

SERFF Tracking Number: MCHX-126301525 State: Arkansas
Filing Company: OM Financial Life Insurance Company State Tracking Number: 43482
Company Tracking Number: OMAD 6228 (08-2009)
TOI: L08 Life - Other Sub-TOI: L08.000 Life - Other
Product Name: OMAD 6228 (08-2009) Individual Life Insurance Appl
Project Name/Number: OMAD 6228 (08-2009) Individual Life Insurance Application/OMAD 6228 (08-2009) Individual Life Insurance Application

Filing at a Glance

Company: OM Financial Life Insurance Company

Product Name: OMAD 6228 (08-2009) SERFF Tr Num: MCHX-126301525 State: Arkansas

Individual Life Insurance Appl

TOI: L08 Life - Other

SERFF Status: Closed-Approved- State Tr Num: 43482
Closed

Sub-TOI: L08.000 Life - Other

Co Tr Num: OMAD 6228 (08-2009) State Status: Approved-Closed

Filing Type: Form

Reviewer(s): Linda Bird

Author: SPI McHughConsulting

Disposition Date: 09/15/2009

Date Submitted: 09/11/2009

Disposition Status: Approved-
Closed

Implementation Date Requested: 10/12/2009

Implementation Date:

State Filing Description:

General Information

Project Name: OMAD 6228 (08-2009) Individual Life Insurance
Application

Status of Filing in Domicile: Pending

Project Number: OMAD 6228 (08-2009) Individual Life Insurance
Application

Date Approved in Domicile:

Requested Filing Mode: Review & Approval

Domicile Status Comments: Filing concurrently
in Maryland.

Explanation for Combination/Other:

Market Type: Individual

Submission Type: New Submission

Group Market Size:

Overall Rate Impact:

Group Market Type:

Filing Status Changed: 09/15/2009

Explanation for Other Group Market Type:

State Status Changed: 09/15/2009

Deemer Date:

Created By: SPI McHughConsulting

Submitted By: SPI McHughConsulting

Corresponding Filing Tracking Number:

Filing Description:

Group Number: 2598

NAIC #:63274

FIN #: 52-6033321

RE: Filing on Behalf of OM Financial Life Insurance Company

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New Life Insurance Application Form Filing for Approval, OMAD 6228 (08/09)

McHugh Consulting Resources, Inc. has been requested to file the enclosed forms on behalf of OM Financial Life Insurance Company. We have provided an authorization letter for your files.

Enclosed for your review and approval is the above captioned life insurance application form. The form is new and does not replace any forms on file with the Department.

This form will also be available electronically so that it may be printed from a computer by an agent for completion and signature.

The form is in final printed format subject only to changes in formatting, font style, margins, page numbers, ink and paper stock. Printing standards will never be less than those required by law.

Thank you for your time and consideration of this filing.

Company and Contact

Filing Contact Information

Tim Hager, Compliance Assistant mcr@mchughconsulting.com
McHugh Consulting Resources 215-230-7960 [Phone]
350 South Main Street, Suite 103 215-230-7961 [FAX]
Doylestown, PA 18901

Filing Company Information

(This filing was made by a third party - McHughConsulting)

OM Financial Life Insurance Company	CoCode: 63274	State of Domicile: Maryland
1001 Fleet Street	Group Code: 2598	Company Type:
Baltimore, MD 21202	Group Name:	State ID Number:
(410) 895-0091 ext. [Phone]	FEIN Number: 52-6033321	

Filing Fees

Fee Required?	Yes
Fee Amount:	\$125.00
Retaliatory?	Yes

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Fee Explanation:
Per Company: No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
OM Financial Life Insurance Company	\$125.00	09/11/2009	30488582

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Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Linda Bird	09/15/2009	09/15/2009

SERFF Tracking Number: MCHX-126301525 *State:* Arkansas
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Disposition

Disposition Date: 09/15/2009

Implementation Date:

Status: Approved-Closed

Comment:

Rate data does NOT apply to filing.

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Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification		Yes
Supporting Document	Application		Yes
Supporting Document	Submission Letter		Yes
Supporting Document	Authorization Letter		Yes
Supporting Document	Form Listing		Yes
Supporting Document	Statement of Variability		Yes
Form	Life Insurance Application		Yes

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Form Schedule

Lead Form Number: OMAD 6228 (08-2009)

Schedule Item Status	Form Number	Form Type Form Name	Action	Action Specific Data	Readability	Attachment
	OMAD 6228 (08-2009)	Application/ Life Insurance Enrollment Application Form	Initial		55.300	OMAD 6228 (08-2009).PDF

OM Financial Life Insurance Company

Life Insurance Application (page [1] of [12])

FOR ANYONE PROPOSED TO BE INSURED: IF YOU HAVE ANY QUESTIONS OR CONCERNS ABOUT ANY OF THE CONTENTS OF THIS FORM OR THE INSURANCE COVERAGE, OR WISH TO DISCUSS THE INSURANCE COVERAGE, CONTACT OUR HOME OFFICE AT [800 638-2255].

PRIMARY INSURED

Name (First, M.I., Last) John J. Doe							
Home Address 1234 Avenue of the America's				City Anytown	State USA	Zip 12345	
Social Security No. 123-45-6789	Sex M	Marital Status M	Date of Birth 1-1-1972	Place of Birth USA		Height (ft., in.) 6ft 2in	Weight (lbs.) 220
Driver's License Number and Issue State 123456789101112, Any state USA			Other Identification Number (if Driver's License not used):			State/Province and Country of Issue:	
Type of Identification: <input checked="" type="checkbox"/> State Issued <input type="checkbox"/> Immigration <input type="checkbox"/> Passport <input type="checkbox"/> Military <input type="checkbox"/> Other (Specify) _____							
[Currently Employed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No]		[Employer] Any Employer		[Occupation and Duties] Manager, Manage 30 Employees			[No. of Years With Current Employer] 10
Earned Annual Income (from last year's W-2) \$60,000			[Email Address] john.doe@anyemployer.com				
Daytime Phone Number xxx xxx-xxxx		Evening Phone Number xxx xxx-xxx1		[Cell Phone Number] xxx xxx-xxx2		[Best Time To Call] after 6pm	

OTHER INSURED

Name (First, M.I., Last) Mary E. Doe				Relationship to Primary Insured Wife			
Home Address 1234 Avenue of the America's				City Anytown	State USA	Zip 12345	
Social Security No. 223-45-6781	Sex F	Marital Status M	Date of Birth 2-1-1972	Place of Birth USA		Height (ft., in.) 5ft 6in	Weight (lbs.) 135
Driver's License Number and Issue State 2345678910121, Any state USA			Other Identification Number (if Driver's License not used):			State/Province and Country of Issue:	
Type of Identification: <input checked="" type="checkbox"/> State Issued <input type="checkbox"/> Immigration <input type="checkbox"/> Passport <input type="checkbox"/> Military <input type="checkbox"/> Other (Specify) _____							
[Currently Employed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No]		[Employer] Other Employer		[Occupation and Duties] Admin Asst, Asst to Dept Head			[No. of Years With Current Employer] 9
Earned Annual Income (from last year's W-2) \$40,000			[Email Address] mary.doe@otheremployer.com				
Daytime Phone Number xxx xxx-xx45		Evening Phone Number xxx xxx-xxx1		[Cell Phone Number] xxx xxx-xxx3		[Best Time To Call] after 6pm	

OWNER(S)

UNLESS OTHERWISE INSTRUCTED, THE OWNER WILL BE THE PRIMARY INSURED.
IF THIS APPLICATION IS FOR CORPORATE OWNED LIFE INSURANCE, THE EMPLOYEE HAS NO OWNERSHIP RIGHTS.
A secondary addressee may be named to receive notice of possible lapse in coverage. (Required in FL, ME, VT)

Name (First, M.I., Last) John J. Doe				Relationship to Primary Insured same			
Home Address				City	State	Zip	
Social Security or Tax I.D. No.		Date of Birth	Place of Birth		[Email Address]		
Driver's License Number and Issue State			Other Identification Number (if Driver's License not used):			State/Province and Country of Issue:	
Type of Identification: <input type="checkbox"/> State Issued <input type="checkbox"/> Immigration <input type="checkbox"/> Passport <input type="checkbox"/> Military <input type="checkbox"/> Other (Specify) _____							
[Currently Employed? <input type="checkbox"/> Yes <input type="checkbox"/> No]		[Employer]		[Occupation and Duties]			[No. of Years With Current Employer]
Earned Annual Income (from last year's W-2)			[Email Address]				
Daytime Phone Number		Evening Phone Number		[Cell Phone Number]		[Best Time To Call]	

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SECONDARY ADDRESSEE

To receive notice of possible lapse in coverage. (Required in [FL, ME, VT])

Name (First, M.I., Last)				Relationship to Primary Insured and/or Owner			
Home Address				City	State	Zip	

BENEFICIARY DESIGNATION – Primary Insured

FOR EACH BENEFICIARY, LIST FULL NAME, ADDRESS, DATE OF BIRTH, SSN, RELATIONSHIP TO PRIMARY INSURED AND % SHARE.
IF THIS APPLICATION IS FOR CORPORATE OWNED LIFE INSURANCE, FILL IN THE EMPLOYER'S INFORMATION

Primary Beneficiary(ies)

Full Name	Address	Date of Birth	Social Security #	Relationship to Primary Insured	%
Christine Doe	1234 Avenue of the America's	7-1-1987	444-32-1988	Daughter	50
June Doe	1234 Avenue of the America's	7-1-1987	444-32-1989	Daughter	50

Contingent Beneficiary(ies)

Full Name	Address	Date of Birth	Social Security #	Relationship to Primary Insured	%
David Doe	1364 Avenue of the America's	1-1-1972	123-45-6788	Brother	100

BENEFICIARY DESIGNATION – Other Insured

Unless otherwise instructed, the beneficiary for other persons proposed to be insured will be the Owner.]

EXISTING INSURANCE

List existing personal and business life insurance, disability income, annuity, and long term care coverage.
Circle **NONE** if there is no coverage.

