

<i>SERFF Tracking Number:</i>	<i>OXFR-126320415</i>	<i>State:</i>	<i>Arkansas</i>
<i>Filing Company:</i>	<i>Oxford Life Insurance Company</i>	<i>State Tracking Number:</i>	<i>43602</i>
<i>Company Tracking Number:</i>	<i>SI110-OLICAR</i>		
<i>TOI:</i>	<i>L071 Individual Life - Whole</i>	<i>Sub-TOI:</i>	<i>L071.101 Fixed/Indeterminate Premium - Single Life</i>
<i>Product Name:</i>	<i>Assurance Final Expense Whole Life Insurance</i>		
<i>Project Name/Number:</i>	<i>Assurance Final Expense Whole Life Insurance/</i>		

Filing at a Glance

Company: Oxford Life Insurance Company

Product Name: Assurance Final Expense Whole Life Insurance
 SERFF Tr Num: OXFR-126320415 State: Arkansas

TOI: L071 Individual Life - Whole
 SERFF Status: Closed-Approved- Closed State Tr Num: 43602

Sub-TOI: L071.101 Fixed/Indeterminate
 Co Tr Num: SI110-OLICAR State Status: Approved-Closed

Premium - Single Life

Filing Type: Form

Reviewer(s): Linda Bird
 Author: Lisa Kaiser Disposition Date: 09/29/2009
 Date Submitted: 09/25/2009 Disposition Status: Approved-Closed

Implementation Date Requested:

Implementation Date:

State Filing Description:

General Information

Project Name: Assurance Final Expense Whole Life Insurance

Status of Filing in Domicile: Pending

Project Number:

Date Approved in Domicile:

Requested Filing Mode: Review & Approval

Domicile Status Comments:

Explanation for Combination/Other:

Market Type: Individual

Submission Type: New Submission

Group Market Size:

Overall Rate Impact:

Group Market Type:

Filing Status Changed: 09/29/2009

Explanation for Other Group Market Type:

State Status Changed: 09/29/2009

Deemer Date:

Created By: Lisa Kaiser

Submitted By: Lisa Kaiser

Corresponding Filing Tracking Number: SI110-OLICAR

Filing Description:

The above-referenced form is being submitted to you for your review and approval. No part of this filing contains any unusual or possibly controversial items from normal company or industry standards. The document is the final and printed version.

This general purpose life application SI110-OLIC Rev 8/2009 is a revised Application and replaces Form SI110-OLIC

SERFF Tracking Number: OXFR-126320415 State: Arkansas
Filing Company: Oxford Life Insurance Company State Tracking Number: 43602
Company Tracking Number: S1110-OLICAR
TOI: L071 Individual Life - Whole Sub-TOI: L071.101 Fixed/Indeterminate Premium - Single Life
Product Name: Assurance Final Expense Whole Life Insurance
Project Name/Number: Assurance Final Expense Whole Life Insurance/

which was approved by your Department on 4/25/2005. We are submitting this replacement Application because we added additional language to:

Page 1 Producer Instructions

Page 2 at the bottom of the page Proposed Insured Initials

Page 3 Only one Proposed Insured information required instead of two Proposed Insured

Page 5

Additional medical questions: Are you taking medication for any impairment in Section C?

Have you used any nicotine based products in the past 12 months?

Have you applied for life insurance with any other insurance companies in the last two years?

Driver's License number

Also added Important Notice language in shaded box

Page 6

Producer's Statement instead of Agent's Statement also added Producer use only for commission splits, if requested language.

Page 7 Pre-Authorized Check (PAC) Or Withdrawal Plan along with new language

Page 8 Added HIPPA page

Page 9 Temporary Receipt is on page 9 and MIB Notice has been moved to page 10

Page 10 Has Privacy Notice, Fair Credit Reporting Act Notice and MIB-Notice

The Application will be used with policy form OL200 approved by your department on 8/1/2007 and future individual term and whole life policy forms.

I certify that I have performed the Flesch readability test on the application, and its score was 50.

Company and Contact

Filing Contact Information

Lisa Kaiser, lisakaiser@oxfordlife.com
2721 North Central Avenue 888-757-3732 [Phone] 5743 [Ext]
Phoenix, AZ 85004

Filing Company Information

Oxford Life Insurance Company CoCode: 76112 State of Domicile: Arizona
2721 N. Central Avenue Group Code: Company Type:
Phoenix, AZ 85004-1172 Group Name: State ID Number:

SERFF Tracking Number: OXFR-126320415 State: Arkansas
Filing Company: Oxford Life Insurance Company State Tracking Number: 43602
Company Tracking Number: S1110-OLICAR
TOI: L071 Individual Life - Whole Sub-TOI: L071.101 Fixed/Indeterminate Premium - Single Life

Product Name: Assurance Final Expense Whole Life Insurance
Project Name/Number: Assurance Final Expense Whole Life Insurance/
(888) 757-3732 ext. [Phone] FEIN Number: 86-0216483

Filing Fees

Fee Required? Yes
Fee Amount: \$20.00
Retaliatory? No
Fee Explanation:
Per Company: No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Oxford Life Insurance Company	\$20.00	09/25/2009	30851269

SERFF Tracking Number: OXFR-126320415 State: Arkansas
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TOI: L071 Individual Life - Whole Sub-TOI: L071.101 Fixed/Indeterminate Premium - Single Life
Product Name: Assurance Final Expense Whole Life Insurance
Project Name/Number: Assurance Final Expense Whole Life Insurance/

Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Linda Bird	09/29/2009	09/29/2009

SERFF Tracking Number: OXFR-126320415 *State:* Arkansas
Filing Company: Oxford Life Insurance Company *State Tracking Number:* 43602
Company Tracking Number: S1110-OLICAR
TOI: L071 Individual Life - Whole *Sub-TOI:* L071.101 Fixed/Indeterminate Premium - Single Life

Product Name: Assurance Final Expense Whole Life Insurance
Project Name/Number: Assurance Final Expense Whole Life Insurance/

Disposition

Disposition Date: 09/29/2009

Implementation Date:

Status: Approved-Closed

Comment:

Rate data does NOT apply to filing.

