

SERFF Tracking Number: HHRN-126288680 State: Arkansas
Filing Company: Household Life Insurance Company State Tracking Number: 43580
Company Tracking Number: 09-016-AR
TOI: L08 Life - Other Sub-TOI: L08.000 Life - Other
Product Name: Life Application and Reinstatement Filing
Project Name/Number: DDU/09-016

Filing at a Glance

Company: Household Life Insurance Company

Product Name: Life Application and Reinstatement Filing SERFF Tr Num: HHRN-126288680 State: Arkansas

TOI: L08 Life - Other SERFF Status: Closed-Approved- Closed State Tr Num: 43580

Sub-TOI: L08.000 Life - Other Co Tr Num: 09-016-AR State Status: Approved-Closed
Filing Type: Form Reviewer(s): Linda Bird

Authors: Deborah Fisher, Sherron Lawson Disposition Date: 09/25/2009

Date Submitted: 09/23/2009 Disposition Status: Approved-Closed

Implementation Date Requested: On Approval Implementation Date:

State Filing Description:

General Information

Project Name: DDU

Project Number: 09-016

Requested Filing Mode: Review & Approval

Explanation for Combination/Other:

Submission Type: New Submission

Overall Rate Impact:

Filing Status Changed: 09/25/2009

Deemer Date:

Submitted By: Deborah Fisher

Filing Description:

RE: Life Insurance Application - HLI-1-212-0809

Life Reinstatement Application – HLI-1-213-0809

NAIC # 93777, FEIN # 38-2341728

Status of Filing in Domicile: Not Filed

Date Approved in Domicile:

Domicile Status Comments: Exempt from filing requirements.

Market Type: Individual

Group Market Size:

Group Market Type:

Explanation for Other Group Market Type:

State Status Changed: 09/25/2009

Created By: Miloslav Dait

Corresponding Filing Tracking Number: 09-016-AR

Dear Commissioner:

SERFF Tracking Number: HHRN-126288680 State: Arkansas
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On behalf of Household Life Insurance Company (HLIC), we are submitting the above captioned applications for your review and approval. The enclosed forms are new and do not replace any previously approved form. These applications will be used with previously approved Term Life policy HLI-8-132-0807 and Whole Life policy HLI-8-135 Ed.0608 and may be used with any future Term or Whole Life policy approved by the Department. These applications may be available and completed via paper, electronic internet or telesales. The telesales method will utilize a system for recording the telephone conversation and application process and provide a method for electronic signature utilizing an electronic sound, symbol, or process that will be attached to, or logically associated with, a contract or other record. The telephone conversations will be recorded and stored electronically and can be readily accessed.

These forms are anticipated to be offered to the general life insurance market both, direct to consumer and through agent channels. The internet channel will use an electronic signature process and technology that will allow customers to review and sign their applications online electronically. HLIC has systems in place to ensure security and to ensure that the privacy of the applicant is protected. The online application, when printed, will have the exact text as the paper version of the application form filed and approved with your Insurance Department.

These forms contain a series of lifestyle and health questions in which a required response is needed by the applicant. Depending on the applicant's responses, additional questions may be asked to collect more detailed information which will be shown within the application.

The rate class will be based upon the current underwriting rules and rate classifications applicable to the underlying policy, at the time the applicant applies for coverage.

In the future, we may provide the opportunity for our customers to receive their policy documents solely electronically. If the Company decides to allow customers with this convenience option, the Company will comply with all applicable laws in obtaining customer consent.

We request approval of bracketed information on a variable basis to reflect different account information. A statement of variability is enclosed. HLIC provides its assurance that no changes to the text other than correction of typographical and grammatical errors will be made to the forms without re-filing them with you. Please note that we may change the appearance, formatting and pagination, but not the text of these forms. No font will be less than a 10-point font size. The color and/or weight of the paper on which these forms are printed may change.

This application is exempt from filing in the company's state of domicile, Michigan

To the best of our knowledge, this filing is complete and intended to comply with the insurance laws of your jurisdiction.

If you have any questions regarding the enclosed submission, please do not hesitate to contact me at 1-800-443-7187,

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extension 62208 or you may e-mail me at debbie.a.fisher@us.hsbc.com.

Regards,

Deborah A. Fisher
 Product Regulatory Officer

Company and Contact

Filing Contact Information

Sherron Lawson, Compliance Officer sherron.n.lawson@us.hsbc.com
 200 Somerset Corporate Blvd. 908-203-4266 [Phone]
 Suite 100 908-203-4229 [FAX]
 Bridgewater, NJ 08807

Filing Company Information

Household Life Insurance Company CoCode: 93777 State of Domicile: Michigan
 500 Woodward Ave. Group Code: 352 Company Type:
 Suite 4000 Group Name: State ID Number:
 Detroit, MI 48226 FEIN Number: 38-2341728
 (800) 443-7187 ext. [Phone]

Filing Fees

Fee Required? Yes
 Fee Amount: \$40.00
 Retaliatory? No
 Fee Explanation: \$20.00 per form 2 X \$20.00=\$40.00
 Per Company: No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Household Life Insurance Company	\$40.00	09/23/2009	30770866

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Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Linda Bird	09/25/2009	09/25/2009

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Disposition

Disposition Date: 09/25/2009

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		No
Supporting Document	Application		No
Supporting Document	Statement of Variability		No
Supporting Document	Arkansas Certification		No
Form	Life Application		No
Form	Reinstatement Application		No

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Form Schedule

Lead Form Number: HLI-1-212-0809

Schedule Item Status	Form Number	Form Type Form Name	Action	Action Specific Data	Readability	Attachment
	HLI-1-212-0809	Application/ Life Application Enrollment Form	Initial		47.200	9-8-09-HLI-1-212-0809 Life Application.pdf
	HLI-1-213-0809	Application/ Reinstatement Enrollment Application Form	Initial		47.500	9-8-09 HLI-1-213-0809 Reinstatement Application final.pdf

HOUSEHOLD LIFE INSURANCE COMPANY

[Home Office: 500 Woodward Avenue, Suite 4000, Detroit, MI 48226-3425
Administrative Office: 200 Somerset Corporate Blvd., Suite 100, Bridgewater, NJ 08807
Toll Free 800-443-7187 www._____]

APPLICATION FOR INDIVIDUAL [TERM LIFE/TERM LIFE WITH ENDOWMENT/WHOLE LIFE] INSURANCE

Your Information

Proposed Insured:

Last Name First Name MI Gender Date of Birth [State or Province/Country of Birth]

Height (feet inches) Weight (lbs) Social Security Number [Marital Status]

Residence Address (Street, City, State & Zip Code)

[Home Phone Number] Email Address [Driver's License Number & State of Issue]
[Optional]

[Occupation] [Annual Income of Proposed Insured \$]

[Have you received "Orders" to be deployed within the next three months in support of combat, peacekeeping or deterrence operations? Yes No]

[Are you a US Citizen or permanent US Resident who holds a valid current Green Card? Yes No]

[Owner (if different from Proposed Insured):

Last Name First Name MI Date of Birth [State or Province/Country of Birth]

