

SERFF Tracking Number: AFLC-126862403 State: Arkansas
Filing Company: Americo Financial Life and Annuity Insurance Company State Tracking Number: 47065
Company Tracking Number: 1257
TOI: L07I Individual Life - Whole Sub-TOI: L07I.101 Fixed/Indeterminate Premium - Single Life
Product Name: 1257: 5099 (10/10)
Project Name/Number: 1257: 5099 (10/10)/1257

Filing at a Glance

Company: Americo Financial Life and Annuity Insurance Company

Product Name: 1257: 5099 (10/10)

SERFF Tr Num: AFLC-126862403 State: Arkansas

TOI: L07I Individual Life - Whole

SERFF Status: Closed-Approved-Closed State Tr Num: 47065

Sub-TOI: L07I.101 Fixed/Indeterminate Premium - Single Life

Co Tr Num: 1257

State Status: Approved-Closed

Filing Type: Form

Reviewer(s): Linda Bird

Authors: Ronni Jones, Rebecca Aguirre

Disposition Date: 10/20/2010

Date Submitted: 10/16/2010

Disposition Status: Approved-Closed

Implementation Date Requested: On Approval

Implementation Date:

State Filing Description:

General Information

Project Name: 1257: 5099 (10/10)

Status of Filing in Domicile: Pending

Project Number: 1257

Date Approved in Domicile:

Requested Filing Mode: Review & Approval

Domicile Status Comments: Texas is our state of domicile.

Explanation for Combination/Other:

Market Type: Individual

Submission Type: New Submission

Group Market Size:

Overall Rate Impact:

Group Market Type:

Filing Status Changed: 10/20/2010

Explanation for Other Group Market Type:

State Status Changed: 10/20/2010

Deemer Date:

Created By: Rebecca Aguirre

Submitted By: Rebecca Aguirre

Corresponding Filing Tracking Number:

Filing Description:

Submission description

Enclosed, for review and approval, is a revised Application for Life Insurance. This application replaces application AAR5099 (09/09), which was previously approved in your jurisdiction on 09/09/2009 under SERFF tracking number

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AFLC-126293976. This application contains no unusual or controversial elements. This application will be used in the individual life insurance market by our licensed independent agents. To the best of our knowledge and belief, this filing is complete and complies with the insurance laws and regulation of your jurisdiction.

ABB5099 (10/10) description

This form is an individual life insurance application that will be used to apply for previously approved individual whole life policies and riders. All previously approved associated forms are described in detail in an attachment provided under the Supporting Documentation tab. The previously approved policy forms are not marketed with an illustration.

This application was revised to update the health questions, as well as to accommodate our electronic initiatives in taking this application for life insurance. There are three electronic application processing methods.

METHOD 1

At the request of the applicant, the agent will contact the applicant by telephone. At the outset, the applicant will be advised that the telephone application will be recorded. The applicant must voice his/her agreement that: 1) a telephone application for a life insurance policy with Americo Financial Life and Annuity Insurance company is being completed; 2) by agreeing to the completion of the telephone application process, his/her signature will be applied to the application documents and will be binding as if he/she had signed each document by a traditional handwritten method; and, 3) he/she is agreeing to proceed with the telephone application process.

The agent will follow a prescribed script of questions, which tracks the language of the approved application. The applicant's responses will be entered electronically by the agent through the Company's secure website and populated to applicable blanks on the captioned application form. A copy of the recording of the telephone application must be received in our Home Office before the policy will be issued.

At the end of the telephone call the applicant is transferred to a recording of the following disclosures: Authorization & Acknowledgment, Conditional Receipt, Information Practices Notice, Accelerated Benefit Disclosure (if applicable), and Replacement Notice (if applicable).

Within 24 business hours of completing an application, the Company will mail, to the proposed insured, paper copies of the aforementioned disclosures.

METHOD 2

The agent meets with the client in person. The applicant's responses will be entered electronically, by the agent, through the Company's secure website and populated to applicable blanks on the captured application form.

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Once the application data has been entered, the agent uses an e-mail delivery system to send the completed application to the appropriate parties for signature. Each party (Owner, Insured, Payor, Agent) responds to the received e-mail by logging into a secure website where they will review the completed application in PDF form and electronically apply their signatures while in the presence of the agent or at a later time using any internet service.

Once the Owner, Insured, and Payor have electronically signed the application, the agent completes the process by applying his/her signature.

METHOD 3

The agent will contact the applicant by telephone, and the agent completes the application interview over the telephone. The call is not recorded. The applicant's responses will be entered electronically by the agent through the Company's secure website and populated to applicable blanks on the captioned application form.

Once the application data has been entered, the agent uses a secure e-mail delivery system to send the completed application to the appropriate parties for signature. Each party (Owner, Insured, Payor, Agent) responds to the received e-mail by logging into a secure website where they will review the completed application in PDF form and electronically apply their signatures.

Once the Owner, Insured, and Payor have electronically signed the application, the agent completes the process by applying his/her signature.

The following is true for all three methods:

The respective name of the Proposed Insured, the Owner, the Payor, and the Agent, as applicable, followed by the words "Signed by Voice Signature" will overprint on the signature lines of the application. The completed application will be attached to the policy at issue. Applicable signatures on all application documents will be affixed by voice signature.

