

SERFF Tracking Number: AEGB-126868202 State: Arkansas  
Filing Company: Transamerica Advisors Life Insurance Company State Tracking Number: 47092  
Company Tracking Number: RA1010AR, APE561010TA  
TOI: L08 Life - Other Sub-TOI: L08.000 Life - Other  
Product Name: RA1010AR, APE561010TA  
Project Name/Number: RA1010AR, APE561010TA/RA1010AR, APE561010TA

## Filing at a Glance

Company: Transamerica Advisors Life Insurance Company

Product Name: RA1010AR, APE561010TA SERFF Tr Num: AEGB-126868202 State: Arkansas  
TOI: L08 Life - Other SERFF Status: Closed-Approved- State Tr Num: 47092  
Closed

Sub-TOI: L08.000 Life - Other Co Tr Num: RA1010AR, State Status: Approved-Closed  
APE561010TA

Filing Type: Form

Reviewer(s): Linda Bird  
Author: Theresa Meyers Disposition Date: 10/22/2010  
Date Submitted: 10/20/2010 Disposition Status: Approved-  
Closed

Implementation Date Requested: On Approval

Implementation Date:

State Filing Description:

## General Information

Project Name: RA1010AR, APE561010TA  
Project Number: RA1010AR, APE561010TA  
Requested Filing Mode: Review & Approval  
Explanation for Combination/Other:  
Submission Type: New Submission  
Overall Rate Impact:  
Filing Status Changed: 10/22/2010

Status of Filing in Domicile: Pending  
Date Approved in Domicile:  
Domicile Status Comments:  
Market Type: Individual  
Group Market Size:  
Group Market Type:  
Explanation for Other Group Market Type:  
State Status Changed: 10/22/2010  
Created By: Theresa Meyers  
Corresponding Filing Tracking Number:  
30823400 (TALIC)

Deemer Date:

Submitted By: Theresa Meyers

Filing Description:

October 20, 2010

Commissioner of Insurance  
Arkansas Insurance Division  
1200 West 3rd Street  
Little Rock, Arkansas 72201-1904

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Re: TRANSAMERICA ADVISORS LIFE INSURANCE COMPANY

NAIC #: 468-79022

FEIN #: 91-1325756

RA1010AR – Application for Reinstatement and/or Policy Change

APE561010TAAR – Personal Supplement to Application for Life Insurance

Dear Sir/Madam:

Please find attached are copies of the above referenced forms. These forms have been submitted in final printed form in which they will be distributed to the Insureds upon a request for reinstatement of a life policy. These forms are subject to only minor modifications in paper size and stock, ink, border, Company logo, Company address, adaptation to computer printing, and Officer's signatures.

Application for Reinstatement and/or Policy Change form RA1010AR is an application for reinstatement that will be used with our life portfolio. This form will be replacing the RA0510AR application which was approved by you Department September 01, 2010.

Personal Supplement to Application for Life Insurance form APE561010TA is used to disclose financial information for Universal life insurance policies.

We would appreciate your review and approval of these forms.

Sincerely,

TRANSAMERICA ADVISORS LIFE INSURANCE COMPANY

Theresa Meyers  
Policy Analyst  
Contract Development  
(319) 355-7520 (collect)  
Fax #: (319) 369-2501  
thmeyers@aegonusa.com

## Company and Contact

### Filing Contact Information

Theresa Meyers, Policy Analyst  
4333 Edgewood Rd. NE

thmeyers@aegonusa.com  
319-355-7520 [Phone]

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 MS 2225 319-355-2501 [FAX]

Cedar Rapids, IA 52499

**Filing Company Information**

Transamerica Advisors Life Insurance CoCode: 79022 State of Domicile: Arkansas  
 Company  
 4333 Edgewood Road NE Group Code: 468 Company Type: Life  
 Cedar Rapids, IA 52499 Group Name: State ID Number:  
 (319) 355-8511 ext. [Phone] FEIN Number: 91-1325756

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**Filing Fees**

Fee Required? Yes  
 Fee Amount: \$100.00  
 Retaliatory? No  
 Fee Explanation: \$50.00 per form X 2 forms = \$100.00  
 Per Company: No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Transamerica Advisors Life Insurance Company	\$100.00	10/20/2010	40951709

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## Correspondence Summary

### Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Linda Bird	10/22/2010	10/22/2010

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## Disposition

Disposition Date: 10/22/2010

Implementation Date:

Status: Approved-Closed

Comment:

Rate data does NOT apply to filing.