Insurance Company	Type of Policy	Policy/Certificate Number	Life Insurance or Disability Income Amount	Accidental Death Benefit Amount	ADB Amount	Year Issued	Replacing	1035
							<input type="checkbox"/>	<input type="checkbox"/>
							<input type="checkbox"/>	<input type="checkbox"/>
							<input type="checkbox"/>	<input type="checkbox"/>

	Primary Insured	Other Insured
1. Will this life insurance, if issued, replace or change any existing life insurance or annuity? If, "Yes," circle which policy and/or certificate(s) listed above that are to be replaced or changed. Amount being replaced \$ _____	<input type="checkbox"/> Y <input checked="" type="checkbox"/> N	<input type="checkbox"/> Y <input checked="" type="checkbox"/> N
2. Has any person proposed to be insured had any insurance application declined, postponed, rescinded or been offered rated or modified life insurance, or refused for renewal or reinstatement? If yes, please provide details:	<input type="checkbox"/> Y <input checked="" type="checkbox"/> N	<input type="checkbox"/> Y <input checked="" type="checkbox"/> N
_____	<input type="checkbox"/>	<input type="checkbox"/>
_____	<input type="checkbox"/>	<input type="checkbox"/>
_____	<input type="checkbox"/>	<input type="checkbox"/>

Life Insurance Application (page [3] of [12])

STATEMENT OF INTENT

THIS SECTION MUST BE COMPLETED BY THE OWNER AND ALL PERSONS APPLYING FOR LIFE INSURANCE WITH THIS APPLICATION

It is OM Financial Life Insurance Company's policy that life insurance should only be purchased to provide protection to those with an insurable interest in the life (lives) of the insured(s). The Company will not knowingly participate in life insurance sales motivated by a possible sale of life insurance contracts to a secondary market or participation of investors in life insurance death benefits.]

3. Does the owner or any person proposed to be insured currently have any applications or preliminary informal quote requests with any other life insurance company, viatical settlement company, or secondary market provider or company? <i>If, "Yes," please provide details.</i>	<input type="checkbox"/> Y <input checked="" type="checkbox"/> N
4. Will the initial or any future premiums for the life insurance being applied for be borrowed, loaned, or otherwise financed by any individual(s) or entity(ies) other than anyone proposed to be insured or immediate family members of anyone proposed to be insured? <i>If, "Yes," please identify all parties involved and provide copies of all financing agreements and promissory notes and all related agreements and schedules and the premium financing disclosure statement. These documents are required before underwriting will begin.</i>	<input type="checkbox"/> Y <input checked="" type="checkbox"/> N
5. Will the premiums for this life insurance contract be paid by any individual(s) or entity(ies) other than anyone proposed to be insured; the employer of anyone proposed to be insured; or immediate family members of anyone proposed to be insured in exchange for any portion of the life insurance death benefit? <i>If, "Yes," please specify how death benefits will be distributed upon the death of anyone proposed to be insured and include the names of all recipients and the percentage or amount to be received.</i>	<input type="checkbox"/> Y <input checked="" type="checkbox"/> N
6. Has a life insurance policy insuring the life of anyone proposed to be insured ever been sold or transferred to a third-party? <i>If, "Yes," please provide the reason the policy was sold or transferred, identify all parties involved and provide details including the policy number, issuing carrier, face amount, date issued, and date sold or transferred.</i>	<input type="checkbox"/> Y <input checked="" type="checkbox"/> N
7. Does the owner or anyone proposed to be insured intend to sell or transfer the life insurance contract being applied for on this application or intend to sell or transfer any other life insurance currently in force or applied for with any company to a life settlement company or other third party? <i>If, "Yes," please provide details.</i>	<input type="checkbox"/> Y <input checked="" type="checkbox"/> N
8. Has the owner or anyone proposed to be insured been solicited to sell or transfer the life insurance contract being applied for on this application or to sell or transfer any other life insurance policy to a life settlement company or other third party? <i>If, "Yes," please provide details.</i>	<input type="checkbox"/> Y <input checked="" type="checkbox"/> N
9. Has the owner or anyone proposed to be insured been involved in any discussions about the possible sale of the life insurance being applied for or the sale or transfer of a beneficial interest in a trust, LLC, LLP, or other entity created, or to be created, that will own the life insurance contract being applied for? <i>If, "Yes," please provide details.</i>	<input type="checkbox"/> Y <input checked="" type="checkbox"/> N
10. Will the owner or anyone proposed to be insured receive: a fee, payment, or any other consideration; from any: individual, group of individuals, or any entity; in connection with the issuance of the life insurance being applied for? <i>If, "Yes," please provide details including expected or promised payment amount and payor.</i>	<input type="checkbox"/> Y <input checked="" type="checkbox"/> N
11. Has a third party offered the owner or anyone proposed to be insured, "free," life insurance? <i>If, "Yes," please provide details including expected or promised payment amount and payor.</i>	<input type="checkbox"/> Y <input checked="" type="checkbox"/> N

ADDITIONAL INFORMATION

If additional space is needed for any, "Yes," answers please use the space below.

Question	Detail	Primary Insured	Other Insured
		<input type="checkbox"/>	<input type="checkbox"/>
		<input type="checkbox"/>	<input type="checkbox"/>
		<input type="checkbox"/>	<input type="checkbox"/>
		<input type="checkbox"/>	<input type="checkbox"/>
		<input type="checkbox"/>	<input type="checkbox"/>
		<input type="checkbox"/>	<input type="checkbox"/>
		<input type="checkbox"/>	<input type="checkbox"/>
		<input type="checkbox"/>	<input type="checkbox"/>
		<input type="checkbox"/>	<input type="checkbox"/>
		<input type="checkbox"/>	<input type="checkbox"/>

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LIFE INSURANCE INFORMATION

Product Name Life Elite	Amount of Insurance \$100,000	Initial Premium \$100	<input checked="" type="checkbox"/> Nontobacco <input type="checkbox"/> Tobacco]
[TERM: <input type="checkbox"/> Level <input type="checkbox"/> Decreasing]	[Term Period (Number of years):]	[Premium Guarantee Period:]	
[UNIVERSAL LIFE: <input type="checkbox"/> Level <input checked="" type="checkbox"/> Increasing] [Planned Premium] \$100 month	[Life Insurance Qualification Test: <input checked="" type="checkbox"/> Guideline Premium <input type="checkbox"/> Cash Value Accumulation] [For Fixed Indexed Products Only: Initial Allocation Percentage Index Interest Option [50]% Fixed Interest Option [50]%]		
Payment Mode: (For bank draft, complete Bank Draft Plan Authorization, and initial payment required.) <input type="checkbox"/> Annual <input type="checkbox"/> Semi-Annual <input type="checkbox"/> Quarterly <input checked="" type="checkbox"/> Monthly Bank Draft <input type="checkbox"/> Bi-Weekly Bank Draft <input type="checkbox"/> Government Allotment <input type="checkbox"/> Payroll Deduction <input type="checkbox"/> Other _____		Payment in Exchange for Conditional Receipt \$100	
Credit Card (See instructions Page for Current Company Practice) <input type="checkbox"/> Visa <input type="checkbox"/> MasterCard	Account Number	Expiration Date	Signature to Authorize Credit Card Charge

NO COVERAGE WILL BE EFFECTIVE EXCEPT IN ACCORDANCE WITH THE TERMS OF THE CONDITIONAL RECEIPT AND UNLESS THE FULL INITIAL MODAL PREMIUM PAYMENT IS SUBMITTED WITH THE APPLICATION.

ADDITIONAL BENEFITS

SUBJECT TO STATE AVAILABILITY. CERTAIN RESTRICTIONS MAY APPLY.

PRIMARY INSURED	OTHER INSURED
<input checked="" type="checkbox"/> Disability Income Rider Class: _____ Monthly Payout: \$ 2,000 <input type="checkbox"/> 3 Month Waiting Period, 2 Year Benefit <input checked="" type="checkbox"/> 6 Month Waiting Period, 5 Year Benefit	<input checked="" type="checkbox"/> Disability Income Rider Class: _____ Monthly Payout: \$ 2,000 <input type="checkbox"/> 3 Month Waiting Period, 2 Year Benefit <input checked="" type="checkbox"/> 6 Month Waiting Period, 5 Year Benefit
<input checked="" type="checkbox"/> Accident Only Disability Income Rider (questions 40, 41, and 42 must also be completed) Monthly Payout: \$ 2,000 <input type="checkbox"/> 3 Month Waiting Period, 2 Year Benefit <input checked="" type="checkbox"/> 6 Month Waiting Period, 5 Year Benefit	<input checked="" type="checkbox"/> Accident Only Disability Income Rider (questions 40, 41, and 42 must also be completed) Monthly Payout: \$ 2,000 <input type="checkbox"/> 3 Month Waiting Period, 2 Year Benefit <input checked="" type="checkbox"/> 6 Month Waiting Period, 5 Year Benefit
<input checked="" type="checkbox"/> Accelerated Benefit Rider	
<input checked="" type="checkbox"/> Accidental Death Benefit Rider Amount: \$ 100,000	
<input type="checkbox"/> Critical Illness / Condition ^(PA) / Specified Medical Condition Rider ^(MA) Amount: \$ _____	<i>Supplemental questionnaire required.</i>
<input type="checkbox"/> Return of Premium Rider: <input type="checkbox"/> 50% <input type="checkbox"/> 100%	
<input checked="" type="checkbox"/> Ultimate Income Option Rider Initial Lump Sum: \$ 10,000 Monthly Income of: \$ 500 for 25 years. Final Lump Sum: \$ balance of proceeds	<i>Illustration Required.</i>
<input checked="" type="checkbox"/> Other Insured Rider Amount: \$ 100,000	
<input checked="" type="checkbox"/> Child Rider Amount: \$ 10,000	<i>Supplemental questionnaire required.</i>
<input checked="" type="checkbox"/> (UL Only) Waiver of Monthly Deduction Rider	
<input type="checkbox"/> (Term Only) Waiver of Premium Rider	
<input type="checkbox"/> Other: _____	

