

SERFF Tracking Number: OXFR-126863496 State: Arkansas  
Filing Company: Oxford Life Insurance Company State Tracking Number: 47064  
Company Tracking Number:  
TOI: L071 Individual Life - Whole Sub-TOI: L071.101 Fixed/Indeterminate Premium - Single Life  
Product Name: OL400 Assurance  
Project Name/Number: /

## Filing at a Glance

Company: Oxford Life Insurance Company

Product Name: OL400 Assurance

TOI: L071 Individual Life - Whole

Sub-TOI: L071.101 Fixed/Indeterminate  
Premium - Single Life

Filing Type: Form

SERFF Tr Num: OXFR-126863496 State: Arkansas

SERFF Status: Closed-Approved-  
Closed State Tr Num: 47064

Co Tr Num:

State Status: Approved-Closed

Author: Pat O'Hara

Date Submitted: 10/15/2010

Reviewer(s): Linda Bird

Disposition Date: 10/20/2010

Disposition Status: Approved-  
Closed

Implementation Date Requested: On Approval

State Filing Description:

Implementation Date:

## General Information

Project Name:

Project Number:

Requested Filing Mode:

Explanation for Combination/Other:

Submission Type: New Submission

Overall Rate Impact:

Filing Status Changed: 10/20/2010

Deemer Date:

Submitted By: Pat O'Hara

Filing Description:

October 15, 2010

Status of Filing in Domicile: Not Filed

Date Approved in Domicile:

Domicile Status Comments: Exempt

Market Type: Individual

Group Market Size:

Group Market Type:

Explanation for Other Group Market Type:

State Status Changed: 10/20/2010

Created By: Pat O'Hara

Corresponding Filing Tracking Number:

Oxford Life Insurance Company

Individual Whole Life Insurance Policy

The attached forms, Form Numbers: OL400 AR, FE400-OLIC Rev 9/2010, AWT/FE400-OLIC Rev 9/2010 and

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EWT/FE400 Rev 9/2010, are being submitted for your review and approval. No part of this filing contains any unusual or possibly controversial items from normal company or industry standards.

The Policy is an Individual Whole Life policy. There are three different plan applications attached to the filing for the various marketing arrangements for the plan, which will be marketed through independent agents.

I certify that I have performed Flesch readability tests on the three application and form combinations, and achieved a minimum Flesch Reading Ease Scores of 65 for OL400AR and 46 for each of the applications.

Please advise if you need any additional information.

Thank you

D. Patrick O'Hara  
Regulatory Compliance Analyst  
Oxford Life Insurance Company  
Phone: 602-263-6666 ext 670130  
Email: patohara@oxfordlife.com

## Company and Contact

### Filing Contact Information

Pat O'Hara, Regulatory Compliance Analyst PatO'Hara@Oxfordlife.com  
2721 N. Central Ave. 602-263-6666 [Phone] 670130  
[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:  
(888) 757-3732 ext. [Phone] FEIN Number: 86-0216483

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## Filing Fees

Fee Required? Yes  
Fee Amount: \$200.00

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Retaliatory? No  
Fee Explanation: \$50 / Policy & \$150.00 3 applications  
Per Company: No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Oxford Life Insurance Company	\$200.00	10/15/2010	40801453

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## Correspondence Summary

### Dispositions

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

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## Disposition

Disposition Date: 10/20/2010

Implementation Date:

Status: Approved-Closed

Comment:

Rate data does NOT apply to filing.

SERFF Tracking Number: OXFR-126863496 State: Arkansas  
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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 - Acturial Memo		No
Form	OL400AR		Yes
Form	OL 400 Application		Yes
Form	AWT-FE 400 Application		Yes
Form	EWT-FE 400 Application		Yes

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## Form Schedule

Lead Form Number: OL400AR

Schedule Item Status	Form Number	Form Type Form Name	Action	Action Specific Data	Readability	Attachment
	OL400AR	Policy/Contract/Fraternal Certificate	Initial		65.000	OL400 AR 10-15-2010.pdf
	FE400-OLIC Rev 9/2010	Application/OL 400 Enrollment Form	Initial		46.000	FE400-OLIC Rev9-28-2010.pdf
	AWT-FE400-OLIC Rev 9/2010	Application/AWT-FE 400 Enrollment Form	Initial		46.000	AWT-FE400-OLIC Rev9-28-10.pdf
	EWT-FE400-OLIC Rev 9/2010	Application/EWT-FE 400 Enrollment Form	Initial		46.000	EWT-FE400-OLIC Rev9-28-10.pdf

## WHOLE LIFE POLICY

**OXFORD LIFE INSURANCE COMPANY** will provide the benefits described in this Policy in consideration of the payment of the premiums as outlined in the Policy Data Page.

This policy is a legal contract between You and Us. ***Upon Written Request, We are required to provide within a reasonable period of time reasonable factual information regarding the benefits and provisions of this Policy.*** To obtain information or to make further inquiries regarding this Policy, You may call Our toll-free number, (866) 641-9999. You may also write to Us at Our Home Office address shown above or visit Our website at [www.oxfordlife.com](http://www.oxfordlife.com).

**NOTICE OF THIRTY DAY RIGHT TO EXAMINE  
- RIGHT TO CANCEL -**

**YOU HAVE PURCHASED A LIFE INSURANCE POLICY. PLEASE READ IT CAREFULLY. THE POLICY INCLUDES THE PROVISIONS BOTH ON THE PAGES WITHIN AND ON ALL AMENDMENTS, RIDERS, AND ENDORSEMENTS THAT ARE ATTACHED.**

**IF, FOR ANY REASON, YOU ARE NOT SATISFIED WITH THIS POLICY, YOU MAY RETURN IT TO US OR TO YOUR AGENT WITHIN THIRTY DAYS FROM THE DATE YOU RECEIVED IT FOR A FULL PREMIUM REFUND. IF WE DO NOT MAKE THE REFUND WITHIN 10 DAYS OF THE DATE WE RECEIVE THE POLICY, WE SHALL PAY INTEREST AS REQUIRED BY THE STATE IN WHICH THE POLICY IS DELIVERED.**

Signed for Oxford Life Insurance Company at Phoenix, Arizona:



President



Secretary

**NO ANNUAL DIVIDENDS  
WHOLE LIFE INSURANCE POLICY  
BENEFIT PAYABLE UPON INSURED'S DEATH  
PREMIUMS PAYABLE DURING LIFETIME OF INSURED**

## POLICY DATA PAGE

<b>Plan Description</b> [Whole Life Insurance]	<b>Policy Number</b> [9876543210]
<b>Name of Insured</b> [John Doe]	<b>Name of Owner</b> [Joan Doe]
<b>Insured's Date of Birth</b> [4/15/1945]	<b>Insured's Gender</b> [Male]
<b>Policy Date</b> [6/1/2010]	<b>Insured's Issue Age</b> [65]
<b>Face Amount</b> [\$10,000]	<b>Risk Class</b> [Non-Tobacco]

<b>Plan Description/Coverage</b>	<b>Face Amount</b>	<b>Premium Payment Period</b>	<b>Annual Premium Payment</b>
[Whole Life Insurance]	[\$10,000]	[56 Years]	[\$540.00]
Total			[\$540.00]
Policy Fee			[\$30.00]
Annual Premium			[\$570.00]
[Quarterly Premium]			[\$151.10]

[State Department of Insurance 1-888-XXX-XXXX]