SERFF Tracking Number: OXFR-126320415 State: Arkansas
 Filing Company: Oxford Life Insurance Company State Tracking Number: 43602
 Company Tracking Number: S1110-OLICAR
 TOI: L071 Individual Life - Whole Sub-TOI: L071.101 Fixed/Indeterminate Premium - Single Life
 Product Name: Assurance Final Expense Whole Life Insurance
 Project Name/Number: Assurance Final Expense Whole Life Insurance/

Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification		Yes
Supporting Document	Application		No
Supporting Document	Life & Annuity - Acturial Memo		No
Supporting Document	Readability Certification		Yes
Supporting Document	NAIC Transmittal		Yes
Form	Assurance Final Expense Whole Life Insurance		Yes

SERFF Tracking Number: OXFR-126320415 State: Arkansas
 Filing Company: Oxford Life Insurance Company State Tracking Number: 43602
 Company Tracking Number: S1110-OLICAR
 TOI: L071 Individual Life - Whole Sub-TOI: L071.101 Fixed/Indeterminate Premium - Single Life
 Product Name: Assurance Final Expense Whole Life Insurance
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Form Schedule

Lead Form Number:

Schedule Item Status	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
	SI110 Rev 8/2009	Application/ Enrollment Form	Assurance Final Expense Whole Life Insurance	Initial		50.000	SI110-OLIC Rev 8-2009 indd.pdf

OXFORD[®]

LIFE INSURANCE COMPANY

2721 NORTH CENTRAL AVENUE
PHOENIX, AZ 85004

ASSURANCE
FINAL EXPENSE WHOLE LIFE INSURANCE

LIFE INSURANCE Application

CONTENTS:

PRODUCER INSTRUCTIONS
FRAUD NOTICE
APPLICATION
PRE-AUTHORIZED CHECK (PAC) OR WITHDRAWAL PLAN
HIPAA AUTHORIZATION RELEASE OF HEALTH RELATED INFORMATION
TEMPORARY LIFE INSURANCE AGREEMENT AND CONDITIONAL RECEIPT
PRIVACY NOTICE
FAIR CREDIT REPORTING ACT NOTICE
MEDICAL INFORMATION BUREAU PRE-NOTICE



Printed with soy ink on recycled paper.
Thanks for recycling.

PRODUCER INSTRUCTIONS

- 1) General Instructions:
 - a. Do not solicit business until you are contracted and appointed by the Company.
 - b. Confirm that the Proposed Insured appears lucid and fully understands all of the questions on the Application.
 - c. Print clearly with black ink. Do not use felt tip pens. Corrections should be initialed and dated by Proposed Insured/ Owner. Do not use white out. THE APPLICANT MUST INITIAL THE BOTTOM OF PAGE 2.
 - d. Submit all pages of the Application, except the last page, even if information is not required.
 - e. Review the Application prior to mailing it to the Company to ensure it is complete and accurate. Include a cover memo with special instructions, if needed.
 - f. **ALL APPLICATIONS, WHETHER APPROVED OR DECLINED, MUST BE SUBMITTED TO THE HOME OFFICE.**
- 2) Proposed Insured Requirements:
 - a. The Proposed Insured must be either a U.S. citizen or a Permanent U.S. Resident with a Green Card. If the Proposed Insured is a Non U.S. Citizen, obtain the Permanent U.S. Resident (Green Card) I.D. number.
 - b. The Proposed Insured's full name should be indicated and the signature should be identical to the name. If the Owner is a trust or business, include the full title and name of trust or business.
 - c. Make sure you have the complete name and date of the trust and whether it is revocable or irrevocable. Example: Barbara James, Trustee: Barbara James, President. Barbara James, Irrevocable Trust, date 01-02-96, Barb's Bistro, Inc.
 - d. The Proposed Insured is required to sign the Application.
- 3) Completing the Application:
 - a. List the Owner's tax ID number on page 3. If the Owner's tax ID number is not included, we will require completed W-9's before issue.
 - b. For Beneficiaries, list all Social Security numbers (if available) and list the percentage share to equal 100%.
 - c. Explain and review the state-appropriate Fraud Notice. It will be reviewed again in the recorded telephone interview. Have the Proposed Insured initial their acknowledgment at the bottom of page 2.
 - d. Explain the Medical Information Bureau (MIB) Pre-Notice, Privacy Notice and Fair Credit Reporting Act Notice and leave it with the Proposed Insured.
- 4) Prior to the Recorded Telephone Interview:
 - a. Complete the Application, including the MIB Authorization and ask all the health questions before initiating the recorded phone interview. **Do not assist the Proposed Insured in answering the health questions.**
 - b. Ask the Proposed Insured whether he or she is on any medication or drugs that might affect the Proposed Insured's ability to fully understand and answer the questions that are about to be asked.
 - c. Verify the personal information of the Proposed Insured by viewing a state-issued driver's license, state-issued I.D. card, military I.D. card, Permanent U.S. Resident (Green Card), passport or other government issued picture I.D. card.
- 5) Point of Sale Recorded Telephone Interview Procedures:
 - a. Call **1-888-801-5123** from the Proposed Insured's home. Provide Oxford Life's name and your name.
 - b. The Point of Sale Telephone Interview Specialist will review the Fraud Notice and will complete the Producer Checklist with you. Be sure to answer the questions accurately.
 - c. The Proposed Insured will speak with the Interview Specialist to confirm the answers to the questions on the Application. When completed, the Interview Specialist will speak with you again.
 - d. If approved, submit the Application along with the first month's premium, making sure all questions on the Application are answered.
 - e. If the Application is written after normal business hours, the Proposed Insured will need to leave a voice message in the 24-hour mailbox for an Interview Specialist to call the Proposed Insured back. Since the Proposed Insured will be completing the interview the next business day, the Producer Checklist will state "Producer Not Present." After the Point of Sale Inspection is complete, the Interview Specialist will call the Producer with the results.
 - f. Non-English speaking Proposed Insured can be processed through a Point of Sale Recorded Telephone Interview Specialist procedure with a language interpreter. The Point of Sale Interview Specialist will arrange for this service when you call.
- 6) Accepting Payment:
 - a. Explain the terms of the policy prior to accepting payment with the Application.
 - b. If accepting payment with the Application, leave the completed Temporary Life Insurance Agreement and Receipt with the Owner.
 - c. Mail the original Application with initial premium to the home office. We will not accept cash, counter (non-personalized) checks or Producer/agency checks.
 - d. Complete the Pre-Authorization Check (PAC) Information and attach a voided check if requesting the Pre-Authorization Check mode of billing.

