

SERFF Tracking Number: CMPL-126867691 State: Arkansas
Filing Company: The Lafayette Life Insurance Company State Tracking Number: 47324
Company Tracking Number: LAFAYETTE IND DISABILITY APP 10-2010
TOI: H111 Individual Health - Disability Income Sub-TOI: H111.008 Combined Short Term and Long Term -
Unrelated to marketing with employer or
association groups
Product Name: LAFAYETTE Ind Disability App 10-2010
Project Name/Number: LAFAYETTE Ind Disability App 10-2010/LAFAYETTE Ind Disability App 10-2010

Filing at a Glance

Company: The Lafayette Life Insurance Company

Product Name: LAFAYETTE Ind Disability App SERFF Tr Num: CMPL-126867691 State: Arkansas
10-2010

TOI: H111 Individual Health - Disability Income SERFF Status: Closed-Approved- State Tr Num: 47324
Closed

Sub-TOI: H111.008 Combined Short Term and Co Tr Num: LAFAYETTE IND State Status: Approved-Closed
Long Term - Unrelated to marketing with
DISABILITY APP 10-2010
employer or association groups

Filing Type: Form

Author: Nancy French

Date Submitted: 11/16/2010

Reviewer(s): Rosalind Minor

Disposition Date: 11/23/2010

Disposition Status: Approved-
Closed

Implementation Date Requested: On Approval

Implementation Date:

State Filing Description:

General Information

Project Name: LAFAYETTE Ind Disability App 10-2010
Project Number: LAFAYETTE Ind Disability App 10-2010
Requested Filing Mode: Review & Approval
Explanation for Combination/Other:
Submission Type: New Submission
Overall Rate Impact:
Filing Status Changed: 11/23/2010

Status of Filing in Domicile: Pending

Date Approved in Domicile:

Domicile Status Comments:

Market Type: Individual

Group Market Size:

Group Market Type:

Explanation for Other Group Market Type:

State Status Changed: 11/23/2010

Created By: Nancy French

Corresponding Filing Tracking Number:

Deemer Date:

Submitted By: Nancy French

Filing Description:

Dear Commissioner/Director:

Compliance Research Services is pleased to submit the enclosed forms on behalf of The Lafayette Life Insurance Company. A letter of filing authorization is enclosed.

SERFF Tracking Number: CMPL-126867691 State: Arkansas
Filing Company: The Lafayette Life Insurance Company State Tracking Number: 47324
Company Tracking Number: LAFAYETTE IND DISABILITY APP 10-2010
TOI: H111 Individual Health - Disability Income Sub-TOI: H111.008 Combined Short Term and Long Term -
Unrelated to marketing with employer or
association groups
Product Name: LAFAYETTE Ind Disability App 10-2010
Project Name/Number: LAFAYETTE Ind Disability App 10-2010/LAFAYETTE Ind Disability App 10-2010

The enclosed forms will be used with individual disability income policies previously approved by your Department. The policies comprise a closed block of business. The enclosed forms will be used to administer changes in the closed block.

The forms will be used to request changes in policies or for policy reinstatement. They include an application for continuance of coverage, request for change or reinstatement, a statement of insurability and a supplemental underwriting questionnaire.

The forms are new forms and will not replace any existing forms on file with your Department. They are in final printed format except for slight font and formatting variations that may occur in printing.

The use of these forms will not result in any changes in rates or actuarial memoranda previously submitted.

The underlined and bracketed language is intended to be variable to allow for policyholder's specific information. The fraud notices are also submitted as variable so that they may be changed without refileing in the event a state-specific notice requires modification due to a change in law or regulation.

We have included any certifications and transmittals required by your state. If you have any questions concerning this filing, please contact me at the phone number or email address shown below.

Sincerely,

J. David Simon, CLU
President
513-984-6050
dsimon@crssolutionsgroup.com

The Lafayette Life Insurance Company
NAIC 65242-0836
Individual Disability Income Forms

From Number Description

SERFF Tracking Number: CMPL-126867691 State: Arkansas
 Filing Company: The Lafayette Life Insurance Company State Tracking Number: 47324
 Company Tracking Number: LAFAYETTE IND DISABILITY APP 10-2010
 TOI: H111 Individual Health - Disability Income Sub-TOI: H111.008 Combined Short Term and Long Term -
 Unrelated to marketing with employer or
 association groups
 Product Name: LAFAYETTE Ind Disability App 10-2010
 Project Name/Number: LAFAYETTE Ind Disability App 10-2010/LAFAYETTE Ind Disability App 10-2010

LAF DI APP 2.0 Policyowner Request for Change or Reinstatement of Disability Income Policy
 LAF DH UND QST 2.0 Supplemental Underwriting Questionnaire
 LAF CCR APP 2.0 Application for Continuance of Coverage on Renewal
 LAF DH SOI 2.0 Statement of Insurability

Company and Contact

Filing Contact Information

Nancy French, Product Manager nfrench@crssolutionsgroup.com
 10921 Reed Hartman Highway 513-984-6050 [Phone]
 Suite 334 513-984-7212 [FAX]
 Cincinnati, OH 45242

Filing Company Information

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

The Lafayette Life Insurance Company CoCode: 65242 State of Domicile: Indiana
 c/o CRS Group Code: Company Type:
 10921 Reed Hartman Highway Group Name: State ID Number:
 Suite 334 FEIN Number: 35-0457540
 Cincinnati, OH 45242
 (513) 984-6050 ext. [Phone]

Filing Fees

Fee Required? Yes
 Fee Amount: \$140.00
 Retaliatory? No
 Fee Explanation: 4 forms filed separately from policy x \$20.00 = 80.00

Home state rate is \$140.00

Per Company: No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
---------	--------	----------------	---------------

SERFF Tracking Number: CMPL-126867691 State: Arkansas
Filing Company: The Lafayette Life Insurance Company State Tracking Number: 47324
Company Tracking Number: LAFAYETTE IND DISABILITY APP 10-2010
TOI: H111 Individual Health - Disability Income Sub-TOI: H111.008 Combined Short Term and Long Term -
Unrelated to marketing with employer or
association groups

Product Name: LAFAYETTE Ind Disability App 10-2010

Project Name/Number: LAFAYETTE Ind Disability App 10-2010/LAFAYETTE Ind Disability App 10-2010

The Lafayette Life Insurance Company \$140.00 11/16/2010 41952050

SERFF Tracking Number: CMPL-126867691 State: Arkansas
Filing Company: The Lafayette Life Insurance Company State Tracking Number: 47324
Company Tracking Number: LAFAYETTE IND DISABILITY APP 10-2010
TOI: H111 Individual Health - Disability Income Sub-TOI: H111.008 Combined Short Term and Long Term -
Unrelated to marketing with employer or
association groups

Product Name: LAFAYETTE Ind Disability App 10-2010
Project Name/Number: LAFAYETTE Ind Disability App 10-2010/LAFAYETTE Ind Disability App 10-2010

Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved- Closed	Rosalind Minor	11/23/2010	11/23/2010

SERFF Tracking Number: CMPL-126867691 State: Arkansas
Filing Company: The Lafayette Life Insurance Company State Tracking Number: 47324
Company Tracking Number: LAFAYETTE IND DISABILITY APP 10-2010
TOI: H111 Individual Health - Disability Income Sub-TOI: H111.008 Combined Short Term and Long Term -
Unrelated to marketing with employer or
association groups

Product Name: LAFAYETTE Ind Disability App 10-2010
Project Name/Number: LAFAYETTE Ind Disability App 10-2010/LAFAYETTE Ind Disability App 10-2010

Disposition

Disposition Date: 11/23/2010

Implementation Date:

Status: Approved-Closed

Comment:

Rate data does NOT apply to filing.