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Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification		Yes
Supporting Document	Application		No
Supporting Document	Statement of Variability		Yes
Form	Application for Reinstatement and/or Policy Change		Yes
Form	Personal Supplement to Application for Life Insurance		Yes

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## Form Schedule

**Lead Form Number: RA1010AR, APE561010TA**

Schedule Item Status	Form Number	Form Type Form Name	Action	Action Specific Data	Readability	Attachment
	RA1010AR	Application/ Enrollment Form	Revised	Replaced Form #: RA0510AR Previous Filing #: AEGB-126693564	50.100	RA1010AR.pdf
	APE561010TA	Application/ Enrollment Form	Initial	Personal Supplement to Application for Life Insurance	50.600	APE561010TA.pdf

# Application for Reinstatement

Policy Number: \_\_\_\_\_ Insured Name: \_\_\_\_\_

If reinstatement is approved, the contestable period will start anew.

## PART 1. PROPOSED INSURED(S) INFORMATION

	Last Name	M.I.	First name	Birth Date	Birth Place	Height Ft. in.	Weight Lbs.	Sex
Primary Insured								
Second Insured								

Telephone Number ( ) \_\_\_\_\_ Best time to call  AM  PM \_\_\_\_\_

## PART 2. MEDICAL QUESTIONS

### Has any proposed insured listed in Part 1

- 1) Within the last 5 years been treated for or been told by a member of the medical profession that they had heart disease or circulatory problems, stroke, cancer, diabetes, kidney or liver disorder, lung or respiratory disorder, Alzheimer's Disease, mental or psychiatric disorder, alcohol or drug abuse? (Please circle the applicable ailments) YES  NO
- 2) Within the last 5 years consulted a medical practitioner? YES  NO
- 3) Within the last 5 years been diagnosed by a member of the medical profession as having AIDS (Acquired Immune Deficiency Syndrome), or tested positive for HIV (Human Immunodeficiency Virus)? YES  NO
- 4) Within the last 12 months used tobacco or other nicotine products in any form? YES  NO

Give details to all YES answers above. Please indicate person(s) to which details apply, dates of visit, reason for visit and findings. Give us the doctor, hospital, clinic, or health care providers full name and address.

Proposed Insured:	Proposed Insured:
Question number:	Question number:
Reason for visit:	Reason for visit:
Dates of visits:	Dates of visits:
Findings:	Findings:
Dr./Clinics address:	Dr./Clinics address:

**PART 3. OCCUPATION AND MISCELLANEOUS QUESTIONS**

5) Has any proposed insured listed in Part 1 had a change in occupation or income since the original application? If yes, indicate whom and describe current occupation and income. YES  NO

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6) State occupation and income for any adult applicant listed in Part 1 to be added to policy:

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7) Has any proposed insured listed in Part 1 had their drivers license suspended, revoked, restricted, or been convicted of a moving violation in the last 12 months? YES  NO

If yes, provide Driver's License number, State of issue and details. \_\_\_\_\_

8) Does any proposed insured listed in Part 1 participate in aviation or any organized hazardous sport or activity? If yes, complete Avocation and Aviation questionnaire and attach to application. YES  NO

9) Will any proposed insured listed in Part 1 travel outside the United States within the next 12 months? YES  NO

If yes, provide details of when, where, and length of time. \_\_\_\_\_

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**PART 4. REPRESENTATIONS**

I represent that the statements and answers in this application are true and complete to the best of my knowledge and belief. It is agreed that:

- (a) The statements and answers given in this application, and any amendments or application supplements to it or statements made to the medical examiner, will be the basis of any reinstatement granted or insurance issued.
- (b) No agent or medical examiner has the authority to make or alter any contract for the Company.
- (c) No reinstatement will be effective or coverage provided until the date the application is approved by the company.
- (d) If a premium deposit is given, no insurance shall take effect until the application is approved by the company while all persons shown in Part 1 are living and their health remains as stated in the reinstatement and policy change application.
- (e) If a premium deposit is not given, no insurance shall take effect until the application is approved by the company and accepted by the owner, all premiums due have been paid and while all persons shown in Part 1 are living and their health remains as stated in the reinstatement and policy change application.
- (f) I further agree that this application will be attached and shall be made a part of the contract for insurance.

**PART 5. AUTHORIZATION TO OBTAIN INFORMATION**

I authorize any physician, medical professional, hospital, clinic, other medical care institution, the Medical Information Bureau, Inc., insurance company, consumer reporting agency, or employer having information available as to employment, other insurance coverage, medical care, advice or treatment with respect to any physical or mental condition regarding me or any of my minor children who are to be insured, to give such information to Transamerica Advisors Life Insurance Company, its reinsurers, or any consumer reporting agency except the Medical Information Bureau, acting on Transamerica Advisors Life Insurance Company's behalf.