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PERSONAL HISTORY QUESTIONS

		Primary Insured	Other Insured
12.	Is any person proposed to be insured a citizen or permanent resident of the United States? <i>If, "No," please complete W8ben form and the Citizenship Questionnaire.</i>	<input checked="" type="checkbox"/> Y <input type="checkbox"/> N	<input checked="" type="checkbox"/> Y <input type="checkbox"/> N
13.	Has any person proposed to be insured <i>(not required in FL and MA)</i> ;		
	a) Traveled outside the United States or Canada within the past 2 years?	<input type="checkbox"/> Y <input checked="" type="checkbox"/> N	<input type="checkbox"/> Y <input checked="" type="checkbox"/> N
	b) Resided outside the United States or Canada within the past 2 years?	<input type="checkbox"/> Y <input checked="" type="checkbox"/> N	<input type="checkbox"/> Y <input checked="" type="checkbox"/> N
14.	Does any person proposed to be insured plan to <i>(not required in FL and MA)</i> ;		
	a) Travel outside the United States or Canada within the next 2 years?	<input type="checkbox"/> Y <input checked="" type="checkbox"/> N	<input type="checkbox"/> Y <input checked="" type="checkbox"/> N
	b) Reside outside the United States or Canada within the next 2 years?	<input type="checkbox"/> Y <input checked="" type="checkbox"/> N	<input type="checkbox"/> Y <input checked="" type="checkbox"/> N
<i>If you answered, "Yes," to questions 15 and 16, please complete the Residence and Travel Questionnaire.</i>			
15.	Has anyone proposed to be insured ever been convicted of or pending trial on any felony and/or misdemeanor crime offense? <i>If, "Yes," please provide details below.</i>	<input type="checkbox"/> Y <input checked="" type="checkbox"/> N	<input type="checkbox"/> Y <input checked="" type="checkbox"/> N
16.	Is anyone proposed to be insured currently on probation or parole for any felony and/or misdemeanor crime offense? <i>If, "Yes," please provide details below.</i>	<input type="checkbox"/> Y <input checked="" type="checkbox"/> N	<input type="checkbox"/> Y <input checked="" type="checkbox"/> N
17.	Has anyone proposed to be insured ever sought or received treatment, advice, or counseling for the use of any narcotic, barbiturate, stimulant, amphetamine, hallucinogenic, street, or prescription drugs? <i>If, "Yes," please provide details below.</i>	<input type="checkbox"/> Y <input checked="" type="checkbox"/> N	<input type="checkbox"/> Y <input checked="" type="checkbox"/> N
18.	Has anyone proposed to be insured ever been arrested and/or convicted for the use or possession of any narcotic, barbiturate, stimulant, amphetamine, hallucinogenic, street, or prescription drugs or is anyone proposed to be insured currently using these drugs. <i>If, "Yes," please provide detail below.</i>	<input type="checkbox"/> Y <input checked="" type="checkbox"/> N	<input type="checkbox"/> Y <input checked="" type="checkbox"/> N
19.	Has anyone proposed to be insured ever sought or received treatment, advice, or counseling for alcohol use? <i>If, "Yes," please provide details below.</i>	<input type="checkbox"/> Y <input checked="" type="checkbox"/> N	<input type="checkbox"/> Y <input checked="" type="checkbox"/> N
20.	In the past 10 years has anyone proposed to be insured been convicted of driving under the influence of alcohol or drugs, reckless driving, motor moving violations or any other type of DWI/DUI, or had a driver's license suspended or revoked? <i>If, "Yes," please provide details below.</i>	<input type="checkbox"/> Y <input checked="" type="checkbox"/> N	<input type="checkbox"/> Y <input checked="" type="checkbox"/> N
21.	Within the past 7 years has anyone proposed to be insured filed for bankruptcy? <i>If, "Yes," please provide details below.</i>	<input type="checkbox"/> Y <input checked="" type="checkbox"/> N	<input type="checkbox"/> Y <input checked="" type="checkbox"/> N
22.	In the past 5 years has anyone proposed to be insured participated in ballooning, bungee jumping, cliff diving, hang gliding, motorized racing, boat racing, parachuting, mountain or rock climbing, skin or scuba diving, rodeo, snowmobiling, competitive skiing, or any other similar activity or avocation or does anyone proposed to be insured plan to participate in any of these or any other similar activity or avocation? <i>If, "Yes," please complete the appropriate questionnaire.</i>	<input type="checkbox"/> Y <input checked="" type="checkbox"/> N	<input type="checkbox"/> Y <input checked="" type="checkbox"/> N
23.	In the past 5 years has anyone proposed to be insured flown as a pilot, student pilot, or crew member of an aircraft or plan to? <i>If, "Yes," please complete the Aviation Questionnaire</i>	<input type="checkbox"/> Y <input checked="" type="checkbox"/> N	<input type="checkbox"/> Y <input checked="" type="checkbox"/> N
24.	In the past 24 months, has anyone proposed to be insured had any of the following life events: <input type="checkbox"/> Marriage <input type="checkbox"/> Divorce <input type="checkbox"/> Birth of Child <input type="checkbox"/> Adoption <i>If, "Yes," to Birth of Child or Adoption, please provide details and complete Children's Questionnaire.</i>	<input type="checkbox"/> Y <input checked="" type="checkbox"/> N	<input type="checkbox"/> Y <input checked="" type="checkbox"/> N

ADDITIONAL INFORMATION

If additional space is needed for any, "Yes," answers (except question 14), please use the space below.

Question	Detail	Primary Insured	Other Insured
		<input type="checkbox"/>	<input type="checkbox"/>
		<input type="checkbox"/>	<input type="checkbox"/>
		<input type="checkbox"/>	<input type="checkbox"/>
		<input type="checkbox"/>	<input type="checkbox"/>
		<input type="checkbox"/>	<input type="checkbox"/>

Life Insurance Application (page [6] of [12])

MEDICAL HISTORY QUESTIONS

		Primary Insured	Other Insured
25.	Has anyone proposed to be insured ever been treated for or diagnosed by a member of the medical profession with:		
a)	Coronary artery disease, heart attack, congenital heart disease or defect, cardiomyopathy, chest pain, or any heart disease; high blood pressure, high cholesterol, heart murmur, palpitations, or any other disorder of the heart or blood vessels; had any coronary bypass surgery, coronary angioplasty, coronary stent, heart valve replacement, or any other heart related treatments, or any abnormality of the brain? <i>If, "Yes," please provide details below.</i>	<input checked="" type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input checked="" type="checkbox"/> N
b)	Any circulatory disease, stroke, TIA, aneurysm, or any other disorder of the veins or arteries? <i>If, "Yes," please provide details below.</i>	<input type="checkbox"/> Y <input checked="" type="checkbox"/> N	<input type="checkbox"/> Y <input checked="" type="checkbox"/> N
c)	Any breathing or respiratory disorders, Chronic Obstructive Pulmonary Disease (COPD), asthma, bronchitis, pleurisy, tuberculosis, sleep apnea, emphysema, sarcoidosis, or cystic fibrosis? <i>If, "Yes," please provide details below.</i>	<input type="checkbox"/> Y <input checked="" type="checkbox"/> N	<input checked="" type="checkbox"/> Y <input type="checkbox"/> N
d)	Diabetes, thyroid, disorder of the immune system, anemia, blood disorder, disorder of the glands, or any other disorders? <i>If, "Yes," please provide details below.</i>	<input type="checkbox"/> Y <input checked="" type="checkbox"/> N	<input type="checkbox"/> Y <input checked="" type="checkbox"/> N
e)	Cancer, growths, tumors, or cysts? <i>If, "Yes," please provide details below and complete the questionnaire.</i>	<input type="checkbox"/> Y <input checked="" type="checkbox"/> N	<input type="checkbox"/> Y <input checked="" type="checkbox"/> N
f)	Depression, bipolar disorder, schizophrenia, anxiety, dementia, Alzheimer's, Parkinson's, demyelinating disease, multiple sclerosis, Huntington's, hydrocephalus, quadriplegia, paraplegia, any other type of paralysis, any other physical, psychiatric or emotional disorder, stress, or any other mental, nervous disease or disorder? <i>If, "Yes," please provide details below.</i>	<input type="checkbox"/> Y <input checked="" type="checkbox"/> N	<input type="checkbox"/> Y <input checked="" type="checkbox"/> N
g)	Jaundice, intestinal bleeding, ulcer, hernia, hepatitis, gastritis, colitis, diverticulitis, recurrent indigestion or any disease or disorder of the liver, stomach, pancreas, or intestines? <i>If, "Yes," please provide details below.</i>	<input type="checkbox"/> Y <input checked="" type="checkbox"/> N	<input type="checkbox"/> Y <input checked="" type="checkbox"/> N
h)	Kidney disease, albumin, blood or pus in urine, renal disease, dialysis, stone or any disease or disorder of the kidneys, bladder, prostate, urinary, breasts, or reproductive systems? <i>If, "Yes," please provide details below.</i>	<input type="checkbox"/> Y <input checked="" type="checkbox"/> N	<input type="checkbox"/> Y <input checked="" type="checkbox"/> N
i)	Arthritis, neuritis, rheumatism, gout, or any disease, disorder or injury to the muscles (includes strains and sprains), tendons, bones, back or joints, nerves, knees, wrists or other joints? <i>If, "Yes," please provide details below.</i>	<input type="checkbox"/> Y <input checked="" type="checkbox"/> N	<input type="checkbox"/> Y <input checked="" type="checkbox"/> N
j)	Any dizziness, vertigo, fainting, seizures, recurrent headache, or speech defect? <i>If, "Yes," please provide details below.</i>	<input type="checkbox"/> Y <input checked="" type="checkbox"/> N	<input type="checkbox"/> Y <input checked="" type="checkbox"/> N
k)	Any disease or disorder of the skin, lymph glands, eyes, ears, nose or throat? <i>If, "Yes," please provide details below.</i>	<input type="checkbox"/> Y <input checked="" type="checkbox"/> N	<input type="checkbox"/> Y <input checked="" type="checkbox"/> N
l)	Chronic fatigue, fibromyalgia, or Epstein-Barr virus? <i>If, "Yes," please provide details below.</i>	<input type="checkbox"/> Y <input checked="" type="checkbox"/> N	<input type="checkbox"/> Y <input checked="" type="checkbox"/> N
m)	C-section, miscarriage, or complication of pregnancy? <i>If, "Yes," please provide details below.</i>	<input type="checkbox"/> Y <input checked="" type="checkbox"/> N	<input type="checkbox"/> Y <input checked="" type="checkbox"/> N
n)	Any mental or physical disorder or disease not mentioned above? <i>If, "Yes," please provide details below.</i>	<input type="checkbox"/> Y <input checked="" type="checkbox"/> N	<input type="checkbox"/> Y <input checked="" type="checkbox"/> N

ADDITIONAL INFORMATION

If additional space is needed for any, "Yes," answers please use the space below.

