

SERFF Tracking Number: IHLI-126872052 State: Arkansas  
 Filing Company: Investors Heritage Life Insurance Company State Tracking Number: 47284  
 Company Tracking Number: PUR-10 PAY WL  
 TOI: L071 Individual Life - Whole Sub-TOI: L071.101 Fixed/Indeterminate Premium - Single Life  
 Product Name: Ten Pay Whole Life Product  
 Project Name/Number: PUR-10 PAY WL

## Filing at a Glance

Company: Investors Heritage Life Insurance Company

Product Name: Ten Pay Whole Life Product SERFF Tr Num: IHLI-126872052 State: Arkansas  
 TOI: L071 Individual Life - Whole SERFF Status: Closed-Approved- State Tr Num: 47284  
 Closed  
 Sub-TOI: L071.101 Fixed/Indeterminate Co Tr Num: PUR-10 PAY WL State Status: Approved-Closed  
 Premium - Single Life  
 Filing Type: Form Reviewer(s): Linda Bird  
 Authors: Julie Hunsinger, Karen Jones, Brad Shepherd Disposition Date: 11/16/2010  
 Date Submitted: 11/10/2010 Disposition Status: Approved-Closed  
 Implementation Date Requested: On Approval Implementation Date:  
 State Filing Description:

## General Information

Project Name: PUR-10 PAY WL Status of Filing in Domicile: Pending  
 Project Number: Date Approved in Domicile:  
 Requested Filing Mode: Review & Approval Domicile Status Comments: Filed in Domicile state of Kentucky pending approval.  
 Explanation for Combination/Other: Market Type: Individual  
 Submission Type: New Submission Group Market Size:  
 Overall Rate Impact: Group Market Type:  
 Filing Status Changed: 11/16/2010 Explanation for Other Group Market Type:  
 State Status Changed: 11/16/2010  
 Deemer Date: Created By: Karen Jones  
 Submitted By: Karen Jones Corresponding Filing Tracking Number:  
 Filing Description:  
 We are submitting the attached numbered forms for your consideration for approval. The whole life policy form has not previously been filed in the state of Arkansas and does not replace any existing form. The attached forms are submitted in final print format. This policy will not be marketed with illustrations.

Form ICC10-WL10-AR (9-2010) - This policy provides level benefit whole life insurance coverage. Level premiums are

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payable annually during the lifetime of the insured for ten years. The cash surrender value is paid to the owner at the maturity date of the policy if the insured is then living and if the policy is in force. The maturity date is the policy anniversary on which the insured attains the age of 120. All policy values are guaranteed. Issue ages are 50 – 85. The minimum policy size is \$5,000. This policy will be issued with normal underwriting.

Form ICC10-PURAPP-REV (9-2010) is the application form that will be used to apply for this policy. This form was previously approved in the state of Arkansas on June 18, 2010, SERFF tracking number IHLI-126652310. Minor changes have been made to the revised application being submitted in this filing. These changes are outlined in the supporting documentation of this filing.

Form ICC10-ABR (4-2010), approved June 18, 2010 may be used with the forms in this filing.

Thank you for your consideration.

## Company and Contact

### Filing Contact Information

Karen Jones, Filing Administrator kjoness@ihlic.com  
 P.O. Box 717 800-422-2011 [Phone] 1007 [Ext]  
 Frankfort, KY 40602-0717 502-875-7084 [FAX]

### Filing Company Information

Investors Heritage Life Insurance Company CoCode: 64904 State of Domicile: Kentucky  
 P.O. Box 717 Group Code: Company Type: LAH  
 200 Capital Avenue Group Name: State ID Number:  
 Frankfort, KY 40602-0717 FEIN Number: 61-0574893  
 (502) 209-1007 ext. [Phone]

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## Filing Fees

Fee Required? Yes  
 Fee Amount: \$100.00  
 Retaliatory? No  
 Fee Explanation: 1 policy form \$50.00  
 1 application form \$50.00  
 Per Company: No

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COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Investors Heritage Life Insurance Company	\$100.00	11/10/2010	41741084

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## Correspondence Summary

### Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Linda Bird	11/16/2010	11/16/2010

*SERFF Tracking Number:* IHLI-126872052      *State:* Arkansas  
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*Product Name:* Ten Pay Whole Life Product  
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## **Disposition**

Disposition Date: 11/16/2010

Implementation Date:

Status: Approved-Closed

Comment:

Rate data does NOT apply to filing.