Social Security Number

Residence Address (Street, City, State & Zip Code, Country)

Home Phone Number Email Address

Relationship to Proposed Insured: _____]

Beneficiary

[Primary Beneficiary First Name Last Name MI Relationship %]

[Residence Address(Street, City, State & Zip Code) Social Security Number]

[Contingent Beneficiary First Name Last Name MI Relationship %]

[Residence Address(Street, City, State & Zip Code) Social Security Number]

Plan Applied For:

[Term Life: Ten Years] Fifteen Years] Twenty Years] Thirty Years]
[Term Life with Endowment: Twenty Years] Twenty-Five Years] Thirty Years]
[Whole Life:]
[Automatic Premium Loan Yes No]

[Additional Coverage Applied For:

Return of Premium Benefit Rider Secondary Insured Term Benefit Rider
 Accidental Death Benefit Rider Dependent Child Benefit Rider
 Waiver of Premium Benefit Rider Accelerated Death Benefit Rider]

Coverage Amount: \$ []

Payment Frequency:

Annual Semi-Annual Quarterly Monthly]

Payment Method:

Charge my credit card: Visa MasterCard Discover American Express

Account # _____ Exp. Date _____

Debit my [checking/savings] account: Bank Name _____ Account # _____
ABA Number _____]

(first 9 numbers in the lower left-hand corner of your check)

Replacement:

[Do you own an existing life insurance policy or annuity contract insuring the proposed insured's life?

Yes No

Do you plan to discontinue, replace, change or modify any existing life insurance as a result of this application?
(if yes, additional forms may be required, depending upon state requirements)

Yes No]

Underwriting Information:

Section 1

- 1) In the past 12 months, have you used tobacco or nicotine in any form?
 Yes No
- 2) Are you currently confined to a hospital, psychiatric facility, extended or assisted care facility, nursing facility, prison or correctional facility, or have you ever been convicted of a felony?
 Yes No
- 3) Are you currently receiving home health care or require assistance with activities of daily living such as bathing, dressing, feeding, taking medications, or use of toilet?
 Yes No
- 4) Have you ever tested HIV positive or been diagnosed with AIDS, AIDS Related Complex (ARC), Alzheimer's or Dementia, Cirrhosis, Hemophilia, Cystic Fibrosis, Emphysema, Chronic Obstructive Lung Disease (COLD) or Chronic Obstructive Pulmonary Disease (COPD), Amyotrophic Lateral Sclerosis (ALS), Huntington's Chorea?
 Yes No

- 5) In the past 12 months, have you been advised to have diagnostic tests, surgery, or hospital confinement which has not yet been started or for which results are not yet known?
 Yes No
- 6) In the past 24 months, have you been diagnosed or advised to have treatment for Cancer (other than Basal Cell Carcinoma), Heart Attack, Stroke or Transient Ischemic Attack (TIA), Alcohol or Drug abuse, Leukemia, or Hepatitis C?
 Yes No
- 7) In the past 24 months, have you had a Driver's License revoked or suspended, been charged with a DUI/DWI or had 3 or more moving driving violations?
 Yes No

[Section 2

- 1) Height _____ *ft.* _____ *in.* Weight _____ *lbs.*

Have you lost more than 15 lbs. in the past year?

Yes No

[If yes, answer the following:

How many pounds have you lost? _____

Reason for loss of weight:

Diet? Pregnancy? Illness? Other?]

- 2) Are you currently taking, or have taken within the past 24 months, any medications other than over the counter non-prescription drugs?
 Yes No
[If yes, please provide all medications:]
- 3) In the past 10 years, have you been advised to have treatment for, or have you been treated for, or consulted a physician, other practitioner, hospital or other medical facility for any of the following:

- Heart or coronary artery disease or disorder? Yes No
[If yes, select all that apply:
 - 1) Heart Attack? Yes No
 - 2) Chest Pain or Angina? Yes No
 - 3) Cardiomyopathy? Yes No
 - 4) Congestive Heart Failure (CHF)? Yes No
 - 5) Cardiac Arrest? Yes No
 - 6) Ventricular Fibrillation? Yes No
 - 7) Abnormality of your Heart beat or pulse? Yes No
 - 8) Disorder or Disease of any Heart valve? Yes No
 - 9) Pacemaker? Yes No
 - 10) Coronary Bypass Surgery? Yes No
 - 11) Angioplasty (balloon procedure) or Coronary Stents? Yes No
 - 12) Heart Transplant? Yes No
 - 13) Other than above? Yes No]

- Stroke, Transient Ischemic Attack (TIA), Aneurysm, or other blood vessel disease or disorder? Yes No
[If yes, select all that apply:
 - 1) Stroke? Yes No
 - 2) Transient Ischemic Attack (TIA)? Yes No
 - 3) Aneurysm? Yes No
 - 4) Blood Clot? Yes No
 - 5) Vasculitis? Yes No
 - 6) Other than above? Yes No]

[Do you require assistance with activities of daily living such as bathing, dressing, feeding, taking medications or use of toilet? Yes No]

[Have you had surgery to correct your Aneurysm? Yes No]

- Peripheral Vascular Disease (PVD)? Yes No
[If yes, select all that apply:
 - 1) Buerger's Disease? Yes No
 - 2) Raynaud's Disease or Syndrome? Yes No
 - 3) Intermittent Claudication? Yes No
 - 4) Other than above? Yes No]

- Cancer? Yes No
[If yes, select all that apply:
 - 1) Melanoma? Yes No
 - 2) Basal Cell Carcinoma? Yes No
 - 3) Breast? Yes No
 - 4) Oral (mouth or tongue)? Yes No
 - 5) Hodgkin's disease? Yes No
 - 6) Lymphoma? Yes No
 - 7) Colon? Yes No
 - 8) Bone? Yes No
 - 9) Brain? Yes No
 - 10) Lung? Yes No
 - 11) Esophagus? Yes No
 - 12) Pancreas? Yes No
 - 13) Liver? Yes No
 - 14) Stomach? Yes No
 - 15) Male or Female Reproductive System Yes No
 - 16) Kidney or Urinary Bladder? Yes No
 - 17) Prostate? Yes No
 - 18) Adrenal Gland? Yes No
 - 19) Other than above? Yes No]

[When did you complete your most recent Cancer treatment or surgery?

- Not completed yet One year ago Two years ago Three years ago Four years ago
 5 or more years ago?]