SERFF Tracking Number: CMPL-126867691 State: Arkansas
 Filing Company: The Lafayette Life Insurance Company State Tracking Number: 47324
 Company Tracking Number: LAFAYETTE IND DISABILITY APP 10-2010
 TOI: H111 Individual Health - Disability Income Sub-TOI: H111.008 Combined Short Term and Long Term -
 Unrelated to marketing with employer or
 association groups

Product Name: LAFAYETTE Ind Disability App 10-2010
 Project Name/Number: LAFAYETTE Ind Disability App 10-2010/LAFAYETTE Ind Disability App 10-2010

Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification	Approved-Closed	Yes
Supporting Document	Application	Approved-Closed	Yes
Supporting Document	Health - Actuarial Justification	Approved-Closed	Yes
Supporting Document	Outline of Coverage	Approved-Closed	Yes
Supporting Document	Authorization Letter	Approved-Closed	Yes
Supporting Document	Certification	Approved-Closed	Yes
Form	Policyowner Request for Change or Reinstatement of Disability Income Policy	Approved-Closed	Yes
Form	Supplemental Underwriting Questionnaire	Approved-Closed	Yes
Form	Application for Continuance of Coverage on Renewal	Approved-Closed	Yes
Form	Statement of Insurability	Approved-Closed	Yes

SERFF Tracking Number: CMPL-126867691 State: Arkansas
 Filing Company: The Lafayette Life Insurance Company State Tracking Number: 47324
 Company Tracking Number: LAFAYETTE IND DISABILITY APP 10-2010
 TOI: H111 Individual Health - Disability Income Sub-TOI: H111.008 Combined Short Term and Long Term -
 Unrelated to marketing with employer or
 association groups

Product Name: LAFAYETTE Ind Disability App 10-2010
 Project Name/Number: LAFAYETTE Ind Disability App 10-2010/LAFAYETTE Ind Disability App 10-2010

Form Schedule

Lead Form Number: LAF DI APP 2.0

Schedule Item	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
Approved-Closed 11/23/2010	LAF DI APP 2.0	Application/ Enrollment Form	Policyowner Request for Change or Reinstatement of Disability Income Policy	Initial		56.000	LAF DI App 2_0 - Std Version - final 020210-John Doe.pdf
Approved-Closed 11/23/2010	LAF DH UND QST 2.0	Application/ Enrollment Form	Supplemental Underwriting Questionnaire	Initial		68.000	LAF DH UND QST 2_0 - final 122109-John Doe.pdf
Approved-Closed 11/23/2010	LAF CCR APP 2.0	Application/ Enrollment Form	Application for Continuance of Coverage on Renewal	Initial		48.000	LAF CCR APP 2_0 - Std Version final 012510-John Doe.pdf
Approved-Closed 11/23/2010	LAF DH SOI 2.0	Application/ Enrollment Form	Statement of Insurability	Initial		62.000	LAF DH SOI 2_0 - Std Version final 012510-John Doe.pdf

POLICYOWNER REQUEST FOR CHANGE OR REINSTATEMENT OF DISABILITY INCOME POLICY

THE LAFAYETTE LIFE INSURANCE COMPANY

Home Office: Fort Wayne, Indiana
 Administrative Office:
 [Post Office Box 9000]
 [Coppell, Texas 75019-9000]
 [Phone: [1-800-678-6227]

Policy Number: [1234567]

Applying For:

- Reinstatement:** I hereby make application for reinstatement, in accordance with the terms of the policy named above which lapsed for non-payment of the premium due on: [10-01-2010]
- Policy Change:** I hereby request the following changes in the policy named above: _____

Insured's Name:	<u>[John Doe]</u>	Date of Birth: (MM/DD/YYYY)	<u>[10-01-1968]</u>
Gender:	<u>[Male]</u>	Place of Birth:	<u>[Any City/Any State]</u>
Residential Address:	<u>[987 Oak Street, Any City, Any State 00000]</u>		
Mailing Address: (if different than above)			
Policyowner's Name and Mailing Address: (if different than above)			
Who will pay the premiums for this policy: <input checked="" type="checkbox"/> Insured <input type="checkbox"/> Employer <input type="checkbox"/> Other; Provide Details			
Is any portion of the premium included in taxable income? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes provide % _____			

For purposes of this application, The Lafayette Life Insurance Company will be referred to as "the Company", "we", "us" or "our".

PART I - I make the following representations:

- EMPLOYMENT:** Name of Employer: [XYZ Company]

Occupation/Job Title: [Accountant]

Specific Duties: _____

Employed full time? Yes No Employed part time? Yes No

Minimum Number of hours worked per week? [40]

Business conducted from home? Yes No If yes, hours per week from home: _____

If professional or self-employed, how many: Full-time employees? _____ Part-time employees? _____
- INCOME:**

If not self-employed, annual income Year to Date: \$ [85,000]

As reported on your last year's (20 [09]) income tax return: \$ [125,000]

As reported on your prior year's (20 [08]) income tax return: \$ [110,000]

If self employed, annual income after deducting business expenses: Year to Date: \$ _____

As reported on your last year's (20 _____) income tax return, net: \$ _____

As reported on your prior year's (20 _____) income tax return, net: \$ _____

Net Worth: \$ _____ Annual Unearned Income: \$ _____

PART I (Continued) - I make the following representations:

3. List all disability or income replacement insurance in force or currently applied for with all companies (including long term disability, worker's compensation, group disability and association coverage). **If none, state "none".**

Issue Year	Company	Disability Income	Benefit Period	Business Overhead Expense
	[none]			

a) Does the disability income policy include a social insurance offset provision or rider? Yes No

b) Are you covered by a state cash sickness plan? Yes No

c) Have you ever received benefits or compensation for sickness or injury, or had life or disability insurance modified, declined, not renewed, or issued with a rating or exclusion? Yes No

If "Yes", provide dates and details:

4. Have you used any form of tobacco including smoking cessation products within the last 12 months? Yes No

5. Have you engaged in, or intend to engage in underwater diving, hang gliding or parachuting, mountain or rock climbing, or out of bounds/heli/cat skiing or any other hazardous sport? Yes No

If "Yes", provide dates and details:

6. Have you ever filed for personal or business bankruptcy? Do you have, or have you ever had, any lawsuits, judgments or liens against you, been charged with a criminal offence or are charges pending? Yes No

If "Yes", provide dates and details:

7. Have you had a driver's license suspended or revoked, been charged or convicted of driving while impaired, intoxicated, or under the influence of drugs or alcohol? Yes No

8. In the past 5 years have you been convicted of a moving violation? Yes No

If "Yes" to either question, provide dates and details (including driver's license #):

PART II

1. What is your current: Height: [5' 9"] Weight: [175] Has your weight changed within the last year? Yes No
If "Yes", indicate weight gained: _____ or lost: _____

2. Personal Physician: Name, Address and Telephone Number: [Dr. James Williams, Any City, Any State] _____

3. Date last consulted: [06/2010] Reason: [annual physical exam]

4. Are you currently taking medication or under treatment? Yes No If Yes, provide details: _____

PART II (Continued)