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Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification		Yes
Supporting Document	Application		Yes
Supporting Document	Life & Annuity - Acturial Memo		No
Form	Ten Pay Whole Life Policy		Yes
Form	Application		Yes

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## Form Schedule

### Lead Form Number: ICC10-WL10-AR (9-2010)

Schedule Item Status	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
	ICC10-WL10-AR (9-2010)	Policy/Contract/Certificate	Ten Pay Whole Life Fraternal Policy	Initial		50.300	ICC10-WL10-AR (9-2010).pdf
	ICC10-PURAPP-REV (9-2010)	Application/Enrollment Form	Application	Revised	Replaced Form #: ICC10-PURAPP (4-2010) Previous Filing #: IHLI-126652310	52.400	ICC10-PURAPP-REV 9-2010-LTR.pdf

# INVESTORS HERITAGE

*Life Insurance Company*

200 CAPITAL AVENUE  
PO BOX 717  
FRANKFORT, KY 40602-0717  
PHONE 1.800.422.2011

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We will pay the proceeds of this policy to the beneficiary upon receipt of due proof of death of the insured while this policy is in force.

We will pay the cash surrender value of this policy to you upon its surrender.

This policy is a legal contract between you and us. It is issued in consideration of the application and the payment of the initial premium on or before the date of policy delivery. Subsequent premiums are payable as provided in the policy.

## **PLEASE READ YOUR POLICY CAREFULLY!**

Signed at our home office at 200 Capital Avenue, Frankfort, Kentucky 40601.



Jane S. Jackson  
Secretary



Harry Lee Waterfield II  
President

## **30 DAY EXAMINATION PERIOD**

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You may return this policy within 30 days after receiving it by mailing it to us, taking it to the agent through whom it was purchased, or by taking it to any other agent of Investors Heritage Life Insurance Company. It will then be void as of the date of issue. Any premium paid will be returned.

**Surrender of this Policy may result in a substantial penalty because the cash value may be less than the premiums paid.**

## **WHOLE LIFE INSURANCE POLICY**

Proceeds payable at death of insured and prior to the maturity date;  
Cash surrender value payable on the maturity date;  
Premiums payable for amount and period stated in policy schedule;  
Non-participating - no dividends.

ICC10-WL10-AR (9-2010)

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**POLICY SCHEDULE  
WHOLE LIFE INSURANCE**

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**POLICY NUMBER:** ..... 991151

**INSURED:** ..... John Doe

**OWNER:** ..... John Doe

**FACE AMOUNT:** ..... \$ 50,000

**DATE OF ISSUE:** ..... October 1, 2010

**ISSUE AGE:** ..... 55

**SEX:** ..... Male

**RISK CLASSIFICATION:** ..... Non-Tobacco

**ANNUAL PREMIUM:** ..... \$ 2,640.00

**INITIAL PREMIUM:** ..... \$ 2,640.00

**PREMIUM PAYMENT PERIOD:** ..... 10 Years

**MATURITY DATE:** ..... October 1, 2075

**BENEFICIARY:** ..... As stated in the application unless changed by you.

The owner and beneficiary are subject to change as described in this policy.

Guaranteed cash values are based on the 2001 CSO Mortality Table, Male or Female, Non-Tobacco or Tobacco, Age Last Birthday, and 5.00% interest per year, compounded annually.

The maximum policy loan interest rate is 7.4% per year, payable in advance, compounded annually.

PREMIUM MODE	MODAL PREMIUM FACTOR	MODAL PREMIUM
Monthly preauthorized transfer	0.088	\$ 232.32
Quarterly preauthorized transfer	0.261	\$ 689.04
Semi-annually (direct and preauthorized transfer)	0.512	\$ 1,351.68
Annual (direct and preauthorized transfer)	1.000	\$ 2,640.00

**TABLE OF GUARANTEED POLICY VALUES**  
**DEATH BENEFITS SHOWN AS OF BEGINNING OF POLICY YEAR**  
**CASH VALUES SHOWN AS OF END OF POLICY YEAR**  
**VALUES ASSUME NO POLICY LOANS OR PARTIAL SURRENDERS**