[Have you had a recurrence of any Cancer? Yes No]

- Parkinson or Cerebral Palsy? Yes No
[If yes, answer the following:
 - 1) Do you require assistance with activities of daily living such as bathing, dressing, feeding, taking medications. or use of toilet? Yes No]

- Kidney or Liver disease or disorder? Yes No
[If yes, select all that apply:]
 - 1) Kidney or Liver Failure? Yes No
 - 2) Currently on Dialysis? Yes No
 - 3) Kidney Stones? Yes No
 - 4) Fatty Liver? Yes No
 - 5) Nephritis? Yes No
 - 6) Congenital Kidney disorder? Yes No
 - 7) Cystic Kidney? Yes No
 - 8) Kidney Transplant? Yes No
 - 9) Other than above? Yes No]

- Alcohol or drug use? Yes No
[If yes, answer the following:]
 - A) Have you been a member of Alcoholics Anonymous, Narcotics Anonymous or similar organizations? Yes No
 - B) Do you presently use Alcohol and/or drugs other than as prescribed by a Doctor or Medical practitioner? Yes No]

- Epilepsy or seizures? Yes No
[Was your Epilepsy or Seizure(s) diagnosed or described as:]
 - 1) Grand Mal? Yes No
 - 2) Brain Tumor? Yes No
 - 3) Petit Mal? Yes No
 - 4) Other than above? Yes No]*[If yes, answer the following:]*
 How many seizures did you experience in the last year?
 None One Two or more]

- Multiple Sclerosis? Yes No
[If yes, answer the following:]
 Do you require assistance with activities of daily living such as bathing, dressing, feeding, taking medications, or use of toilet? Yes No]

4) In the past 5 years, have you been advised to have treatment for, or have you been treated for, or consulted a physician, other practitioner, hospital or other medical facility for any of the following:

- Diabetes? Yes No
[If yes, answer the following:]
 Do you currently take insulin? Yes No]
- High blood pressure (Hypertension)? Yes No
[If yes, answer the following:]
 Do you currently take more than one medication to control your high blood pressure (Hypertension)? Yes No]
- Hepatitis B? Yes No
- Pancreas disease or disorder? Yes No
- Anemia? Yes No
- Chronic lung or Pulmonary disease? Yes No
[If yes, select all that apply:]
 - 1) Chronic Bronchitis? Yes No
 - 2) Black Lung Disease? Yes No
 - 3) Asbestosis? Yes No
 - 4) Mesothelioma? Yes No
 - 5) Pulmonary Fibrosis? Yes No
 - 6) Interstitial Fibrosis Sarcoid? Yes No
 - 7) Lung Transplant? Yes No
 - 8) Other than above? Yes No]

- Depression, Anxiety or other mental or nervous disorder? Yes No
[If yes, select all that apply:]
 - 1) Psychosis? Yes No
 - 2) Schizophrenia? Yes No
 - 3) Manic Depression? Yes No
 - 4) Bipolar Disorder? Yes No
 - 5) Major Depression? Yes No
 - 6) Attention Deficit Hyperactivity Disorder (ADHD)? Yes No
 - 7) Down Syndrome? Yes No
 - 8) Autism? Yes No
 - 9) Obsessive Compulsive Disorder (OCD)? Yes No
 - 10) Anxiety or Panic Disorder? Yes No
 - 11) Seasonal Affective Disorder (SAD)? Yes No
 - 12) Other than above? Yes No]
- [Have you ever attempted or threatened suicide? Yes No]
- [Have you lost time at work or are you currently disabled because of your condition? Yes No]
- [Do you require assistance with activities of daily living such as bathing, dressing, feeding, taking medications, or use of toilet? Yes No]
- Connective tissue disease? Yes No
[If yes, select all that apply:]
 - 1) Lupus? Yes No
 - 2) Progressive Systemic Sclerosis? Yes No
 - 3) Diffuse Sclerosis or Scleroderma? Yes No
 - 4) Polymyositis? Yes No
 - 5) Dermatomyositis? Yes No
 - 6) Polymyalgia Rheumatica? Yes No
 - 7) Temporal Arteritis? Yes No
 - 8) Other than above? Yes No]
- Asthma? Yes No
[If yes, answer the following:]
 - Chronic asthma or asthma requiring ongoing treatment and/or medication? Yes No
 - Seasonal asthma or Allergic asthma requiring temporary medication and/or treatment? Yes No]

5) Are you currently disabled and/or receiving disability benefits?
 Yes No

6) In the past 24 months have you on more than one occasion participated in, or do you plan to participate in, any hazardous sports, hobby or avocation other than routine jogging or exercise?
 Yes No

[If yes, select all that apply:]

- 1) Piloted or been on an aircraft other than as a passenger? Yes No
- 2) Hang Gliding or Ultra-light Flying? Yes No
- 3) Skydiving, Base Jumping or Parachute Jumping? Yes No
- 4) Ballooning? Yes No
- 5) Car, Motorcycle or Boat Racing? Yes No
- 6) Scuba? Yes No
- 7) Ice, Mountain or Rock Climbing? Yes No
- 8) Rodeo Riding? Yes No
- 9) Other than above? Yes No]

[Section 3 – Family History

Family Member

Living

[Cause of Death

[Age at Death

Mother:

Yes

No

Father:

Yes

No

Sisters:

Yes

No None

Brothers:

Yes

No None

 _____]

 _____]

[Fraud Warning: 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.

Notice to residents of Arkansas, Kentucky and Ohio: Any person who knowingly and with intent to defraud any insurance company or other person files a request for insurance or statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

Notice to residents of Colorado: It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado division of insurance within the department of regulatory agencies.

Notice to residents of New Jersey: Any person who includes any false or misleading information on a request for an insurance policy is subject to criminal and civil penalties.

Notice to residents of Louisiana, New Mexico and West Virginia: 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.

Notice to residents of Maine, Tennessee and Washington: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or a denial for insurance benefits.

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

Notice to residents of Oklahoma: WARNING: Any person who knowingly and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

Notice to residents of Pennsylvania: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.]

[MIB, Inc. (MIB) Pre-Notice:

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

Upon receipt of a request from you, MIB will arrange disclosure of any information it may have in your file. Please contact MIB at 866 692-6901 (TTY 866 346-3642). If you question the accuracy of information in MIB's file, you may contact MIB and seek correction in accordance with the procedures set forth in the federal Fair Credit Reporting Act. The address of MIB's information office is 50 Braintree Hill Park, Suite 400, Braintree, Massachusetts 02184-8734.

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

Authorization & Signing:

I, the Proposed Insured, hereby authorize any health plan, licensed physician, medical practitioner, health care professional, hospital, clinic, laboratory, pharmacy, pharmacist, pharmacy benefit manager, medical facility, VA facility, the MIB, Inc. (MIB), any other health care provider, employer, insurance company, union welfare fund, public or private agency, consumer reporting agency, worker’s compensation carrier, Motor Vehicle Agency, and any other person or organization that has provided payment, treatment or services to me or on my behalf (My Providers) to give any and all information relating to my health (except psycho-therapy notes) and my insurance policies and claims to Household Life Insurance Company and any and all affiliates and subsidiaries, their agents, employees, representatives, and reinsurers, and any persons providing services to them (the “Company”).

I hereby acknowledge that the information released will be used and disclosed so the Company may:

- 1) underwrite my insurance application, make eligibility, risk rating, policy issuance, and enrollment determinations;
- 2) obtain reinsurance;
- 3) administer claims and determine or fulfill any coverage obligations and provide any applicable benefits;
- 4) administer coverage; and /or
- 5) conduct other legally permissible activities relating to any past, present, or future insurance products or applications for any insurance products with the Company.