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## TABLE OF GUARANTEED VALUES

[per \$10,000 Face Amount]

End of Policy Year	Attained Age	Cash Value	Extended Term		End of Policy Year	Attained Age	Cash Value	Extended Term	
			Years	Days				Years	Days
1	66	0	0	0	36	101	8,241	4	1
2	67	23	0	44	37	102	8,327	3	331
3	68	341	1	235	38	103	8,412	3	294
4	69	664	2	326	39	104	8,494	3	255
5	70	993	3	317	40	105	8,574	3	211
6	71	1325	4	236	41	106	8,651	3	162
7	72	1658	5	98	42	107	8,727	3	105
8	73	1990	5	274	43	108	8,801	3	38
9	74	2321	6	39	44	109	8,873	2	349
10	75	2652	6	133	45	110	8,942	2	314
11	76	2983	6	199	46	111	9,010	2	276
12	77	3312	6	242	47	112	9,075	2	231
13	78	3,638	6	265	48	113	9,137	2	176
14	79	3,957	6	272	49	114	9,198	2	101
15	80	4,269	6	264	50	115	9,256	1	364
16	81	4,571	6	245	51	116	9,313	1	337
17	82	4,864	6	215	52	117	9,367	1	304
18	83	5,148	6	177	53	118	9,418	1	257
19	84	5,423	6	132	54	119	9,468	1	146
20	85	5,687	6	83	55	120	9,513	0	356
21	86	5,939	6	30	56	121	10,000	0	0
22	87	6,176	5	344					
23	88	6,399	5	298					
24	89	6,605	5	249					
25	90	6,796	5	198					
26	91	6,973	5	145					
27	92	7,141	5	91					
28	93	7,298	5	33					
29	94	7,446	4	345					
30	95	7,583	4	300					
31	96	7,710	4	254					
32	97	7,833	4	206					
33	98	7,949	4	158					
34	99	8,057	4	110					
35	100	8,153	4	58					

The above Table of Guaranteed Values is based on the Commissioner's 2001 Standard Ordinary Mortality Table, gender- and smoker-distinct, age last birthday, at an annual rate of 5.0%, using continuous functions. These values assume that all due premiums have been paid and that there is no Indebtedness. A detailed description of the method by which these Cash Values are computed has been filed with the Insurance Department in the state where the Policy was delivered. All values are greater than or equal to those required by the laws of that state, assuming no Policy Fee. Interim Cash Values will be adjusted for the time elapsed and the payment of premiums since the last anniversary.

## DEFINITIONS

**Assignee** – A person to whom some right or interest in this Policy is transferred.

**Attained Age** – The Issue Age increased by the number of completed Policy Years.

**Beneficiary** – The person or entity designated at the time of the Insured's death to receive Death Benefits under this Policy. The originally designated Beneficiary is shown in the application, a copy of which is attached. The Beneficiary may be changed according to the Change of Owner or Beneficiary provision. If the Death Benefit is payable to more than one person, payment will be made in equal shares unless specified otherwise.

**Cash Value** – Unless this Policy is continuing as Extended Term Insurance, the minimum Cash Values are as described on Page 4.

**Death Benefit** – The amount We pay upon the death of the Insured.

**Extended Term Insurance** – In the event a policy is in default, the Net Cash Value may be used as a single premium to purchase insurance that is effective for a specified length of time with the same Face Amount as this Policy. The length of time the insurance is effective depends on the amount of the Net Cash Value and the Attained Age of the Insured.

**Face Amount** – The amount shown on the Policy Data Page.

**Home Office** – The Home Office of Oxford Life Insurance Company is 2721 N. Central Ave., Phoenix, AZ 85004-1172.

**Indebtedness** – The sum of any outstanding loans against this Policy plus accumulated interest at the Loan Interest Rate.

**Insured** – The person named on the Policy Data Page whose life is insured under this Policy.

**Issue Age** – The age on the Insured's last birthday as of the Policy Date. It is shown on the Policy Data Page.

**Loan Interest Rate** – The annual interest rate is [7.4%], payable in advance, compounded annually.

**Net Cash Value** – The Cash Value less any Indebtedness. Should the Insured live to the Attained Age of 121, We shall pay You the Net Cash Value in full satisfaction of Our obligations under this Policy.

**Owner, You, Your** – The person or entity named on the Policy Data Page who possesses all rights and privileges under this Policy.

**Parties** – Owner, Insured, payee, Beneficiary, claimant or heirs and Oxford Life Insurance Company.

**Policy Date** – The date this Policy is issued and the premium is applied by Us to Your Policy. It is shown on the Policy Data Page.

**Policy Month** – The first Policy Month begins on the Policy Date. Subsequent Policy Months begin on the same day of each subsequent month.

**Policy Year** – The first Policy Year begins on the Policy Date. Subsequent Policy Years begin on the same month and day of each subsequent year.

**We, Us, Our** – Oxford Life Insurance Company.

**Written Request** – Instructions received by Us at Our Home Office, in writing, using a form provided by Us. A Written Request must be signed and dated by all Owners and Assignees. We reserve the right to reject any incomplete or unclear Written Request.

## GENERAL PROVISIONS

**Assignment of Policy** - No assignment of this Policy will be binding on Us unless it a Written Request that has been recorded at Our Home Office. This Policy may not be assigned without the written consent of all irrevocable Beneficiaries, if any. Any assignment will be subject to any prior assignment of record. We will not assume responsibility for the validity of any assignment. Any claim under an assignment will be subject to proof of the Assignee's interest. Unless otherwise specified by the Owner, the assignment shall take effect on the date the notice of assignment is signed by the Owner, subject to any payments made or actions taken by Us prior to receipt of this notice.

**Change of Owner or Beneficiary** – During the lifetime of the Insured, and subject to the prior written consent of any Assignee or irrevocable Beneficiary, to the extent permitted by law, You may make a Written Request to change the Owner or Beneficiary. We will not be bound by any change unless it is recorded at Our Home Office. Unless otherwise specified by the Owner, the change in Owner or Beneficiary shall take effect on the date the Written Request is signed by the Owner, subject to any payments made or actions taken by Us prior to receipt of this notice.

**Currency** – All financial transactions under this Policy are to be made in United States dollars.

**Entire Contract** - This Policy is issued in consideration of the application and payment of the premium shown on the Policy Data Page. This Policy, the application, a copy of which is attached, and any attached amendments, endorsements and riders make the entire contract.

**Incontestability** – This Policy is not contestable, except for nonpayment of premiums, after it has been in force during the lifetime of the Insured for two years from the later of the Policy Date or the most recent reinstatement. In the absence of fraud, all statements made while applying for this Policy or for its reinstatement will be deemed representations and not warranties. Only material misstatements contained in an application for reinstatement may be used to contest such reinstatement.

**Jurisdiction** – This Policy is subject to the laws of the State in which it is delivered. If any provision of this Policy is contrary to any law to which it is subject, such provision is amended to conform to the minimum requirements of such law.

**Misstatement of Age, Gender or Tobacco** - If the Issue Age, gender or tobacco status of the Insured has been misstated, all amounts payable under this Policy will be those that would have been provided had the correct Issue Age, gender or tobacco status been stated.

**Policy Changes** - Only Our President and Secretary have the authority to make any change to this Policy. No other person has the authority to make any change to this Policy. Any change must be made in writing. Unless You object in writing, We will change this Policy, as necessary, to permit it to be treated as a Life Insurance Policy under any applicable Federal or State law, rule or regulation.

