION TO RELEASE 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 information regarding me or my dependent or the past or present health of me or my dependent 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 to you upon request to the Company.

X \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_  
 Signature of Employee

Employee's Name: \_\_\_\_\_ Social Security # \_\_\_\_\_  
 (Print)

**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.**



**VARIABILITY MEMORANDUM**  
**Application for Term Life Insurance**  
**Form No. 362012-AR-909**

| <b>Bracketed Information</b> | <b>Options/Reasons</b>  |
|------------------------------|---|
| 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.     |

**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<br>NAME | CONTRACT OR<br>POLICY # | INSURED OR<br>ANNUITANT | REPLACED (R) OR<br>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**

**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 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<br>NAME | CONTRACT OR<br>POLICY # | INSURED OR<br>ANNUITANT | REPLACED (R) OR<br>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

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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:

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**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)*

| <b>CONTRACT OR POLICY PROVISION</b>                    | <b>EXISTING CONTRACT/POLICY</b> | <b>REPLACEMENT CONTRACT/POLICY</b> |
|--|---------------------------------|------------------------------------|
| <b>Current Proposed Premium / Annual Consideration</b> |                                 |                                    |
| <b>Current Contract Value</b>                          |                                 |                                    |
| <b>Current Surrender Value</b>                         |                                 |                                    |
| <b>Death Benefit Amount</b>                            |                                 |                                    |
| <b>Current Interest Rate &amp; Guarantee Period</b>    |                                 |                                    |
| <b>Guaranteed Minimum Accumulation/Interest Rate</b>   |                                 |                                    |

\* 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)*

| <b>CONTRACT OR POLICY PROVISION</b>                    | <b>EXISTING CONTRACT/POLICY</b> | <b>REPLACEMENT CONTRACT/POLICY</b> |
|--|---------------------------------|------------------------------------|
| <b>Current Proposed Premium / Annual Consideration</b> |                                 |                                    |
| <b>Current Contract Value</b>                          |                                 |                                    |
| <b>Current Surrender Value</b>                         |                                 |                                    |
| <b>Death Benefit Amount</b>                            |                                 |                                    |
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