I understand all or part of the information collected may be disclosed to MIB and any reinsurance companies with which the Company does business, and any other insurance company with which the insured may have insurance. Information may also be disclosed to persons performing business or legal functions for the Company. The Company may also disclose information to prevent fraud or misrepresentations or when required by subpoena or by court or governmental order.

I understand that if I refuse to sign this authorization, the Company will not be able to process my application. I understand that I may revoke this authorization by notifying the Company in writing of my desire to revoke it. However, I understand that if I revoke this authorization, it will not have any effect on actions already taken by the Company or My Providers in reliance on this authorization and may result in application denial *or* a claim being denied. I understand that a copy of this authorization will be included in my policy(ies).

I understand that the information described herein and disclosed to the Company is protected by certain federal and/or state privacy regulations. Once the Company discloses this information, as allowed in this Authorization, the information may no longer be subject to such privacy regulations. I understand, however, that the Company requires the entities listed above with whom it shares this information to enter into confidentiality agreements prohibiting the disclosure of this information except as allowed herein.

I understand that the coverage shall take effect as of the policy issue date only if the proposed insured is an insurable risk on the date of this application and the Company receives payment of the first scheduled premium.

By signing your name and date below, you agree: (1) that you have read and fully understand all of the questions, answers and statements given in this application; (2) that the statements and answers on this application are full, complete and *true* to the best of your knowledge; (3) you intend to form a legally binding contract; (4) this authorization shall remain in force for [two and one-half years] from the date shown below; and (5) a printout of the terms stated above will constitute a "writing" under any applicable law or regulation.

Proposed Insured’s Signature Date

[_____
Owner’s Signature (if different from Proposed Insured) Date]

[Company Representative Replacement Questionnaire: To the best of your knowledge, does the applicant own an existing life insurance policy insuring the proposed insured’s life?

Yes No

Company Representative Replacement Questionnaire: To the best of your knowledge, will this insurance that is applied for replace or change an existing life insurance or annuity?

Yes No

(if yes, please complete additional forms as required)

Authorized Company Representative Signature Date]

HOUSEHOLD LIFE INSURANCE COMPANY

[Home Office: 500 Woodward Avenue, Suite 4000, Detroit, MI 48226-3425
Administrative Office: 200 Somerset Corporate Blvd., P.O. Box 6989, Suite 100, Bridgewater, NJ 08807
Toll Free 800-443-7187 www._____]

APPLICATION FOR REINSTATEMENT OF LIFE INSURANCE POLICY

Policy Number: _____

Last Name First Name MI Gender Date of Birth [State or Province/Country of Birth]

Height (feet inches) Weight (lbs) Social Security Number [Marital Status]

Residence Address (Street, City, State & Zip Code)

[Home Phone Number] Email Address [Driver's License Number & State of Issue]
[Optional]

[Occupation] [Annual Income of Proposed Insured \$]

[Are you currently in the Military? Yes No]
[[If yes,] have you received "Orders" to be deployed within the next three months in support of combat, peacekeeping or
deterrence operations? Yes No]

[Owner (if different from Proposed Insured):

[[Last Name] [First Name] [MI] Date of Birth [State or Province/Country of Birth]

Social Security Number

Residence Address (Street, City, State & Zip Code, Country)

Home Phone Number Email Address

Relationship to Proposed Insured: _____]]

Application is made for reinstatement of the above numbered policy [and riders, if applicable] [as indicated below] which lapsed by failure to pay premium due

- Return of Premium Benefit Rider
- Accidental Death Benefit Rider
- Waiver of Premium Benefit Rider
- Accelerated Death Benefit Rider

- Secondary Insured Term Benefit Rider
- Dependent Child Benefit Rider - list each eligible child:
Name _____ Date of Birth _____

_____]

Statement of insurability to be completed by Insured person:

Underwriting Information:

Section 1

- 1) In the past 12 months, have you used tobacco or nicotine in any form?
 Yes No

- 2) Are you currently confined to a hospital, psychiatric facility, extended or assisted care facility, nursing facility, prison or correctional facility, or have you ever been convicted of a felony?
 Yes No

- 3) Are you currently receiving home health care or require assistance with activities of daily living such as bathing, dressing, feeding, taking medications, or use of toilet?
 Yes No

- 4) Have you ever tested HIV positive or been diagnosed with AIDS, AIDS Related Complex (ARC), Alzheimer's or Dementia, Cirrhosis, Hemophilia, Cystic Fibrosis, Emphysema, Chronic Obstructive Lung Disease (COLD) or Chronic Obstructive Pulmonary Disease (COPD), Amyotrophic Lateral Sclerosis (ALS), Huntington's Chorea?

 Yes No

- 5) In the past 12 months, have you been advised to have diagnostic tests, surgery, or hospital confinement which has not yet been started or for which results are not yet known?
 Yes No

- 6) In the past 24 months, have you been diagnosed or advised to have treatment for Cancer (other than Basal Cell Carcinoma), Heart Attack, Stroke or Transient Ischemic Attack (TIA), Alcohol or Drug abuse, Leukemia, or Hepatitis C?
 Yes No

- 7) In the past 24 months, have you had a Driver's License revoked or suspended, been charged with a DUI/DWI or had 3 or more moving driving violations?
 Yes No

[Section 2

- 1) Height _____ft. _____in. Weight _____lbs.
Have you lost more than 15 lbs. in the past year?
 Yes No
[If yes, answer the following:
How many pounds have you lost? _____

Reason for loss of weight:
 Diet? Pregnancy? Illness? Other?]

- 2) Are you currently taking, or have taken within the past 24 months, any medications other than over the counter non-prescription drugs?

 Yes No]
[If yes, please provide all medications:]

3) In the past 10 years, have you been advised to have treatment for, or have you been treated for, or consulted a physician, other practitioner, hospital or other medical facility for any of the following:

- a. Heart or coronary artery disease or disorder? Yes No
[If yes, select all that apply:
- 1) Heart Attack? Yes No
 - 2) Chest Pain or Angina? Yes No
 - 3) Cardiomyopathy? Yes No
 - 4) Congestive Heart Failure (CHF)? Yes No
 - 5) Cardiac Arrest? Yes No
 - 6) Ventricular Fibrillation? Yes No
 - 7) Abnormality of your Heart beat or pulse? Yes No
 - 8) Disorder or Disease of any Heart valve? Yes No
 - 9) Pacemaker? Yes No
 - 10) Coronary Bypass Surgery? Yes No
 - 11) Angioplasty (balloon procedure) or Coronary Stents? Yes No
 - 12) Heart Transplant? Yes No
 - 13) Other than above? Yes No
- b. Stroke, Transient Ischemic Attack (TIA), Aneurysm, or other blood vessel disease or disorder? Yes No
[If yes, select all that apply:
- 1) Stroke? Yes No
 - 2) Transient Ischemic Attack (TIA)? Yes No
[If yes, answer the following:
 Do you require assistance with activities of daily living such as bathing, dressing, feeding, taking medication, or use of toilet? Yes No]
 - 3) Aneurysm? Yes No
[If yes, answer the following:
 [Have you had surgery to correct your Aneurysm? Yes No]
 - 4) Blood Clot? Yes No
[If yes, answer the following:
 Do you require assistance with activities of daily living such as bathing, dressing, feeding, taking medication, or use of toilet? Yes No]
 - 5) Vasculitis? Yes No
 - 6) Other than above? Yes No
 [Do you require assistance with activities of daily living such as bathing, dressing, feeding, taking medication, or use of toilet? Yes No]
- c. Peripheral Vascular Disease (PVD)? Yes No
[If yes, select all that apply:
- 1) Buerger's Disease? Yes No
 - 2) Raynaud's Disease or Syndrome? Yes No
 - 3) Intermittent Claudication? Yes No
 - 4) Other than above? Yes No