**Reinstatement** - This Policy may be reinstated within three years after it ceases to be in force unless it has been surrendered for its Net Cash Value or any Extended Term Insurance period has expired. Reinstatement is subject to You providing Us with evidence of insurability that is satisfactory to Us. You must also pay all premiums in arrears and repay any Indebtedness, both with interest at 6% per annum, compounded annually.

**Rights of the Owner** - You may exercise all rights, privileges, options, and benefits provided by this Policy.

**Settlement Options** - Upon request, We will offer Your Beneficiaries settlement options as a means to receive the Death Benefit. We have the right to require proof of any payee's age and gender, including a certified copy of the Birth Certificate and/or a copy of the State identification of such payee.

**Suicide Exclusion** - If the Insured commits suicide within two years from the Policy Date, while sane or insane, the Death Benefit will be limited to the premiums paid less any Indebtedness.

## **POLICY VALUES**

**Net Cash Value** – The Net Cash Value is the Cash Value, less any Indebtedness. Upon Written Request, You may surrender this Policy for its Net Cash Value.

**Surrender** – Upon Written Request, You may surrender this policy for the Net Cash Value at any time, and if surrendered within 30 days following a policy anniversary, the value available shall not be less than the Cash Value as of the anniversary date, less any Indebtedness. We may defer the payment for the period permitted by law, but not more than six months after receiving Your Written Request.

**Default** – When a premium is in default, and upon Written Request, You may:

- Surrender this Policy for its Net Cash Value, if any, as of the due date of the first unpaid premium. We may defer the payment for the period permitted by law, but not more than six months after receiving Your Written Request, or
- Elect to continue this Policy for a period as Extended Term Insurance. The Extended Term Insurance period will be determined as of the due date of the first unpaid premium by applying the Net Cash Value, if any, at the net single premium rate. The net single premium rate depends on the Issue Age and on the length of time since the Policy Date. During the Extended Term Insurance period there will be a surrender value but no loan value. Such surrender value will equal the net single premium for the amount and remaining period of Extended Term Insurance. During the thirty-day period following each anniversary such surrender value will not be less than the surrender value on that anniversary. The Death Benefit during the Extended Term Insurance period is the Face Amount.

If the option to Surrender is not elected within sixty days after the due date of an unpaid premium, the Extended Term Insurance option will automatically apply.

## PREMIUM PROVISIONS

**Premiums** - Each premium is payable in advance on or before its due date. Premiums shall be paid to Us at Our Home Office. A receipt will be given upon request.

**Grace Period** - A grace period of 31 days will be allowed for the payment of each premium after the first due date is missed. During this grace period this Policy will remain in force. If the Insured dies during a grace period, any premium due will be deducted from the Death Benefit. If any premium is unpaid at the end of the grace period, this Policy will terminate, subject to the Automatic Premium Loan and Policy Values Provisions, as of the date such premium was due. The Owner shall have the entire grace period within which to remit payment. Any payments sent by U.S. mail shall be postmarked within the grace period.

**Automatic Premium Loan Provision** – Unless You have elected otherwise, if any premium is not paid before the end of the grace period, We will charge as a loan against this Policy that premium, as well as any remaining premium to the end of the then current Policy Year, both including Loan Interest from the end of the grace period in accordance with the Policy Loan Provisions. If the resulting total Indebtedness would exceed the Cash Value at the end of the current Policy Year, this Policy will be continued as Extended Term Insurance as described under the Policy Values provisions.

## POLICY LOAN PROVISIONS

Upon Written Request, so long as no premium is in default beyond the end of the grace period, You may borrow money from Us on the sole security of this Policy. The resulting total Indebtedness may not exceed the Cash Value at the end of the then current Policy Year reduced by any unpaid premium for that year, including any Loan Interest that would be payable on a loan of such premium. We may defer the granting of any loan, other than for the payment of premiums, for no more than six months after receiving Your Written Request.

**Loan Interest** – Loan interest is payable on each Policy anniversary, except at the time a loan is made. At that time interest to the next Policy anniversary will be payable on the date of the loan. Interest not paid when due will be added to the loan and will bear interest thereafter at the Loan Interest Rate.

**Loan Repayment** – You may repay any portion of the Indebtedness at any time while the Insured is living and while this Policy is in force and not being continued as Extended Term Insurance. We will refund any corresponding unearned interest or credit it to the Indebtedness as of the date of payment.

**Loan Exceeding Cash Value** – If the Indebtedness exceeds the Cash Value, We will notify You or the last Assignee by mail at the last known address. If You do not pay such excess within 31 days after We mail the notice, this Policy will terminate on the 32<sup>nd</sup> day.

## DEATH BENEFIT PROVISIONS

**Amount Paid** – The amount paid to the Beneficiary is the Face Amount less any Indebtedness, less any unpaid premium, if you are in the grace period. The amount paid may be increased by the portion of any premium paid beyond the Policy Month in which the Insured died. If the Policy is continuing as Extended Term Insurance, the amount paid will be the Face Amount. Upon making this payment, We are discharged from all future claims.

**Interest on Death Benefit** – Interest shall accrue at a rate of 8% per year and be payable from the date of death if the Company does not provide payment of policy proceeds within 31 days of the following:

- (i) The date that due proof of death is received by the company;
- (ii) The date We receive sufficient information to determine Our liability, the extent of the liability, and the appropriate payee legally entitled to the proceeds; and

(iii) The date that legal impediments to payment of proceeds that depend on the action of parties other than the company are resolved and sufficient evidence of the same is provided to the company. Legal impediments to payment include, but are not limited to (a) The establishment of guardianships and conservatorships; (b) the appointment and qualification of trustees, executors and administrators; and (c) the submission of information required to satisfy a state and federal reporting requirements.

**Payment of Policy Proceeds** – We will pay the Death Benefit within 31 days of Our receipt of all of the following:

- Sufficient proof of the Insured's death;
- Sufficient proof of the Beneficiary's identity;
- A properly completed claim form; and
- This Policy or a lost Policy statement.

An original, certified copy of the Death Certificate issued by the State Office of Vital Records and Statistics is sufficient Proof of Death. We may accept alternative proof at Our sole discretion.

We will make payment in accordance with the latest Beneficiary designation. The interest of any Beneficiary who dies before the Insured will terminate at the death of such Beneficiary. The interest of any Beneficiary who dies at the time of, or within fifteen days after, the death of the Insured will also terminate if no benefits have been paid to such Beneficiary.

If no Beneficiary survives the Insured, then the Owner, if living, will be the Beneficiary. If the Owner is not living, the Owner's estate will be the Beneficiary.



2721 NORTH CENTRAL AVENUE, PHOENIX, ARIZONA 85004-1172  
(866) 641-9999

**NO ANNUAL DIVIDENDS  
WHOLE LIFE INSURANCE POLICY  
BENEFIT PAYABLE UPON INSURED'S DEATH  
PREMIUMS PAYABLE DURING LIFETIME OF INSURED**

**APPLICATION**

**TELEPHONE INTERVIEW 1-888-801-5123**

**Section A — Personal Information**

**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  Yes  No

If no, are you a Permanent U.S. Resident  Yes  No

**OWNER (If other than Proposed Insured)**

Owner's 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?  Yes  No

Is this policy being purchased to replace any existing life insurance or annuity coverage?  Yes  No If Yes, please list:

Company

Policy No.