5. Have you been:
- a) Diagnosed or treated by a member of the medical profession for specified symptoms such as: immune deficiency, anemia, recurrent fever, fatigue or unexplained weight loss, malaise, loss of appetite, diarrhea, fever of unknown origin, severe night sweats; unexplained or unusual infections or skin lesions; unexplained swelling of the lymph glands; Kaposi's Sarcoma or Pneumocystis Carinii Pneumonia? Yes No
 - b) Diagnosed by a member of the medical profession as having Human Immunodeficiency Virus (AIDS virus) or Acquired Immune Deficiency Syndrome (AIDS)? Yes No
- [Residents of Delaware, New Jersey, North Dakota and South Dakota need not respond:]**
- c) Tested positive for Human Immunodeficiency Virus (AIDS virus) or Acquired Immune Deficiency Syndrome (AIDS)? Yes No
6. Have you ever had any symptom, known indication of, or been treated for:
- a) Enlargement of the lymph nodes (glands) chronic diarrhea, unusual or persistent skin lesions or unexplained infections or any other immune system disorder? Yes No
 - b) Drug or alcohol abuse, sought treatment, advice or been advised to reduce your alcohol consumption? Yes No
 - c) Any disease or disorder of the eyes, ears, nose, throat skin, thyroid or any other glands, muscles, spine, back or joints including arthritis, amputation or deformity, hernia or rupture? Yes No
 - d) Any disease or disorder of the heart or circulatory system, chest pain or discomfort, heart attack, angina, heart murmur, high blood pressure, stroke, varicose veins or phlebitis? Yes No
 - e) Any disease or disorder of the kidneys, urinary tract, bladder, prostate, reproductive organs or breasts, venereal disease or other infectious disease, diabetes or sugar in urine? Yes No
 - f) Any disease or disorder of the brain or nervous system, stroke, headaches, Parkinson's disease, Alzheimer's disease, fainting spells, dizziness, seizures, epilepsy, multiple sclerosis or fatigue? Yes No
 - g) A psychiatric disorder, mental or emotional disorder including anxiety, depression, stress, burnout or ever attempted suicide? Yes No
 - h) Any tumors, cancer, polyp, cyst, blood disorder or any form of malignant disease? Yes No
 - i) Any disease or disorder of the respiratory system, chest or lungs including tuberculosis, asthma, emphysema, bronchitis or pleurisy? Yes No
 - j) Any disease or disorder of the stomach, colon, intestines, gall bladder, or liver, any type of ulcer, indigestion, colitis or tested positive for hepatitis or been told you are a carrier? Yes No
 - k) Caesarean section, ectopic pregnancy, or any other complication of pregnancy? Yes No
7. Other than the above, have you been disabled, consulted or been treated by a physician or health care practitioner since the date of the original application for the policy for which you are applying to reinstate or change, or been advised to have any diagnostic test, hospitalization or surgery which was not completed? Yes No
8. Have you been off work for more than 5 consecutive days in the past 5 years for any injury or illness, or had any symptom or complaint for which you have not yet sought treatment or consulted a physician? Yes No

PART II (Continued)

Give full details to any "Yes" answers. For each answer, include question number, symptoms, diagnosis, treatment, date and duration of each occurrence. Include time lost from work, whether recovery is complete and if not, provide details. Provide the name, complete address and phone number of the treating doctor and medical facility. If more space is needed to provide complete answers, use a separate sheet of paper that includes your name, date completed and signature.

Question #	Details

IMPORTANT NOTICES (Please Read Carefully)

For purposes of this application, The Lafayette Life Insurance Company will be referred to as "the Company", "we", "us" or "our".

I have read the completed application and understand that any false statement or misrepresentations herein which materially affect the acceptance of the risk or the hazard assumed may result in loss of coverage under the policy which this application is a part.

INCONTESTABILITY

We may contest the validity of any reinstatement or policy change made to the policy for which this application was completed if any statement or answer in the application misrepresents any fact material to the insurance. After two years from the effective date of the reinstatement or policy change approved as a result of this application, no misstatements except fraudulent misstatements, made by the applicant in the application for such policy change or reinstatement shall be used to void the policy or to deny a claim for disability benefits (as defined in this policy) commencing after the expiration of such two year period.

[NOTICE TO UNITED STATES RESIDENTS UNDER FAIR CREDIT REPORTING ACT

We would like to explain a part of our underwriting process that is frequently misunderstood. You are entitled to know that, as part of our routine selection procedure, we **may** request an investigative consumer report ("report") concerning the insurability of each person proposed for coverage. This report would include information as to character, general reputation, personal characteristics and mode of living obtained through personal interviews with friends, neighbors, and associates of the Proposed Insured.

If we request a report and you want: 1) additional information about the nature and scope of the report; or 2) to be interviewed in connection with the report; or 3) to receive a copy of the report; please make a written request to the **Servicing Office, [insert address here]**. Please include the name of your agent as well as your own full name, date of birth and return address.

In order to provide the best possible products on the most favorable basis, it is necessary for us to be somewhat selective in issuing our policies. We sincerely believe that the consumer investigative report is an essential and proper tool to assist us in meeting these mutual objectives. We will do our best to serve you both now and in the future. Please call us any time at our toll-free number: **[insert toll free number]**. You may obtain a written summary of your rights under the Fair Credit Reporting Act online at www.ftc.gov/credit or by writing to: Consumer Response Center, Room 130-A, Federal Trade Commission, 600 Pennsylvania Avenue, NW, Washington, DC 20580.]

West Virginia Notice: No information collected concerning the sexual orientation of the Proposed Insured will be used to determine his/her eligibility for insurance.

[NOTICE REGARDING MEDICAL INFORMATION BUREAU

Information regarding your insurability will be treated as confidential. The Company or its reinsurers may, however, make a brief report thereon to the MIB, Inc., formerly known as Medical Information Bureau, a not-for-profit membership organization of insurance companies, which operates an information exchange on behalf of its members. If you apply to another MIB member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, MIB, upon request, will supply such company with the information about you in its file.

Upon receipt of a request from you, MIB will arrange disclosure of any information in your file. Please contact MIB at 866-692-6901 (TTY 886 346-3642). If you question the accuracy of the information in MIB's file, you may contact MIB and seek a correction in accordance with the procedures set forth in the federal Fair Credit Reporting Act. The address of MIB's information office is 50 Braintree Hill Park, Suite 400, Braintree, Massachusetts 02184-8734.

The Company, or its reinsurers, may also release information from its file to other insurance companies to whom you apply for life or health insurance, or to whom a claim for benefits may be submitted. Information for consumers about MIB may be obtained on its website at www.mib.com.

Note: Canadian Members should continue to use the following address: 330 University Avenue, Suite 501, Toronto, Ontario M5G 1R7, telephone number (416) 597-0590.]

FRAUD NOTICES

[For Residents of Alaska, Nebraska and New Hampshire: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance may be guilty of a crime and may be subject to fines and confinement in prison.]

[For Residents of Colorado: It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado division of insurance within the department of regulatory agencies.]

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

[For Residents of New Jersey: Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.]

[For Residents of New Mexico: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to civil fines and criminal penalties.]

[For Residents of New York: Please see the Signature section of this form.]

[For Residents of Puerto Rico: Any person who, knowingly and with intent to defraud, presents false information in an insurance request form, or who presents, helps or has presented a fraudulent claim for the payment of a loss or other benefit, or presents more than one claim for the same damage or loss, will incur a felony, and upon conviction will be penalized for each violation with a fine no less than five thousand (5,000) dollars nor more than ten thousand (10,000) dollars, or imprisonment for a fixed term of three (3) years, or both penalties. If aggravated circumstances prevail, the fixed established imprisonment may be increased to a maximum of five (5) years; if attenuating circumstances prevail, it may be reduced to a minimum of two (2) years.]

[For Residents of Tennessee and Washington: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.]

[For Residents of All Other States: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.]

[AUTHORIZATION FOR RELEASE OF PERSONAL INFORMATION

This authorization complies with the HIPAA Privacy Rule and applies to each undersigned. Please read carefully and sign below.