- d. Cancer? Yes No
- [If yes, select all that apply:***
- 1) Melanoma? Yes No
 - 2) Basal Cell Carcinoma? Yes No
 - 3) Breast? Yes No
 - 4) Oral (mouth or tongue)? Yes No
 - 5) Hodgkin's disease? Yes No
 - 6) Lymphoma? Yes No
 - 7) Colon? Yes No
 - 8) Bone? Yes No
 - 9) Brain? Yes No
 - 10) Lung? Yes No
 - 11) Esophagus? Yes No
 - 12) Pancreas? Yes No
 - 13) Liver? Yes No
 - 14) Stomach? Yes No
 - 15) Male or Female Reproductive System Yes No
 - 16) Kidney or Urinary Bladder? Yes No
 - 17) Prostate? Yes No
 - 18) Adrenal Gland? Yes No
 - 19) Other than above? Yes No]

[[If yes to any of the above:]

[When did you complete your most recent Cancer treatment or surgery?

- Not completed yet One year ago Two years ago Three years ago Four years ago
 5 or more years ago?]

[[If yes to any of the above:]

[Have you had a recurrence of any Cancer? Yes No]

- e. Parkinson or Cerebral Palsy? Yes No
- [If yes, answer the following:***
- 1) Do you require assistance with activities of daily living such as bathing, dressing, feeding, taking medications, or use of toilet? Yes No]

- f. Kidney or Liver disease or disorder? Yes No
- [If yes, select all that apply:***
- 1) Kidney or Liver Failure? Yes No
 - 2) Currently on Dialysis? Yes No
 - 3) Kidney Stones? Yes No
 - 4) Fatty Liver? Yes No
 - 5) Nephritis? Yes No
 - 6) Congenital Kidney disorder? Yes No
 - 7) Cystic Kidney? Yes No
 - 8) Kidney Transplant? Yes No
 - 9) Other than above? Yes No]

- g. Alcohol or drug use? Yes No
- [If yes, answer the following:***
- A) Have you been a member of Alcoholics Anonymous, Narcotics Anonymous or similar organizations? Yes No
 - B) Do you presently use Alcohol and/or drugs other than as prescribed by a Doctor or Medical practitioner? Yes No]

h. Epilepsy or seizures? Yes No

[[If yes,] Was your Epilepsy or Seizure(s) diagnosed or described as:

- 1) Grand Mal? Yes No
- 2) Brain Tumor? Yes No
- 3) Petit Mal? Yes No
- 4) Other than above? Yes No

[If yes, answer the following:

How many seizures did you experience in the last year?

- None One Two or more]

i. Multiple Sclerosis? Yes No

[If yes, answer the following:

Do you require assistance with activities of daily living such as bathing, dressing, feeding, taking medications, or use of toilet?

- Yes No]

4) In the past 5 years, have you been advised to have treatment for, or have you been treated for, or consulted a physician, other practitioner, hospital or other medical facility for any of the following:

a. Diabetes? Yes No

[If yes, answer the following:

[Do you currently take insulin?

- Yes No]

b. High blood pressure (Hypertension)? Yes No

[If yes, answer the following:

Do you currently take more than one medication to control your high blood pressure (Hypertension)?

- Yes No]

c. Hepatitis B? Yes No

d. Pancreas disease or disorder? Yes No

e. Anemia? Yes No

f. Chronic lung or Pulmonary disease? Yes No

[If yes, select all that apply:

- 1) Chronic Bronchitis? Yes No
- 2) Black Lung Disease? Yes No
- 3) Asbestosis? Yes No
- 4) Mesothelioma? Yes No
- 5) Pulmonary Fibrosis? Yes No
- 6) Interstitial Fibrosis Sarcoid? Yes No
- 7) Lung Transplant? Yes No
- 8) Other than above? Yes No

- g. Depression, Anxiety or other mental or nervous disorder? Yes No
[If yes, select all that apply:
 1) Psychosis? Yes No
 2) Schizophrenia? Yes No
 3) Manic Depression? Yes No
 4) Bipolar Disorder? Yes No
 5) Major Depression? Yes No
 6) Attention Deficit Hyperactivity Disorder (ADHD)? Yes No
 7) Down Syndrome? Yes No
 8) Autism? Yes No
 9) Obsessive Compulsive Disorder (OCD)? Yes No
 10) Anxiety or Panic Disorder? Yes No
 11) Seasonal Affective Disorder (SAD)? Yes No
 12) Other than above? Yes No]
 [Have you ever attempted or threatened suicide? Yes No]
 [Have you lost time at work or are you currently disabled because of your condition? Yes No]
 [Do you require assistance with activities of daily living such as bathing, dressing, feeding, taking medications, or use of toilet? Yes No]

- h. Connective tissue disease? Yes No
[If yes, select all that apply:
 1) Lupus? Yes No
 2) Progressive Systemic Sclerosis? Yes No
 3) Diffuse Sclerosis or Scleroderma? Yes No
 4) Polymyositis? Yes No
 5) Dermatomyositis? Yes No
 6) Polymyalgia Rheumatica? Yes No
 7) Temporal Arteritis? Yes No
 8) Other than above? Yes No]

- i. Asthma? Yes No
[If yes, answer the following:
 Chronic asthma or asthma requiring ongoing treatment and/or medications? Yes No
 Seasonal asthma or Allergic asthma requiring temporary medication and/or treatment? Yes No]

5) Are you currently disabled and/or receiving disability benefits?
 Yes No

6) In the past 24 months have you on more than one occasion participated in, or do you plan to participate in, any hazardous sports, hobby or avocation other than routine jogging or exercise?
 Yes No

- [If yes, select all that apply:**
 1) Piloted or been on an aircraft other than as a passenger? Yes No
 2) Hang Gliding or Ultra-light Flying? Yes No
 3) Skydiving, Base Jumping or Parachute Jumping? Yes No
 4) Ballooning? Yes No
 5) Car, Motorcycle or Boat Racing? Yes No
 6) Scuba? Yes No
 7) Ice, Mountain or Rock Climbing? Yes No
 8) Rodeo Riding? Yes No
 9) Other than above? Yes No]

[Section 3 – Family History

<u>Family Member</u>	<u>Living</u>	<u>[Cause of Death</u>	<u>[Age at Death</u>
Mother:	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____	_____
Father:	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____	_____
Sisters:	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> None	_____	_____
Brothers:	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> None	_____]	_____]

[Payment Method

Charge my Credit Card Visa MasterCard Discover American Express

Account # _____ Exp. Date _____

Debit my [checking/savings] Bank Name _____ Account # _____
Account

ABA Number _____ Type _____
(first 9 numbers in the lower left-hand corner of your check)

Certified Check/Money Order Enclosed Total Premium Enclosed/Due \$ _____]

[Fraud Warning:

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.