Address, City, State, Zip Code

Has the Owner, Proposed Insured or Beneficiary entered into or made plans to enter into any agreement or contract to sell or assign the ownership of, or a beneficial interest in this policy?  Yes  No If yes, no coverage will be issued.

**BENEFICIARY**

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

%

**Section B — Policy Information**

PREMIUM AMOUNT \$ \_\_\_\_\_

FACE AMOUNT \$ \_\_\_\_\_

PAYMENT FREQUENCY:  Monthly  Quarterly  Semi-Annually  Annually

Additional out-of-pocket costs may apply should you choose to pay your premiums monthly, quarterly or semi-annually.

Check here if Owner does **not** want the Automatic Premium Loan provision:

Section C — If any question in Section C is answered "Yes", or if height and weight exceeds the maximum range, NO COVERAGE CAN BE ISSUED.	ANSWER FOR PROPOSED INSURED	
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 or do you have paralysis of two or more extremities?	<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 or were you diagnosed with Diabetes prior to age 30?	<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, organic brain syndrome, 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, leukemia, lymphoma, stroke, transient ischemic attack (TIA) or have you had an amputation caused by any disease?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
9. Have you had more than one occurrence or any metastasis of any cancer in your lifetime (excluding basal or squamous cell skin cancer), or are you currently being treated for cancer or recurrence of cancer?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
10. Within the past 24 months have you:		
a. been medically diagnosed, treated or taken medication for: angina, chronic hepatitis, cystic fibrosis, Pulmonary Fibrosis, chronic obstructive pulmonary disease (COPD), chronic bronchitis, emphysema, respiratory failure 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, 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
11. 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
12. 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
13. Have you been declined or postponed for life or health insurance in the past two years?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
14. Do you have any impairment, whether physical or mental, for which you need or receive assistance or supervision in performing normal activities of daily living such as dressing, eating, bathing, incontinence, toileting, taking medications, or moving without any type of physical assistance?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
<b>Section D – If any question in Section D is answered "Yes", it may not necessarily exclude coverage.</b>		
15. Are you taking medication for any impairment in Section C?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
16. Have you used any nicotine based products in the past 12 months?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
17. Have you applied for life insurance with any other insurance companies in the last two years?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
18. Proposed Insured's driver's license number _____ State _____	<input type="checkbox"/> None	

**Section E — Statements and Authorizations**

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

I have read and understood the 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 representations in Sections A, B, C, D and E are true. I agree the policies shall not be in effect until they have been issued by Oxford Life Insurance Company ("the Company") and the premium is paid during my lifetime. I understand that the Producer has no authority to approve the Application, change the policies, or waive any policy provisions. I understand no insurance will be effective until the date stated in the policies and all eligibility requirements are met. The purpose of this Application is not to sell or assign it to any type of viatical settlement, senior settlement or life settlement company.

\_\_\_\_\_  
Proposed Insured's Initials

**MEDICAL AUTHORIZATION**

I authorize any physician, medical practitioner, hospital, medical care facility, the Veteran's Administration, insurance company, the Medical Information Bureau (MIB), 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 on page 7. 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 36 months, except for HIV-related information, which is only valid for 180 days from the date below.

**WARNING**

**FRAUD NOTICE**

**Any person who knowingly submits a false statement in an Application or files a claim containing false or deceptive statements may be guilty of insurance fraud and subject to penalties under state law.**

**I have read, understand, and acknowledge the Fraud Notice.**

\_\_\_\_\_  
Proposed Insured's Initials

\_\_\_\_\_  
Owner's Initials

**MISREPRESENTATION NOTICE**

**If your answers to the questions in the application are incorrect or untrue, Oxford Life Insurance Company may deny coverage by voiding or canceling your policy and returning your premium payments to you or your estate. Be aware that voiding or canceling your policy may have an adverse impact to your intended beneficiary (ies).**

**I have read, understand, and acknowledge the Misrepresentation Notice. I agree that the information on this application will be relied on to determine insurability and that incorrect or untrue information may result in coverage being voided, subject to the Incontestability provision in the policy.**

\_\_\_\_\_  
Proposed Insured's Initials

\_\_\_\_\_  
Owner's Initials

\_\_\_\_\_  
Proposed Insured's Signature

\_\_\_\_\_  
Owner's Signature

\_\_\_\_\_  
Date

**Section F — Producer Only**

**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 Applicant 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 the Proposed Insured and Owner appeared to me to be lucid and to fully understand all of the questions on this Application. I certify to the best of my knowledge that the Owner or Proposed Insured is not being paid cash or promised services as an inducement to enter into this insurance transaction and to my knowledge, this insurance transaction will not be sold or assigned for any type of senior settlement, life settlement or any other secondary market.

\_\_\_\_\_  
Writing Producer's Signature

\_\_\_\_\_  
Producer's Printed Name / Producer's Number

\_\_\_\_\_  
Date

**PRODUCER USE ONLY IF REQUESTING COMMISSION SPLITS**

\_\_\_\_\_  
Producer's Printed Name

\_\_\_\_\_  
Producer's Number

\_\_\_\_\_  
Split

\_\_\_\_\_  
/

\_\_\_\_\_  
%

\_\_\_\_\_  
Producer's Printed Name

\_\_\_\_\_  
Producer's Number

\_\_\_\_\_  
Split

\_\_\_\_\_  
/

\_\_\_\_\_  
%

**MAIL POLICY TO:**  **Owner**  **Producer**

**ASSURANCE – FINAL EXPENSE PRE-AUTHORIZED WITHDRAWAL PLAN**

**Complete the following information for initial and future recurring automatic withdrawals of premium payments**

I, the undersigned, agree that I want all premiums withdrawn from the account listed below in an amount sufficient to pay the premium due for the insurance policy. Additionally, I hereby authorize and request Oxford Life Insurance Company to initiate electronic debit entries or effect a change by any other commercially accepted practice to my 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 request that this Authorization, unless previously revoked, continue to apply to any conversion, renewal, or change later made in the policy. I agree that this Authorization in no way affects the terms of the policy, other than the frequency of payment and I 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 non forfeiture provision of the policy. This Authorization may be terminated by either party by giving written notice to the other.

**Premium Amount to Withdraw** \$ \_\_\_\_\_  Monthly  Quarterly  Semi-Annually  Annually

The effective date and draft date must be the same. If no effective/draft date is designated, the policy's effective date and initial draft date will be the date that the application was received by Oxford Life.  
Future draft dates must occur within 30 days of application date. Please select the draft date you prefer.

**Policy Effective/Draft Date (Between the 1<sup>st</sup> and 28<sup>th</sup>):** Month: \_\_\_\_\_ Day: \_\_\_\_\_

**Bank Account Information:**

Bank Name and Phone Number: \_\_\_\_\_

Bank Address: \_\_\_\_\_

Payor Name: \_\_\_\_\_

Bank Routing Number: \_\_\_\_\_ Account Number: \_\_\_\_\_

Type of Account:  **Savings** (write routing and account numbers below and circle the corresponding numbers)  
 **Checking** (attach void check)

Bank Routing Number

Bank Account Number

0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1
2	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2
3	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3
4	4	4	4	4	4	4	4	4	4	4	4	4	4	4	4	4	4	4	4
5	5	5	5	5	5	5	5	5	5	5	5	5	5	5	5	5	5	5	5
6	6	6	6	6	6	6	6	6	6	6	6	6	6	6	6	6	6	6	6
7	7	7	7	7	7	7	7	7	7	7	7	7	7	7	7	7	7	7	7
8	8	8	8	8	8	8	8	8	8	8	8	8	8	8	8	8	8	8	8
9	9	9	9	9	9	9	9	9	9	9	9	9	9	9	9	9	9	9	9

**FOR CHECKING ACCOUNTS**  
**TAPE COPY OF VOIDED CHECK HERE**

**PAYOR SIGNATURE:** (as on financial institution's records). A copy of this document sent via electronic transmission is as valid as the original.