I authorize any health plan, physician, health care professional, hospital, clinic, laboratory, pharmacy, pharmacy benefit manager, medical or medically-related facility, federally assisted alcohol or substance abuse program, Veterans Affairs health care facility, or other health care provider or facility that has provided payment, treatment, or services to me or on my behalf or the behalf of me and my minor children who are insured or for whom I am seeking insurance, if any, ("My Providers"), to disclose the entire medical record and any other protected health information concerning me or me and my minor children to the Company and its agents, employees, and representatives. This includes information on the testing, diagnosis, treatment or prognosis of any physical or mental condition, including, but not limited to, Human Immunodeficiency Virus (HIV) infection and

AIDS (Acquired Immune Deficiency Syndrome), sexually transmitted or communicable diseases, mental illness, developmental disabilities, sickle cell anemia, and the use of alcohol, drugs, and tobacco, but excludes psychotherapy notes. By my signature below, I acknowledge that any agreements I have made with My Providers to restrict my or my minor children's protected health information do not apply to this Authorization. I further instruct My Providers to release and disclose my/our entire medical records without restriction, if requested under this Authorization.

I also authorize any insurance or reinsuring company, the MIB, Inc., employer or any other organization, institution, person, consumer reporting agency, or insurance support organization that has any personal (medical or non medical) information of mine or my minor children to release such information, including the entire medical record without restriction if requested, to the Company, its agents, employees and representatives.

The Company may use and disclose information received under this Authorization to: 1) underwrite my application for coverage and make eligibility, risk rating, policy issuance and enrollment determinations; 2) obtain reinsurance; 3) administer claims and determine or fulfill responsibility for coverage and provision of benefits; 4) administer coverage; and 5) conduct other legally permissible activities that relate to any coverage I have or have applied for with the Company. I understand that any information that is disclosed pursuant to this Authorization may be re-disclosed and no longer covered by federal rules governing privacy and confidentiality of health insurance.

This authorization shall remain valid for 24 months following the date of my signature below. A copy of this Authorization is as valid as the original.

I have the right to revoke this Authorization in writing, at any time, by sending a written request for revocation to the Company at [insert address]. A revocation of this Authorization is not effective to the extent that the Company or others have relied on it, 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. My Providers may not refuse to provide treatment or payment for health care services if I refuse to sign this Authorization. I understand that if I refuse to sign this Authorization, 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 have received a copy of this Authorization, which I have signed and will retain for my records.]

SIGNATURES

[For Residents of New York: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.]

I acknowledge that I have received a copy of the IMPORTANT NOTICES and the AUTHORIZATION FOR RELEASE OF PERSONAL INFORMATION.

I have read and understand all the provisions and notices included on this Policyowner Request for Change or Reinstatement.

Dated at [Any Ctiy, Any State] this [30th] day of [October] 20 [10]
City/State

[William Porter]

Witness

[John Doe]

Signature of Primary Insured or Legal Representative

Description of Legal Representative's Authority
or Relationship to Primary Insured

Policyowner's Signature (if other than the Primary Insured)

I certify that I have personally asked the above questions of the insured, and have truly and accurately recorded the information supplied by the insured.

[Robert Smith]

Agent's Name

Signed

[Robert Smith]

Agent's Signature (If Application is taken by Agent)

IMPORTANT NOTICES

Please retain this page for your records. This is your copy of the Important Notices appearing on the Policyowner Request For Change or Reinstatement of Disability Income Policy. For purposes of this application, The Lafayette Life Insurance Company will be referred to as "the Company", "we", "us" or "our".

[NOTICE TO UNITED STATES RESIDENTS UNDER FAIR CREDIT REPORTING ACT

We would like to explain a part of our underwriting process that is frequently misunderstood. You are entitled to know that, as part of our routine selection procedure, we **may** request an investigative consumer report ("report") concerning the insurability of each person proposed for coverage. This report would include information as to character, general reputation, personal characteristics and mode of living obtained through personal interviews with friends, neighbors, and associates of the Proposed Insured.

If we request a report and you want: 1) additional information about the nature and scope of the report; or 2) to be interviewed in connection with the report; or 3) to receive a copy of the report; please make a written request to the **Servicing Office, [insert address here]**. Please include the name of your agent as well as your own full name, date of birth and return address.

In order to provide the best possible products on the most favorable basis, it is necessary for us to be somewhat selective in issuing our policies. We sincerely believe that the consumer investigative report is an essential and proper tool to assist us in meeting these mutual objectives. We will do our best to serve you both now and in the future. Please call us any time at our toll-free number: **[insert toll free number]**. You may obtain a written summary of your rights under the Fair Credit Reporting Act online at www.ftc.gov/credit or by writing to: Consumer Response Center, Room 130-A, Federal Trade Commission, 600 Pennsylvania Avenue, NW, Washington, DC 20580.

[NOTICE REGARDING MEDICAL INFORMATION BUREAU

Information regarding your insurability will be treated as confidential. The Company or its reinsurers may, however, make a brief report thereon to the MIB, Inc., formerly known as Medical Information Bureau, a not-for-profit membership organization of insurance companies, which operates an information exchange on behalf of its members. If you apply to another MIB member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, MIB, upon request, will supply such company with the information about you in its file.

Upon receipt of a request from you, MIB will arrange disclosure of any information in your file. Please contact MIB at 866-692-6901 (TTY 886 346-3642). If you question the accuracy of the information in MIB's file, you may contact MIB and seek a correction in accordance with the procedures set forth in the federal Fair Credit Reporting Act. The address of MIB's information office is 50 Braintree Hill Park, Suite 400, Braintree, Massachusetts 02184-8734.

The Company, or its reinsurers, may also release information from its file to other insurance companies to whom you apply for life or health insurance, or to whom a claim for benefits may be submitted. Information for consumers about MIB may be obtained on its website at www.mib.com.

Note: Canadian Members should continue to use the following address: 330 University Avenue, Suite 501, Toronto, Ontario M5G 1R7, telephone number (416) 597-0590.]

[AUTHORIZATION FOR RELEASE OF PERSONAL INFORMATION - This authorization complies with the HIPAA Privacy Rule and applies to each undersigned. Please read carefully and sign below.

I **authorize** any health plan, physician, health care professional, hospital, clinic, laboratory, pharmacy, pharmacy benefit manager, medical or medically-related facility, federally assisted alcohol or substance abuse program, Veterans Affairs health care facility, or other health care provider or facility that has provided payment, treatment, or services to me or on my behalf or the behalf of me and my minor children who are insured or for whom I am seeking insurance, if any, ("My Providers"), to disclose the entire medical record and any other protected health information concerning me or me and my minor children to the Company and its agents, employees, and representatives. This includes information on the testing, diagnosis, treatment or prognosis of any physical or mental condition, including, but not limited to, Human Immunodeficiency Virus (HIV) infection and AIDS (Acquired Immune Deficiency Syndrome), sexually transmitted or communicable diseases, mental illness, developmental disabilities, sickle cell anemia, and the use of alcohol, drugs, and tobacco, but excludes psychotherapy notes. By my signature below, I acknowledge that any agreements I have made with My Providers to restrict my or my minor children's protected health information do not apply to this Authorization. I further instruct My Providers to release and disclose my/our entire medical records without restriction, if requested under this Authorization.

I **also authorize** any insurance or reinsuring company, the MIB, Inc., employer or any other organization, institution, person, consumer reporting agency, or insurance support organization that has any personal (medical or non medical) information of mine or my minor children to release such information, including the entire medical record without restriction if requested, to the Company, its agents, employees and representatives.

The Company may use and disclose information received under this Authorization to: 1) underwrite my application for coverage and make eligibility, risk rating, policy issuance and enrollment determinations; 2) obtain reinsurance; 3) administer claims and determine or fulfill responsibility for coverage and provision of benefits; 4) administer coverage; and 5) conduct other legally permissible activities that relate to any coverage I have or have applied for with the Company. I understand that any information that is disclosed pursuant to this Authorization may be re-disclosed and no longer covered by federal rules governing privacy and confidentiality of health insurance.

This authorization shall remain valid for 24 months following the date of my signature below. A copy of this Authorization is as valid as the original.