I authorize Transamerica Advisors Life Insurance Company to obtain an investigative consumer report on me and upon my request I am entitled to receive a free copy of this report.

I authorize Transamerica Advisors Life Insurance Company to obtain a motor vehicle report on me.

I understand that this information will be used by Transamerica Advisors Life Insurance Company or its reinsurers, to determine eligibility for life insurance.

I agree that this authorization is valid for two and one-half years from the date signed. I know that I or my authorized representative have a right to receive a copy of this authorization upon request. I agree that a photographic copy of this authorization is as valid as the original.

I also hereby authorize Transamerica Advisors Life Insurance Company to provide its affiliated companies any and all information provided herein and obtained hereafter on me. This authorization shall be valid from the date signed below until affirmatively withdrawn in writing by myself.

- I elect not to have personal information disclosed to non-affiliates of Transamerica Advisors Life Insurance Company for marketing purposes.
- I elect to be interviewed if an investigative consumer report is prepared in connection with this application.

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

Signed at \_\_\_\_\_ (city) \_\_\_\_\_ (state) \_\_\_\_\_ on \_\_\_\_\_ (date)

\_\_\_\_\_  
Signature of Primary Insured or Proposed Insured  
(if over age 15 must sign)

\_\_\_\_\_  
Signature of Owner if other than proposed Insured

\_\_\_\_\_  
Signature of Spouse (if applicable)

\_\_\_\_\_  
Signature of Other Insured age 15 or over

**FAIR CREDIT REPORTING ACT**

A routine investigative consumer report may possibly be made regarding your general reputation, character, mode of living and personal characteristics. This information may be obtained through personal interviews with your friends, neighbors and associates. Should you desire additional information on the nature and scope of such a report, you may write the Underwriting Department, Transamerica Advisors Life Insurance Company, [P.O. Box 19100, Greenville, SC 29602-9100]. You may also request information concerning the nature and scope of the investigation to be performed.

**THE MEDICAL INFORMATION BUREAU PRE-NOTICE**

The Medical Information Bureau (“MIB”) is a non-profit organization of life insurance companies which operates as an information exchange for its members.

We may make reports to the MIB regarding factors affecting your insurability. Underwriting decision, however, are not reported to the MIB. If you apply to another Bureau member company for life or health insurance or submit a claim for benefits, the MIB will, upon request, provide that company with information in its file.

Upon your written request, the MIB will arrange for disclosure to you of any information it has in your file. If you feel the information in the MIB’s file is incorrect, you may contact the MIB and seek a correction in accordance with procedures outlined in the Federal Fair Credit Reporting Act. The address of the MIB’s office is: MIB, Inc., 50 Braintree Hill, Suite 400, Braintree, MA 02184-8734; telephone number 866-692-6901 (TTY 866-346-3642 for hearing impaired).

If you would like to know more about how we collect, evaluate and control information about you as one of our applicants for insurance, our sales representatives will be happy to assist you or you may contact us at our office.



Transamerica Advisors Life Insurance Company  
 [P.O. Box 19100  
 Greenville, SC 29602-9100]

**Personal Supplement to  
 Application for  
 Life Insurance**

File # \_\_\_\_\_

Name of Proposed Insured: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Name of Additional Proposed Insured: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

**Section A. PURPOSE OF INSURANCE**

- 1.  Personal
  - Income
  - Estate Planning
- 2.  Business
  - Keyperson
  - Stock Repurchase
  - Buy-Sell
  - Creditor Amount of Loan \$ \_\_\_\_\_
  - Yes  No Is Insurance required by the Creditor?

3. How was the amount of insurance arrived at? \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

(If applying for personal insurance, proceed to questions 7, 8, 9 & 10.)

**Section B. BUSINESS INFORMATION**

4.  Yes  No Are other Corporate Officers or partners insured or being insured?  
 Give details and explanation \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

5. Percent of corporation or partnership owned by Proposed Insured? \_\_\_\_ % Additional Proposed Insured? \_\_\_\_ %

6. Corporation or Partnerships:

	Estimated Current Year	Past Year
Net Worth \$		
Gross Sales \$		
Net Income \$		

Current estimated market value of the business \$ \_\_\_\_\_

**FINANCIAL INFORMATION**

If a joint policy is being applied for, complete questions 7 through 10 jointly for both the Proposed Insured and the Additional Proposed Insured.

7.