**ISSUE AGE 55**

Policy Year	Attained Age	Guar. Death Benefit	Basic Cash Value	Paid-up Insurance	Policy Year	Attained Age	Guar. Death Benefit	Basic Cash Value	Paid-up Insurance
1	56	\$ 50,000	\$ 0.00	\$ 0	34	89	\$ 50,000	\$ 40,625.50	\$ 50,000
2	57	50,000	1,459.50	4,396	35	90	50,000	41,083.50	50,000
3	58	50,000	3,752.50	10,833	36	91	50,000	41,510.00	50,000
4	59	50,000	6,143.00	17,011	37	92	50,000	41,912.50	50,000
5	60	50,000	8,637.00	22,955	38	93	50,000	42,292.50	50,000
6	61	50,000	11,235.00	28,682	39	94	50,000	42,648.00	50,000
7	62	50,000	13,936.50	34,214	40	95	50,000	42,976.50	50,000
8	63	50,000	16,747.50	39,585	41	96	50,000	43,283.50	50,000
9	64	50,000	19,681.00	44,835	42	97	50,000	43,577.50	50,000
10	65	50,000	22,749.00	50,000	43	98	50,000	43,856.00	50,000
11	66	50,000	23,557.50	50,000	44	99	50,000	44,116.00	50,000
12	67	50,000	24,369.00	50,000	45	100	50,000	44,348.50	50,000
13	68	50,000	25,186.00	50,000	46	101	50,000	44,560.00	50,000
14	69	50,000	26,012.50	50,000	47	102	50,000	44,767.50	50,000
15	70	50,000	26,845.50	50,000	48	103	50,000	44,970.00	50,000
16	71	50,000	27,679.50	50,000	49	104	50,000	45,167.50	50,000
17	72	50,000	28,515.00	50,000	50	105	50,000	45,359.50	50,000
18	73	50,000	29,353.00	50,000	51	106	50,000	45,546.50	50,000
19	74	50,000	30,191.00	50,000	52	107	50,000	45,729.00	50,000
20	75	50,000	31,021.50	50,000	53	108	50,000	45,906.50	50,000
21	76	50,000	31,847.50	50,000	54	109	50,000	46,079.00	50,000
22	77	50,000	32,665.00	50,000	55	110	50,000	46,246.00	50,000
23	78	50,000	33,467.00	50,000	56	111	50,000	46,408.00	50,000
24	79	50,000	34,246.50	50,000	57	112	50,000	46,564.50	50,000
25	80	50,000	35,006.50	50,000	58	113	50,000	46,715.50	50,000
26	81	50,000	35,733.50	50,000	59	114	50,000	46,861.50	50,000
27	82	50,000	36,437.50	50,000	60	115	50,000	47,002.00	50,000
28	83	50,000	37,120.50	50,000	61	116	50,000	47,137.00	50,000
29	84	50,000	37,781.50	50,000	62	117	50,000	47,268.00	50,000
30	85	50,000	38,417.00	50,000	63	118	50,000	47,401.00	50,000
31	86	50,000	39,022.50	50,000	64	119	50,000	47,619.00	50,000
32	87	50,000	39,594.00	50,000	65	120	50,000	50,000.00	50,000
33	88	50,000	40,128.50	50,000					

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## **DEFINITIONS**

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### **ATTAINED AGE**

The issue age of the insured plus the number of completed policy years.

### **EVIDENCE OF INSURABILITY**

Proof of the good health of the insured that is satisfactory to us.

### **INDEBTEDNESS**

Unpaid policy loans and unpaid policy loan interest, if any.

### **INSURED**

The individual named as the insured in the policy schedule.

### **ISSUE AGE**

Age on the insured's last birthday on or preceding the issue date.

### **ISSUE DATE**

The date from which policy anniversaries, policy years and policy months are determined.

### **MATURITY DATE**

The final date on which any proceeds are payable under this policy if the insured is still alive.

### **POLICY ANNIVERSARY**

The same day and month as the issue date for each succeeding year this policy remains in force.

### **POLICY SCHEDULE**

On the issue date, page 3 of this policy. An updated policy schedule will be provided after the exercise of a partial withdrawal option.

### **PREMIUM PERIOD**

The number of years for which premiums are payable.

### **PROCEEDS**

The amount we are obligated to pay under the terms of this policy.

### **RIDER**

A rider is an attachment to this policy which provides additional benefits.