The security measures in place to protect customer privacy are: agents will be required to authenticate with Americo's extranet by entering a unique user name and password. The extranet site uses a Secured Socket Layer (SSL) encryption certificate. All data collected and transferred to Americo will be SSL encrypted and stored in database files on the Company's main data repository. The voice signature is stored in a .WAV file format and placed in the Company's repository. A Corporate firewall protects these files from external threats and the files are secured by access groups. Only the employees who have a valid business need, as approved by management, have access to these files.

Upon receipt of the policy, the Owner has a 20-day free look period (30 days in the case of replacement), pursuant to

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the terms of the policy, to review coverage and return the policy for a full refund of premium if he/she decides not to accept the policy.

The applicant can end the telephone application at any time during the process.

Company and Contact

Filing Contact Information

Ronni Jones, Associate Compliance Analyst ronni.jones@americo.com
 300 W. 11th Street 816-512-2831 [Phone]
 Kansas City, MO 64105 816-391-2083 [FAX]

Filing Company Information

Americo Financial Life and Annuity Insurance CoCode: 61999 State of Domicile: Texas
 Company
 300 West 11th Street Group Code: 449 Company Type:
 Kansas City, MO 64105 Group Name: State ID Number:
 (800) 231-0801 ext. [Phone] FEIN Number: 35-0810610

Filing Fees

Fee Required? Yes
 Fee Amount: \$50.00
 Retaliatory? Yes
 Fee Explanation: 1 X \$50.00 (exempt filing status)
 Per Company: No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Americo Financial Life and Annuity Insurance Company	\$50.00	10/16/2010	40819764

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Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Linda Bird	10/20/2010	10/20/2010

Amendments

Schedule	Schedule Item Name	Created By	Created On	Date Submitted
Form	Application for Life Insurance	Rebecca Aguirre	10/16/2010	10/16/2010
Supporting Document	Agent's Report	Rebecca Aguirre	10/16/2010	10/16/2010

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Disposition

Disposition Date: 10/20/2010

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	Life & Annuity - Actuarial Memo		No
Supporting Document	Statement of Variability		Yes
Supporting Document	Associated Forms List		Yes
Supporting Document	Certification of Compliance		Yes
Supporting Document	Agent's Report		Yes
Form (revised)	Application for Life Insurance		Yes
Form	Application for Life Insurance		Yes

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Amendment Letter

Submitted Date: 10/16/2010

Comments:

Incorrect filing form initially submitted.

Changed Items:

Form Schedule Item Changes:

Form Schedule Item Changes:

Form Number	Form Type	Form Name	Action	Form Action Other	Previous Filing #	Replaced Form #	Readability Score	Attachments
ABB5099 (10/10)	Application/EApplication nrollment Form	for Life Insurance	Initial				50.800	ABB5099 (10-10) [Filing Form 2010-10-14].pdf

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Life
Product Name: 1257: 5099 (10/10)
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Amendment Letter

Submitted Date: 10/16/2010

Comments:

Agent Report - Submitted for your information.

Changed Items:

Supporting Document Schedule Item Changes:

User Added -Name: Agent's Report

Comment:

ABB5099 (10-10)-AS [Filing Form 2010-10-14].pdf

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Form Schedule

Lead Form Number: ABB5099 (10/10)

Schedule Item Status	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
	ABB5099 (10/10)	Application/ Enrollment Form	Application for Life Insurance	Initial		50.800	ABB5099 (10-10) [Filing Form 2010-10-14].pdf

1. PROPOSED INSURED INFORMATION

Name (Last, First, Middle Initial)	Address (If address is a PO BOX, a street address is also required.)
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Years at current address: _____ If less than five (5) years, prior address required. Male Female

Phone Number	SSN or Taxpayer ID	Date of Birth	Age	Place of Birth (City, State, Country)
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2. OWNER INFORMATION (If different from the Proposed Insured.)

Name (Last, First, Middle Initial)	Relationship to Proposed Insured	SSN or Taxpayer ID
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Address (If address is a PO BOX, a street address is also required.)

Years at current address: _____ If less than five (5) years, prior address required.

3. BENEFICIARY INFORMATION (Include percentage shares. If shares are not given, they will be equal.)

<i>If not specified, all beneficiaries will be Primary.</i>	Name	SSN or Taxpayer ID	Relationship	% of Share (Must total 100%)
Primary				
<input type="checkbox"/> Primary <input type="checkbox"/> Contingent				
<input type="checkbox"/> Primary <input type="checkbox"/> Contingent				

4. PRODUCT INFORMATION

<input type="checkbox"/> Ultra Protector I] <input type="checkbox"/> Ultra Protector II] <input type="checkbox"/> Ultra Protector III] <input type="checkbox"/> Check here if you are willing to accept any [Ultra Protector] product for which you qualify based on this application. The insurance for which you qualify may have a graded death benefit for the first two (2) or three (3) years, a face amount less than any indicated on this application, and riders may not be available. All premiums will be applied toward the insurance for which you qualify.	Face Amount <input type="checkbox"/> Solve for Face Amount <input type="checkbox"/> Face Amount \$ _____	Premium Mode <input type="checkbox"/> Monthly Bank Draft] <input type="checkbox"/> Quarterly] <input type="checkbox"/> Semiannually] <input type="checkbox"/> Annually]	Modal Premium \$ _____	<input type="checkbox"/> Check here to select Automatic Premium Loan.
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Children's Term Rider: This rider is only available on [Ultra Protector I].