X \_\_\_\_\_ Date \_\_\_\_\_

This authorization complies with the HIPAA Privacy Rule

HIPAA Authorization  
for Release of Health  
Related Information

\_\_\_\_\_  
Name(s) of Primary Proposed Insured/Patient

\_\_\_\_\_  
Date of Birth

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

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 for use in underwriting risk selection purposes.

This protected health information can 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 will remain in force for 36 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 (**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): \_\_\_\_\_

**CONDITIONAL RECEIPT**

**PLEASE READ THIS CAREFULLY.** This Conditional Receipt will not become effective unless each of the following conditions are met:

- 1) The premium is paid according to the method of premium payment selected in the application in an amount equal to or greater than the minimum required by the Policy; and is received by the Company.
- 2) All underwriting and application requirements are completed no more than 45 days after the date of this Receipt;
- 3) There is no material misrepresentation in the Application, telephone or other interviews, or medical information provided to the Company and
- 4) On the effective date, the Proposed Insured is insurable for the insurance requested in the Application.

If all requirements are not met, or the person(s) to be insured dies by suicide, the liability of the Company is limited to a full refund to the Owner of all premiums received by the Company.

In the event of an adverse underwriting decision, the Company will mail notice to the Owner of the rejection of the Application for insurance and refund the premium, thereby terminating this Receipt. This Receipt provides no insurance for riders or additional benefits.

All checks must be made payable to Oxford Life Insurance Company. Do not make checks payable to the Producer or leave payee blank.

The Company's liability is limited to a refund of the premium paid.

I have advised the Proposed Insured and Owner of the terms, conditions, and limitations of this Conditional Receipt. If the premium is paid by Pre-Authorized Withdrawal Plan, the Payor has completed the form. If the premium is received by check, I have received from \_\_\_\_\_ a check in the amount of \$\_\_\_\_\_. The Application bears the same date as this Receipt. I acknowledge that no producer or broker is authorized to alter or waive the terms of this Receipt, or pass on insurability.

\_\_\_\_\_  
Dated at (City & State)

\_\_\_\_\_  
On (Date)

\_\_\_\_\_  
Producer's Signature

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

**PRIVACY NOTICE**

Your privacy is protected. Oxford Life Insurance Company (We, Us, Our), 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 career.) We also use this information to administer 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 that 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.

**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, that 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.

**STRANGER OWNED LIFE INSURANCE (STOLI) NOTICE**

State insurance law may prohibit the owner of a life insurance policy from entering into any agreement to sell, transfer or assign a life insurance policy prior to the date the policy was issued, or within a period of time specified by state law after the date the policy was issued. You should consult with legal advisors if you have any questions about these matters.

**LEAVE THIS PAGE WITH OWNER**

For Use With Life Insurance Applications

# OXFORD<sup>®</sup>

LIFE INSURANCE COMPANY

2721 NORTH CENTRAL AVENUE  
PHOENIX, AZ 85004



**SINGLE PREMIUM LIFE INSURANCE**

and/or



## **LIFE INSURANCE APPLICATION**

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CONDITIONAL RECEIPT

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MEDICAL INFORMATION BUREAU (MIB) PRE-NOTICE

STRANGER OWNED LIFE INSURANCE (STOLI) NOTICE



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

**TELEPHONE INTERVIEW**  
**1-888-801-5123**



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

**Section A — Personal Information**

**PROPOSED INSURED**

**LIFE INSURANCE APPLICATION**

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 If no, are you a Permanent U.S. Resident <input type="checkbox"/> Yes <input type="checkbox"/> No
---------------	--

**OWNER (If other than Proposed Insured)**

Owner's 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?  Yes  No  
Is this policy being purchased to replace any existing life insurance or annuity coverage?  Yes  No If Yes, please list:

Company	Policies No.	Address, City, State, Zip Code
---------	--------------	--------------------------------

Has the Owner, Proposed Insured or Beneficiary entered into or made plans to enter into any agreement or contract to sell or assign the ownership of, or a beneficial interest in this policy?  Yes  No If yes, no coverage will be issued.

**Section B — Policy Information. Select the plan(s) for which you are applying.**

**■ ADVANCE WEALTH TRANSFER SINGLE PREMIUM LIFE INSURANCE**

PREMIUM AMOUNT \$ _____	FACE AMOUNT \$ _____
-------------------------	----------------------

**BENEFICIARY — Advance Wealth Transfer Single Premium Life Insurance**

Primary	Address, City, State, Zip Code	SSN	%
Primary	Address, City, State, Zip Code	SSN	%
Contingent	Address, City, State, Zip Code	SSN	%
Contingent	Address, City, State, Zip Code	SSN	%

**■ ASSURANCE FINAL EXPENSE WHOLE LIFE INSURANCE**

PREMIUM AMOUNT \$ _____	FACE AMOUNT \$ _____
-------------------------	----------------------

**PAYMENT FREQUENCY:**  Monthly  Quarterly  Semi-Annually  Annually  
Additional out-of-pocket costs may apply should you choose to pay your premiums monthly, quarterly or semi-annually.

Check here if Owner does **not** want the Automatic Premium Loan provision:

**BENEFICIARY — Assurance Final Expense Whole Life Insurance**  Same Beneficiaries

Primary	Address, City, State, Zip Code	SSN	%
Primary	Address, City, State, Zip Code	SSN	%
Contingent	Address, City, State, Zip Code	SSN	%
Contingent	Address, City, State, Zip Code	SSN	%

Section C — If any question in Section C is answered "Yes", or if height and weight exceeds the maximum range, NO COVERAGE CAN BE ISSUED.	ANSWER FOR PROPOSED INSURED	
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 or do you have paralysis of two or more extremities?	<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 or were you diagnosed with Diabetes prior to age 30?	<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, organic brain syndrome, 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, leukemia, lymphoma, stroke, transient ischemic attack (TIA) or have you had an amputation caused by any disease?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
9. Have you had more than one occurrence or any metastasis of any cancer in your lifetime (excluding basal or squamous cell skin cancer), or are you currently being treated for cancer or recurrence of cancer?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
10. Within the past 24 months have you: a. been medically diagnosed, treated or taken medication for: angina, chronic hepatitis, cystic fibrosis, Pulmonary Fibrosis, chronic obstructive pulmonary disease (COPD), chronic bronchitis, emphysema, respiratory failure or required oxygen equipment to assist in breathing? 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? c. had Hodgkin's Disease, cirrhosis, liver disease, or systemic lupus (SLE)? 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
11. 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
12. 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
13. Have you been declined or postponed for life or health insurance in the past two years?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
14. Do you have any impairment, whether physical or mental, for which you need or receive assistance or supervision in performing normal activities of daily living such as dressing, eating, bathing, incontinence, toileting, taking medications, or moving without any type of physical assistance?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
<b>Section D – If any question in Section D is answered "Yes", it may not necessarily exclude coverage.</b>		
15. Are you taking medication for any impairment in Section C?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
16. Have you used any nicotine based products in the past 12 months?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
17. Have you applied for life insurance with any other insurance companies in the last two years?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
18. Proposed Insured's driver's license number _____ State _____	<input type="checkbox"/> None	

**Section E — Statements and Authorizations**

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

I have read and understood the 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 representations in Sections A, B, C, D and E are true. I agree the policies shall not be in effect until they have been issued by Oxford Life Insurance Company ("the Company") and the premium is paid during my lifetime. I understand that the Producer has no authority to approve the Application, change the policies, or waive any policy provisions. I understand no insurance will be effective until the date stated in the policies and all eligibility requirements are met. The purpose of this Application is not to sell or assign it to any type of viatical settlement, senior settlement or life settlement company.