### **TABLE OF GUARANTEED POLICY VALUES**

On the issue date, page 4 of this policy. An updated table of guaranteed policy values will be provided after the exercise of a partial withdrawal option.

### **WE, OUR, US**

Investors Heritage Life Insurance Company.

### **WRITTEN REQUEST**

A notification or request received from the owner in a form satisfactory to us. Written requests are recorded at our home office. We will not be responsible for the validity of any written request.

### **YOU, YOURS**

The owner of this policy. The owner is designated in the application unless later changed by written notice to us.

## GENERAL PROVISIONS

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### CONTRACT

The entire contract between you and us consists of this policy, any riders or endorsements, and the written application, a copy of which is attached at issue or delivery. All statements between you and us in the application, in the absence of fraud, are representations and not warranties. No statement shall be used in defense of a claim under this policy unless it is contained in a written application that is attached to the policy when issued or delivered.

### AUTHORITY TO CHANGE

Only our officers may change the terms of this policy. Any change must be made in writing.

### INCONTESTABILITY

We will not contest the validity of this policy after it has been in force during the lifetime of the insured for a period of two (2) years from the issue date as shown in the policy schedule, except for non-payment of premium.

A reinstatement of this policy will be incontestable after it has been in force during the lifetime of the insured for two (2) years from the effective date of reinstatement. Contest of a reinstatement may be made only with respect to material misrepresentations made in the application for reinstatement.

No statement made by the owner or by the insured related to the insured's insurability may be used in a contest or to reduce benefits unless (a) it is contained in a written instrument signed by the owner or the insured, and (b) the statement on which the contest is based is material to the risk accepted by us, and (c) a copy of such instrument has been given to the owner, the insured, or the beneficiary.

### SUICIDE

If the insured commits suicide, while sane or insane, within two (2) years from the issue date, the proceeds under the policy will be an amount equal to the premiums paid.

### MISSTATEMENT OF AGE OR SEX

If the age or sex of the insured is misstated, any amount of proceeds payable will be adjusted to that amount which the premiums paid would have purchased at the true age and sex of the insured.

### NON-PARTICIPATING

This policy will not share in our surplus earnings. No dividends will be paid.

### TERMINATION

This policy will terminate and all coverage will cease on the earliest of the following dates:

1. The date we receive your written request to surrender this policy;
2. The date on which the grace period ends if a premium is then in default and this policy has no cash value;
3. The date of death of the insured;
4. If indebtedness equals or exceeds the cash value, the date that falls thirty (30) days after notice of termination has been mailed to your last known address and to any assignee of record; or
5. The maturity date shown on the policy schedule.

## **OWNERSHIP AND BENEFICIARY PROVISIONS**

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### **OWNER**

The owner of this policy is the person or party designated to exercise the rights and receive the benefits of ownership. The insured is the owner unless otherwise stated in the application or later changed.

Subject to the terms of any beneficiary designation or assignment, the owner may, during the lifetime of the insured:

1. Assign or surrender this policy;
2. Obtain a policy loan;
3. Obtain a partial surrender;
4. With our consent, make a change in this policy;
5. Transfer the ownership of this policy; and
6. Exercise other rights and receive other benefits as defined in this policy.

If the owner has not named a successor owner, at the death of the owner, the insured becomes the owner of this policy unless the insured is a minor or otherwise legally incompetent, in which case the owner will be the legally appointed guardian of the insured.

### **BENEFICIARY**

The beneficiary is as shown in the application. The beneficiary will receive the amount of proceeds payable at the death of the insured subject to any assignment made by you. The interest of a beneficiary terminates if the beneficiary dies before the insured. If no beneficiary survives at the death of the insured, payment may be made to you or to your estate or successors.

If more than one beneficiary survives at the death of the insured, proceeds will be allocated according to written instructions from the owner of this policy received by us prior to the death of the insured. If no allocation of proceeds between beneficiaries is specified, proceeds will be divided equally among all surviving beneficiaries.

### **CHANGE OF OWNER OR BENEFICIARY**

You may change the designations of owner and beneficiary while the insured is alive. Any change is subject to the consent of an irrevocable beneficiary. Written request of change must be filed at our home office. Unless otherwise specified by you, the new designation will then take effect as of the date you signed the notice. Such a change does not affect any payment made or other action taken by us before we received the notice.