**FRAUD NOTICE
FOR YOUR PROTECTION
THE LAW REQUIRES THE FOLLOWING TO APPEAR ON THIS FORM**

ARKANSAS, LOUISIANA, AND TEXAS — Any person who knowingly presents a false or fraudulent claim for payment of 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.

COLORADO — It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or Producer of an insurance company who knowingly provides false, incomplete or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

DISTRICT OF COLUMBIA — 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.

FLORIDA — 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.

GEORGIA, NEBRASKA, OREGON, AND WYOMING — Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an Application or files a claim containing a false or deceptive statement, may be guilty of insurance fraud.

KANSAS — Any person who knowingly and with intent to defraud presents false information in an Application for insurance may be guilty of a crime and may be subject to fines and confinement in prison.

KENTUCKY — Any person who knowingly, and with intent to defraud any insurance company or other person, files an Application for insurance 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.

MAINE, TENNESSEE, VIRGINIA, AND WASHINGTON — It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines and denial of insurance benefits.

MARYLAND — Any person who knowingly and willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly and willfully presents false information in an Application for insurance, is guilty of a crime and may be subject to fines and confinement in prison.

MINNESOTA — Any person who knowingly or willfully makes a false or fraudulent statement in, or relative to, any Application for insurance or membership for any purpose shall be guilty of a gross misdemeanor.

NEW JERSEY — Any person who includes any false or misleading information on an Application for an insurance policy, is subject to criminal and civil penalties.

NEW MEXICO — Any person who knowingly presents a false or fraudulent claim for payment of loss or benefit, or knowingly presents false information in an Application for insurance, is guilty of a crime and may be subject to civil fines and criminal penalties.

OKLAHOMA — 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.

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

IN ALL OTHER STATES — Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an Application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

<hr/> Proposed Insured Initials
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APPLICATION

Section A —				
PROPOSED INSURED				
Name (First, MI, Last)		Address, City, State, Zip Code		
SSN, Tax I.D.# or Green Card Number	Gender	Date of Birth	Birth State	Phone Number ()
Email Address:	U.S. Citizen <input type="checkbox"/> Yes <input type="checkbox"/> No or Permanent U.S. Resident <input type="checkbox"/> Yes <input type="checkbox"/> No			
OWNER (If other than Proposed Insured)				
Owner Name (First, MI, Last)		Owner's Address, City, State, Zip Code		
Owner's SSN, Tax I.D.# or Green Card Number	Relationship		Phone Number ()	
Does the Proposed Insured and/or Owner, have any existing life insurance or annuity coverage? <input type="checkbox"/> Yes <input type="checkbox"/> No Is this policy being purchased to replace any existing life insurance or annuity coverage? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, please list:				
Company	Policy No.	Address, City, State, Zip Code		
BENEFICIARY				
Primary	Address, City, State, Zip Code	Relationship	SSN	%
Primary	Address, City, State, Zip Code	Relationship	SSN	%
Primary	Address, City, State, Zip Code	Relationship	SSN	%
Contingent	Address, City, State, Zip Code	Relationship	SSN	%
Contingent	Address, City, State, Zip Code	Relationship	SSN	%
Contingent	Address, City, State, Zip Code	Relationship	SSN	%
Section B —				
FACE AMOUNT \$ _____		PREMIUM PAYMENT MODE <input type="checkbox"/> PAC Monthly <input type="checkbox"/> Quarterly <input type="checkbox"/> Semi-Annually <input type="checkbox"/> Annually		
Check here if Owner does not want the Automatic Premium Loan provision: <input type="checkbox"/> Owner				

If any question in Section C is answered "Yes," NO COVERAGE CAN BE ISSUED. If height and weight exceeds maximum range for this product, no coverage can be issued.