I **have the right to revoke this Authorization in writing**, at any time, by sending a written request for revocation to the Company at **[insert address]**. A revocation of this Authorization is not effective to the extent that the Company or others have relied on it, 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. My Providers may not refuse to provide treatment or payment for health care services if I refuse to sign this Authorization. I understand that if I refuse to sign this Authorization, 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 have received a copy of this Authorization, which I have signed and will retain for my records.]

SUPPLEMENTAL UNDERWRITING QUESTIONNAIRE

THE LAFAYETTE LIFE INSURANCE COMPANY

Home Office: Fort Wayne, Indiana

Administrative Office:

[Post Office Box 9000]

[Coppell, Texas 75019-9000]

Alcohol Questionnaire

1. How often do you drink currently?
 Daily Socially Weekly Less than Weekly None
2. How many drinks (glasses, bottles, cans) do (did) you consume at a time? _____
3. What types of alcohol do (did) you drink? Wine Beer Hard Liquor
4. What is the date of last alcohol consumption (month/year): _____/_____/_____
5. Has a counselor or medical professional ever told you to reduce or stop drinking alcoholic beverages? Yes No If yes, provide details:

6. Have you ever been treated or hospitalized for alcohol use? Yes No If yes, when and where:

7. [**Nevada and North Carolina Residents need not respond.**] Have you been a member of an alcohol support group? Yes No If yes, provide the name of the group and the last meeting attended:

8. Have you ever had any relapses since treated? Yes No If yes, what was the date of your last relapse (month/year)? _____/_____/_____
9. Have you ever been arrested because of excessive alcohol use or been charged with driving under the influence of alcohol? Yes No If yes, provide details and dates (month/year):

SUPPLEMENTAL UNDERWRITING QUESTIONNAIRE

THE LAFAYETTE LIFE INSURANCE COMPANY

Home Office: Fort Wayne, Indiana

Administrative Office:

[Post Office Box 9000]

[Coppell, Texas 75019-9000]

Aviation Questionnaire

A. Flying Time (Indicate hours as pilot, co-pilot, crew member, or passenger with duties aboard aircraft)

1. How many hours have you logged flying for Pay? Insert hours in the appropriate boxes below.

	1-2 Years Ago	Past 12 Months	Next 12 Months
Scheduled passenger airline			
Employer owned aircraft for employee travel			
Other freight or passenger service			
Crop dusting or aerial spraying			
Flight Instructor			
Other: _____			

2. If you do not fly for Pay, how many hours have you logged for the categories below?

	1-2 Years Ago	Past 12 Months	Next 12 Months
Pleasure		[50]	[50]
Personal business transportation			
Student Pilot			
Other: _____			

3. What is your total number of solo hours flown as a pilot? _____ [500] _____

4. What is the date of your last flight? (month/year): _____ [10/2010] _____

B. Licenses and Certificates

1. What type of certificate do you now have?

Student Private Commercial ATR

Other; Provide details: _____

2. What date was your certificate/license obtained? (month/year): _____ [05/2000] _____

3. Do you have an Instrument Flight Rating (IFR)? Yes No

a) How many hours of instrument flight time have you logged in the past 12 months? _____ [50] _____

4. What other ratings do you have? _____ [VFR] _____

SUPPLEMENTAL UNDERWRITING QUESTIONNAIRE

THE LAFAYETTE LIFE INSURANCE COMPANY

Home Office: Fort Wayne, Indiana

Administrative Office:

[Post Office Box 9000]

[Coppell, Texas 75019-9000]

C. Flying Details

1. In what types of aircraft do you fly? (Provide make and model) _____ [Cessna 172] _____

Description: Fixed-wing Rotorcraft Piston Turboprop Jet
 Single-engine Multi-engine

2. What is the seating capacity? ___[4]_____

3. Have you flown or do you intend to fly any of the following? Yes No If yes, which ones:
 Prototype Experimental Homebuilt/kit Ultra light
 Hang glider Balloon Sailplane

4. Do you participate in aerobatic flying? Yes No If yes, provide details and number of hours per year:

5. How much of your flying time is with a qualified co-pilot? ___[None]_____

6. Have you ever had an aircraft accident, or been grounded, fined, or reprimanded for violation(s) of air regulation? Yes No If yes, provide details:

7. Have you flown, or do you intend to fly outside the United States? Yes No If yes, when and where? _____

8. If a rating is required would you prefer to have an Aviation Exclusion Rider? Yes No

SUPPLEMENTAL UNDERWRITING QUESTIONNAIRE

THE LAFAYETTE LIFE INSURANCE COMPANY

Home Office: Fort Wayne, Indiana

Administrative Office:

[Post Office Box 9000]

[Coppell, Texas 75019-9000]

Avocation Questionnaire

A. Mountain Climbing

1. Which types of climbing do you participate in?
 Mountain Climbing Hiking Trail Blazing Rock Climbing
2. Which type of climber are you?
 I have a professional climber status I am an amateur climber_____
3. At what heights do you climb?
 I do not climb mountains/rocks I do climb but: under 13,000 feet Over 13,000 feet
4. What are the locations of climbs? (Past & Future):
 US only (lower 48 states) Africa Alps Andes
 Alaska & Canada, excluding Mt McKinley Mt McKinley Brooks Range
 Himalayas Other; Provide details _____
5. What is your experience level? Less than 2 years More than 2 years
6. What is your total number of climbs? Less than 6 More than 6
7. What is the date of your last climb? (month/year): _____ [09/2010] _____

B. Sky Diving

1. What type of sky diving do you participate in?
 Amateur Professional Instructor Stunt Other; Provide details: _____
2. What is the number of jumps per year? 0-50 51-100 101-200 201+
3. Do you jump: Static Line Free Fall Exhibition Competition
4. What is the date of your last jump? (month/year): _____/_____
5. If a rating is required would you prefer to have an Aviation Exclusion Rider? Yes No

SUPPLEMENTAL UNDERWRITING QUESTIONNAIRE

THE LAFAYETTE LIFE INSURANCE COMPANY

Home Office: Fort Wayne, Indiana

Administrative Office:

[Post Office Box 9000]

[Coppell, Texas 75019-9000]

C. Ballooning

1. Which types apply? Tethered Free Flight_____
2. Do you participate in:
 Record Attempts Ocean Crossing Mountain Crossing
 Other;.Provide details _____
3. What is your experience level? 0 -34 hours 35+hours
4. What is the date of your last flight? (month/year) _____/_____
5. If a rating is required would you prefer to have an Aviation Exclusion Rider? Yes No

D. Hang Gliding

1. Are you a USGH member? Yes No
2. Are you an amateur status? Yes No
3. Are you an Instructor? Yes No
4. Do you participate in record attempts? Yes No
5. Do you use powered Hang Gliders? Yes No If No, describe the gliders that you use.