\_\_\_\_\_  
Proposed Insured's Initials

**MEDICAL AUTHORIZATION**

I authorize any physician, medical practitioner, hospital, medical care facility, the Veteran's Administration, insurance company, the Medical Information Bureau (MIB), 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 on page 7. 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 36 months, except for HIV-related information, which is only valid for 180 days from the date below.

**WARNING**

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**I have read, understand, and acknowledge the Fraud Notice.** \_\_\_\_\_  
Proposed Insured's Initials                      Owner's Initials

**MISREPRESENTATION NOTICE**

**If your answers to the questions in the application are incorrect or untrue, Oxford Life Insurance Company may deny coverage by voiding or canceling your policy and returning your premium payments to you or your estate. Be aware that voiding or canceling your policy may have an adverse impact to your intended beneficiary (ies).**

**I have read, understand, and acknowledge the Misrepresentation Notice. I agree that the information on this application will be relied on to determine insurability and that incorrect or untrue information may result in coverage being voided, subject to the Incontestability provision in the policy.** \_\_\_\_\_  
Proposed Insured's Initials                      Owner's Initials

\_\_\_\_\_  
Proposed Insured's Signature                      Owner's Signature                      Date

**Section F — Producer Only**

**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 Applicant 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 the Proposed Insured and Owner appeared to me to be lucid and to fully understand all of the questions on this Application. I certify to the best of my knowledge that the Owner or Proposed Insured is not being paid cash or promised services as an inducement to enter into this insurance transaction and to my knowledge, this insurance transaction will not be sold or assigned for any type of senior settlement, life settlement or any other secondary market.

\_\_\_\_\_  
Writing Producer's Signature                      Producer's Printed Name / Producer's Number                      Date

**PRODUCER USE ONLY IF REQUESTING COMMISSION SPLITS**     **Assurance**     **Advanced Wealth Transfer**

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

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

**MAIL POLICY TO:**     **Owner**     **Producer**



## ASSURANCE – FINAL EXPENSE PRE-AUTHORIZED WITHDRAWAL PLAN

**Complete the following information for initial and future recurring automatic withdrawals of premium payments**

I, the undersigned, agree that I want all premiums withdrawn from the account listed below in an amount sufficient to pay the premium due for the insurance policy. Additionally, I hereby authorize and request Oxford Life Insurance Company to initiate electronic debit entries or effect a change by any other commercially accepted practice to my 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 request that this Authorization, unless previously revoked, continue to apply to any conversion, renewal, or change later made in the policy. I agree that this Authorization in no way affects the terms of the policy, other than the frequency of payment and I 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 non forfeiture provision of the policy. This Authorization may be terminated by either party by giving written notice to the other.

**Premium Amount to Withdraw** \$ \_\_\_\_\_  Monthly  Quarterly  Semi-Annually  Annually

The effective date and draft date must be the same. If no effective/draft date is designated, the policy's effective date and initial draft date will be the date that the application was received by Oxford Life.  
Future draft dates must occur within 30 days of application date. Please select the draft date you prefer.

**Policy Effective/Draft Date (Between the 1<sup>st</sup> and 28<sup>th</sup>):** Month: \_\_\_\_\_ Day: \_\_\_\_\_

**Bank Account Information:**

Bank Name and Phone Number: \_\_\_\_\_

Bank Address: \_\_\_\_\_

Payor Name: \_\_\_\_\_

Bank Routing Number: \_\_\_\_\_ Account Number: \_\_\_\_\_

Type of Account:  **Savings** (write routing and account numbers below and circle the corresponding numbers)  
 **Checking** (attach void check)

Bank Routing Number

Bank Account Number

0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1
2	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2
3	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3
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6	6	6	6	6	6	6	6	6	6	6	6	6	6	6	6	6	6	6	6
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8	8	8	8	8	8	8	8	8	8	8	8	8	8	8	8	8	8	8	8
9	9	9	9	9	9	9	9	9	9	9	9	9	9	9	9	9	9	9	9

**FOR CHECKING ACCOUNTS**  
**TAPE COPY OF VOIDED CHECK HERE**

**PAYOR SIGNATURE:** (as on financial institution's records). A copy of this document sent via electronic transmission is as valid as the original.

X \_\_\_\_\_ Date \_\_\_\_\_

This authorization complies with the HIPAA Privacy Rule

HIPAA Authorization  
for Release of Health  
Related Information

\_\_\_\_\_  
Name(s) of Primary Proposed Insured/Patient

\_\_\_\_\_  
Date of Birth

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

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 for use in underwriting risk selection purposes.

This protected health information can 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 will remain in force for 36 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 (**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): \_\_\_\_\_

**CONDITIONAL RECEIPT**

**PLEASE READ THIS CAREFULLY.** This Conditional Receipt will not become effective unless each of the following conditions are met:

- 1) The premium is paid according to the method of premium payment selected in the application in an amount equal to or greater than the minimum required by the Policy; and is received by the Company.
- 2) All underwriting and application requirements are completed no more than 45 days after the date of this Receipt;
- 3) There is no material misrepresentation in the Application, telephone or other interviews, or medical information provided to the Company and
- 4) On the effective date, the Proposed Insured is insurable for the insurance requested in the Application.

If all requirements are not met, or the person(s) to be insured dies by suicide, the liability of the Company is limited to a full refund to the Owner of all premiums received by the Company.

In the event of an adverse underwriting decision, the Company will mail notice to the Owner of the rejection of the Application for insurance and refund the premium, thereby terminating this Receipt. This Receipt provides no insurance for riders or additional benefits.

All checks must be made payable to Oxford Life Insurance Company. Do not make checks payable to the Producer or leave payee blank.

The Company's liability is limited to a refund of the premium paid.

I have advised the Proposed Insured and Owner of the terms, conditions, and limitations of this Conditional Receipt. If the premium is paid by Pre-Authorized Withdrawal Plan, the Payor has completed the form. If the premium is received by check, I have received from \_\_\_\_\_ a check in the amount of \$\_\_\_\_\_. The Application bears the same date as this Receipt. I acknowledge that no producer or broker is authorized to alter or waive the terms of this Receipt, or pass on insurability.

\_\_\_\_\_  
Dated at (City & State)

\_\_\_\_\_  
On (Date)

\_\_\_\_\_  
Producer's Signature

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

Conditional Receipt

**PRIVACY NOTICE**

Your privacy is protected. Oxford Life Insurance Company (We, Us, Our), 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 career.) We also use this information to administer 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 that 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.