ANSWER FOR
PROPOSED INSURED

Section C —

1. What is your height and weight?	H_____ W_____
2. Have you had, or been medically advised to have, an organ transplant, or have you been medically diagnosed as having a terminal illness or life expectancy of 12 months or less, or have you been diagnosed, treated (including dialysis) or taken medication for chronic kidney disease or kidney (renal) insufficiency or kidney or liver failure?	<input type="checkbox"/> Yes <input type="checkbox"/> No
3. Have you been medically treated or diagnosed by a medical professional as having Acquired Immune Deficiency Syndrome (AIDS), AIDS related complex (ARC), or any immune deficiency related disorder or tested positive for the Human Immunodeficiency Virus (HIV)?	<input type="checkbox"/> Yes <input type="checkbox"/> No
4. Are you currently: hospitalized, confined to a bed or nursing facility, or using oxygen equipment to assist in breathing, or receiving Hospice Care?	<input type="checkbox"/> Yes <input type="checkbox"/> No
5. Have you been treated for insulin shock, diabetic coma, or ever taken insulin shots prior to the age of 50?	<input type="checkbox"/> Yes <input type="checkbox"/> No
6. Have you ever been medically diagnosed, treated, or taken medication for: congestive heart failure (CHF), cardiomyopathy, Alzheimer's, dementia, schizophrenia, bipolar disorder, mental incapacity, Lou Gehrig's disease (ALS), or Huntington's disease?	<input type="checkbox"/> Yes <input type="checkbox"/> No
7. Within the past 24 months, have you been confined more than twice to a hospital, nursing facility, convalescent care facility, assisted living facility, mental facility or Hospice Care?	<input type="checkbox"/> Yes <input type="checkbox"/> No
8. Within the past 24 months have you been diagnosed with internal cancer or melanoma or have had more than one occurrence of any cancer in your lifetime (excluding basal or squamous cell skin cancer), or are you currently being treated for cancer, or reoccurrence of cancer, amputation caused by disease, stroke or transient ischemic attack (TIA), or leukemia?	<input type="checkbox"/> Yes <input type="checkbox"/> No
9. Within the past 24 months have you:	
a. been medically diagnosed, treated or taken medication for: angina, chronic hepatitis, cystic fibrosis, chronic obstructive pulmonary disease (COPD), chronic bronchitis, emphysema or required oxygen equipment to assist in breathing?	<input type="checkbox"/> Yes <input type="checkbox"/> No
b. been diagnosed as having, been treated for or hospitalized for: heart attack, heart disease, heart or circulatory surgery (including pacemaker, by-pass, heart valve replacement, angioplasty or stent implant), uncontrolled high blood pressure or any procedure to improve circulation to the heart or brain?	<input type="checkbox"/> Yes <input type="checkbox"/> No
c. had Hodgkin's Disease, cirrhosis, liver disease, lymphoma, or systemic lupus (SLE)?	<input type="checkbox"/> Yes <input type="checkbox"/> No
d. had any neuromuscular disease (including cerebral palsy, multiple sclerosis, grand mal seizures, or Parkinson's disease)?	<input type="checkbox"/> Yes <input type="checkbox"/> No
10. Within the past 10 years, have you been convicted of a felony or are you currently on parole or on probation?	<input type="checkbox"/> Yes <input type="checkbox"/> No
11. Within the last 5 years have you been treated for, been advised to have treatment for, or excessively used, alcohol or any drugs of abuse, or have you been convicted of operating a vehicle while impaired or under the influence of alcohol or any drugs, or had your driver's license suspended or revoked, or attempted suicide?	<input type="checkbox"/> Yes <input type="checkbox"/> No
12. Have you been declined or postponed for Life or Health Insurance in the past two years?	<input type="checkbox"/> Yes <input type="checkbox"/> No
13. Are you, or have you been disabled in the last 6 months?	<input type="checkbox"/> Yes <input type="checkbox"/> No

Continued health questions	ANSWER FOR PROPOSED INSURED
Section D —	
14. Are you taking medication for any impairment in Section C?	<input type="checkbox"/> Yes <input type="checkbox"/> No
15. Have you used any nicotine based products in the past 12 months?	<input type="checkbox"/> Yes <input type="checkbox"/> No
16. Have you applied for life insurance with any other insurance companies in the last two years?	<input type="checkbox"/> Yes <input type="checkbox"/> No
17. Driver's License number Proposed Insured _____ State _____	

Section E —

PROPOSED INSURED'S STATEMENT (or Owner if legal representative)

I have read and understood the completed Application. I am not currently taking and I am not under the influence of any medications or drugs that would affect my ability to fully understand and to fully and accurately complete this Application. The above representations are true. I agree the policy shall not be in effect until it has been issued by Oxford Life Insurance Company ("the Company") and the first premium is paid during my lifetime. I understand that the Producer has no authority to approve the Application, change the policy, or waive any policy provisions. I understand no insurance will be effective until the date stated in the policy and all eligibility requirements are met.

MEDICAL AUTHORIZATION

I authorize any physician, medical practitioner, hospital, medical care facility, the Veteran's Administration, insurance company, the Medical Information Bureau, pharmacy, pharmacy benefit manager, insurance laboratories, my employer or consumer reporting agency, to give Oxford Life Insurance Company or its reinsurers any information they have about my health, including confidential HIV-related information. I acknowledge receipt of the Medical Information Bureau Pre-Notice. I agree that a copy of this authorization is as valid as the original and I can obtain a copy on request. This authorization is valid for use in underwriting risk selection purposes only and is valid for 24 months, except for HIV-related information, which is only valid for 180 days from the date below.