	Estimated Current Year	Past Year		Estimated Current Year	Past Year
<b>ANNUAL INCOME</b>					
<b>Earned Income</b>			<b>ASSETS</b>		
Annual Salary or Wages	\$	\$	Cash	\$	\$
Bonuses	\$	\$	Real Estate	\$	\$
Other Earned Income	\$	\$	Stocks & Bonds	\$	\$
<b>Total Earned Income</b>	\$	\$	Autos	\$	\$
			Personal	\$	\$
<b>Unearned Income</b>			Business Equity	\$	\$
Dividends & Interest	\$	\$	Other	\$	\$
Net Real Estate Income	\$	\$	<b>Total Assets</b>	\$	\$
Net Business Investment Income	\$	\$			
Other:	\$	\$	<b>LIABILITIES</b>		
Other:	\$	\$	Mortgages	\$	\$
<b>Total Unearned Income</b>	\$	\$	Business	\$	\$
			All Other Personal	\$	\$
<b>TOTAL ANNUAL INCOME</b>	\$	\$	<b>Total Liabilities</b>	\$	\$

8. Estimated Net Worth \$ \_\_\_\_\_

9.  Yes  No At this time are you currently in bankruptcy or have you been the subject of any voluntary or involuntary bankruptcy proceeding pending within the past 12 months? If yes, please provide full details including Chapter 7, 11, or 13, date filed, and date of discharge and dismissal, if any.

10.  Yes  No Do you have a prepared financial statement? If yes, please attach a copy.

It is represented that the statements and answers given in this supplement to the application are true, complete and correctly recorded. It is agreed that this supplement shall be a part of the application to the Company for insurance on the life of the Proposed Insured and any Additional Proposed Insured, and shall be the basis for any policy issued on this application.

Signed at \_\_\_\_\_ on \_\_\_\_\_, \_\_\_\_\_

\_\_\_\_\_  
Signature of Proposed Insured

\_\_\_\_\_  
Signature of Witness

\_\_\_\_\_  
Signature of Additional Proposed Insured

\_\_\_\_\_  
Signature of Witness

**AGREEMENT OF OWNER IF OTHER THAN PROPOSED INSURED**

The Owner agrees to be bound by all statements, answers, and agreements made by the Proposed Insured and any Additional Proposed Insured in this supplement to the application.

Signed at \_\_\_\_\_ on \_\_\_\_\_, \_\_\_\_\_

\_\_\_\_\_  
Signature of Owner

\_\_\_\_\_  
Signature of Witness

If Owner is a corporation, an authorized officer, other than the Proposed Insured, must sign as owner, give Corporate title and full name of Corporation. Corporation Name: \_\_\_\_\_

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## Supporting Document Schedules

**Item Status:**

**Status**

**Date:**

**Satisfied - Item:** Flesch Certification

**Comments:**

**Attachments:**

AR - Rule and Regulation 19.pdf

Flesch Score.pdf

**Item Status:**

**Status**

**Date:**

**Satisfied - Item:** Statement of Variability

**Comments:**

**Attachment:**

Statement of Variability.pdf

**Transamerica Advisors Life Insurance Company  
Home Office: Cedar Rapids, Iowa**

**COMPLIANCE CERTIFICATION  
RULE AND REGULATION 19  
STATE OF ARKANSAS**

Form Number: RA01010AR, APE561010TA

Date: October 20, 2010

We certify that, to the best of our knowledge and belief, this submission meets the provisions of Rule and Regulation 19 as well as all applicable requirements of the Insurance Division of the State of Arkansas.

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Cheryl Bock, Assistant Vice President, Contract Development

**TRANSAMERICA ADVISORS LIFE INSURANCE COMPANY  
FLESCH READABILITY CERTIFICATION**

**Form Number (may vary by state)**

**Flesch Score**

RA1010

50.1

APE561010TA

50.6

I certify that the machine scored Flesch Readability score(s) for the above mentioned form(s) is/are accurate.

---

Cheryl Bock, Assistant Vice President, Contract Development

**TRANSAMERICA ADVISORS LIFE INSURANCE COMPANY  
STATEMENT OF VARIABILITY**

**APPLICATION: RA1010  
PERSONAL SUPPLEMENT TO APPLICATION: APE561010TA**

We have bracketed the variable items in these forms. No change in the variability will be made which in any way expands the scope of the wording. Transamerica Advisors Life Insurance Company reserves the right to correct, at any time, any and all typographical errors that do not impact the benefits or intent of language.

**RA1010 – Application for Reinstatement and/or Policy Change**

1. **Mailing Address** (page 1): This may change to another location in the future.
2. **Underwriting Department Address** (page 3): This may change to another location in the future.

**APE561010TA – Personal Supplement to Application for Life Insurance**

**Mailing Address** (page 1): This may change to another location in the future.