- Are you applying for the Children's Term Rider? Yes No *If Yes, complete this section.*
- Amount of Children's Term coverage desired: \$ _____

3. Please list below any **Eligible Child proposed for coverage**. **NOTE:** An Eligible Child means any child, stepchild, legally adopted child, or dependent grandchild of the Proposed Insured. A dependent grandchild means a grandchild who is eligible to be claimed on the federal tax return of, and resides with, the Proposed Insured.

Full Name of Eligible Child Proposed for Coverage	Date of Birth	Sex	Height	Weight
		<input type="checkbox"/> M <input type="checkbox"/> F		
		<input type="checkbox"/> M <input type="checkbox"/> F		
		<input type="checkbox"/> M <input type="checkbox"/> F		

4. In the past seven (7) years, has any Eligible Child proposed for coverage ever been diagnosed or treated by a member of the medical profession for: birth defects or blood disorders, cancer, convulsions or seizures, diabetes, Down's syndrome, digestive disorder, emotional or psychiatric disorder, heart disorder, kidney or liver disorder, lung or respiratory disorder, nervous system disorder, alcohol or drug abuse, Acquired Immune Deficiency Syndrome (AIDS) or AIDS-Related Complex (ARC), or any immune deficiency related disorder; or tested positive for antibodies to the Human Immunodeficiency Virus (HIV)? *If Yes, circle the condition(s) and provide details below.* Yes No

5. Has any Eligible Child proposed for coverage been diagnosed or treated by a member of the medical profession for any disease or disorder not mentioned above? *If Yes, provide details below.* Yes No

Name of Eligible Child	Reason Treated	Date(s) of Treatment	Name/Address/Phone Number of Doctor/Hospital Where Treated

5. REPLACEMENT INFORMATION

- 1. Is there any existing life insurance or annuity coverage on the life of any Proposed Insured? *If Yes, provide information below.* Yes No
- 2. Will the life insurance applied for replace or otherwise reduce in value any existing life insurance or annuities now in force? *If Yes, complete applicable replacement form(s) and submit with application. Application and replacement form(s) must be dated on the same date.* Yes No

Insured's Name	Company	Owner	Life Amount	Accidental Death Benefit	Policy Date

6. HEALTH INFORMATION *(Provide details of all Yes answers in the Health Question Details/Remarks section.)*

The Proposed Insured elects [Ultra Protector III] and to not answer health questions.

Has the Proposed Insured smoked cigarettes within the last twelve (12) months? ... <input type="checkbox"/> Yes <input type="checkbox"/> No	Proposed Insured's Height	Proposed Insured's Weight
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PART 1 Yes No

- 1. Is the Proposed Insured currently: hospitalized, bedridden, confined to a nursing facility, receiving hospice or home health care; using oxygen to assist in breathing now or within the last six (6) months; confined to a wheelchair or using a walker for a chronic illness now or within the last six (6) months; waiting for or have received an organ transplant; advised to have tests or surgery which have not been completed within the last twelve (12) months; diagnosed with a terminal illness; or paralyzed? Yes No
- 2. Has the Proposed Insured ever:
 - a. Had, been told they have, been treated for, or been prescribed medication for: Alzheimer's disease, dementia, memory loss, muscular dystrophy, or ALS (Lou Gehrig's Disease)? Yes No
 - b. Been diagnosed as having, been treated by a medical professional for, or tested positive for: Acquired Immune Deficiency Syndrome (AIDS), AIDS-Related Complex (ARC), or the Human Immunodeficiency Virus (HIV)? Yes No
- 3. In the past three (3) years, has the Proposed Insured been told they have, or been treated by surgery, chemotherapy, radiation, taken or been prescribed medication for any internal cancer or malignant melanoma (not basal cell skin cancer)? Yes No
- 4. In the past twelve (12) months, has the Proposed Insured had, been told they have, been treated for, taken or been prescribed medication or had surgery for: heart bypass, angioplasty (balloon procedure), stent placement, heart valve disorder; cardiac arrhythmia (including atrial fibrillation or flutter and ventricular fibrillation or flutter), heart attack, or angina (chest pain)? Yes No
- 5. In the past two (2) years, has the Proposed Insured had, been told they have, been treated for, or been prescribed medication or had surgery for congestive heart failure, cardiomyopathy, stroke, circulation or blood clot problems in the legs or to the heart or brain, systemic lupus, chronic kidney disease, or kidney failure? Yes No
- 6. In the past two (2) years has the Proposed Insured:
 - a. Had, been told they have, been treated for, or been prescribed medication for drug or alcohol abuse/dependency or addiction? Yes No
 - b. Been asked to discontinue use or reduce intake of drugs or alcohol? Yes No
- 7. In the past two (2) years, has the Proposed Insured been told they have, been treated for, or taken medication for diabetes in combination with stroke or TIA, heart disease or disorders, kidney disease, eye problems or any other circulatory disease (any disease that affects the heart and the blood vessels)? Yes No