IMPORTANT NOTICE

CAUTION: If your answers on this Application are incorrect or untrue, Oxford Life Insurance Company may deny benefits, cancel, rescind and void your policy.

I have read, understood and acknowledge the Fraud Notice.

I _____ understand and agree that the information on this Application will be relied on to determine insurability and that incorrect information may result in coverage being voided, subject to the policy's incontestability provision.

Signature of Proposed Insured Signature of Owner Date

Section F —

PRODUCER'S STATEMENT

To the best of my knowledge and belief the Proposed Insured and/or Owner **does** **does not** have any existing life insurance or annuity coverage and the life insurance applied for **will** **will not** replace any existing life insurance or annuity coverage.

I certify that I have verified the personal information of the Application(s) by viewing a state issued driver's license, state issued I.D. card, military I.D. card, Permanent U.S. Resident (Green Card), passport or other government issued picture I.D. card.

I further certify that any information recorded by me on this Application is true and accurate to the best of my knowledge and that I witnessed the signing of the Application by the Proposed Insured and Owner who appeared to me to be lucid and to fully understand all of the questions on this Application at _____

City _____ State _____

Writing Producer's Signature Producer's Printed Name Date

PRODUCER USE ONLY FOR COMMISSION SPLITS, IF REQUESTED

Producer's Printed Name Producer's Number / %
Split

Producer's Printed Name Producer's Number / %
Split

Producer's Printed Name Producer's Number / %
Split

MAIL POLICY TO: **Owner** **Agent**

PRE-AUTHORIZED CHECK (PAC) OR WITHDRAWAL PLAN

I/we, the undersigned, hereby authorize and request Oxford Life Insurance Company ("the Company") to initiate electronic debit entries or effect a charge by any other commercially accepted practice to my/our account indicated on the attached check (or the information provided below) for premiums and other such payments that may become due in any amount under this policy. I/we request that this Authorization, unless previously revoked, continue to apply to any conversion, renewal, or change later made in the policy. I/we agree that this Authorization in no way affects the terms of the policy, other than the mode of payment and I/we understand that if premiums are not paid within the grace period allowed by the policy, as in the event of withdrawals being dishonored, or for any other reason, then the policy shall terminate subject to any nonforfeiture provision of the policy. This Authorization may be terminated by either party by giving written notice to the other.

PREMIUM PAYMENT (CHECK ALL THAT APPLY)

- CHECK:** Check this box if you are attaching a check for the initial premiums. The check will be deposited upon receipt of the Application by the Company. I/we understand that no insurance will be provided except under the terms of temporary coverage given at the time the Application is taken, and then only if and when all conditions and requirements of the temporary coverage have been satisfied.
- AUTOMATIC WITHDRAWAL:** Check this box to have **subsequent** premiums withdrawn from the account listed below. By checking this box, I/we agree that I/we want an amount sufficient to pay the premium due for the insurance policy withdrawn from the account. This premium amount may not equal the amount reflected below.

ACCOUNT INFORMATION

TAPE VOIDED CHECK HERE
(Place tape along TOP of check)

If not attaching void check or if withdrawing from Savings Account, complete the following information:

Bank Name, Office Or Branch Phone Number

Bank Address City State Zip Code

Payor Name(s) Check one: Checking Savings

Transit Routing Number Account Number

COMPLETE THE FOLLOWING INFORMATION FOR FUTURE RECURRING PAYMENTS

Premium to Withdraw Withdraw on day of the month matching the policy's effective date (this will be elected if no box is checked)

\$ _____ Withdraw on a different day of the month; choose a day between 1 and 28 _____

SIGNATURE

Payor Signature(s) - as on financial institution's records. A copy is as valid as the original.

X _____ **Date:** _____

HIPAA Authorization
for Release of Health
Related Information

This authorization complies with the HIPAA Privacy Rule

Name(s) of Primary Proposed Insured/patient

Date of birth

I authorize any health plan, physician, health care professional, hospital, clinic, laboratory, pharmacy, pharmacy benefit manager, medical facility, insurance company, insurance support organization (such as MIB Group, Inc. or any of its members or affiliates), or other health care provider that has provided payment, treatment or services to me or on my behalf (collectively, "My Providers") to disclose the entire medical record and any other protected health information concerning me to the company referenced on this authorization ("the Company") and their Producers, employees, and representatives. This includes information on the diagnosis or treatment of Human Immunodeficiency Virus (HIV) infection and sexually transmitted diseases. This also includes information on the diagnosis and treatment of mental illness and the use of alcohol, drugs, and tobacco, but excludes psychotherapy notes.

By my signature below, I acknowledge that any agreements I have made to restrict my protected health information do not apply to this authorization and I instruct My Providers to release and disclose the entire medical record without restriction.

This protected health information is to be disclosed under the authorization at my request, as permitted by § 164.508 of the privacy regulations issued pursuant to the Health Insurance Portability and Accountability Act ("HIPAA Privacy Rule").

This authorization shall remain in force for 24 months following the date of my signature below, regardless of my condition and whether living or deceased, and a copy of this authorization is as valid as the original. I understand that I have the right to revoke this authorization in writing, at any time, by sending a written request for revocation to the Company addressed, **Attention: Policyholder Service Department, 2721 North Central Avenue, Phoenix, AZ 85004**. I understand that a revocation is not effective to the extent that any of My Providers has relied on this Authorization or to the extent that the Company has a legal right to contest a claim under an insurance policy or to contest the policy itself. I understand that any information disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal regulations governing privacy and confidentiality of health information (such as the HIPAA Privacy Rule). However, the Company will protect the privacy of health information in accordance with other applicable state and/or federal privacy laws and its own privacy policies.