Notice to residents of Arkansas, Kentucky and Ohio: Any person who knowingly and with intent to defraud any insurance company or other person files a request for insurance or statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

Notice to residents of Colorado: It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado division of insurance within the department of regulatory agencies.

Notice to residents of New Jersey: Any person who includes any false or misleading information on a request for an insurance policy is subject to criminal and civil penalties.

Notice to residents of Louisiana, New Mexico and West Virginia: 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.

Notice to residents of Maine, Tennessee, and Washington: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or a denial for insurance benefits.

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

Notice to residents of Oklahoma: WARNING: Any person who knowingly and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

Notice to residents of Pennsylvania: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.]

[MIB, Inc. (MIB) Pre-Notice:

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

Upon receipt of a request from you, MIB will arrange disclosure of any information it may have in your file. Please contact MIB at 866 692-6901 (TTY 866 346-3642). If you question the accuracy of information in MIB's file, you may contact MIB and seek correction in accordance with the procedures set forth in the federal Fair Credit Reporting Act. The address of MIB's information office is 50 Braintree Hill Park, Suite 400, Braintree, Massachusetts 02184-8734.

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

Authorization & Signing

I, the Proposed Insured, hereby authorize any health plan, licensed physician, medical practitioner, health care professional, hospital, clinic, laboratory, pharmacy, pharmacist, pharmacy benefit manager, medical facility, VA facility, the MIB, Inc. (MIB), any other health care provider, employer, insurance company, union welfare fund, public or private agency, consumer reporting agency, worker's compensation carrier, Motor Vehicle Agency, and any other person or organization that has provided payment, treatment or services to me or on my behalf (My Providers) to give any and all information relating to my health (except psycho-therapy notes) and my insurance policies and claims to Household Life Insurance Company and any and all affiliates and subsidiaries, their agents, employees, representatives, and reinsurers, and any persons providing services to them (the "Company").

I hereby acknowledge that the information released will be used and disclosed so the Company may:

- 1) underwrite my insurance reinstatement application, make eligibility, risk rating, policy reinstatement, and enrollment determinations;
- 2) obtain reinsurance;
- 3) administer claims and determine or fulfill any coverage obligations and provide any applicable benefits;
- 4) administer coverage; and/or
- 5) conduct other legally permissible activities relating to any past, present, or future insurance products or applications for any insurance products with the Company.

I understand all or part of the information collected may be disclosed to MIB and any reinsurance companies with which the Company does business, and any other insurance company with which the insured may have insurance. Information may also be disclosed to persons performing business or legal functions for the Company. The Company may also disclose information to prevent fraud or misrepresentations or when required by subpoena or by court or governmental order.

I understand that if I refuse to sign this authorization, the Company will not be able to process my application. I understand that I may revoke this authorization by notifying the Company in writing of my desire to revoke it. However, I understand that if I revoke this authorization, it will not have any affect on actions already taken by the Company or My Providers in reliance on this authorization and may result in this application or a claim being denied. I understand that a copy of this authorization will be included in my policy.

I understand that the information described herein and disclosed to the Company is protected by certain federal and/or state privacy regulations. Once the Company discloses this information, as allowed in this Authorization, the information may no longer be subject to such privacy regulations. I understand, however, that the Company requires the entities listed above with whom it shares this information to enter into confidentiality agreements prohibiting the disclosure of this information except as allowed herein.

I understand that the coverage shall be in effect as of the date of this reinstatement if and only if the proposed insured is accepted as an insurable risk by the Company for reinstatement purposes at this time, and all overdue premiums are paid with interest as stated in the policy. For purposes of this reinstatement, the reinstated policy will be incontestable after it has been in force during the Insured's lifetime for two years from the date of reinstatement, except for non-payment of premiums.

By signing your name and date below, you agree: (1) that you have read and fully understand all of the questions, answers and statements given in this application; (2) that the statements and answers on this application are full, complete and true to the best of your knowledge; (3) you intend to form a legally binding contract; (4) this authorization shall remain in force for [two and one-half years] from this application date; and (5) a printout of the terms stated above will constitute a "writing" under any applicable law or regulation.

Insured's Signature

Date

[_____
Owner's Signature (if different from Insured)

Date]

[Notice Regarding Information Practices

To issue an insurance policy, we need to obtain information about you and any other persons proposed for insurance. Some of that information will come from you. Some will come from other sources. That information and any information collected by us later may, in certain circumstances, be disclosed to third parties without your specific permission. You have a right to access and correction with respect to the information collected about you.]

SERFF Tracking Number: HHRN-126288680 State: Arkansas
Filing Company: Household Life Insurance Company State Tracking Number: 43580
Company Tracking Number: 09-016-AR
TOI: L08 Life - Other Sub-TOI: L08.000 Life - Other
Product Name: Life Application and Reinstatement Filing
Project Name/Number: DDU/09-016

Supporting Document Schedules

	Item Status:	Status Date:
Satisfied - Item: Flesch Certification Comments: Flesch Certification attached. Attachment: Readability Certification.pdf		

	Item Status:	Status Date:
Bypassed - Item: Application Bypass Reason: Not applicable as this is an application filing. Comments:		

	Item Status:	Status Date:
Satisfied - Item: Statement of Variability Comments: Statement of Variability attached for each document form. Attachments: Life Application EOV.pdf Reinstatement Application EOV.pdf		

	Item Status:	Status Date:
Satisfied - Item: Arkansas Certification Comments: AR Certification form attached. Attachment: STATE OF AR CERTIFICATION.pdf		

HOUSEHOLD LIFE INSURANCE COMPANY

Home office: 500 Woodward Avenue, Suite 4000, Detroit, MI 48226-3425
Administrative Office: 200 Somerset Corporate Blvd., Suite 100, Bridgewater, NJ 08807

READABILITY CERTIFICATION

Company Name: Household Life Insurance Company

I hereby certify, that the form(s) listed below has (have) the following readability score(s) as calculated by the Flesch Reading Ease Test.

Form Number	Score
HLI-1-212-0809	47.2
HLI-1-213-0809	47.5



Michael Palace ASA, MAAA - Assistant Vice President / Product Design and Pricing

September 22, 2009
Date

INDIVIDUAL LIFE
Explanation of Variable Areas

Application Form HLI-1-212-0809

Heading:

The Company's address, phone number and website may be changed as required.

Title

Title "APPLICATION FOR INDIVIDUAL [TERM LIFE/TERM LIFE WITH ENDOWMENT/WHOLE LIFE] INSURANCE" will show either term life, term life with endowment, or whole life depending upon which is applied for or will show or include another marketing name. Any title will make clear to the proposed insured that he or she is applying for life insurance.