### **ASSIGNMENT**

You may assign this policy by written request. We are not responsible for the validity or effect of any assignment of this policy. No assignment will bind us until it is received at our home office. Unless otherwise specified, any assignment will take effect on the date the notice of assignment is signed by you, subject to any payments made or actions taken by us prior to receipt of the assignment.

## **INSURANCE PROVISIONS**

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### **DEATH BENEFIT**

The death benefit payable under this policy is equal to:

1. The face amount as shown in the policy schedule; plus
2. The amount of insurance on the life of the insured provided by riders; less
3. Any policy loan balance.

### **PROCEEDS AT DEATH**

The amount of proceeds payable at death of the insured while this policy is in force will be the death benefit described above adjusted for any misstatement of age or sex.

### **INTEREST ON PROCEEDS**

Interest on proceeds will be paid from the date of death of the insured to the date of payment. Interest will accrue at a rate which is the greater of (a) the rate declared by us for proceeds left on deposit, or (b) the rate required by law.

Additional interest will accrue at an annual rate of ten (10) percent from thirty-one (31) days after the latest of the following:

1. The date we receive due proof of death;
2. The date we receive sufficient information to determine the amount of payment and the appropriate payee legally entitled to the proceeds; and
3. The date that any legal impediments to payment of proceeds that depend on the action of parties other than us are resolved and sufficient evidence of the same is provided to us. Legal impediments include, but are not limited to (a) the establishment of guardianships and conservatorships, or (b) the appointment and qualification of trustees, executors and administrators, or (c) the submission of information required to satisfy a state and federal reporting requirement.

### **PAYMENT OF PROCEEDS**

To claim the proceeds, due proof of death must be furnished. Due proof of death will consist of a certified copy of the death certificate of the insured, or other lawful evidence providing equivalent information, and proof of the claimant's interest in the proceeds.

## **POLICY VALUE PROVISIONS**

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### **CASH SURRENDER VALUE**

The cash surrender value at the end of any policy year is equal to the cash value as shown in the policy schedule, less any indebtedness. The cash surrender value at any other point in time will be calculated with allowance for lapse of time from the last preceding policy anniversary.

### **POLICY VALUE OPTIONS**

If you discontinue premium payments after this policy has a cash value, you may select one of the following policy values options subject to any conditions and limitations that apply.

1. **Cash Surrender.** You may surrender this policy for its cash surrender value. If you surrender this policy it is no longer eligible for reinstatement.
2. **Paid-up insurance.** You may apply the cash surrender value to purchase a fully paid-up life policy for a reduced amount of insurance. The amount of paid-up insurance will be that amount which the cash surrender value will purchase when applied as a net single premium at the attained age of the insured on the due date of the first unpaid premium. Reduced paid-up insurance has a cash value. The cash value of reduced paid-up insurance is equal to the net single premium at the attained age of the insured for the amount of reduced paid up insurance in effect at the date of determination.

### **EXERCISING THE CASH SURRENDER POLICY OPTION**

You may surrender this policy by returning it to our home office and filing a written request in a form acceptable to us. The date of surrender will be the date you signed the request provided the insured was then living. The amount that will be paid is the cash surrender value. The payment of the cash surrender value may be deferred for a period up to six (6) months after the request is received at our home office.

If surrender is requested within thirty (30) days after a policy anniversary, the cash surrender value will not be less than the cash surrender value on the policy anniversary. This policy will terminate as of the date of surrender.

**AUTOMATIC OPTION**

You may elect a policy value option within sixty (60) days of the due date of the first unpaid premium by sending us a written request at our home office. If no election has been made by the end of the sixty (60) day period, the paid-up insurance option will apply automatically. The effective date of this automatic option is the due date of the first unpaid premium.

**BASIS OF POLICY VALUES**

Cash value calculations are based on the Commissioners 2001 Standard Ordinary Mortality Table, Male or Female, Non-Tobacco or Tobacco, Age Last Birthday, with interest as shown in the policy schedule. Any cash values and paid-up nonforfeiture benefits available under this policy are not less than the minimum values and benefits required by or pursuant to the NAIC Standard Nonforfeiture Law for Life Insurance, model #808. A detailed statement of the method of computing policy values and benefits has been filed with the insurance department of the state in which this policy was delivered. Any cash values and paid-up nonforfeiture benefits available under this policy are not less than the minimum values and benefits required by or pursuant to the NAIC Standard Nonforfeiture Law for Life Insurance, model #808.