I understand that My Providers may not refuse to provide treatment or payment for health care services because I refuse to sign this authorization. I further understand that if I refuse to sign this authorization to release my complete medical record the Company may not be able to process my Application, or if coverage has been issued, may not be able to make any benefit payments. I acknowledge that I have received a copy of this authorization.

Signature of Primary Proposed Insured/Personal Representative

Date

If signed by an individual's Personal Representative, describe authority to sign on behalf of the individual:

Power of Attorney Other (please describe): _____

Proposed Insured Policy or contract number (If known): _____



TEMPORARY LIFE INSURANCE AGREEMENT AND CONDITIONAL RECEIPT

PLEASE READ THIS CAREFULLY. All checks must be made payable to Oxford Life Insurance Company ("the Company"). Do not make checks payable to the Producer or leave payee blank.

This temporary life insurance agreement and conditional receipt ("Receipt") provides confirmation of temporary insurance coverage as of the date of this Receipt. If the Proposed Insured cancels the life insurance policy, the cancellation of the life insurance policy and Receipt will be effective on the date of the cancellation. In the event of an adverse underwriting decision, the 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 _____ a check in the amount of \$ _____ paid with a life insurance Application to the Company. The Application bears the same date as this Receipt. I have advised each Proposed Insured of the terms, conditions, and limitations of this Receipt.

Dated at (City & State)

On (Date)

Producer's Signature

If there is any material misrepresentation in any requests or application for life insurance, telephone or other interviews, or medical examinations or tests submitted to the Company related to any person proposed to be insured, this Receipt will be void from the beginning.

If all requirements of the Application are not met, or the person(s) to be insured dies by suicide, the liability of the Company shall be limited to a full refund to the Applicant of the premium payment received by the Company.

The aggregate amount of life insurance provided on the life of any person proposed to be insured which may become effective under this Receipt and any other conditional receipt issued by the Company on the life of that person shall be the lesser of the amount applied for or \$5,000.

This Receipt provides no insurance for riders or additional benefits.

No Producer or broker is authorized to alter the terms of this Receipt, waive any terms or conditions, or pass on insurability. I have read this Receipt and understand and agree to its terms. I understand this Receipt provides no insurance unless all conditions are met. I declare that the answers to the questions in the Application are true and complete.

Date

Signature of Proposed Insured

Producer

Owner (If other than Proposed Insured)

LEAVE THIS PAGE WITH OWNER IF PAYMENT IS MADE WITH APPLICATION.

PRIVACY NOTICE

Your privacy is protected. Oxford Life Insurance Company, like other insurance companies, sometimes evaluates the medical history and other personal information about Applicants to determine their eligibility for certain policies. (Personal information includes information such as age, occupation, physical condition, health history, habits, general reputation, credit and avocation.) We also use this information for the administration of Your insurance coverage after it is in force.

We rely heavily on information provided by You. We may also supplement this information from other sources, such as medical professionals or institutions that have treated You or family members covered under Your policy, insurance support organizations, other insurance companies to which You have applied, and employers.

Any information You give Us regarding Your insurability and any information received from other sources will be treated as strictly confidential. In some situations, and in compliance with applicable law, We may disclose necessary items of information to third parties, who may retain a copy and disclose the information to others for whom they perform such services, without Your specific authorization. Unless You request otherwise, Your name, address, date of birth and phone number may be used by Us or Our affiliates to inform you of other insurance products or services which are available. We may also disclose this information to: (1) an organization performing administrative, business or professional services for Us; (2) other insurance companies to which You apply; and (3) your physician or medical professional.

You have the right to be told about and to copy, if you wish, items of personal information which appear in our files. You also have the right to seek correction of information you believe to be inaccurate.

THE ABOVE IS A GENERAL DESCRIPTION OF OUR PRIVACY PRACTICES. IF YOU WOULD LIKE A MORE DETAILED EXPLANATION OF OUR PRACTICES AND THE CIRCUMSTANCES UNDER WHICH WE MAY USE OR DISCLOSE INFORMATION, PLEASE WRITE TO OUR PRIVACY OFFICER AT OXFORD LIFE INSURANCE COMPANY, 2721 NORTH CENTRAL AVENUE, PHOENIX, AZ 85004-1172, OR VISIT WWW.OXFORDLIFE.COM.

FAIR CREDIT REPORTING ACT NOTICE

With regard to Your Application, We may have requested an investigative consumer report. These reports contain information about Your character, general reputation, mode of living and health except as may be related directly or indirectly to Your sexual orientation. The information may have been obtained through interviews with You, Your neighbors, friends and others who know You. Upon request, We will give You the name and address of the consumer reporting firm so that You may request a copy of the report.

OXFORD LIFE INSURANCE COMPANY

2721 North Central Avenue • Phoenix, Arizona 85004 • (866) 641-9999

MIB PRE-NOTICE

—PROPOSED INSURED—

Information regarding Your insurability will be treated as confidential. Oxford Life Insurance Company, or its reinsurers, may, however, make a brief report thereon to the Medical Information Bureau (MIB), a not-for-profit membership organization of insurance companies, which operates an information exchange on behalf of its members. If You apply to another MIB member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, the MIB, upon request, will supply Oxford Life Insurance 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. Please contact MIB at 866-692-6901 (TTY: 866-346-3642). 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 the Bureau's information office is: 50 Braintree Hill, Suite 400, Braintree, Massachusetts 02184-8734.