PART 2 Yes No

- 1. In the past two (2) years, has the Proposed Insured ever been told they have, been treated for, or been prescribed medication for: Parkinson's disease, cirrhosis of the liver, chronic hepatitis, or other liver diseases or disorders? Yes No
- 2. In the past three (3) years, has the Proposed Insured experienced complications of diabetes including: amputation, eye or kidney problems, insulin shock, or diabetic coma? Yes No
- 3. In the past two (2) years, has the Proposed Insured had, or been told they have, been treated for, or been prescribed medication for heart bypass, angioplasty (balloon procedure), stent placement, heart valve disorder, heart attack, angina (chest pain), or coronary disease? Yes No
- 4. In the past two (2) years, has the Proposed Insured had, been told they have, been treated for, or been prescribed medication for: emphysema, chronic bronchitis that is not seasonal, or any other chronic respiratory or lung problem excluding allergies or asthma? Yes No

Eligibility for [Ultra Protector I], a level death benefit policy, is based on answers to the Health Questions and additional underwriting criteria.

7. HEALTH QUESTION DETAILS/REMARKS *(Attach a separate sheet if more space is needed; additional sheet must be signed and dated by Proposed Insured/Owner to avoid amendments.)*

8. AUTHORIZATION AND ACKNOWLEDGMENT

I/We authorize any insurance company, employer, physician, medical professional, hospital, medical facility, consumer reporting agency, the Medical Information Bureau, or any other person or organization that has any record of information about me/us or my/our minor children who are to be insured, to give to Americo Financial Life and Annuity Insurance Company (Americo), its reinsurers or its authorized representatives, information about other insurance coverage, employment, age, general character, finances, participation in hazardous activities, medical care or advice about any physical or mental condition including information about drugs and alcoholism, or other information Americo requires to determine insurability or eligibility for benefits. I/We further authorize the sources listed above except the Medical Information Bureau to give such information to a consumer reporting agency acting on behalf of Americo.

Americo may release information obtained by this Authorization to its reinsurers, to the Medical Information Bureau, to other insurers with whom I/we have policies or to whom I/we may apply or submit a claim, to other persons or organizations performing business or legal services in connection with an insurance transaction for me/us, or as may otherwise be lawfully required.

I/We have received a copy of the Notice of Insurance Information Practices. I/We, or my/our authorized representative, may obtain a copy of this Authorization on request. This Authorization will be valid for two (2) years from the date signed. It is Americo's practice to prohibit third parties who lawfully receive nonpublic health information from redisclosing or reusing the disclosed information. A photographic copy shall be as valid as the original. I/We understand that a copy of this authorization will be provided, upon request, to me/us or a person authorized on my/our behalf. I/We understand that disclosure of information to Americo may subject the information to redisclosure in accordance with Americo's privacy policy and MIB, Inc. rules. This authorization may be revoked; however, it may not be revoked during the contestability period of the policy or to the extent Americo has taken action in reliance on this authorization. Notice of revocation may be sent, in writing, to Americo at its Administrative Office address.

IN ACCORDANCE WITH STATE LAW, WE MUST PROVIDE YOU WITH THE FOLLOWING FRAUD NOTICE: 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.

District of Columbia Residents Only: WARNING: 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.

TN Residents only: 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 benefits.

The **USA PATRIOT Act** requires all financial institutions, including insurance companies, to verify the identity of their customers. Providing your name, address, date of birth and taxpayer identification number allows us to verify your identity. Our verification process may include the use of third-party sources to verify the information provided.

REQUEST FOR OWNER'S TAXPAYER IDENTIFICATION NUMBER AND CERTIFICATION: Under penalties of perjury, I as the Owner, certify that the number shown on this form is my correct taxpayer identification number (or I am waiting for a number to be issued to me).

Any policy issued on this application will be deemed to be delivered in and governed by the laws of the jurisdiction in which this application was signed. Notwithstanding the foregoing, if this application is not solicited face to face and is effected through any electronic means, any policy issued on this application will be deemed to be delivered in and governed by the laws of the jurisdiction of the Owner, and said jurisdiction will also be the "Signed at (City and State)" inserted below.

No agent or medical examiner can waive the answer to any question in this application nor decide on insurability nor waive any of the company's underwriting requirements nor make or change any contract. The company shall have no knowledge of statements made by or to the Agent or medical examiner unless such statements are shown on the application.