Question	Detail	Primary Insured	Other Insured
25a	John Doe - being treated for high blood pressure, currently under control with medication.	<input checked="" type="checkbox"/>	<input type="checkbox"/>
		<input type="checkbox"/>	<input type="checkbox"/>
		<input type="checkbox"/>	<input type="checkbox"/>
25c	Mary Doe - being treated for asthma, currently under control with medication.	<input type="checkbox"/>	<input checked="" type="checkbox"/>
		<input type="checkbox"/>	<input type="checkbox"/>
		<input type="checkbox"/>	<input type="checkbox"/>

Life Insurance Application (page [7] of [12])

MEDICAL HISTORY QUESTIONS (Continued)

							Primary Insured	Other Insured
26. Has anyone proposed to be insured ever tested positive for exposure to the HIV (Human Immunodeficiency Virus) infection or been diagnosed as having ARC (AIDS-Related Complex) or AIDS (Acquired Immune Deficiency) caused by the HIV infection or other sickness or condition derived from such infection? <i>If, "Yes," please provide details below.</i>							<input type="checkbox"/> Y <input checked="" type="checkbox"/> N	<input type="checkbox"/> Y <input checked="" type="checkbox"/> N
27. Is anyone proposed to be insured currently bedridden or confined to any hospital, nursing home, or other medical facility? <i>If, "Yes," please provide details below.</i>							<input type="checkbox"/> Y <input checked="" type="checkbox"/> N	<input type="checkbox"/> Y <input checked="" type="checkbox"/> N
28. In the past 10 years, has anyone proposed to be insured:								
a) Been hospitalized or had surgery? <i>If, "Yes," please provide details below.</i>							<input type="checkbox"/> Y <input checked="" type="checkbox"/> N	<input type="checkbox"/> Y <input checked="" type="checkbox"/> N
b) Been hospitalized for high blood pressure, any mental or nervous disorder, asthma, or epilepsy? <i>If, "Yes," please provide details below.</i>							<input type="checkbox"/> Y <input checked="" type="checkbox"/> N	<input type="checkbox"/> Y <input checked="" type="checkbox"/> N
c) Had any electrocardiograms, x-rays, laboratory tests, treatments, or procedures? <i>If, "Yes," please provide details below.</i>							<input type="checkbox"/> Y <input checked="" type="checkbox"/> N	<input type="checkbox"/> Y <input checked="" type="checkbox"/> N
d) Been recommended to have any test, treatment, surgery or other procedure which has not been performed? <i>If, "Yes," please provide details below.</i>							<input type="checkbox"/> Y <input checked="" type="checkbox"/> N	<input type="checkbox"/> Y <input checked="" type="checkbox"/> N
e) Received medical care for any illness, disease, or injury that is not included in other answers? <i>If, "Yes," please provide details below.</i>							<input type="checkbox"/> Y <input checked="" type="checkbox"/> N	<input type="checkbox"/> Y <input checked="" type="checkbox"/> N
29. Is anyone proposed to be insured currently prescribed any medication? <i>If, "Yes," please provide details.</i>							<input checked="" type="checkbox"/> Y <input type="checkbox"/> N	<input checked="" type="checkbox"/> Y <input type="checkbox"/> N
Current Medication Name(s)	Condition or Disorder Medication Is Treating	Dosage	Frequency	Prescribing Physician	Beginning Date	Primary Insured	Other Insured	
Diovan	High blood Pressure	10mg	1 daily	Dr. J. Kline	1-2-2005	<input checked="" type="checkbox"/>	<input type="checkbox"/>	
Singulair	Asthma	10mg	1 daily	Dr. J. Kline	2-6-2006	<input type="checkbox"/>	<input checked="" type="checkbox"/>	
						<input type="checkbox"/>	<input type="checkbox"/>	
						<input type="checkbox"/>	<input type="checkbox"/>	
30. Has anyone proposed to be insured been prescribed medication in the past 5 years not previously mentioned? <i>If, "Yes," please provide details.</i>							<input type="checkbox"/> Y <input checked="" type="checkbox"/> N	<input type="checkbox"/> Y <input checked="" type="checkbox"/> N
Past Medication Name(s)	Condition or Disorder Medication Treated	Dosage	Frequency	Prescribing Physician	From (Date)	To (Date)	Primary Insured	Other Insured
							<input type="checkbox"/>	<input type="checkbox"/>
							<input type="checkbox"/>	<input type="checkbox"/>
							<input type="checkbox"/>	<input type="checkbox"/>
							<input type="checkbox"/>	<input type="checkbox"/>
31. Is anyone proposed to be insured currently pregnant? <i>If, "Yes," please provide details below.</i>							<input type="checkbox"/> Y <input checked="" type="checkbox"/> N	<input type="checkbox"/> Y <input checked="" type="checkbox"/> N

ADDITIONAL INFORMATION

If additional space is needed for any, "Yes," answers please use the space below.

Question	Detail	Primary Insured	Other Insured
		<input type="checkbox"/>	<input type="checkbox"/>
		<input type="checkbox"/>	<input type="checkbox"/>
		<input type="checkbox"/>	<input type="checkbox"/>
		<input type="checkbox"/>	<input type="checkbox"/>
		<input type="checkbox"/>	<input type="checkbox"/>
		<input type="checkbox"/>	<input type="checkbox"/>

Life Insurance Application (page [10] of [12])

[FRAUD WARNING NOTICES]

*Please review the fraud notice that applies in your state and sign this page.
If your state is not listed, please review the general FRAUD NOTICE and sign this page.*

FRAUD NOTICE: 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 may be a crime and may be subject to criminal and civil penalties.

AR, LA: 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.

CO: 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 life insurance policy or certificate holder or claimant for the purpose of defrauding or attempting to defraud the life insurance policy or certificate holder 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 regulatory services.

DC: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.

FL: Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.
_____ (Owner's Initials)

KY, OH: I understand that any person who, with intent to defraud, or knowing that he or she is facilitating a fraud against an insurer, submits an application containing a false or deceptive statement is guilty of insurance fraud.
_____ (Owner's Initials)

ME, TN, WA: 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 denial of insurance benefit.

NJ: Any person who includes any false or misleading information on an application for an insurance policy or certificate is subject to criminal and civil penalties.

OK: 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.

NM, PA: 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.]

Signed at (City and State) Anytown, USA	Date 9 / 2 / 2009
Signature of Primary Insured Age 15 or More John J. Doe	
Signature(s) of Additional Insured(s) Age 15 or More Mary E. Doe	
Signature of Owner(s) (If not the Primary Insured or if Primary Insured is less than Age 18)	

Life Insurance Application (page [11] of [12])

AUTHORIZATION

I (We) have read the questions and answers on this application. I (We) certify that to the best of my (our) knowledge and belief, the statements made in this application are: complete; true; and correctly recorded and are subject to the applicable **FRAUD WARNING** notice. I (We) agree that: a copy of this application will form a part of any life insurance contract issued; and that no agent can pass on insurability or modify any life insurance contract issued by OM Financial Life Insurance Company. I (We) also agree that, except as provided in this application's Conditional Receipt, if issued, no insurance will take effect unless and until both of the following conditions are satisfied during each proposed insured's lifetime and while each proposed insured's health is as stated in this application: (1) the life insurance contract is delivered to and accepted by the Owner; and (2) the full initial premium for the mode of payment chosen is paid at our Home Office. I (We) acknowledge that I (we) have received, read and understand the notices required by the Medical Information Bureau, and the Federal Fair Credit Reporting Act regarding investigative consumer reports. I (We) understand that if requested, I (we) may inspect or obtain a copy of this report.

In order to evaluation my application for life insurance, I (We) authorize any licensed physician, medical practitioner, hospital, clinic, the Veterans Administration, laboratory or other medical or medically related facility, the Medical Information Bureau, Inc., insurance companies, a consumer reporting agency, prescription records, Pharmacy Benefit Manager, and my employer to give to OM Financial Life Insurance Company, its reinsurers, or other designee, medical and other information which may be pertinent to the evaluation regarding me or any member of my family who is applying for life insurance.

I (We) understand such information may concern my (our): physical history, condition and treatment, including drug or alcohol abuse or mental health information protected by Federal law; general character, habits, reputation, mode of living; financial status, income; occupation; avocations, sports, hobbies and aviation activities.

I (We) also authorize OM Financial Life Insurance Company to obtain an investigative consumer report on me and/or any member of my family who is also applying for life insurance. I (We) understand that I am (we are) entitled to be interviewed by any consumer reporting agency which may be requested to prepare such a report as long as I (we) can reasonably be contacted during normal business hours. Check here if interview is requested:

I (We) understand that if my coverage includes the Accelerated Benefit Rider and I am later diagnosed with a terminal illness, terminal condition, or specified medical condition as defined in the rider, I may receive up to 50% of the life insurance death benefit. Since I would receive a portion of my benefits early, the amount payable at my death will be reduced. There is no premium charged for this rider. I (We) understand that receipt of benefits may be taxable, and that OM Financial Life Insurance Company recommends consultation with a tax advisor prior to exercising this benefit.

I (We) understand that if I am (we are) purchasing a life event simplified term life insurance product, the life event information I (we) supplied will be relied upon to determine my (our) eligibility for that product in conjunction with my (our) health information. I (We) understand that any inaccurate information regarding my (our) life event may result in a denial, rating, or rescission of my (our) insurance coverage.

I (We) authorize OM Financial Life Insurance Company and/or its reinsurer(s); or other designee to release information in my (our) file to other insurance companies to which I (we) may apply for life or health insurance coverage or to which a claim may be submitted.

This Authorization will be valid from the date signed for a period of 24 months unless revoked in writing by me (us) and delivered to OM Financial Life Insurance Company. A photographic copy of this Authorization will be as valid as the original; I (we), or any of my (our) representatives are entitled to receive a copy of this Authorization. Failure to sign or revocation of this authorization may impair the ability of a regulated insurance agency to evaluate claims or process applications and may be a basis for denying an application or claim for benefits.

I (We) understand that the information obtained by use of this Authorization will be used to determine eligibility for insurance and/or benefits.