**PARTIAL SURRENDERS**

A partial surrender may be made at any time after the first policy year and prior to the termination of this policy. The minimum partial surrender is \$500. The maximum partial surrender varies by policy year, and is equal to the smaller of:

1. The available partial surrender amount on the date the partial surrender is requested, minus \$1,000; and
2. The available partial surrender amount on the date the partial surrender is requested, multiplied by the percentage as set forth in the table below.

Policy Year	Maximum Partial Surrender Percentage
1	0%
2	10%
3	20%
4	30%
5	40%
6+	100%

The available partial surrender amount is:

1. The cash surrender value; less
2. Indebtedness; less
3. The policy loan interest from the calculation date of the partial surrender amount to the next policy anniversary.

Only one partial surrender is allowed in any policy year.

A surrender fee of \$25 will be deducted from each partial surrender amount. Payment of the partial surrender may be deferred for a period up to six (6) months after the request is received at our home office.

When a partial surrender is made, the face amount of this policy will be reduced by (a) the face amount just prior to the partial surrender, multiplied by (b) the partial surrender amount (including the partial surrender fee); divided by (c) the cash value just prior to the partial surrender.

We will amend this policy to show the face amount after the partial surrender. We will send you a new policy schedule and a new table of guaranteed policy values to attach to your policy.

## **LOAN PROVISIONS**

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### **POLICY LOAN**

We will make a loan to you upon the sole security and assignment of this policy. You may obtain a loan at any time while this policy is in force. The amount of the loan may not exceed the loan value, as defined below. We may defer making a policy loan up to six months after written request is received at our home office unless the loan is used to pay a premium to us.

You may repay the loan in full or in part while your policy is in force prior to the death of the insured. Any payments received will be credited as loan repayments only if so designated.

### **LOAN VALUE**

The loan value is equal to the cash surrender value on the date of the loan. The amount advanced as a policy loan may not exceed (a) the loan value, less (b) the amount of any existing loan, less (c) loan interest to the end of the current policy year. Unless it is paid in cash at the date of the loan, any existing policy loan, along with interest to the date of the loan, will be added to and become a part of the new policy loan.

### **LOAN INTEREST**

Policy loan interest accrues from the date of the loan. It is payable in arrears on each policy anniversary and on the date the loan is settled. If interest is not paid when due, it will be added to the loan and will bear interest at the policy loan interest rate.

The maximum annual interest rate for loans is stated in the policy schedule. Interest is compounded annually.

### **INDEBTEDNESS**

Indebtedness means all outstanding policy loans on this policy including interest accrued and accruing from day to day. Indebtedness may be repaid in full or in part while the insured is alive. If not repaid, it will be deducted in one sum from the proceeds of this policy.

If indebtedness exceeds the cash surrender value, this policy will terminate thirty (30) days after notice of termination has been mailed to your last known address and to any assignee of record.

## **PREMIUM PROVISIONS**

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### **PREMIUM PAYMENTS**

The initial premium shown in the policy schedule is due on the policy date. There is no insurance coverage in effect until the initial premium is paid while the insured is alive.

Additional premiums are payable in advance at our home office. Each premium, including the initial premium, may be paid to our authorized agent who will provide a receipt. The receipt must be signed by the agent who receives the payment on our behalf.

### **PREMIUM DUE DATE**

Each premium, after the initial premium, is due on or before the end of the period covered by the preceding premium. Any premium not paid on or before its premium due date is in default.

### **GRACE PERIOD**

A grace period of thirty-one (31) days is allowed for payment without interest of any premium falling due after the policy date. During the grace period this policy will stay in force. If a premium in default has not been paid by the end of the grace period, this policy will terminate as of the premium due date of the unpaid premium. If the insured dies during the grace period, the premium required to keep this policy in force to the end of the policy month in which death occurs will be deducted from the proceeds. This thirty-one (31) day grace period does not apply to the initial premium payment.

### **MODES OF PREMIUM PAYMENT**

Premiums may be paid monthly, quarterly, semi-annually, or annually. Payment of premiums is subject to our current minimum premium requirements and permitted methods of payment. You may change your method of premium payment with our consent.