I/We represent to Americo that the statements made on this application are true, complete and correctly recorded to the best of my/our knowledge and belief. I/We agree that Americo can rely on these statements. I/We agree that this application and/or any medical exam form and any supplemental application or amendment to the application will be the basis for any policy issued on this application or any amendment to the application. **I/WE AGREE THAT ALL ANSWERS TO THE HEALTH QUESTIONS ON PAGE 2 OF THIS APPLICATION, SIGNED AND DATED BELOW, ARE COMPLETE AND ACCURATE.**

Signed at (City and State) _____ on (Month/Day/Year) _____

Signature of Proposed Insured (required) Signature of Owner (if different than Proposed Insured) Signature of Witnessing Agent (required)

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Supporting Document Schedules

	Item Status:	Status Date:
Satisfied - Item: Flesch Certification Comments: Attachment: Certification of Compliance [G] [ABB].pdf		

	Item Status:	Status Date:
Satisfied - Item: Statement of Variability Comments: Attachment: Statement of Variability - SERIES 5099 (10-10).pdf		

	Item Status:	Status Date:
Satisfied - Item: Associated Forms List Comments: Attachment: Associated Forms List - AR.pdf		

	Item Status:	Status Date:
Satisfied - Item: Certification of Compliance Comments: Attachment: Certification of Compliance [G] [ABB].pdf		

	Item Status:	Status Date:
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Satisfied - Item: Agent's Report
Comments:
Attachment:
ABB5099 (10-10)-AS [Filing Form 2010-10-14].pdf

AMERICO FINANCIAL LIFE AND ANNUITY INSURANCE COMPANY

NAIC number: 0449-61999

FEIN number: 35-0810610

Certification of Compliance

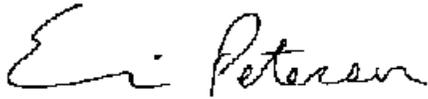
I, Eric H. Petersen – FSA, MAAA hereby certify that, to the best of my knowledge and belief, that the form(s) listed below comply with the laws, rules, and regulations in your jurisdiction.

Form Number(s)

Form Description(s)

ABB5099 (10/10)

Application for Life Insurance



Eric H. Petersen – FSA, MAAA
Assistant Vice President – Product Development

10/15/2010

Date

AMERICO FINANCIAL LIFE AND ANNUITY INSURANCE COMPANY

Statement of Variability for Form Series 5099

PRODUCT INFORMATION - Product Names

The product names are bracketed to facilitate the removal of products that are discontinued, to add products as they become approved for use in your jurisdiction, or modify marketing names without re-filing. We will never add a product for which we have not received authorization from your jurisdiction (if required) to use.

PRODUCT INFORMATION - Premium Mode

The premium mode is bracketed to facilitate any change to availability of payment mode. If availability of a payment mode is eliminated, then it will be eliminated for all new applicants. Americo Financial Life and Annuity Insurance Company will never administer in a discriminatory manner.

Life Application Filing

Arkansas Associated Forms List

Description	Form Number	Disposition	Disposition Date	SERFF Tracking No.
Whole Life Policy – Level Death Benefit	AAR281	Approved	12/26/2007	AFLC-125385961
Accelerated Death Benefit Payment Rider (automatic rider with Policy Series 281 only)	AAR2146	Approved	07/03/2003	SERT-5JLLVF299
Whole Life Policy – Level Death Benefit	AAR284	Approved	12/26/2007	AFLC-125385961
Children's Term Rider (optional rider)	AAA2147	Approved	6/17/2004	USPH-5ZTNAF573

AMERICO FINANCIAL LIFE AND ANNUITY INSURANCE COMPANY

NAIC number: 0449-61999

FEIN number: 35-0810610

Certification of Compliance

I, Eric H. Petersen – FSA, MAAA hereby certify that, to the best of my knowledge and belief, that the form(s) listed below comply with the laws, rules, and regulations in your jurisdiction.

Form Number(s)

Form Description(s)

ABB5099 (10/10)

Application for Life Insurance



Eric H. Petersen – FSA, MAAA
Assistant Vice President – Product Development

10/15/2010

Date

AGENT'S REPORT

Proposed Insured's Name: _____

1. Is the Agent related to the Proposed Insured(s)? Yes No If Yes, provide relationship: _____

Provide details of all No answers in the Agent Comments/Remarks section.

2. How long has the Agent known the Proposed Insured(s)? _____ Yes No

3. At the time this application was taken, were all of the Proposed Insured(s) present and did you witness their signatures?.....

4. Did the Proposed Insured(s) directly respond to each application question?.....

5. Was a government-issued picture I.D. requested, reviewed, and confirmed (by reviewing a second document such as a utility bill, tax return, etc.) for the Proposed Insured, Owner, and Payor (if different than the Proposed Insured)?.....

Provide details of all Yes answers in the Agent Comments/Remarks section.

6. Did the applicant approach you to purchase insurance? (If Yes, list their stated need for the insurance in the Agent Comments/Remarks section.)

7. Does the applicant have any existing life insurance or annuities on the life of any Proposed Insured?.....

8. Will the life insurance applied for replace, or otherwise reduce in value, any life insurance or annuity now in force? **If Yes, complete applicable replacement form(s). Provide copies of replacement form(s) to the Owner and the Company. Leave copies of sales materials with Owner. If you used an electronic sales presentation, you must mail a copy to the Owner.**

Agent Comments/Remarks:

I hereby certify that I have personally asked each question on this application to the Proposed Insured(s), that I have truly and accurately recorded on the application the information supplied by him/her, and that I have no reason to believe that any of the information provided is inaccurate or incomplete. If not, I have set forth my reservations in the Agent Comments/Remarks section above.