For any fixed index life insurance issued, I (we) understand that I am (we are) purchasing fixed indexed life insurance. I (We) have received a copy of the indexed disclosure material for the fixed indexed life insurance applied for. I (We) understand that while the values of this life insurance may be affected by an external index, the life insurance does not directly participate in any stock, bond, or equity investments and that any values shown, other than guaranteed minimum values, are not guarantees, promises, or warranties.

Life Insurance Application (page [12] of [12])

AUTHORIZATION *(Continued)*

[CERTIFICATION: I (We) certify, under penalties of perjury, that I am (we are) the person(s) identified in this application, I am a (we are) U.S. Citizen(s) or resident(s) of the U.S. (includes U.S. resident aliens) and that the taxpayer identification number(s) is (are) correct. I (We) understand that federal law requires all financial institutions to obtain identity information in order to verify my (our) identity(ies) and I (we) authorize its use for this purpose. This information includes, but is not limited to, the name(s), residential address(es), date(s) of birth, Social Security or taxpayer identification number(s); and any other information necessary to sufficiently verify identity(ies). I (we) understand that failure to provide this information could result in the application be rejected. Third party sources may be used to verify the information provided.]

Signed at (City and State) Anytown, USA	Date 9/2/2009
Signature of Primary Insured Age 15 or More John J. Doe	
Signature(s) of Additional Insured(s) Age 15 or More Mary E. Doe	
Signature of Owner(s) (If not the Primary Insured or if Primary Insured is less than Age 18)	

AGENT CERTIFICATION

1) I have asked the questions contained in this application of the proposed Insured(s) and Owner and duly recorded the answers; 2) to the best of my knowledge there is nothing affecting the insurability of any persons proposed for insurance as stated in this application; 3) if the initial premium was paid with the application, I have remitted it to OM Financial Life Insurance Company and delivered a Conditional Receipt to the Owner; 4) if Disclosure Statements are required by the state, I have given them to the applicant; 5) I have witnessed the signatures on this application; 6) I have verified the identity of the Primary Insured, Other Insured, and Owner, if other than the Primary Insured, through examination of a state or federal government photo identification card provided by the Primary Insured, Other Insured and/or Owner, such as a driver's license or passport.

To the best of my knowledge, this application does replace does not replace existing life insurance or annuities.

If so, will this replacement be considered a 1035 exchange? Yes No

I certify that the indexed disclosure material has been presented to the Applicant. A copy was provided to the Applicant. I have not made statements which differ in any significant manner from this material. I have not made any promises or guarantees about the future value of any non-guaranteed elements.

Signature of Agent/Producer David D. Roe		Print Agent/Producer Name David D. Roe		Date 9/2/2009
Agent /Producer OMFLIC Number 123456789	Agent/Producer State License Number (FL)	Agent/Producer Phone Number xxx xxx-xx67	Agent/Producer Fax Number xxx xxx-xx68	
If Bank Representative:	Name of Financial Institution	Branch Number	Employee Number	

Life Insurance Application

Leave this page with the applicant if cash is paid with the application.

LIFE INSURANCE CONDITIONAL RECEIPT

PLEASE READ THIS CAREFULLY.

All premium checks must be made payable to: OM Financial Life Insurance Company.

Do not make check payable to agent/producer or leave payee blank.

In the event of any adverse underwriting decision, OM Financial Life Insurance Company will mail notice to the applicant of the rejection of the application for insurance and refund the premium, thereby terminating this receipt.

Received from John J. Doe a check in the amount of \$100.00 paid with this life insurance application to OM Financial Life Insurance Company. The application bears the same date as this Conditional Receipt. I have advised each proposed insured of the terms, conditions, and limitations of this Conditional Receipt.

No agent, producer, or broker is authorized to alter the terms of this Conditional Receipt, waive any requirements, terms or conditions, or to pass on insurability.

Date at (City and State) <u>Anytown, USA</u>	On (Date) <u>9/2/09</u>	Agent/Producer Signature <u>David D. Roe</u>
---	----------------------------	---

If there is any materially false information or misrepresentation in any request for life insurance, application, telephone or other interviews, or medical examinations or tests submitted to OM Financial Life Insurance Company related to any person proposed to be insured, this Conditional Receipt and any coverage provided thereby will be void from the beginning.

The life insurance contract you have applied for will not provide insurance coverage unless and until a contract is delivered to you. However, subject to the terms, conditions, and limitations of this Conditional Receipt, conditional insurance as provided by the terms and conditions of the life insurance applied for will become effective prior to contract delivery under the following conditions.

This Conditional Receipt will provide life insurance coverage beginning on the effective date. The Effective Date is the latest date of the following events:

- Signing of all parts of this Application, including any Supplemental Questionnaires, Addenda, or Amendment to this Application, and completion of any medical examination portion of this Application;
- The date requested in this Application that is agreed to by OM Financial Life Insurance Company;
- The full initial premium for the mode of payment chosen is received at our Home Office within the lifetime of the proposed insured(s); or
- Any additional information required by us, including attending physician statement/report, is received at our Home Office.

This Conditional Receipt will provide no life insurance coverage unless and until each of the following Requirements are fulfilled during the lifetime of the persons(s) proposed to be insured:

- As of the Effective Date hereinabove defined, each person proposed to be insured is found to be insurable exactly as applied for in this Application submitted to OM Financial Life Insurance Company and in accordance with our underwriting rules and standards, without any modification of the life insurance applied for, amount of life insurance coverage, or premium rate;
- The payment taken with this Application is not less than the full initial premium for the mode of payment chosen in the Application and is honored immediately upon presentation. If the above amount is uncollectible, this Conditional Receipt is void;
- All medical examinations, tests, and other screenings required by OM Financial Life Insurance Company are completed, with results received at our Home Office within 60 days from the date of completion of the Application; and
- As of the Effective Date, the health and all factors affecting the insurability of each person proposed to be insured are as stated in the Application.

If all requirements are not met, or the person(s) proposed to be insured die(s) by suicide or self-inflicted injury, while sane on insane, the liability of OM Financial Life Insurance Company will be limited to a full refund to the Applicant of the premium payment received by OM Financial Life Insurance Company.

This Conditional Receipt will terminate on the earliest of the following:

- 60 days from the date this Conditional Receipt was executed;
- The date OM Financial Life Insurance Company mails notice to the Applicant of an adverse underwriting decision and declination of the Application for insurance;
- The day before the date insurance becomes effective under the life insurance applied for; or
- The date OM Financial Life Insurance Company offers insurance other than as applied for.

The aggregate amount of life insurance provided for the life of any one person proposed to be insured which may become effective under this Conditional Receipt and any other Conditional Receipt issued by OM Financial Life Insurance Company on the life of that person, shall be the lesser of the amount applied for or [\$500,000].

This Conditional Receipt provides no insurance for riders or additional benefits.

Life Insurance Application

Leave this page with the applicant.

INVESTIGATIVE CONSUMER REPORT PRE-NOTIFICATION

To Primary Insured And Other Persons Proposed To Be Insured, If Any

We may ask for an investigative consumer report in connection with your application. In addition, a report may be requested to update our records if you apply for more coverage. You may ask to be interviewed when such a report is being prepared. We will, upon written request, let you know whether a report was requested and, if so, give you the name, address, and telephone number of the agency making the report. By contacting that agency and giving proper identification, you may inspect or obtain a copy of the report.

Typically, the report will contain information regarding character, general reputation, personal characteristics, health, job, and finances. When applicable, it will contain information on your: past and present employment records (including job duties); driving record; health history; use of alcohol or drugs; sports, hobbies, or aviation activities; and marital status. This report will not be used by us or our reinsurers to determine the sexual orientation of any person on whose life an application for insurance has been made. The agency may get information by talking to you or members of your family, business associates, financial sources, neighbors, and others you know.

MEDICAL INFORMATION BUREAU, INC., (MIB) PRE-NOTIFICATION

To Primary Insured And Other Persons Proposed To Be Insured, If Any

Information regarding your insurability will be treated as confidential. We or our reinsurer(s) may, however, make a brief report thereon to MIB, a not-for-profit membership organization of life 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, the MIB, upon request, will supply such company with the information in its file.

Upon receipt of a request from you, the MIB will arrange disclosure of any information it may have in your file. If you question the accuracy of information in the MIB's file, you may contact the MIB and seek a correction in accordance with the procedures set forth in the Federal Fair Credit Reporting Act.

The address of MIB's information office is: [MIB, Inc.; 50 Braintree Hill Park; Suite 400; Braintree, MA 02184-8734]; telephone number [(866) 692-6901]; hearing impaired [TTY (866) 346-3642]. The MIB information office may also be contacted at: [www.infoline@mib.com]; or [www.mib.com].

We or our reinsurer(s) may also release information in our file to other insurance companies to which you may apply for life or health insurance coverage or to which a claim may be submitted.

OM ICR/MIB (08-2009)

Life Insurance Application

BANK DRAFT PLAN

Please attach a voided check here in addition to your initial premium.

BANK DRAFT PLAN: EFT PREMIUM AUTHORIZATION TO MY BANK

I authorize the payment of debits drawn on my account payable OM Financial Life Insurance Company, provided there are sufficient funds in said account. I agree that if any such debit be dishonored, OM Financial Life Insurance Company has the right to debit my account the following month for the dishonored debit as well as the scheduled debit for that month. I further agree that if any debit be dishonored, OM Financial Life Insurance Company shall be under no liability in the event the dishonored debit results in the forfeiture of insurance. This authority shall remain in effect until revoked by me in writing and until OM Financial Life Insurance Company actually receives such notice of revocation.

By checking this box, I authorize OM Financial Life Insurance Company to draft my initial premium upon approval of my application.