Oxford Life Insurance Company, or its reinsurers, may also release information in its file to MIB and to other life or health insurance companies to whom You may apply for life or health insurance, or to whom a claim for benefits may be submitted.

LEAVE THIS PAGE WITH OWNER

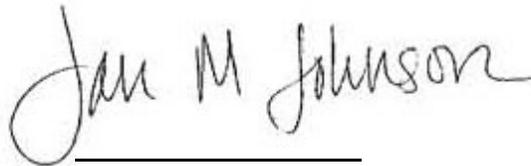
SERFF Tracking Number: OXFR-126320415 State: Arkansas
 Filing Company: Oxford Life Insurance Company State Tracking Number: 43602
 Company Tracking Number: S1110-OLICAR
 TOI: L071 Individual Life - Whole Sub-TOI: L071.101 Fixed/Indeterminate Premium - Single Life
 Product Name: Assurance Final Expense Whole Life Insurance
 Project Name/Number: Assurance Final Expense Whole Life Insurance/

Supporting Document Schedules

	Item Status:	Status Date:
Satisfied - Item: Flesch Certification Comments: Attachment: CertofCompl.pdf		
Bypassed - Item: Application Bypass Reason: N/A Comments:		
Satisfied - Item: Readability Certification Comments: Attachment: FLCERTAR.pdf		
Satisfied - Item: NAIC Transmittal Comments: Attachment: NAIC Transmittal.pdf		

CERTIFICATE OF COMPLIANCE

I, Jan Johnson, Secretary certify that the forms in this submission comply with all laws, rules, bulletins, and published guidelines applicable to this particular type of form in the State of Arkansas.

A handwritten signature in black ink that reads "Jan M Johnson". The signature is written in a cursive style with a large initial "J".

Jan Johnson
Secretary

September 25, 2009

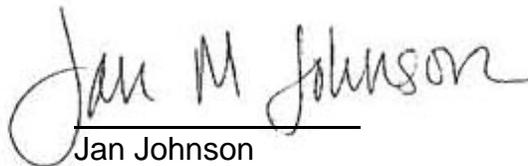
Date

READABILITY CERTIFICATION

To Whom It May Concern:

This is to certify that the attached forms SI110-OLIC Rev 8/2009, achieved a Flesch Reading Ease Score of 50 respectively and are in compliance with applicable laws and regulations of the state of Arkansas.

Oxford Life Insurance Company



Jan Johnson

Secretary

Title

September 25, 2009

Date

Life, Accident & Health, Annuity, Credit Transmittal Document

1.	Prepared for the State of	Arkansas
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2.	Department Use Only
	State Tracking ID

3.	Insurer Name & Address	Domicile	Insurer License Type	NAIC Group #	NAIC #	FEIN #	State #
	Oxford Life Insurance Company 2721 North Central Avenue Phoenix, AZ 85004-1172	AZ		0574	76112	86-0216483	

4.	Contact Name & Address	Telephone #	Fax #	E-mail Address
	Lisa Kaiser Compliance Regulatory Analyst (same as above)	(888) 747-3732, ext 670130	(602) 277-5901	lisakaiser@oxfordlife.com

5.	Requested Filing Mode	<input checked="" type="checkbox"/> Review & Approval <input type="checkbox"/> File & Use <input type="checkbox"/> Informational <input type="checkbox"/> Combination (please explain): _____ <input type="checkbox"/> Other (please explain): _____
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6.	Company Tracking Number	SI110-OLICAR
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7.	<input checked="" type="checkbox"/> New Submission <input type="checkbox"/> Resubmission Previous file # _____
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8.	Market	<input checked="" type="checkbox"/> Individual <input type="checkbox"/> Franchise <input type="checkbox"/> Small <input type="checkbox"/> Large <input type="checkbox"/> Small and Large <input type="checkbox"/> Employer <input type="checkbox"/> Association <input type="checkbox"/> Blanket <input type="checkbox"/> Discretionary <input type="checkbox"/> Trust <input type="checkbox"/> Other: _____
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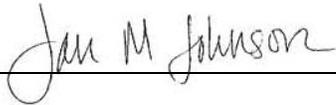
9.	Type of Insurance (TOI)	L071 Individual Life – Whole
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10.	Sub-Type of Insurance (Sub-TOI)	L071-101 Fixed/Indeterminate Premium – Single Life
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11.	Submitted Documents	<input checked="" type="checkbox"/> FORMS <input type="checkbox"/> Policy <input type="checkbox"/> Outline of Coverage <input type="checkbox"/> Certificate <input checked="" type="checkbox"/> Application/Enrollment <input type="checkbox"/> Rider/Endorsement <input type="checkbox"/> Advertising <input type="checkbox"/> Schedule of Benefits <input type="checkbox"/> Other <u>Disclosure</u> <u>Rates</u> <input type="checkbox"/> New Rate <input type="checkbox"/> Revised Rate <input type="checkbox"/> FILING OTHER THAN FORM OR RATE: Please explain: _____ <u>SUPPORTING DOCUMENTATION</u> <input type="checkbox"/> Articles of Incorporation <input type="checkbox"/> Third Party Authorization <input type="checkbox"/> Association Bylaws <input type="checkbox"/> Trust Agreements <input type="checkbox"/> Statement of Variability <input type="checkbox"/> Certifications <input type="checkbox"/> Actuarial Memorandum <input type="checkbox"/> Other _____
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12.	Filing Submission Date	9/25/2009	
13	Filing Fee (If required)	Amount _____	Check Date _____
		Retaliatory <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Check Number _____
14.	Date of Domiciliary Approval		
15.	Filing Description:		
<p>The above-referenced form is being submitted to you for your review and approval. No part of this filing contains any unusual or possibly controversial items from normal company or industry standards. The document is the final and printed version.</p> <p>This general purpose life application SI110-OLIC Rev 8/2009 is a revised Application and replaces Form SI110-OLIC which was approved by your Department on 4/25/2005. We are submitting this replacement Application because we added additional language to:</p> <p>Page 1 Producer Instructions</p> <p>Page 2 at the bottom of the page Proposed Insured Initials</p> <p>Page 3 Only one Proposed Insured information required instead of two Proposed Insured</p> <p>Page 5 Additional medical questions: Are you taking medication for any impairment in Section C? Have you used any nicotine based products in the past 12 months? Have you applied for life insurance with any other insurance companies in the last two years? Driver's License number Also added Important Notice language in shaded box</p> <p>Page 6 Producer's Statement instead of Agent's Statement also added Producer use only for commission splits, if requested language.</p> <p>Page 7 Pre-Authorized Check (PAC) Or Withdrawal Plan along with new language</p> <p>Page 8 Added HIPPA page</p> <p>Page 9 Temporary Receipt is on page 9 and MIB Notice has been moved to page 10</p> <p>Page 10 Has Privacy Notice, Fair Credit Reporting Act Notice and MIB-Notice</p> <p>The Application will be used with policy form OL200 approved by your department on 8/1/2007 and future individual term and whole life policy forms.</p> <p>I certify that I have performed the Flesch readability test on the application, and its score was 50.</p>			