Insured Information:

- "State or Province/Country of Birth" will be included or omitted depending on plan design and underwriting considerations.
- "Marital Status" will be included or omitted depending on plan design and/or underwriting considerations.
- "Home Phone Number" will be included or omitted depending on plan design and underwriting considerations. "Optional" will be included or omitted depending on plan design.
- "Driver's License Number & State of Issue" will be included or omitted depending on plan design and underwriting considerations. The company may reword text depending on State Law.
- "Occupation" selections will be included or omitted depending on plan design and underwriting considerations. Selections may vary depending on underwriting requirements.
- "Annual Income of Proposed Insured \$" will be included or omitted depending on plan design and underwriting considerations.
- If occupation section is provided and the proposed insured selects "Military" as his/her occupation the following text will appear "Have you received "Orders" to be deployed within the next three months in support of combat, peacekeeping or deterrence operations?" The proposed insured will either select "yes" or "no". The Company may add, delete or revise the text of this question depending on plan design and underwriting considerations.
- Question regarding citizenship will be included or omitted depending on plan design and underwriting considerations.

Owner Information

- Owner information may appear when the owner is someone other than the Insured. Specific owner fields may or may not appear as applicable on the application according to plan design. The Owner fields may or may not appear when the application is presented through our agent channels depending on plan design.
- "State or Province/Country of Birth" will be included or omitted depending on plan design and underwriting considerations.

Beneficiary:

Information for one Primary Beneficiary will be included. If the Company is able to display fields for additional primary and/or contingent beneficiaries, the applicable fields will be displayed depending on plan design.

Plan Applied For:

- The terms currently available for term life insurance will be included or omitted at the option of the Company. Additional terms may be added in the future depending on plan design.
- The terms currently available for term life with endowment insurance will be included or omitted at the option of the Company. Additional terms may be added in the future depending on plan design.
- Whole Life plan will be included or omitted at the option of the Company.
- The Automatic Premium Loan election will be included if required by State law and/or in accordance with the Policy and will appear only when applicable.

Additional Coverage Applied For:

This section will be included when riders are offered to the Insured; each rider will be included or omitted according to plan design. Additional approved riders may be displayed and titles of riders may be revised as applicable.

Coverage Amount:

The amount of coverage on the policy will be included in this area.

Payment Frequency:

Depending on plan design, the proposed insured may choose to pay premiums annually, semiannually, quarterly, or monthly.

Payment Method:

The following Payment captions may be available to applicants and bracketed information will either be displayed, rearranged or deleted depending upon plan design.

• **Option #1**

Charge my Credit Card Visa MasterCard Discover American Express
Account # _____ Exp. Date _____

Debit my [checking/savings] account [Bank Name _____] Account # _____
ABA Number _____ Type _____
(First 9 numbers in the lower left-hand corner of your check)

• **Option #2**

Charge my Credit Card/Debit Card Visa MasterCard Discover [Type of Card]
Account # _____ Exp. Date _____

Debit my [checking/savings] account [Bank Name _____] Account # _____
ABA Number _____ Type _____
(First 9 numbers in the lower left-hand corner of your check)

• **Option #3**

Charge my Credit Card/Debit Card Visa MasterCard Discover [Type of Card]
Account # _____ Exp. Date _____

Debit my [checking/savings] account [Bank Name _____] Account # _____
ABA Number _____ Type _____
(First 9 numbers in the lower left-hand corner of your check)

[Or enclose a voided check from the [checking] account from which you want to make a payment]

• **Option #4**

Charge my Credit Card/Debit Card Visa MasterCard Discover [Type of Card]
Account # _____ Exp. Date _____

Debit my [checking/savings] account [Bank Name _____] Account # _____
ABA Number _____ Type _____

(First 9 numbers in the lower left-hand corner of your check)

[Or enclose a voided check from the [checking] account from which you want to make a payment]

Bill me directly for the premiums

• **Option #5**

Charge my Credit Card/Debit Card Visa MasterCard Discover [Type of Card]

Account # _____ Exp. Date _____

• **Option #6**

Charge my Credit Card Visa MasterCard Discover American Express

Account # _____ Exp. Date _____

• **Option #7**

Debit my [checking/savings] account [Bank Name _____] Account # _____

ABA Number _____ Type _____

(First 9 numbers in the lower left-hand corner of your check)

• **Option #8**

Bill me directly for the premiums

• **Option #9**

Charge the premium for the coverage to my [Bank Name] credit card account.

• **Option #10**

Debit the premium for the coverage to [Bank Name] [type of] account

• **Option #11**

Bill me for my coverage on my mortgage bill with [Mortgage Company Name].

• **Option #12**

Bill me for my coverage on my [consumer loan/equity] bill with [Lending Institution Name].

• **Option #13**

Bill me later

Check enclosed – start coverage faster

I am enclosing a Check for my first payment of \$_____. Please make check payable to [Name of Company]. Write billing frequency selected on the check. You will be billed for future payments.

• **Option #14**

Bill me later

Check enclosed – start coverage faster

I am enclosing a Check for my first payment of \$_____. Please make check payable to [Name of Company]. Write billing frequency selected on the check. You will be billed for future payments.

Debit my[checking/savings] account [Bank Name _____] Account # _____
ABA Number _____Type _____
(First 9 numbers in the lower left-hand corner of your check)

[Or enclose a voided check from the [checking] account from which you want to make a payment]

• **Option #15**

Check enclosed – start coverage faster

I am enclosing a Check for my first payment of \$_____. Please make check payable to [Name of Company]. Write billing frequency selected on the check. You will be billed for future payments.

• **Option #16**

Charge my Debit Card Visa MasterCard Discover Other

Account # _____ Exp. Date _____

• **Option #17**

Please [charge/debit] [to] my existing [Financial Institution Name] [Card/Bank Account] on file.

Replacement:

Replacement questions will show as required by state law and will conform to model law requirements if/ when adopted by state. Company may revise wording within the questions but will comply with state law. Company may remove the following statement if additional forms are not required: (If yes, additional forms may be required, depending upon your state)?

Underwriting Information:

Section 2

This entire section will be included if the proposed insured has answered “No” to all questions in section 1 of the application.

Question 1:

The entire variable text will appear if the proposed insured has lost more than [15] lbs in the past year. Company may revise wording within the variable field or add additional options for “Reason for loss of weight” selections depending on underwriting requirements.

Question 2:

“If yes, please provide all medications” will appear if the proposed insured has selected yes to Question #2. Company may revise wording within the variable field according to plan design.

Question 3:

The variable fields under each sub-question will appear if the proposed insured answers “Yes” to any of the succeeding questions under question #3. The Company may add or delete individual selections from each subsection depending on underwriting requirements. The Company may also revise wording within the sub-question(s) depending on underwriting requirements.

Question 4:

The variable fields under each sub-question will appear if the proposed insured answers “Yes” to any of the succeeding questions under question #4. The Company may add or delete individual selections from each subsection depending on underwriting requirements. The Company may also revise wording within the sub-question(s) depending on underwriting requirements.