Signature As It Appears On Bank Records	Date
John J. Doe	9/2/09

OM BDP (08-2009)

SERFF Tracking Number: MCHX-126301525 State: Arkansas
 Filing Company: OM Financial Life Insurance Company State Tracking Number: 43482
 Company Tracking Number: OMAD 6228 (08-2009)
 TOI: L08 Life - Other Sub-TOI: L08.000 Life - Other
 Product Name: OMAD 6228 (08-2009) Individual Life Insurance Appl
 Project Name/Number: OMAD 6228 (08-2009) Individual Life Insurance Application/OMAD 6228 (08-2009) Individual Life Insurance Application

Supporting Document Schedules

	Item Status:	Status Date:
<p>Satisfied - Item: Flesch Certification Comments: Attachments: AR Readability Certification.PDF Certification of Compliance Rule 19.PDF Certification of Compliance 23-79-138 and R&R 49.PDF Certification of Compliance Bulletin 11-83.PDF</p>		
<p>Satisfied - Item: Application Comments: See forms schedule.</p>		
<p>Satisfied - Item: Submission Letter Comments: Attachment: Submission Letter.PDF</p>		
<p>Satisfied - Item: Authorization Letter Comments: Attachment: Authorization Letter.PDF</p>		

SERFF Tracking Number: MCHX-126301525 State: Arkansas
Filing Company: OM Financial Life Insurance Company State Tracking Number: 43482
Company Tracking Number: OMAD 6228 (08-2009)
TOI: L08 Life - Other Sub-TOI: L08.000 Life - Other
Product Name: OMAD 6228 (08-2009) Individual Life Insurance Appl
Project Name/Number: OMAD 6228 (08-2009) Individual Life Insurance Application/OMAD 6228 (08-2009) Individual Life Insurance Application
Satisfied - Item: Form Listing
Comments:
Attachment:
Form Listing.PDF

Item Status:

**Status
Date:**

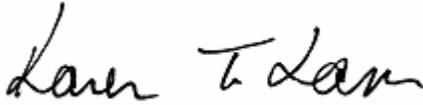
Satisfied - Item: Statement of Variability
Comments:
Attachment:
Statement of Variability.PDF

STATE OF ARKANSAS
READABILITY CERTIFICATION

COMPANY NAME: OM Financial Life Insurance Company

This is to certify that the form(s) referenced below has achieved a Flesch Reading Ease Score as indicated below and complies with the requirements of Ark. Stat. Ann. Section 66-3251 through 66-3258, cited as the Life and Disability Insurance Policy Language Simplification Act.

Form Number	Score
OMAD 6228 (08-2009)	55.3

Signed: 
Name: Karen T. Lam
Title: Vice President – Product and Advertising Compliance
Date: 9/11/09

Certificate of Compliance with Arkansas Rule and Regulation 19

Insurer: OM Financial Life Insurance Company

Form Number(s): OM 6228 (08-2009)

I hereby certify that to the best of my knowledge and belief, the filing above meets all applicable Arkansas requirements including the requirements of Rule and Regulation 19.



Signature of Company Officer

Karen T. Lam

Name

Vice President - Product and Advertising
Compliance

Title

9/11/09

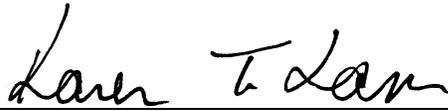
Date

CERTIFICATE OF COMPLIANCE

Insurer: OM Financial Life Insurance Company

Form Numbers: OM 6228 (08-2009)

I hereby certify that the filing above meets all applicable Arkansas requirements including Regulation 49 (Life and Health Guaranty Fund Notice) and Ark. Code Ann. 23-79-138 and Bulletin 11-88 (Consumer Information Notice).



Signature of Company Officer

Karen T. Lam

Name

Vice President - Product and
Advertising Compliance

Title

9/11/09

Date

STATE OF ARKANSAS

Certification

Name of Company: OM Financial Life Insurance Company

The above named company certifies that Life Insurance Application Form OM 6228 (08-2009) has been reviewed and complies with Arkansas Insurance Department Guidelines identified in its Bulletin No. 11-83.



Signature

Karen T. Lam

Print or Type Name

Vice President - Product and Advertising Compliance

Title

350 South Main Street Suite 103
Doylestown, PA 18901
Ph# 215-230-7960
Fax # 215-230-7961
Email:mcr@mchughconsulting.com
www.mchughconsulting.com

.....

McHugh Consulting Resources, Inc.

September 11, 2009

via SERFF

Group Number: 2598
NAIC #:63274
FIN #: 52-6033321

Jay Bradford
Insurance Commissioner
Arkansas Department of Insurance
Compliance - Life and Health
1200 West Third Street
Little Rock, AR 72201-1904

**RE: Filing on Behalf of OM Financial Life Insurance Company
New Life Insurance Application Form Filing for Approval, OMAD 6228 (08/09)**

Dear Commissioner Bradford:

McHugh Consulting Resources, Inc. has been requested to file the enclosed forms on behalf of OM Financial Life Insurance Company. We have provided an authorization letter for your files.

Enclosed for your review and approval is the above captioned life insurance application form. The form is new and does not replace any forms on file with the Department.

This form will also be available electronically so that it may be printed from a computer by an agent for completion and signature.

The form is in final printed format subject only to changes in formatting, font style, margins, page numbers, ink and paper stock. Printing standards will never be less than those required by law.

Thank you for your time and consideration of this filing. If you have any questions or comments, please do not hesitate to contact me.

Sincerely,



Betty Dabrowski
Consultant
215-230-7960
mcr@mchughconsulting.com

Attachments

*Insurance Compliance Services...
Your Outsourcing Resource*

.....



Old Mutual Financial Network
1001 Fleet Street
Baltimore, Maryland 21202
PH 410.895.0100
1.888.697.LIFE
FX 410.895.0162
www.oldmutualus.com

January 1, 2009

NAIC Company Code: 63274

To: The Insurance Commissioner

Re: Authorization

This letter, or a copy thereof, will authorize the consulting firm of McHugh Consulting Resources, Inc., 350 South Main, Suite 103 Doylestown, PA 18901, to represent this Company in matters before the Insurance Department.

This Authorization shall be valid until revoked by us.

OM Financial Life Insurance Company

BY:

Karen T. Lam, FLMI, AIRC
Manager, Product Compliance

OM FINANCIAL LIFE INSURANCE COMPANY

FORM LISTING

Form Number	Description
OMAD 6228 (08-2009)	Life Insurance Application

Statement of Variability

Application Form Number: OMAD 6228 (08-2009)

Variable Item	Need for Variability	Anticipated Frequency of Change	Time At Which These Items Become Fixed	Anticipated Range
Page 1				
Page Number (this item applies to all pages on this form).	May change if additional information is required by federal or state law and those changes increase the number of pages.	Currently, there is no anticipation of changing this item.	This item becomes fixed when the application is printed.	The range for this item is open to any language provided by the company or by federal or state law.
Primary Insured Section				
The following items will change with each Primary Insured, Other Insured and Owner(s)				
Name	This item varies according to each new application's Primary Insured, Other Insured, and Owner(s).	Varies on each application.	This item becomes fixed at issue for the Primary Insured.	The Primary Insured may not be changed after issue. However, Other Insured's and the Owner(s) may be changed after issue.
Address	This item varies according to each new application's Primary Insured, Other Insured, and Owner(s).	Varies on each application.	This item does not become fixed at issue.	The range for this item is open to any address.
Social Security Number	This item varies according to each new application's Primary Insured, Other Insured, and Owner(s).	Varies on each application.	This item becomes fixed at issue.	The range for this item is open to the social security numbers issued by the U.S.A.
Birth Date and Sex	This item varies according to each new application's Primary Insured, Other Insured, and Owner(s).	Varies on each application.	This item becomes fixed at issue.	May not be changed after the Date of Issue unless the Primary or Other Insured(s) age and/or sex have been misstated on the application.
Place of Birth	This item varies according to each new application's Primary Insured, Other Insured, and Owner(s).	Varies on each application.	This item becomes fixed at issue.	This item may not be changed after issue unless it has been misstated on the application.

Statement of Variability

Application Form Number: OMAD 6228 (08-2009)

Variable Item	Need for Variability	Anticipated Frequency of Change	Time At Which These Items Become Fixed	Anticipated Range
Page 1, Primary Insured Section (Continued)				
Height and Weight	These items vary according to each new application's Primary and Other Insured.	Varies on each application.	These items do not become fixed at issue.	The range for these items is open to any height and weight and may be changed after issue.
Driver's License Number and Issue State; Other Identification Number (if Driver's License not used); State/Province and Country of Issue; Type of Identification	These items vary according to each new application's Primary Insured, Other Insured, and Owner(s).	Varies on each application.	These items become fixed at issue.	The range for these items is open to any Driver's License Number and Issue State; Other Identification Number (if Driver's License not used); State/Province and Country of Issue; and Type of Identification used.
Employment Information; Occupation and Duties; Number of Years with Current Employer; Earned Annual Income, Email Address; Daytime Phone Number; Evening Phone Number; Cell Phone Number; and Best Time to Call	These items vary according to each new application's Primary Insured, Other Insured, and Owner(s).	Varies on each application.	These items do not become fixed at issue.	The range for these items is open to any employer information and may be changed after issue.
Owner(s)	This item varies according to each new application's Owner.	Varies on each application.	This item does not become fixed at issue.	The range for this item is open and may change if Ownership is changed prior to or at death of the Owner.
Secondary Addressee	This item varies according to each new application and allows a secondary addressee be named to receive lapse notices. However this information is currently required in FL, ME and VT.	Varies on each application.	This item does not become fixed at issue.	The range for this item is open to any secondary addressee provided by the Owner to receive any lapse notices.

Statement of Variability

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Variable Item	Need for Variability	Anticipated Frequency of Change	Time At Which These Items Become Fixed	Anticipated Range
Page 2				
Beneficiary Designation – Primary Insured Section				
Primary Beneficiary (ies) Full Name; Address; Date of Birth; Social Security Number; Relationship to Primary Insured; and Percentage Share of Life Insurance Proceeds	These items vary according to each new application's Primary Beneficiary(ies).	Varies on each application.	These items do not become fixed at issue.	The range for these items is any primary beneficiary(ies) that have a vested interest in the Primary Insured. These items may be changed after issue.
Contingent Beneficiary (ies) Full Name; Address; Date of Birth; Social Security Number; Relationship to Primary Insured; and Percentage Share of Life Insurance Proceeds	These items vary according to each new application's Contingent Beneficiary(ies).	Varies on each application.	These items do not become fixed at issue.	The range for these items is any contingent beneficiary(ies) that have a vested interest in the Primary Insured. These items may be changed after issue.
Existing Insurance Section				
The Insurance Company; Type of Policy; it's Policy or Certificate Number; Life Insurance or Disability Income Amount; Accidental Death Benefit Amount; ADB Amount; Year Issued; Replacement; and 1035 Exchange	These items vary according to each new application.	Varies on each application.	These items become fixed at issue.	The range for these items is open to any insurance company that this application and policy, if issued, will be replacing or exchanging.