6. What is the date of your last flight? (month/year): _____/_____
7. How many times a year do you glide? _____
8. If a rating is required would you prefer to have an Aviation Exclusion Rider? Yes No

E. Ultralight

1. Are you a fully licensed airplane pilot? Yes No
2. What types of ultralight do you fly? Commercially produced
 Homebuilt and/or an Experimental craft
3. At what altitudes do you fly? Under 3000 feet Over 3000 feet
4. What is the date of your last flight? (month/year): _____/_____
5. If a rating is required would you prefer to have an Aviation Exclusion Rider? Yes No

SUPPLEMENTAL UNDERWRITING QUESTIONNAIRE

THE LAFAYETTE LIFE INSURANCE COMPANY

Home Office: Fort Wayne, Indiana

Administrative Office:

[Post Office Box 9000]

[Coppell, Texas 75019-9000]

F. Other Sports or Avocations

1. Have you in the past or do you currently participate in another sport or avocation? Yes No
If yes, describe in detail the sport or avocation: _____

- 2.. What is your experience level? Less than 1 year 1-2 years More than 2 years

3. How many times a year do you participate in each activity? _____

4. What is the date of the last activity? (month/year) ____/____

5. Location? _____

6. Do you have a certificate or license? _____

7. Are you a member of any Clubs or Associations? _____

8. Additional Details:

SUPPLEMENTAL UNDERWRITING QUESTIONNAIRE

THE LAFAYETTE LIFE INSURANCE COMPANY

Home Office: Fort Wayne, Indiana

Administrative Office:

[Post Office Box 9000]

[Coppell, Texas 75019-9000]

Back Pain Questionnaire

1. Have you ever had pain in your back? Yes No If yes, indicate location(s):
 Neck (Cervical) Middle Back (Thoracic) Low Back (Lumbar)
2. Any disc involvement? Yes No If yes, provide details: _____

3. What was the diagnosis? _____
4. What causes your back pain? _____
5. When was your first episode of back pain? (month/year): _____/_____
6. Did you have any surgery? Yes No ___ If yes, provide date and details:

7. Is any future surgery or other treatment planned? Yes No If yes, provide date and details:

8. What treatment or medication prescribed? _____
9. Are you currently on treatment or medication? Yes No ___ If no, when did treatment or medication stop? _____/_____
10. Are your symptoms currently: Improving Resolved Stable Worsening
11. When was your last episode of back pain? (month/year) _____/_____
12. Have you missed any time from work due to back pain? Yes No If yes, provide dates and duration _____
13. Please provide the following information regarding the doctor treating your back condition/pain:

Name and Telephone Number	Address
_____	_____
_____	_____
(____) _____	_____

SUPPLEMENTAL UNDERWRITING QUESTIONNAIRE

THE LAFAYETTE LIFE INSURANCE COMPANY

Home Office: Fort Wayne, Indiana

Administrative Office:

[Post Office Box 9000]

[Coppell, Texas 75019-9000]

Disability Questionnaire

1. Have you been disabled (unable to work) in the past ten years? Yes No If yes, provide approximate date disability began (month/year): _____/_____

2. Are you currently disabled? Yes No If no, provide approximate date you returned to work (month/year): _____/_____

3. What injury or disease caused the disability? _____

4. Please provide the name of the physician or medical facility that provided treatment and follow-up care during your disability?

Name and Telephone Number

Address

(____) _____

When did you last consult the physician or medical facility (month/year): _____/_____

5. Please complete the following information regarding your current attending physician:

Name & Telephone Number

Address

(____) _____

SUPPLEMENTAL UNDERWRITING QUESTIONNAIRE

THE LAFAYETTE LIFE INSURANCE COMPANY

Home Office: Fort Wayne, Indiana

Administrative Office:

[Post Office Box 9000]

[Coppell, Texas 75019-9000]

Drug Questionnaire

1. In the past 10 years, have you used:
- | | Yes | No |
|--|--------------------------|-------------------------------------|
| a) Cocaine or other stimulants? | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| b) Marijuana | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| c) LSD or other Hallucinogenics? | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| d) Heroin, Demerol or other narcotics? | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| e) Barbiturates, sedatives or tranquilizers? | <input type="checkbox"/> | <input checked="" type="checkbox"/> |

2. What drugs have you taken over what time periods and with what frequency?

Drugs	Dates Used		How often
	From	To	
[None]			

3. What is the date of last drug use (month/year): ____/____
4. Have you ever been treated or hospitalized for drug use? Yes No If yes, when and where?

5. Have you ever acquired a disease secondary to drug use? Yes No If yes, what disease and when was it diagnosed? _____

6. [Nevada and North Carolina residents need not respond:] Have you ever been a member of a drug rehabilitation support group? Yes No If yes, provide the name of the group and the last meeting attended? _____

7. Have you ever been arrested because of drug use (including motor vehicle violations)?
 Yes No If yes, provide details and dates (month/year): _____

SUPPLEMENTAL UNDERWRITING QUESTIONNAIRE

THE LAFAYETTE LIFE INSURANCE COMPANY

Home Office: Fort Wayne, Indiana

Administrative Office:

[Post Office Box 9000]

[Coppell, Texas 75019-9000]

Financial Questionnaire

1. What is your current financial situation? Please complete the financial worksheet below. This information is used as part of the evaluation of your disability insurance application and is kept strictly confidential.

Assets		Liabilities	
Cash on Hand	[\$2,000]	Accounts Payable	[None]
Personal Residence	[\$350,000]	Personal Loans	
Stocks		Mortgages	
Bonds		Other Debts	
Mutual Funds		Total Liabilities	\$
Personal Property		Net Worth <i>(Total Assets & Total Liabilities)</i>	\$
Accounts Receivable & Notes			
Other Real Estate		Earnings	
Business Ownership		Annual Earned Income	
Other Assets		Passive Income <i>(Investments, rent, etc.)</i>	
Total Assets	\$	Total Annual Income	\$

2. Are you the subject of any liens, legal judgments or pending lawsuits? Yes No
3. Have you undergone bankruptcy in the past five years? Yes No If yes, has the bankruptcy been satisfied? Yes No
4. How much life insurance do you have (all policies totaled)? \$ \$500,000

SUPPLEMENTAL UNDERWRITING QUESTIONNAIRE

THE LAFAYETTE LIFE INSURANCE COMPANY

Home Office: Fort Wayne, Indiana

Administrative Office:

[Post Office Box 9000]

[Coppell, Texas 75019-9000]

Medical Condition Questionnaire

Please answer the following questions relating to: _____

1. When did you first know you had this disease or condition (month/year)? _____/_____
2. Are your symptoms currently: Improving Resolved Stable Worsening
3. If the condition is no longer present, when were you told that you had recovered from it (month/year)? _____/_____
4. Were you ever hospitalized for this condition? Yes No If so, provide the name, telephone number, address of the facility and date (month/year):

Name and Telephone Number

Address

(____) _____

Date of hospitalization (month/year): _____/_____

5. Are you currently taking any medication or treatment for this condition? Yes No If so, list the medication(s) used and dosage(s):

Medication(s)/Treatment(s)

Dosage(s)

6. Is any future surgery or other treatment planned? Yes No If yes, provide details:

7. Please provide the following information regarding your current doctor:

Name and Telephone Number

Address

(____) _____

8. When was your last consultation with your doctor (month/year)? _____/_____

9. Have you ever been required to take any time off work as a result of this condition?
 Yes No If so, provide dates and details including number of days off work:

SUPPLEMENTAL UNDERWRITING QUESTIONNAIRE

THE LAFAYETTE LIFE INSURANCE COMPANY

Home Office: Fort Wayne, Indiana

Administrative Office:

[Post Office Box 9000]

[Coppell, Texas 75019-9000]

Mental/Nervous Disorder Questionnaire

1. Have you ever consulted a doctor for any of the following?

Anxiety disorder Chronic Fatigue Syndrome Depression Insomnia

Manic depression Panic disorder Schizophrenia Suicidal thoughts

Suicide Attempt Other; Provide details: _____

2. Please provide the name(s) of the doctor that has the most complete records of treatment and follow-up care for this condition:

Name and Telephone Number

Address

(____) _____

3. What is the date of your last doctor visit? (month/year) _____/_____/_____

4. At what frequency do you visit the doctor? _____

5. What is the date of your last episode (month/year): _____/_____/_____

6. Are you currently receiving treatment? Yes No If yes, what types of treatment have you received? Counseling ECT (shock therapy) Stress management

Medication (include dosage and name): _____

Other; Provide details: _____

7. Are your symptoms: Improving Resolved Stable Worsening

8. Have you ever been or recommended to be hospitalized? Yes No If yes, provide the name of the medical facility and date (month/year):

Name and Telephone Number

Address

(____) _____

Date hospitalized (month/year): _____/_____/_____

9. Please feel free to add any additional information you feel may help us in evaluating your application:

SUPPLEMENTAL UNDERWRITING QUESTIONNAIRE

THE LAFAYETTE LIFE INSURANCE COMPANY

Home Office: Fort Wayne, Indiana

Administrative Office:

[Post Office Box 9000]

[Coppell, Texas 75019-9000]

Other Insurance Questionnaire

We have reason to believe you applied for life or health insurance from _____.
Because the product for which you have applied requires very little underwriting, we need to know more about these applications.