Question 6:

These selections will appear if the proposed insured answers “Yes” to question #6. The Company may add or delete selections depending on underwriting requirements. The Company may also revise wording within the question(s) depending on underwriting requirements.

Section 3

This section may or may not appear based upon underwriting requirements. The Company may also revise wording within the questions depending on underwriting requirements. “Cause of Death” may or may not appear. “Age of Death” may or may not appear.

Fraud Warnings:

The NAIC model fraud warning language will be added, deleted or revised as required according to model law regulations and will appear in states that do not have state mandated fraud warning language, where allowed. The fraud notice applicable to the state will appear on the application. The state fraud warning language will be added, deleted or revised as required according to state law. The fraud warning may be moved and appear above the signature lines.

MIB Notice:

The MIB notice is bracketed to allow for revision without refilling due to mandated changes by MIB. The MIB notice may appear as shown or as a separate document.

Authorization:

The authorization will be valid for two and one-half years or will be revised to conform to the time period required by state law.

Owner Signature and date

This signature and date block will be included when the Owner of the policy is someone other than the applicant.

Company Representative Replacement Questionnaire

These questions will be included when coverage is effectuated by a company representative. Company may revise wording within the questions but will comply with state law.

All page numbering may be subject to change.

INDIVIDUAL LIFE
Explanation of Variable Areas
Application Form HLI-1-213-0809

Heading:

Company addresses, website and phone number may be changed as required.

Insured Information:

- The following customer information may be pre-populated: Insured's name, policy number, date of birth, and name of owner (if different than the Insured). If any information has changed prior to reinstatement, we will provide the Insured with the appropriate mechanisms to allow for change at the time of reinstatement.
- "State or Province/Country of Birth" will be included or omitted depending on plan design and underwriting considerations.
- "Marital Status" will be included or omitted depending on plan design and underwriting considerations.
- "Home Phone Number" will be included or omitted depending on plan design and underwriting considerations. "Optional" will be included or omitted depending on plan design.
- "Driver's License Number & State of Issue" will be included or omitted depending on plan design and underwriting considerations.
- "Occupation" selections will be included or omitted depending on plan design and underwriting considerations.
- "Annual Income of Proposed Insured \$" will be included or omitted depending on plan design and underwriting considerations.
- "Are you currently in the Military?" will appear in the current format. If systemic capabilities change this text may or may not appear based on the "Occupation" selection. The following text will appear "[If yes], have you received "Orders" to be deployed within the next three months in support of combat, peacekeeping or deterrence operations?" "If yes" will be included or omitted depending on systemic capabilities. The Company may add, delete or revise text of this question depending on plan design and underwriting considerations. In addition, these questions may or may not appear based systemic capabilities.
- "and riders, if applicable" will be included or omitted depending if rider elections will be reinstated with the Policy or/ are available for election at the time of reinstatement. The inclusion or omission of this language will depend on plan design.
- "as indicated below" will be included or omitted if rider elections are available at the time of reinstatement.
- All, none, or only applicable rider elections will appear at the time of reinstatement. Additional approved riders will be displayed and titles of riders may be revised as applicable.

Owner Information

- Owner information may or may not appear. Owner information may appear when the owner is someone other than the Insured. Specific owner fields may or may not appear as applicable on the application according to plan design.
- If Owner information appears, either the owner's name will appear or the owner's name and all other fields.
- "State or Province/Country of Birth" will be included or omitted depending on plan design and underwriting considerations.

Underwriting Information

Section 2

This entire section will be included if the applicant has answered “No” to all questions in section 1 of the application.

Question 1:

The entire variable text will appear if the proposed insured has lost more than [15] lbs in the past year. Company may revise wording within the variable field or add additional options for “Reason for loss of weight” selections depending on underwriting requirements.

Question 2:

The entire question may or may not appear depending on systemic capabilities and/or underwriting considerations. [If yes, please provide all medications:] may or may not appear depending on systemic capabilities if the applicant selects “yes” to question #2. Company may revise the wording within the variable field according to plan design.

Question 3:

All variable fields will currently appear. Depending on systemic capabilities the variable fields under each sub-question may or may not appear depending on the applicants’ response to question #3. The Company may add or delete individual selections from each subsection depending on underwriting requirements. The text [If yes, select all that apply:”] may be subject to change. The Company may also add or delete questions within the subsections depending on underwriting requirements.

Question 4:

All variable fields will currently appear. Depending on systemic capabilities the variable fields under each sub-question may or may not appear depending on the applicants’ response to question #4. The Company may add or delete individual selections from each subsection depending on underwriting requirements. The text [If yes, select all that apply:”] may be subject to change. The Company may also add or delete questions within the subsections depending on underwriting requirements.

Question 6

These selections will appear. Depending on systemic capabilities the variable subsections may or may not appear depending on the applicants’ responses to question #6. The Company may add or delete selections depending on underwriting requirements. The text [If yes, select all that apply:”] may be subject to change.

Section 3

This section may or may not appear based upon underwriting requirements. The Company may also revise wording with this section depending on underwriting requirements. Additional lines may be added for additional “Sisters” and “Brothers” depending on underwriting requirements

Payment Method Information:

The following Payment captions may be available to applicants and bracketed information will either be displayed, rearranged or deleted depending upon plan design.

Charge my Credit Card Visa MasterCard Discover American Express
Account # _____ Exp. Date _____

Debit my [checking/savings] account Bank Name _____ Account # _____
ABA Number _____ Type _____
(first 9 numbers in the lower left-hand corner of your check)

Certified Check/Money Order Enclosed Total Premium Enclosed/Due \$_____]

Fraud Warnings:

The NAIC model fraud warning language will be added, deleted or revised as required according to model law regulations and will appear in states that do not have state mandated fraud warning language, where allowed. The fraud notice applicable to the state will appear on the application. The state fraud warning language will be added, deleted or revised as required according to state law. The fraud warning may be moved and appear above the signature lines.

MIB Notice:

The MIB notice is bracketed to allow for revision without refiling due to mandated changes by MIB. The MIB notice may appear as shown or as a separate document.

Authorization:

The authorization will be valid for two and one-half years or will be revised to conform to the time period required by state law.

Owner Signature and date

This signature and date block will be included when the Owner of the policy is someone other than the applicant.

Notice of Information Practices

Notice language is not part of the application and may be shown at the bottom of the application or as a separate document. Notice may be revised without refiling, but will always conform to state law.

All page numbering may be subject to change.

The Policy number on each page may be subject to change.

STATE OF ARKANSAS
CERTIFICATION OF COMPLIANCE

Company Name: HOUSEHOLD LIFE INSURANCE COMPANY

Form Numbers: HLI-1-212-0809, HLI-1-213-0809

I hereby certify that to the best of my knowledge and belief, the above form(s) and submission complies with Reg. 19, as well as the other laws and regulations of the State of Arkansas.

Michael Palace

Michael Palace ASA, MAAA- Assistant Vice President / Product Design and Pricing

September 23, 2009

Date