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16.	Certification (If required)
I HEREBY CERTIFY that I have reviewed the applicable filing requirements for this filing, and the filing complies with all applicable statutory and regulatory provisions for the state of <u>Arkansas</u> .	
Print Name	
<u>Jan Johnson</u>	
Title <u>Secretary</u>	
Signature	<u></u>
Date:	<u>9/25/2009</u>

LHTD-1, Page 2 of 2

17.	Form Filing Attachment	
This filing transmittal is part of company tracking number		SI110-OLICAR
This filing corresponds to rate filing company tracking number		

	Document Name	Form Number		Replaced Form Number
	Description			Previous State Filing Number
01	Assurance Final Expense Whole Life Insurance	SI110-OLIC Rev 8/2009	<input type="checkbox"/> Initial <input type="checkbox"/> Revised <input type="checkbox"/> Other _____	
	Application			
02			<input type="checkbox"/> Initial <input type="checkbox"/> Revised <input type="checkbox"/> Other _____	
03			<input type="checkbox"/> Initial <input type="checkbox"/> Revised <input type="checkbox"/> Other _____	
04			<input type="checkbox"/> Initial <input type="checkbox"/> Revised <input type="checkbox"/> Other _____	
05			<input type="checkbox"/> Initial <input type="checkbox"/> Revised <input type="checkbox"/> Other _____	
06			<input type="checkbox"/> Initial <input type="checkbox"/> Revised <input type="checkbox"/> Other _____	
07			<input type="checkbox"/> Initial <input type="checkbox"/> Revised <input type="checkbox"/> Other _____	
08			<input type="checkbox"/> Initial <input type="checkbox"/> Revised <input type="checkbox"/> Other _____	
09			<input type="checkbox"/> Initial <input type="checkbox"/> Revised <input type="checkbox"/> Other _____	
10			<input type="checkbox"/> Initial <input type="checkbox"/> Revised <input type="checkbox"/> Other _____	

LH FFA-1

18.		Rate Filing Attachment		
This filing transmittal is part of company tracking number				
This filing corresponds to form filing company tracking number				
Overall percentage rate indication (when applicable)				
Overall percentage rate impact for this filing		%		
	Document Name	Affected Form Numbers		Previous State Filing Number
	Description			
01			<input type="checkbox"/> New <input type="checkbox"/> Revised Request +____% -____% <input type="checkbox"/> Other _____	
02			<input type="checkbox"/> New <input type="checkbox"/> Revised Request +____% -____% <input type="checkbox"/> Other _____	
03			<input type="checkbox"/> New <input type="checkbox"/> Revised Request +____% -____% <input type="checkbox"/> Other _____	
04			<input type="checkbox"/> New <input type="checkbox"/> Revised Request +____% -____% <input type="checkbox"/> Other _____	
05			<input type="checkbox"/> New <input type="checkbox"/> Revised Request +____% -____% <input type="checkbox"/> Other _____	
06			<input type="checkbox"/> New <input type="checkbox"/> Revised Request +____% -____% <input type="checkbox"/> Other _____	
07			<input type="checkbox"/> New <input type="checkbox"/> Revised Request +____% -____% <input type="checkbox"/> Other _____	
08			<input type="checkbox"/> New <input type="checkbox"/> Revised Request +____% -____% <input type="checkbox"/> Other _____	
09			<input type="checkbox"/> New <input type="checkbox"/> Revised Request +____% -____% <input type="checkbox"/> Other _____	
10			<input type="checkbox"/> New <input type="checkbox"/> Revised Request +____% -____% <input type="checkbox"/> Other _____	

LH RFA-1