Insurance Company	Type of Insurance applied for	Amount applied for	Purpose of insurance applied for
	<input type="checkbox"/> Life <input type="checkbox"/> Disability <input type="checkbox"/> Health <input type="checkbox"/> LTC <input type="checkbox"/> Other _____		
What final action was taken on the application?			
<input type="checkbox"/> Policy was issued	<input type="checkbox"/> Policy was not issued		
<input type="checkbox"/> As Applied for	<input type="checkbox"/> Declined		
	Reason		
<input type="checkbox"/> With extra premium	<input type="checkbox"/> Application Withdrawn		
Reason	Reason		
<input type="checkbox"/> Coverage modified or limited	<input type="checkbox"/> Requirements not completed		
Reason	Reason		

[Above format to be repeated to capture multiple prior applications]

If approved, will this application cause you to change or cancel any existing life insurance or annuity?
 Yes No IS THIS QUESTION NECESSARY?

Who is your regular doctor?	
Name	Date of last visit
Address	Reason for last visit
Address	
City State ZIP	

SUPPLEMENTAL UNDERWRITING QUESTIONNAIRE

THE LAFAYETTE LIFE INSURANCE COMPANY

Home Office: Fort Wayne, Indiana

Administrative Office:

[Post Office Box 9000]

[Coppell, Texas 75019-9000]

Overhead Expense Questionnaire

1. Type of Business Organization: Sole Proprietor Partnership Corporation

2. How many persons share the expenses? _____ Your share in percentage _____

3. Number of employees _____ State position held by each:

4. Overhead expense coverage in force:

Company Name	Policy Number	Amount	Replacing Yes or No

5. List your average monthly business expenses:

	Monthly Amount
a) Rent and/or property taxes	
b) Office Maintenance (i.e. janitorial, laundry)	
c) Utilities (heat, water, electricity)	
d) Telephone	
e) Accounting fee or services	
f) Employee salaries and benefits (exclude remuneration for yourself and associates or partners)	
g) Professional association membership fees	
h) Property and liability insurance	
i) Leased equipment and interest payments or scheduled principal payments	
j) Interest plus principal payments for business loans	
k) Itemize other fixed customary business expenses:	
Total Monthly Expenses	

SUPPLEMENTAL UNDERWRITING QUESTIONNAIRE

THE LAFAYETTE LIFE INSURANCE COMPANY

Home Office: Fort Wayne, Indiana

Administrative Office:

[Post Office Box 9000]

[Coppell, Texas 75019-9000]

FRAUD NOTICES

[For Residents of Alaska, Arizona, Nebraska, New Hampshire and Oregon: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance may be guilty of a crime and may be subject to fines and confinement in prison.]

[For Residents of Colorado: It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado division of insurance within the department of regulatory agencies.]

[For Residents of Florida: Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.]

[For Residents of Kansas: Any person who knowingly and with intent to defraud presents false information in an application for insurance may be guilty of a crime and may be subject to fines and confinement in prison.]

[For Residents of Kentucky, Ohio and Pennsylvania: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.]

[For Residents of Maine, Tennessee and Washington: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.]

[For Residents of Minnesota: Any person who knowingly or willfully makes a false or fraudulent statement in, or relative to, any application for insurance or membership for any purpose shall be guilty of a gross misdemeanor.]

[For Residents of New Jersey: Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.]

[For Residents of New Mexico: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to civil fines and criminal penalties.]

SUPPLEMENTAL UNDERWRITING QUESTIONNAIRE

THE LAFAYETTE LIFE INSURANCE COMPANY

Home Office: Fort Wayne, Indiana

Administrative Office:

[Post Office Box 9000]

[Coppell, Texas 75019-9000]

[For Residents of Puerto Rico: Any person who, knowingly and with intent to defraud, presents false information in an insurance request form, or who presents, helps or has presented a fraudulent claim for the payment of a loss or other benefit, or presents more than one claim for the same damage or loss, will incur a felony, and upon conviction will be penalized for each violation with a fine no less than five thousand (5,000) dollars nor more than ten thousand (10,000) dollars, or imprisonment for a fixed term of three (3) years, or both penalties. If aggravated circumstances prevail, the fixed established imprisonment may be increased to a maximum of five (5) years; if attenuating circumstances prevail, it may be reduced to a minimum of two (2) years.]

[For Residents of All Other States: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.]

SIGNATURE

I represent that all statements and answers made in all parts of this application are complete and true to the best of my knowledge and belief. I agree that this questionnaire shall form a part of my application for insurance.

[John Doe]
Proposed Insured

[10/30/2010]
Date

[For Residents of Minnesota: Any person who knowingly or willfully makes a false or fraudulent statement in, or relative to, any application for insurance or membership for any purpose shall be guilty of a gross misdemeanor.]

[For Residents of New Jersey: Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.]

[For Residents of New Mexico: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to civil fines and criminal penalties.]

[For Residents of New York: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.]

[For Residents of Puerto Rico: Any person who, knowingly and with intent to defraud, presents false information in an insurance request form, or who presents, helps or has presented a fraudulent claim for the payment of a loss or other benefit, or presents more than one claim for the same damage or loss, will incur a felony, and upon conviction will be penalized for each violation with a fine no less than five thousand (5,000) dollars nor more than ten thousand (10,000) dollars, or imprisonment for a fixed term of three (3) years, or both penalties. If aggravated circumstances prevail, the fixed established imprisonment may be increased to a maximum of five (5) years; if attenuating circumstances prevail, it may be reduced to a minimum of two (2) years.]

[For Residents of All Other States: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.]

SIGNATURES

I have read the completed application and realize that any false statements or representations herein which materially affect the acceptance of the risk or hazard assumed may result in loss of coverage under the policy of which this application is a part.

Dated at _____ [Any City/Any State] _____ this _____ [30th] _____ day of _____ [October] _____ 20__ [10] _____
City/State

Applicant's Signature: _____ [John Doe] _____ Witness: _____ [William Porter] _____

I certify that I have personally asked the above questions of the insured, and have truly and accurately recorded the information supplied by the insured.

_____ [Robert Smith] _____ Signed _____ [*Robert Smith*] _____
Agent's Name Agent's Signature (If Application is taken by Agent)

STATEMENT OF INSURABILITY

THE LAFAYETTE LIFE INSURANCE COMPANY

Home Office: Fort Wayne, Indiana

Administrative Office:

[Post Office Box 9000]

[Coppell, Texas 75019-9000]

[Phone: [1-800-678-6227]

This statement has been completed as a condition of the delivery and acceptance of the application for reinstatement or policy change completed on the following policy:

Policy Number: [1234567] Insured: [John Doe]

Since the date of the application for reinstatement or policy change completed on:

 [10/20/2010]
(date mm/dd/yyyy)

Has any person proposed for policy change or reinstatement of coverage:

1. Had a change in health, employment status or income? Yes No
2. Made an application for insurance which has been declined, postponed or modified? Yes No
3. Made an application for disability or health insurance with any other company? Yes No
4. Consulted or been examined by a physician or practitioner, or been referred to another physician or had any known indication of any medical condition which was not indicated on the original application as mentioned above?
 Yes No

If you have answered YES to any of the above statements, please provide full details below. In regard to #4 above, please provide dates, diagnosis, doctor's complete name, address and phone number.