Statement of Variability

Application Form Number: OMAD 6228 (08-2009)

Variable Item	Need for Variability	Anticipated Frequency of Change	Time At Which These Items Become Fixed	Anticipated Range
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Page 2 (Continued)

Existing Insurance Section (Continued)

Existing Insurance questions	These items vary according to the answers to the questions given by the Primary and Other Insured.	Varies on each application.	These items become fixed at issue.	The ranges for the responses to these questions are, "Yes," or, "No," with space for explanations for any, "Yes," answers.
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Pages 3 and 4

Statement of Intent Section

Stranger Oriented Life Insurance (STOLI) questions.	<p>These items vary according to the answers to these questions given by the applicant.</p> <p>The section is also bracketed in the event the questions are changed by any future federal or state laws.</p>	<p>Varies on each application.</p> <p>Currently, there is no anticipation of changing these items.</p>	<p>These items become fixed at issue.</p> <p>These items become fixed at the time the application is printed.</p>	<p>The ranges for the responses to these questions are, "Yes," or, "No," with space for explanations for any, "Yes," answers.</p> <p>The ranges for these questions are open to language developed by the company or by federal and/or state laws.</p>
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Page 5

Life Insurance Information section

Product Name	This item varies according to the product the applicant is applying for.	Varies on each application.	This item becomes fixed at issue.	The range for this item is open to the life insurance products sold by the company.
Amount of Insurance	This item varies according to the amount of insurance the applicant is applying for for the Primary and/or Other Insured.	Varies on each application.	This item does not become fixed at issue.	<p>The range for this item is open to the amount of insurance the company is willing to underwrite.</p> <p>Currently there is no maximum limit.</p>
Initial Premium	This item varies according to the Insured's premium class and the periodic payment mode selected at application.	Varies on each application.	This item becomes fixed at issue.	The range for this item is open to the planned premiums and modes used by the company for each Insured's premium class.

Statement of Variability

Application Form Number: OMAD 6228 (08-2009)

Variable Item	Need for Variability	Anticipated Frequency of Change	Time At Which These Items Become Fixed	Anticipated Range
Page 5 (Continued)				
Life Insurance Information section (Continued)				
Premium Class	This item varies according to the premium class selected by the Owner for the Insured on the application.	Varies on each application.	This item becomes fixed at issue.	<p>The range for this item may vary by any other premium class(es) added to this product or developed in the future.</p> <p>The range for this item is:</p> <ul style="list-style-type: none"> • Tobacco; or • Nontobacco.
Term	This item varies according to the term selected at application.	Varies on each application.	This item becomes fixed at issue.	<p>The range for this item may vary by any other premium class(es) added to this product or developed in the future.</p> <p>The range for this item is:</p> <ul style="list-style-type: none"> • Level; or • Decreasing.
Term Period	This item varies according to the term periods offered by the company.	Varies on each application.	This item becomes fixed at issue.	<p>The range (term periods) for this item is:</p> <ul style="list-style-type: none"> • 5-10; • 10-10; • 5-15; • 15-15; • 5-20; • 20-20; • 5-25; • 25-25; • 15-30; • 30-30.

Statement of Variability

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Variable Item	Need for Variability	Anticipated Frequency of Change	Time At Which These Items Become Fixed	Anticipated Range
Page 5 (Continued)				
Life Insurance Information section (Continued)				
Term Premium Guarantee Period	This item varies according to the guarantee periods offered by the company.	Varies on each application.	This item becomes fixed at issue.	<p>The range (guarantee periods) for this item is:</p> <ul style="list-style-type: none"> • 5-10; • 10-10; • 5-15; • 15-15; • 5-20; • 20-20; • 5-25; • 25-25; • 15-30; • 30-30.
UL	This item varies according to the death benefit option selected at application.	Varies on each application.	This item does not become fixed at issue.	<p>The range for this item may vary by any other death benefit options added to this product or developed in the future.</p> <p>The range for this item is a choice between:</p> <ul style="list-style-type: none"> • Level; or • Increasing. <p>The death benefit option may be changed after issue.</p>
UL Life Insurance Qualification Test	This item varies according to the life insurance qualification test selected at application	Varies on each application.	This item becomes fixed at issue.	<p>The range for this item is a choice between the:</p> <ul style="list-style-type: none"> • Guideline Premium Test; or • the Cash Value Accumulation Test. <p>The life insurance qualification test may vary by any other life insurance qualification test developed in the future according to federal and state laws.</p>

Statement of Variability

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Variable Item	Need for Variability	Anticipated Frequency of Change	Time At Which These Items Become Fixed	Anticipated Range
Page 5 (Continued)				
Life Insurance Information section (Continued)				
UL Planned Premium	This item varies according to the Insured's premium class and the periodic payment mode selected at application.	Varies on each application.	This item becomes fixed at issue.	The range for this item is open to the planned premiums and modes used by the company.
UL Initial Allocation % for Fixed Indexed Products	This item varies according to the allocation percentages selected at application.	Varies on each application.	This item does not become fixed at issue. This item may be changed on each premium segment anniversary.	<p>The range for this item is the following:</p> <ul style="list-style-type: none"> • Fixed Interest Option; • The Fixed Index Interest Option; and/or • Any other interest crediting option offered by rider at or after issue. <p>The total percentages must add up to 100%.</p>
Payment Mode	This item varies according to the payment mode selected at application.	Varies on each application.	This item does not become fixed at issue. This item may be changed by written request.	<p>The range for this item is the following payment modes:</p> <ul style="list-style-type: none"> • Annual; • Semi-Annual; • Quarterly; • Monthly Bank Draft; • Bi-Weekly Bank Draft; • Government Allotment; • Payroll Deduction; or • Other.
Payment in Exchange for Conditional Receipt	This item varies according to the payment made in exchange for the Conditional Insurance Receipt.	Varies on each application.	This item becomes fixed at the time of application if payment is made at the time of application.	The range for this item is open to any amount of premium paid at the time of application to cover an aggregate amount of the lesser of the amount of insurance applied for or \$500,000.

Statement of Variability

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Variable Item	Need for Variability	Anticipated Frequency of Change	Time At Which These Items Become Fixed	Anticipated Range
Page 5 (Continued)				
Life Insurance Information section (Continued)				
Credit Card Information	This item varies according to whether the first premium is made by credit card.	Varies on each application.	This item does not become fixed at the time of application.	The range for this item is open to the following: <ul style="list-style-type: none"> • Visa; or • MasterCard. However, other credit cards may be accepted in the future.
Credit Card Account Number	This item varies according to the credit card used for the transaction.	Varies on each application.	This item does not become fixed at the time of application. The credit card used may be changed at any time before processing.	The range for this item is open to the numbering conventions used by the credit card company.
Credit Card Expiration Date	This item varies according to the credit card used for the transaction.	Varies on each application.	This item becomes fixed at the time of application. However, if the credit card used for the transaction is changed, the expiration date may also change.	The range for this item is open to the dates used by the credit card company.
Credit Card Signature to Authorize Credit Card Charge	This item varies according to the credit card used for the transaction.	Varies on each application.	This item becomes fixed at the time of application.	The range for this item is open to the signature for the credit card transaction.

Statement of Variability

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Variable Item	Need for Variability	Anticipated Frequency of Change	Time At Which These Items Become Fixed	Anticipated Range
Page 5 (Continued)				
Additional Benefits Section				
Primary Insured Disability Income Rider	This item varies according to whether the disability income rider is selected at application.	Varies on each application.	This item may be selected at issue only.	The range for this item is selecting the rider or not selecting the rider.
Primary Insured Disability Income Rider Class	This item varies according to the Primary Insured's class.	Varies on each application.	This item may be changed after issue.	Currently, the range for this item is: <ul style="list-style-type: none"> • <u>Class 1</u>, which includes professional, technical, managerial, and office duty; • <u>Class 2</u>, which includes supervisory and other skilled clerical and technical people; • <u>Class 3</u>, nonhazardous light manual workers; and • <u>Class 4</u>, hazardous work with heavy manual labor or using heavy equipment.
Primary Insured Disability Income Rider Amount of Monthly Income	This item varies according to the Primary Insured's monthly income if this rider is selected at application.	Varies on each application.	This item may be changed after issue.	Currently, the range for this item is the lesser of: <ul style="list-style-type: none"> • 66 2/3 of the Primary Insured's Monthly Income; or • \$3,000 monthly.
Primary Insured Disability Income Rider Waiting Period and Benefit Period	This item varies according to the waiting and benefit period selected at application.	Varies on each application.	This item may not be changed after issue.	Currently, the range for this item is: <ul style="list-style-type: none"> • 3 month waiting period, 2 year benefit; or • 6 month waiting period, 5 year benefit.
Other Insured Disability Income Rider	This item varies according to whether the disability income rider is selected at application.	Varies on each application.	This item does not become fixed at issue.	The range for this item is selecting the rider or not selecting the rider.

Statement of Variability

Application Form Number: OMAD 6228 (08-2009)

Variable Item	Need for Variability	Anticipated Frequency of Change	Time At Which These Items Become Fixed	Anticipated Range
Page 5 (Continued)				
Additional Benefits Section				
Other Insured Disability Income Rider Class	This item varies according to the Other Insured's class.	Varies on each application.	This item may be changed after issue.	Currently, the range for this item is: <ul style="list-style-type: none"> • <u>Class 1</u>, which includes professional, technical, managerial, and office duty; • <u>Class 2</u>, which includes supervisory and other skilled clerical and technical people; • <u>Class 3</u>, nonhazardous light manual workers; and • <u>Class 4</u>, hazardous work with heavy manual labor or using heavy equipment.
Other Insured Disability Income Rider Amount of Monthly Income	This item varies according to the Other Insured's monthly income if this rider is selected at application.	Varies on each application.	This item may be changed after issue.	Currently, the range for this item is the lesser of: <ul style="list-style-type: none"> • 66 2/3 of the Primary Insured's Monthly Income; or • \$3,000 monthly.
Other Insured Disability Income Rider Waiting Period and Benefit Period	This item varies according to the waiting and benefit period selected at application.	Varies on each application.	This item may not be changed after issue.	Currently, the range for this item is: <ul style="list-style-type: none"> • 3 month waiting period, 2 year benefit; or • 6 month waiting period, 5 year benefit.
Primary Insured Accident Only Disability Income Rider	This item varies according to whether the disability income rider is selected at application.	Varies on each application.	This item may be selected at issue only.	The range for this item is selecting the rider or not selecting the rider.