**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, that 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.

**STRANGER OWNED LIFE INSURANCE (STOLI) NOTICE**

State insurance law may prohibit the owner of a life insurance policy from entering into any agreement to sell, transfer or assign a life insurance policy prior to the date the policy was issued, or within a period of time specified by state law after the date the policy was issued. You should consult with legal advisors if you have any questions about these matters.

**LEAVE THIS PAGE WITH OWNER**

For Use With Life Insurance Applications

# OXFORD<sup>®</sup>

LIFE INSURANCE COMPANY

2721 NORTH CENTRAL AVENUE  
PHOENIX, AZ 85004



SINGLE PREMIUM IMMEDIATE TEMPORARY ANNUITY  
AND WHOLE LIFE INSURANCE

and



## APPLICATION

### CONTENTS:

APPLICATION  
PRE-AUTHORIZED WITHDRAWAL PLAN  
HIPAA AUTHORIZATION RELEASE OF HEALTH RELATED INFORMATION  
CONDITIONAL RECEIPT  
PRIVACY NOTICE  
FAIR CREDIT REPORTING ACT NOTICE  
MEDICAL INFORMATION BUREAU (MIB) PRE-NOTICE  
STRANGER OWNED LIFE INSURANCE (STOLI) NOTICE



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



**TELEPHONE INTERVIEW 1-888-801-5123**

**Section A — Personal Information**

**PROPOSED INSURED is also the ANNUITANT**

**SINGLE PREMIUM IMMEDIATE TEMPORARY ANNUITY AND LIFE INSURANCE APPLICATION**

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  Yes  No  
If no, are you a Permanent U.S. Resident  Yes  No

**OWNER (If other than Proposed Insured)**

Owner's 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?  Yes  No  
Are any of these policies being purchased to replace any existing life insurance or annuity coverage?  Yes  No If Yes, please list:

Company	Policy No.	Address, City, State, Zip Code
---------	------------	--------------------------------

Has the Owner, Proposed Insured or Beneficiary entered into or made plans to enter into any agreement or contract to sell or assign the ownership of, or a beneficial interest in this policy?  Yes  No If yes, no coverage will be issued.

**Section B — Policy Information. Select the plan(s) for which you are applying.**

**■ SINGLE PREMIUM IMMEDIATE TEMPORARY ANNUITY**

<b>ANNUITY PAYOUT SCHEDULES</b>	Ages 60-75: The earlier of [10] Years or Life Ages 76-80: The earlier of [7] Years or Life	<b>ESTIMATED ANNUITY PREMIUM AMOUNT</b> \$ _____
---------------------------------	---	---

<b>ANNUITY TAX STATUS</b>	<input type="checkbox"/> Roth IRA <input type="checkbox"/> Non-Qualified <input type="checkbox"/> IRA <input type="checkbox"/> Other _____
---------------------------	--

<b>Annuity Payout Payee:</b> [Oxford Life Insurance Company]	<b>ESTIMATED START DATE:</b> _____
--	------------------------------------

**Notice of Tax Withholding and Election:** I understand that all or a portion of each annual payment from my Single Premium Immediate Temporary Annuity (SPITA) may be considered taxable income, depending on whether the source of funds is qualified or non-qualified. I acknowledge that I am responsible for payments of income taxes on the portion of my annuity distribution. I understand that I may be subject to tax penalties if my payments of tax and withholding are not adequate.

**I understand that if I elect tax withholding from each SPITA payout, that will decrease the SPITA payout amount and may decrease my life insurance death benefit. I understand that I will be billed for any additional premium due on the life insurance policy. If the entire annual premium is not paid, my policy may lapse. If I do not complete the election below, the Company is required to withhold federal and/or state income tax on the annuity distributions.**

\_\_\_\_\_  
Owner's Initials

I elect **not** to withhold any income tax from the annuity payments.     Withhold income tax from the annuity payments.  
Federal:  10%     15%     20%

<b>Section B — Policy Information continued</b>			
<b>■ LIMITED PREMIUM WHOLE LIFE INSURANCE</b>			
ESTIMATED FACE AMOUNT \$ _____			
<b>BENEFICIARY — Limited Premium Whole Life Insurance</b>			
Primary	Address, City, State, Zip Code	SSN	%
Primary	Address, City, State, Zip Code	SSN	%
Contingent	Address, City, State, Zip Code	SSN	%
Contingent	Address, City, State, Zip Code	SSN	%

<b>■ ASSURANCE FINAL EXPENSE WHOLE LIFE INSURANCE</b>			
PREMIUM AMOUNT \$ _____		FACE AMOUNT \$ _____	
<b>PAYMENT FREQUENCY:</b> <input type="checkbox"/> Monthly <input type="checkbox"/> Quarterly <input type="checkbox"/> Semi-Annually <input type="checkbox"/> Annually Additional out-of-pocket costs may apply should you choose to pay your premiums monthly, quarterly or semi-annually.			
Check here if Owner does <b>not</b> want the Automatic Premium Loan provision: <input type="checkbox"/>			
<b>BENEFICIARY — Assurance Final Expense Whole Life Insurance</b> <input type="checkbox"/> Same Beneficiaries as indicated above			
Primary	Address, City, State, Zip Code	SSN	%
Primary	Address, City, State, Zip Code	SSN	%
Contingent	Address, City, State, Zip Code	SSN	%
Contingent	Address, City, State, Zip Code	SSN	%

Section C — If any question in Section C is answered "Yes", or if height and weight exceeds the maximum range, NO COVERAGE CAN BE ISSUED.	ANSWER FOR PROPOSED INSURED	
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 or do you have paralysis of two or more extremities?	<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 or were you diagnosed with Diabetes prior to age 30?	<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, organic brain syndrome, 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, leukemia, lymphoma, stroke, transient ischemic attack (TIA) or have you had an amputation caused by any disease?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
9. Have you had more than one occurrence or any metastasis of any cancer in your lifetime (excluding basal or squamous cell skin cancer), or are you currently being treated for cancer or recurrence of cancer?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
10. Within the past 24 months have you:		
a. been medically diagnosed, treated or taken medication for: angina, chronic hepatitis, cystic fibrosis, Pulmonary Fibrosis, chronic obstructive pulmonary disease (COPD), chronic bronchitis, emphysema, respiratory failure 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, 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
11. 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
12. 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
13. Have you been declined or postponed for life or health insurance in the past two years?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
14. Do you have any impairment, whether physical or mental, for which you need or receive assistance or supervision in performing normal activities of daily living such as dressing, eating, bathing, incontinence, toileting, taking medications, or moving without any type of physical assistance?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
<b>Section D – If any question in Section D is answered "Yes", it may not necessarily exclude coverage.</b>		
15. Are you taking medication for any impairment in Section C?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
16. Have you used any nicotine based products in the past 12 months?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
17. Have you applied for life insurance with any other insurance companies in the last two years?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
18. Proposed Insured's driver's license number _____ State _____	<input type="checkbox"/> None	

**Section E — Statements and Authorizations**

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

I have read and understood the 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 representations in Sections A, B, C, D and E are true. I agree the policies shall not be in effect until they have been issued by Oxford Life Insurance Company ("the Company") and the premium is paid during my lifetime. I understand that the Producer has no authority to approve the Application, change the policies, or waive any policy provisions. I understand no insurance will be effective until the date stated in the policies and all eligibility requirements are met. The purpose of this Application is not to sell or assign it to any type of viatical settlement, senior settlement or life settlement company.