Agent Signature	Print Agent Name	Agent Phone Number	Agent Email Address	Agent #	%

ABB5099 (10/10)-AS

Agent's Report

1. PROPOSED INSURED INFORMATION

Name (Last, First, Middle Initial)	Address (If address is a PO BOX, a street address is also required.)
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Years at current address: _____ If less than five (5) years, prior address required. Male Female

Phone Number	SSN or Taxpayer ID	Date of Birth	Age	Place of Birth (City, State, Country)
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2. OWNER INFORMATION (If different from the Proposed Insured.)

Name (Last, First, Middle Initial)	Relationship to Proposed Insured	SSN or Taxpayer ID
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Address (If address is a PO BOX, a street address is also required.)

Years at current address: _____ If less than five (5) years, prior address required.

3. BENEFICIARY INFORMATION (Include percentage shares. If shares are not given, they will be equal.)

<i>If not specified, all beneficiaries will be Primary.</i>	Name	SSN or Taxpayer ID	Relationship	% of Share (Must total 100%)
Primary				
<input type="checkbox"/> Primary <input type="checkbox"/> Contingent				
<input type="checkbox"/> Primary <input type="checkbox"/> Contingent				

4. PRODUCT INFORMATION

<input type="checkbox"/> Ultra Protector I] <input type="checkbox"/> Ultra Protector II] <input type="checkbox"/> Ultra Protector III] <input type="checkbox"/> Check here if you are willing to accept any [Ultra Protector] product for which you qualify based on this application. The insurance for which you qualify may have a graded death benefit for the first two (2) or three (3) years, a face amount less than any indicated on this application, and riders may not be available. All premiums will be applied toward the insurance for which you qualify.	Face Amount <input type="checkbox"/> Solve for Face Amount <input type="checkbox"/> Face Amount \$ _____	Premium Mode <input type="checkbox"/> Monthly Bank Draft] <input type="checkbox"/> Quarterly] <input type="checkbox"/> Semiannually] <input type="checkbox"/> Annually]	Modal Premium \$ _____	<input type="checkbox"/> Check here to select Automatic Premium Loan.
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Children's Term Rider: This rider is only available on [Ultra Protector I].

- Are you applying for the Children's Term Rider? Yes No *If Yes, complete this section.*
- Amount of Children's Term coverage desired: \$ _____

3. Please list below any **Eligible Child proposed for coverage**. **NOTE:** An Eligible Child means any child, stepchild, legally adopted child, or dependent grandchild of the Proposed Insured. A dependent grandchild means a grandchild who is eligible to be claimed on the federal tax return of, and resides with, the Proposed Insured.

Full Name of Eligible Child Proposed for Coverage	Date of Birth	Sex	Height	Weight
		<input type="checkbox"/> M <input type="checkbox"/> F		
		<input type="checkbox"/> M <input type="checkbox"/> F		
		<input type="checkbox"/> M <input type="checkbox"/> F		

4. In the past seven (7) years, has any Eligible Child proposed for coverage ever been diagnosed or treated by a member of the medical profession for: birth defects or blood disorders, cancer, convulsions or seizures, diabetes, Down's syndrome, digestive disorder, emotional or psychiatric disorder, heart disorder, kidney or liver disorder, lung or respiratory disorder, nervous system disorder, alcohol or drug abuse, Acquired Immune Deficiency Syndrome (AIDS) or AIDS-Related Complex (ARC), or any immune deficiency related disorder; or tested positive for antibodies to the Human Immunodeficiency Virus (HIV)? *If Yes, circle the condition(s) and provide details below.* Yes No

5. Has any Eligible Child proposed for coverage been diagnosed or treated by a member of the medical profession for any disease or disorder not mentioned above? *If Yes, provide details below.* Yes No

Name of Eligible Child	Reason Treated	Date(s) of Treatment	Name/Address/Phone Number of Doctor/Hospital Where Treated

5. REPLACEMENT INFORMATION

- 1. Is there any existing life insurance or annuity coverage on the life of any Proposed Insured? *If Yes, provide information below.* Yes No
- 2. Will the life insurance applied for replace or otherwise reduce in value any existing life insurance or annuities now in force? *If Yes, complete applicable replacement form(s) and submit with application. Application and replacement form(s) must be dated on the same date.* Yes No

Insured's Name	Company	Owner	Life Amount	Accidental Death Benefit	Policy Date

6. HEALTH INFORMATION *(Provide details of all Yes answers in the Health Question Details/Remarks section.)*

The Proposed Insured elects [Ultra Protector III] and to not answer health questions.

Has the Proposed Insured smoked cigarettes within the last twelve (12) months? ... <input type="checkbox"/> Yes <input type="checkbox"/> No	Proposed Insured's Height	Proposed Insured's Weight
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PART 1 Yes No