Statement of Variability

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Variable Item	Need for Variability	Anticipated Frequency of Change	Time At Which These Items Become Fixed	Anticipated Range
Page 5 (Continued)				
Additional Benefits Section				
Primary Insured Accident Only Disability Income Rider Class	This item varies according to the Primary Insured's class.	Varies on each application.	This item may be changed after issue.	The range for this item is a sudden, unforeseen and unexpected event that occurs without the Primary Insured's intent which results in an injury to the Primary Insured.
Primary Insured Accident Only Disability Income Rider Amount of Monthly Income	This item varies according to the Primary Insured's monthly income if this rider is selected at application.	Varies on each application.	This item may be changed after issue.	The range for this item is the lesser of: <ul style="list-style-type: none"> • 1.5% of the life insurance amount; • The insured's monthly mortgage, property tax, and insurance amount; • 66 2/3 of the Primary Insured's Monthly Income; or • \$3,000 monthly.
Primary Insured Accident Only Disability Income Rider Waiting Period and Benefit	This item varies according to the waiting and benefit period selected at application.	Varies on each application.	This item may not be changed after issue.	The range for this item is: <ul style="list-style-type: none"> • 3 month waiting period, 2 year benefit.
Other Insured Accident Only Disability Income Rider	This item varies according to whether the disability income rider is selected at application.	Varies on each application.	This item may be selected at issue only.	The range for this item is selecting the rider or not selecting the rider.
Other Insured Accident Only Disability Income Rider Class	This item varies according to the Other Insured's class.	Varies on each application.	This item may be changed after issue.	The range for this item is a sudden, unforeseen and unexpected event that occurs without the Other Insured's intent which results in an injury to the Other Insured.

Statement of Variability

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Variable Item	Need for Variability	Anticipated Frequency of Change	Time At Which These Items Become Fixed	Anticipated Range
Page 5 (Continued)				
Additional Benefits Section				
Other Insured Accident Only Disability Income Rider Amount of Monthly Income	This item varies according to the Other Insured's monthly income if this rider is selected at application.	Varies on each application.	This item may be changed after issue.	Currently, the range for this item is the lesser of: <ul style="list-style-type: none"> • 1.5% of the life insurance amount; • The insured's monthly mortgage, property tax, and insurance amount; • $66 \frac{2}{3}$ of the Primary Insured's Monthly Income; or • \$3,000 monthly.
Other Insured Accident Only Disability Income Rider Waiting Period and Benefit	This item varies according to the waiting and benefit period selected at application.	Varies on each application.	This item may not be changed after issue.	Currently, the range for this item is: <ul style="list-style-type: none"> • 3 month waiting period, 2 year benefit.
Primary Insured Accelerated Benefit Rider	This item varies according to whether the rider is selected at application.	Varies on each application.	This item may be selected at issue only.	The range for this item is selecting the rider or not selecting the rider.
Primary Insured Accidental Death Benefit Rider	This item varies according to whether the rider is selected at application.	Varies on each application.	This item may be selected at or after issue.	The range for this item is selecting the rider or not selecting the rider.
Primary Insured Accidental Death Benefit Rider Amount of ADB	This item varies according to whether the rider is selected at application.	Varies on each application.	This item may be selected at or after issue.	The range for this item is the lesser of: <ul style="list-style-type: none"> • Up to the face amount of the insurance in effect; or • \$250,000.
Primary Insured Critical Illness/Condition/ Specified Medical Condition Rider	This item varies according to whether the rider is selected at application.	Varies on each application.	This item may be selected at issue only.	The range for this item is the lesser of: <ul style="list-style-type: none"> • Up to one half of face amount of the insurance in effect; or • \$250,000.

Statement of Variability

Application Form Number: OMAD 6228 (08-2009)

Variable Item	Need for Variability	Anticipated Frequency of Change	Time At Which These Items Become Fixed	Anticipated Range
Page 5 (Continued)				
Additional Benefits Section				
Primary Insured Return of Premium Rider	This item varies according to whether the rider is selected at application.	Varies on each application.	This item may be selected at issue only.	<p>The range for this item is:</p> <ul style="list-style-type: none"> • Up to 50% of premiums paid depending on the year in which the life insurance is surrendered; or • Up to 100% of premiums paid depending on the year in which the life insurance is surrendered. <p>If the life insurance is in effect at the end of the term period, either 50% or 100% of premiums paid will be returned.</p>
Primary Insured Ultimate Income Rider	This item varies according to whether the rider is selected at application.	Varies on each application.	This item may be selected at or after issue.	<p>The range for this item will specify the following:</p> <ul style="list-style-type: none"> • The death benefit will not be paid to the beneficiary(ies) in a lump sum; • \$X lump sum at death; • \$Y monthly for Z years period certain only; • \$A lump sum at end of Z years. <p>The amounts \$X, \$Y, and \$A are flexible and may change at the discretion of the owner.</p>
Other Insured Rider	This item varies according to whether the rider is selected at application.	Varies on each application.	This item may be selected at or after issue.	The range for this item is selecting the rider or not selecting the rider.
Primary Insured Child Rider	This item varies according to whether the rider is selected at application.	Varies on each application.	This item may be selected at or after issue.	The range for this item is selecting the rider or not selecting the rider.

Statement of Variability

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Variable Item	Need for Variability	Anticipated Frequency of Change	Time At Which These Items Become Fixed	Anticipated Range
Page 5 (Continued)				
Additional Benefits Section				
Primary Insured Waiver of Monthly Deduction Rider (UL)	This item varies according to whether the rider is selected at application.	Varies on each application.	This item may be selected at or after issue.	The range for this item is selecting the rider or not selecting the rider.
Primary Insured Waiver of Premium Rider (Term)	This item varies according to whether the rider is selected at application.	Varies on each application.	This item may be selected at or after issue.	The range for this item is selecting the rider or not selecting the rider.
Other	This item varies according to whether there are any other riders not currently listed on the application that are available with the product being applying for and may be written in.	Varies on each application.	This item may be selected at or after issue.	The range for this item is selecting the rider or not selecting the rider and writing in the rider name.

Pages 6 through 11				
Personal History and Medical Questions sections				
Personal History and Medical Questions	The answers to these questions vary by applicant.	The responses to the question vary on each application.	This item becomes fixed at issue.	The ranges for the responses to these questions are, "Yes," or, "No," with space for explanations for any, "Yes," answers.
Personal Physician Information – Primary Insured	This item varies by applicant.	Varies on each application.	This item does not become fixed at issue.	The range for this item is open to any medical practioner attending to the Primary insured.
Personal Physician Information – Other Insured	This item varies by applicant.	Varies on each application.	This item does not become fixed at issue.	The range for this item is open to any medical practioner attending to the Other Insured.

Statement of Variability

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Variable Item	Need for Variability	Anticipated Frequency of Change	Time At Which These Items Become Fixed	Anticipated Range
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Page 12

Fraud Warning Notices section

Standard and State variation Fraud Notices	This item is variable in the event the federal or state laws are changed and the notice is revised.	Currently, there is no anticipation of changing this item.	This item becomes fixed when the application is printed.	The range for this item is open to any language provided by federal or state law.
Signature and Date Lines for Fraud Notices	This item varies by applicant.	Varies on each application.	This item becomes fixed after signature.	The range for this item is limited to the signature and date signed by each applicant.

Page 14

Authorization Section (Cont'd)

Certification	This item is variable in the event the federal or state laws are changed.	Currently, there is no anticipation of changing this item.	This item becomes fixed when the application is printed.	The range for this item is open to any language provided by federal or state law.
Signature and Date Lines for Authorization	This item varies by applicant.	Varies on each application.	This item becomes fixed after signature.	The range for this item is limited to the signature and date signed by each applicant.

Page 14

Agent Certification Section

Signature, Date, and other Agent/Producer/ Bank Representative Information lines for Agent Certification	This item varies by agent/producer.	Varies on each application.	This item becomes fixed after signature.	The range for this item is limited to the signature and date signed by each agent/producer.
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Statement of Variability

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Variable Item	Need for Variability	Anticipated Frequency of Change	Time At Which These Items Become Fixed	Anticipated Range
Page 15				
Life Insurance Conditional Receipt				
Name of Person making payment in exchange for the Life Insurance Conditional Receipt	This item varies by applicant.	Varies on each application.	This item becomes fixed when payment is made at application.	The range for this item is limited to the name of the person paying the amount in exchange for the conditional receipt.
Amount of Payment in Exchange for Life Insurance Conditional Receipt	This item varies by applicant.	Varies on each application.	This item becomes fixed when payment is made at application.	The range for this item is limited to the amount paid in exchange for the conditional receipt.
Agent/Producer Signature lines for Life Insurance Conditional Receipt	This item varies by applicant.	Varies on each application.	This item becomes fixed when payment is made at application.	The range for this item is limited to the place, date, and signature of the agent/producer.
Aggregate Amount of Life Insurance Covered by the Life Insurance Conditional Receipt	This item is variable in the event the business decision is made to increase or decrease the amount provided under the Life Insurance Conditional Receipt.	Currently, there is no anticipation of changing this item.	This item becomes fixed when the application is printed.	The range for this item is limited to the amount provided by the company.

Page 16				
Medical Information Bureau, Inc., (MIB) Pre-Notification Section				
MIB Information Office Address	This item may be revised if MIB information office moves.	Currently, there is no anticipation of changing this item.	This item becomes fixed when the application is printed.	The range for this item is open to any address the MIB may move to.
MIB Telephone Number	This item may be revised if MIB telephone number changes.	Currently, there is no anticipation of changing this item.	This item becomes fixed when the application is printed.	The range for this item is open to any telephone number used by the MIB.
MIB Hearing Impaired Telephone Number	This item may be revised if MIB hearing impaired telephone number changes.	Currently, there is no anticipation of changing this item.	This item becomes fixed when the application is printed.	The range for this item is open to any hearing impaired telephone number used by the MIB.
MIB website addresses	This item may be revised if the MIB website information or generic address changes.	Currently, there is no anticipation of changing this item.	This item becomes fixed when the application is printed.	The range for this item is open to any website address used by the MIB.