FRAUD NOTICES

[For Residents of Alaska, Arizona, Nebraska, New Hampshire and Oregon: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance may be guilty of a crime and may be subject to fines and confinement in prison.]

[**For Residents of Colorado:** It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado division of insurance within the department of regulatory agencies.]

[**For Residents of Florida:** Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.]

[**For Residents of Kansas:** Any person who knowingly and with intent to defraud presents false information in an application for insurance may be guilty of a crime and may be subject to fines and confinement in prison.]

[**For Residents of Kentucky and Ohio:** Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.]

[**For Residents of Maine, Tennessee and Washington:** It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.]

[**For Residents of New Jersey:** Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.]

[**For Residents of New Mexico:** Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to civil fines and criminal penalties.]

[**For Residents of New York:** Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.]

[**For Residents of Puerto Rico:** Any person who, knowingly and with intent to defraud, presents false information in an insurance request form, or who presents, helps or has presented a fraudulent claim for the payment of a loss or other benefit, or presents more than one claim for the same damage or loss, will incur a felony, and upon conviction will be penalized for each violation with a fine no less than five thousand (5,000) dollars nor more than ten thousand (10,000) dollars, or imprisonment for a fixed term of three (3) years, or both penalties. If aggravated circumstances prevail, the fixed established imprisonment may be increased to a maximum of five (5) years; if attenuating circumstances prevail, it may be reduced to a minimum of two (2) years.]

[**For Residents of All Other States:** Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.]

INCONTESTABILITY

We may contest the validity of any reinstatement or policy change made to the policy, for which this statement was completed, if any statement or answer in the application or statement of insurability misrepresents any fact material to the insurance. After two years from the effective date of the reinstatement or policy change approved as a result of this application, no misstatements, except fraudulent misstatements made by the proposed insured in the application or statement of insurability for such policy change or reinstatement, shall be used to void the policy or to deny a claim for benefits (as defined in this policy) commencing after the expiration of such two year period.

SIGNATURES

I represent that all statements and answers made above are complete and true to the best of my knowledge and belief. I agree that this statement of insurability shall form a part of my application for policy change or reinstatement.

Dated at _____ Any City/Any State _____ this [30th] _____ day of [October] 20 [10] _____
City/State

Signed [John Doe] _____ Signed _____
Proposed Insured Policyowner (if other than the proposed insured)

Signed [William Porter] _____
Witness

I certify that I have personally asked the above questions of the insured, and have truly and accurately recorded the information supplied by the insured.

[Robert Smith] _____ Signed [Robert Smith] _____
Agent's Name Agent's Signature (If Application is taken by Agent)

SERFF Tracking Number: CMPL-126867691 State: Arkansas
 Filing Company: The Lafayette Life Insurance Company State Tracking Number: 47324
 Company Tracking Number: LAFAYETTE IND DISABILITY APP 10-2010
 TOI: H111 Individual Health - Disability Income Sub-TOI: H111.008 Combined Short Term and Long Term -
 Unrelated to marketing with employer or
 association groups

Product Name: LAFAYETTE Ind Disability App 10-2010
 Project Name/Number: LAFAYETTE Ind Disability App 10-2010/LAFAYETTE Ind Disability App 10-2010

Supporting Document Schedules

	Item Status:	Status Date:
Satisfied - Item: Flesch Certification	Approved-Closed	11/23/2010
Comments:		
Attachment: READABILITY CERTIFICATION - G.pdf		

	Item Status:	Status Date:
Satisfied - Item: Application	Approved-Closed	11/23/2010
Comments: We acknowledge this request and note this is an application only submission.		

	Item Status:	Status Date:
Bypassed - Item: Health - Actuarial Justification	Approved-Closed	11/23/2010
Bypass Reason: no rates are included with this filing. Please see filing description for details.		
Comments:		

	Item Status:	Status Date:
Bypassed - Item: Outline of Coverage	Approved-Closed	11/23/2010
Bypass Reason: this is an application only filing.		
Comments:		

	Item Status:	Status Date:
Satisfied - Item: Authorization Letter	Approved-Closed	11/23/2010
Comments:		
Attachment:		

SERFF Tracking Number: CMPL-126867691 State: Arkansas
Filing Company: The Lafayette Life Insurance Company State Tracking Number: 47324
Company Tracking Number: LAFAYETTE IND DISABILITY APP 10-2010
TOI: H111 Individual Health - Disability Income Sub-TOI: H111.008 Combined Short Term and Long Term -
Unrelated to marketing with employer or
association groups

Product Name: LAFAYETTE Ind Disability App 10-2010
Project Name/Number: LAFAYETTE Ind Disability App 10-2010/LAFAYETTE Ind Disability App 10-2010
THE LAFAYETTE LIFE INSURANCE COMPANY authorization _2_.pdf

	Item Status:	Status
Satisfied - Item: Certification	Approved-Closed	Date: 11/23/2010
Comments:		
Attachment:		
AR Certif of Compliance with Rule 19.pdf		

READABILITY CERTIFICATION

RE: The Lafayette Life Insurance Company
NAIC 65242-0836 • FEIN 35-0457540

Individual Disability Income forms

This is to certify that form(s) listed below have achieved at least the minimum required score on the Flesch Reading Ease Test.

Form No	Description	Score
LAF DI APP 2.0	Policyowner Request for Change or Reinstatement of Disability Income Policy	56
LAF DH UND QST 2.0	Supplemental Underwriting Questionnaire	68
LAF CCR APP 2.0	Application for Continuance of Coverage on Renewal	58
LAF DH SOI 2.0	Statement of Insurability	48



J. David Simon, CLU
President
513-984-6050
dsimon@crssolutionsgroup.com
October 20, 2010



Lafayette Life
Insurance Company

A member of Western & Southern Financial Group

THE LAFAYETTE LIFE INSURANCE COMPANY

STATEMENT OF AUTHORITY

RE: Individual Disability Income

NAIC: 65242-0836

FEIN: 35-0457540

To whomever it may concern, please be advised that all of The Lafayette Life Insurance Company's Individual Disability Income Policies (the "Policies") are 100% coinsured and administered by Reassure America Life Insurance Company, Fort Wayne, Indiana (formerly known as Lone Star Life Insurance Company, Dallas, Texas). Therefore, The Lafayette Life Insurance Company ("Lafayette") authorizes Reassure America Life Insurance Company, or its designee Compliance Research Services, LLC, to take any and all actions with respect to the Policies and the administration thereof which Lafayette itself could take or could have taken in regard to the Policies. This authorization includes but is not limited to using Reassure America Life Insurance Company forms to administer the Policies and making State Insurance Department filings on behalf of The Lafayette Life Insurance Company in order to make rate, form or policy changes. This Authorization is valid until revoked in writing by Lafayette.

A handwritten signature in black ink that reads "Deborah J. Vargo".

Officer Signature for The Lafayette Life Insurance Company

Deborah J. Vargo

Officer's Name

Senior Vice President, General Counsel, and Corporate Secretary

Title

September 10, 2010

Date

Certificate of Compliance with Arkansas Rule and Regulation 19

Insurer: **The Lafayette Life Insurance Company**

Form Number(s): LAF DI APP 2.0 Policyowner Request for Change or Reinstatement of Disability Income Policy
 LAF DH UND QST 2.0 Supplemental Underwriting Questionnaire
 LAF CCR APP 2.0 Application for Continuance of Coverage on Renewal
 LAF DH SOI 2.0 Statement of Insurability

I hereby certify that the filing above meets all applicable Arkansas requirements including the requirements of Rule and Regulation 19.

Signature of Company Officer

Greg Mitchell

Name

Senior Vice President, Chief Actuary & Treasurer

Title

10-26-2010

Date