- 1. Is the Proposed Insured currently: hospitalized, bedridden, confined to a nursing facility, receiving hospice or home health care; using oxygen to assist in breathing now or within the last six (6) months; confined to a wheelchair or using a walker for a chronic illness now or within the last six (6) months; waiting for or have received an organ transplant; advised to have tests or surgery which have not been completed within the last twelve (12) months; diagnosed with a terminal illness; or paralyzed? Yes No
- 2. Has the Proposed Insured ever:
 - a. Had, been told they have, been treated for, or been prescribed medication for: Alzheimer's disease, dementia, memory loss, muscular dystrophy, or ALS (Lou Gehrig's Disease)? Yes No
 - b. Been diagnosed as having, been treated by a medical professional for, or tested positive for: Acquired Immune Deficiency Syndrome (AIDS), AIDS-Related Complex (ARC), or the Human Immunodeficiency Virus (HIV)? Yes No
- 3. In the past three (3) years, has the Proposed Insured been told they have, or been treated by surgery, chemotherapy, radiation, taken or been prescribed medication for any internal cancer or malignant melanoma (not basal cell skin cancer)? Yes No
- 4. In the past twelve (12) months, has the Proposed Insured had, been told they have, been treated for, taken or been prescribed medication or had surgery for: heart bypass, angioplasty (balloon procedure), stent placement, heart valve disorder; cardiac arrhythmia (including atrial fibrillation or flutter and ventricular fibrillation or flutter), heart attack, or angina (chest pain)? Yes No
- 5. In the past two (2) years, has the Proposed Insured had, been told they have, been treated for, or been prescribed medication or had surgery for congestive heart failure, cardiomyopathy, stroke, circulation or blood clot problems in the legs or to the heart or brain, systemic lupus, chronic kidney disease, or kidney failure? Yes No
- 6. In the past two (2) years has the Proposed Insured:
 - a. Had, been told they have, been treated for, or been prescribed medication for drug or alcohol abuse/dependency or addiction? Yes No
 - b. Been asked to discontinue use or reduce intake of drugs or alcohol? Yes No
- 7. In the past two (2) years, has the Proposed Insured been told they have, been treated for, or taken medication for diabetes in combination with stroke or TIA, heart disease or disorders, kidney disease, eye problems or any other circulatory disease (any disease that affects the heart and the blood vessels)? Yes No

PART 2 Yes No

- 1. In the past two (2) years, has the Proposed Insured ever been told they have, been treated for, or been prescribed medication for: Parkinson's disease, cirrhosis of the liver, chronic hepatitis, or other liver diseases or disorders? Yes No
- 2. In the past three (3) years, has the Proposed Insured experienced complications of diabetes including: amputation, eye or kidney problems, insulin shock, or diabetic coma? Yes No
- 3. In the past two (2) years, has the Proposed Insured had, or been told they have, been treated for, or been prescribed medication for heart bypass, angioplasty (balloon procedure), stent placement, heart valve disorder, heart attack, angina (chest pain), or coronary disease? Yes No
- 4. In the past two (2) years, has the Proposed Insured had, been told they have, been treated for, or been prescribed medication for: emphysema, chronic bronchitis that is not seasonal, or any other chronic respiratory or lung problem excluding allergies or asthma? Yes No

Eligibility for [Ultra Protector I], a level death benefit policy, is based on answers to the Health Questions and additional underwriting criteria.

7. HEALTH QUESTION DETAILS/REMARKS *(Attach a separate sheet if more space is needed; additional sheet must be signed and dated by Proposed Insured/Owner to avoid amendments.)*

8. AUTHORIZATION AND ACKNOWLEDGMENT

I/We authorize any insurance company, employer, physician, medical professional, hospital, medical facility, consumer reporting agency, the Medical Information Bureau, or any other person or organization that has any record of information about me/us or my/our minor children who are to be insured, to give to Americo Financial Life and Annuity Insurance Company (Americo), its reinsurers or its authorized representatives, information about other insurance coverage, employment, age, general character, finances, participation in hazardous activities, medical care or advice about any physical or mental condition including information about drugs and alcoholism, or other information Americo requires to determine insurability or eligibility for benefits. I/We further authorize the sources listed above except the Medical Information Bureau to give such information to a consumer reporting agency acting on behalf of Americo.

Americo may release information obtained by this Authorization to its reinsurers, to the Medical Information Bureau, to other insurers with whom I/we have policies or to whom I/we may apply or submit a claim, to other persons or organizations performing business or legal services in connection with an insurance transaction for me/us, or as may otherwise be lawfully required.

I/We have received a copy of the Notice of Insurance Information Practices. I/We, or my/our authorized representative, may obtain a copy of this Authorization on request. This Authorization will be valid for two (2) years from the date signed. It is Americo's practice to prohibit third parties who lawfully receive nonpublic health information from redisclosing or reusing the disclosed information. A photographic copy shall be as valid as the original. I/We understand that a copy of this authorization will be provided, upon request, to me/us or a person authorized on my/our behalf. I/We understand that disclosure of information to Americo may subject the information to redisclosure in accordance with Americo's privacy policy and MIB, Inc. rules. This authorization may be revoked; however, it may not be revoked during the contestability period of the policy or to the extent Americo has taken action in reliance on this authorization. Notice of revocation may be sent, in writing, to Americo at its Administrative Office address.

IN ACCORDANCE WITH STATE LAW, WE MUST PROVIDE YOU WITH THE FOLLOWING FRAUD NOTICE: 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.

District of Columbia Residents Only: WARNING: 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.

TN Residents only: 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 benefits.

The **USA PATRIOT Act** requires all financial institutions, including insurance companies, to verify the identity of their customers. Providing your name, address, date of birth and taxpayer identification number allows us to verify your identity. Our verification process may include the use of third-party sources to verify the information provided.