Proposed Insured's Initials

**MEDICAL AUTHORIZATION**

I authorize any physician, medical practitioner, hospital, medical care facility, the Veteran's Administration, insurance company, the Medical Information Bureau (MIB), 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 on page 8. 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 36 months, except for HIV-related information, which is only valid for 180 days from the date below.

**WARNING**

**FRAUD NOTICE**

Any person who knowingly submits a false statement in an Application or files a claim containing false or deceptive statements may be guilty of insurance fraud and subject to penalties under state law.

I have read, understand, and acknowledge the Fraud Notice. \_\_\_\_\_  
Proposed Insured's Initials                      Owner's Initials

**MISREPRESENTATION NOTICE**

If your answers to the questions in the application are incorrect or untrue, Oxford Life Insurance Company may deny coverage by voiding or canceling your policy and returning your premium payments to you or your estate. Be aware that voiding or canceling your policy may have an adverse impact to your intended beneficiary (ies).

I have read, understand, and acknowledge the Misrepresentation Notice. I agree that the information on this application will be relied on to determine insurability and that incorrect or untrue information may result in coverage being voided, subject to the Incontestability provision in the policy. \_\_\_\_\_  
Proposed Insured's Initials                      Owner's Initials

Proposed Insured's Signature                      Owner's Signature                      Date

**Section F — Producer Only**

**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 Applicant 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 the Proposed Insured and Owner appeared to me to be lucid and to fully understand all of the questions on this Application. I certify to the best of my knowledge that the Owner or Proposed Insured is not being paid cash or promised services as an inducement to enter into this insurance transaction and to my knowledge, this insurance transaction will not be sold or assigned for any type of senior settlement, life settlement or any other secondary market.

Writing Producer's Signature                      Producer's Printed Name / Producer's Number                      Date

**PRODUCER USE ONLY IF REQUESTING COMMISSION SPLITS**

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

**MAIL POLICY TO:**     Owner     Producer



## ASSURANCE – FINAL EXPENSE PRE-AUTHORIZED WITHDRAWAL PLAN

**Complete the following information for initial and future recurring automatic withdrawals of premium payments**

I, the undersigned, agree that I want all premiums withdrawn from the account listed below in an amount sufficient to pay the premium due for the insurance policy. Additionally, I hereby authorize and request Oxford Life Insurance Company to initiate electronic debit entries or effect a change by any other commercially accepted practice to my 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 request that this Authorization, unless previously revoked, continue to apply to any conversion, renewal, or change later made in the policy. I agree that this Authorization in no way affects the terms of the policy, other than the frequency of payment and I 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 non forfeiture provision of the policy. This Authorization may be terminated by either party by giving written notice to the other.

**Premium Amount to Withdraw** \$ \_\_\_\_\_  Monthly  Quarterly  Semi-Annually  Annually

The effective date and draft date must be the same. If no effective/draft date is designated, the policy's effective date and initial draft date will be the date that the application was received by Oxford Life.  
Future draft dates must occur within 30 days of application date. Please select the draft date you prefer.

**Policy Effective/Draft Date (Between the 1<sup>st</sup> and 28<sup>th</sup>):** Month: \_\_\_\_\_ Day: \_\_\_\_\_

**Bank Account Information:**

Bank Name and Phone Number: \_\_\_\_\_

Bank Address: \_\_\_\_\_

Payor Name: \_\_\_\_\_

Bank Routing Number: \_\_\_\_\_ Account Number: \_\_\_\_\_

Type of Account:  **Savings** (write routing and account numbers below and circle the corresponding numbers)  
 **Checking** (attach void check)

Bank Routing Number

Bank Account Number

0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1
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9	9	9	9	9	9	9	9	9	9	9	9	9	9	9	9	9	9	9	9

**FOR CHECKING ACCOUNTS**  
**TAPE COPY OF VOIDED CHECK HERE**

**PAYOR SIGNATURE:** (as on financial institution's records). A copy of this document sent via electronic transmission 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

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

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 for use in underwriting risk selection purposes.

This protected health information can 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 will remain in force for 36 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 (**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): \_\_\_\_\_

**CONDITIONAL RECEIPT**

**PLEASE READ THIS CAREFULLY.** This Conditional Receipt will not become effective unless each of the following conditions are met:

- 1) The premium is paid according to the method of premium payment selected in the application in an amount equal to or greater than the minimum required by the Policy; and is received by the Company.
- 2) All underwriting and application requirements are completed no more than 45 days after the date of this Receipt;
- 3) There is no material misrepresentation in the Application, telephone or other interviews, or medical information provided to the Company and
- 4) On the effective date, the Proposed Insured is insurable for the insurance requested in the Application.

If all requirements are not met, or the person(s) to be insured dies by suicide, the liability of the Company is limited to a full refund to the Owner of all premiums received by the Company.

In the event of an adverse underwriting decision, the Company will mail notice to the Owner of the rejection of the Application for insurance and refund the premium, thereby terminating this Receipt. This Receipt provides no insurance for riders or additional benefits.

All checks must be made payable to Oxford Life Insurance Company. Do not make checks payable to the Producer or leave payee blank.

The Company's liability is limited to a refund of the premium paid.

I have advised the Proposed Insured and Owner of the terms, conditions, and limitations of this Conditional Receipt. If the premium is paid by Pre-Authorized Withdrawal Plan, the Payor has completed the form. If the premium is received by check, I have received from \_\_\_\_\_ a check in the amount of \$\_\_\_\_\_. The Application bears the same date as this Receipt. I acknowledge that no producer or broker is authorized to alter or waive the terms of this Receipt, or pass on insurability.

\_\_\_\_\_  
Dated at (City & State)

\_\_\_\_\_  
On (Date)

\_\_\_\_\_  
Producer's Signature

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

**PRIVACY NOTICE**

Your privacy is protected. Oxford Life Insurance Company (We, Us, Our), 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 career.) We also use this information to administer 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 that 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.

**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, that 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.

**STRANGER OWNED LIFE INSURANCE (STOLI) NOTICE**

State insurance law may prohibit the owner of a life insurance policy from entering into any agreement to sell, transfer or assign a life insurance policy prior to the date the policy was issued, or within a period of time specified by state law after the date the policy was issued. You should consult with legal advisors if you have any questions about these matters.

**LEAVE THIS PAGE WITH OWNER**

For Use With Life Insurance Applications

SERFF Tracking Number: OXFR-126863496 State: Arkansas  
Filing Company: Oxford Life Insurance Company State Tracking Number: 47064  
Company Tracking Number:  
TOI: L071 Individual Life - Whole Sub-TOI: L071.101 Fixed/Indeterminate Premium - Single Life  
Product Name: OL400 Assurance  
Project Name/Number: /

## Supporting Document Schedules

**Item Status:**

**Status**

**Date:**

**Satisfied - Item:** Flesch Certification

**Comments:**

**Attachments:**

Readability Cert 1.pdf

Readability Cert 2.pdf

Readability Cert 3.pdf

# READABILITY CERTIFICATION

This is to certify that the attached forms, OL400 AR & EWT-FE400-OLIC, achieved a minimum Flesch Reading Ease Scores of 65 and 46 respectively, and are in compliance with applicable state laws and regulations.

Oxford Life Insurance Company

\_\_\_\_\_  
Jan Riedell

\_\_\_\_\_  
Secretary  
Title

\_\_\_\_\_  
October 15, 2010  
Date

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