REQUEST FOR OWNER'S TAXPAYER IDENTIFICATION NUMBER AND CERTIFICATION: Under penalties of perjury, I as the Owner, certify that the number shown on this form is my correct taxpayer identification number (or I am waiting for a number to be issued to me).

Any policy issued on this application will be deemed to be delivered in and governed by the laws of the jurisdiction in which this application was signed. Notwithstanding the foregoing, if this application is not solicited face to face and is effected through any electronic means, any policy issued on this application will be deemed to be delivered in and governed by the laws of the jurisdiction of the Owner, and said jurisdiction will also be the "Signed at (City and State)" inserted below.

No agent or medical examiner can waive the answer to any question in this application nor decide on insurability nor waive any of the company's underwriting requirements nor make or change any contract. The company shall have no knowledge of statements made by or to the Agent or medical examiner unless such statements are shown on the application.

I/We represent to Americo that the statements made on this application are true, complete and correctly recorded to the best of my/our knowledge and belief. I/We agree that Americo can rely on these statements. I/We agree that this application and/or any medical exam form and any supplemental application or amendment to the application will be the basis for any policy issued on this application or any amendment to the application. **I/WE AGREE THAT ALL ANSWERS TO THE HEALTH QUESTIONS ON PAGE 2 OF THIS APPLICATION, SIGNED AND DATED BELOW, ARE COMPLETE AND ACCURATE.**

Signed at (City and State) _____ on (Month/Day/Year) _____

Signature of Proposed Insured (required) Signature of Owner (if different than Proposed Insured) Signature of Witnessing Agent (required)

AGENT'S REPORT

Proposed Insured's Name: _____

1. Is the Agent related to the Proposed Insured(s)? Yes No If Yes, provide relationship: _____

Provide details of all No answers in the Agent Comments/Remarks section.

2. How long has the Agent known the Proposed Insured(s)? _____ Yes No
3. At the time this application was taken, were all of the Proposed Insured(s) present and did you witness their signatures?.....
4. Did the Proposed Insured(s) directly respond to each application question?.....
5. Was a government-issued picture I.D. requested, reviewed, and confirmed (by reviewing a second document such as a utility bill, tax return, etc.) for the Proposed Insured, Owner, and Payor (if different than the Proposed Insured)?.....

Provide details of all Yes answers in the Agent Comments/Remarks section.

6. Did the applicant approach you to purchase insurance? (If Yes, list their stated need for the insurance in the Agent Comments/Remarks section.)
7. Does the applicant have any existing life insurance or annuities on the life of any Proposed Insured?.....
8. Will the life insurance applied for replace, or otherwise reduce in value, any life insurance or annuity now in force? **If Yes, complete applicable replacement form(s). Provide copies of replacement form(s) to the Owner and the Company. Leave copies of sales materials with Owner. If you used an electronic sales presentation, you must mail a copy to the Owner.**

Agent Comments/Remarks:

I hereby certify that I have personally asked each question on this application to the Proposed Insured(s), that I have truly and accurately recorded on the application the information supplied by him/her, and that I have no reason to believe that any of the information provided is inaccurate or incomplete. If not, I have set forth my reservations in the Agent Comments/Remarks section above.

Agent Signature	Print Agent Name	Agent Phone Number	Agent Email Address	Agent #	%

ABB5099 (10/10)-AS

Agent's Report

BANK DRAFT AUTHORIZATION

As a convenience to me, I hereby request and authorize the banking institution below (the "Bank") to pay and charge to my account drafts on my account by and payable to the order of the company who issued or assumed the policy listed below (the "Company") administering my insurance policy provided there are sufficient collected funds in said account to pay the same upon presentation. I agree that the Bank's rights in respect to such draft shall be the same as if it were a check drawn on the bank and signed personally by me. This authority is to remain in effect until revoked by me. I agree that the Bank shall be fully protected in honoring any such draft. I further agree that if any such draft be dishonored, whether with or without cause and whether intentionally or inadvertently, the Bank shall be under no liability whatsoever. Should any draft not be honored by the Bank upon presentation, I understand that this method of payment may be terminated.

I understand that Americo requires a five business day advance notice to set up, change, or discontinue my bank draft information. I understand also that my insurance policy may lapse if said draft is returned unpaid by my Bank or if I discontinue payments prior to receiving confirmation of draft processing from the Company.

Requested Draft Date: _____ (Note: bank drafts cannot occur on the 29th, 30th, or 31st of the month) **Unless otherwise requested, premium will be drafted from your account IMMEDIATELY upon policy issuance.**

- Check One** Checking Account (include voided check)
 Savings Account (include deposit slip)
 Check with Application (Use the deposit and routing number from the enclosed check in lieu of a voided check.)

Payor's Signature (as it appears on bank records) _____ Date _____

PAYOR INFORMATION (Complete only when Payor is different than Proposed Insured and Owner.)

Name	Relationship to Proposed Insured	SSN or Taxpayer ID	Proposed Insured's Name
Address (If address is a PO BOX, a street address is also required.)		Years at current address: _____ If less than 5 years, prior address required.	

Attach voided check or deposit slip here.