### **AMOUNTS OF PREMIUM**

The amount of premium due on any premium due date is equal to the total annual premium in effect on that date multiplied by the modal premium factor. The total annual premium is the sum of the annual premiums for this policy and for any benefits attached by rider. The total annual premium and the modal premium factors for each allowable premium mode are shown in the policy schedule.

### **REFUND OF UNEARNED PREMIUMS**

Any premiums paid for coverage beyond the end of the premium month in which you surrender or terminate this policy will be returned to you.

### **REINSTATEMENT PROVISIONS**

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#### **REINSTATEMENT**

If this policy terminated because indebtedness exceeded the cash surrender value, it may be reinstated within five (5) years after termination if:

1. This policy was not surrendered for its cash surrender value; and
2. You submit a written request and application during the lifetime of the insured; and
3. You provide evidence of insurability satisfactory to us; and
4. You pay all premiums in default together with interest at the rate of 6% per year, compounded annually, from the premium due date of each premium in default to the date of reinstatement; and
5. You pay or reinstate any indebtedness which existed at the date of termination to the date of reinstatement at the policy loan interest rate stated in the policy schedule.

The date of reinstatement will be the latest of (a) the date we approve your application for reinstatement, or (b) the date we receive all past amounts due.

### **SETTLEMENT PROVISIONS**

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#### **POLICY PROCEEDS**

Proceeds payable under this policy may be paid in a single sum or left with us for payment under any settlement option we then provide. The amount applied under an option must be at least \$5,000.

#### **ELECTION OF OPTIONS**

With the consent of any irrevocable beneficiary, you may elect or revoke a settlement option at any time before the proceeds are payable. If no settlement option election is in effect at the time the proceeds become payable, the payee may make an election. Written notice of election or revocation must be filed at our home office in a form acceptable to us. The notice will then take effect as of the date you or the payee signed the notice. An election does not affect any payment made or other action taken by us before the notice is received. A payee who is not a natural person may elect a settlement option only with our consent. An assignee cannot elect a settlement option. Change of owner or beneficiary automatically revokes any election in effect.

**EFFECTIVE DATE**

The first payment under options 1, 2, and 4 is payable on the effective date of the option. The effective date is (a) the date of the death of the insured, or (2) any later date agreeable with us.

**DEATH OF PAYEE**

Unless otherwise specified, at the death of the last payee a final payment will be made to the estate of the payee. For options 1 and 2 the final payment will be the commuted value of the remaining unpaid installments certain. Such value will be computed based on the rate of interest used in the calculation of payments. For options 3 and 4 the final payment will be the unpaid proceeds with any unpaid interest to the date of death of the payee.

**SETTLEMENT OPTION INTEREST RATE**

The guaranteed interest rate for options 1, 2, 3, and 4 is 3% per year, compounded annually. Additional interest may be declared by us from time to time.

**OPTION 1**

Proceeds will be paid for a fixed period. The amount of each payment is determined from the option 1 table on the following page.

**OPTION 2**

Proceeds will be paid in equal installments throughout the certain period. After the certain period, payments will continue to be made throughout the lifetime of the payee. The amount and certain period of the payments are determined from the option 2 table on the following page. Satisfactory proof of the age and sex of the payee is required. We may require evidence that the payee is living on the due date of any payment.

**OPTION 3**

Interest on the proceeds will be paid in the manner agreed upon when the option is elected.

**OPTION 4**

Proceeds will be paid in fixed installments at regular intervals until the proceeds, together with interest on the unpaid balance, are exhausted.

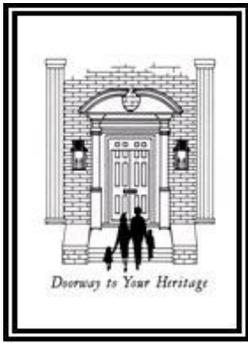
**OPTION 5**

Proceeds will be used to purchase any single premium annuity we offer at the time proceeds are applied. The annuity benefits at the time of their commencement will not be less than those that would be provided by the application of the cash surrender value to purchase a single consideration immediate annuity contract at purchase rates offered by us at the time to the same class of annuitants whether the annuity benefits are payable in fixed or variable amounts or both.

OPTION 1 TABLE							
Monthly payments for a fixed number of years for each \$1,000 of proceeds							
Number of years	Monthly payment	Number of years	Monthly payment	Number of years	Monthly payment	Number of years	Monthly payment
1	84.48	6	15.16	11	8.88	16	6.55
2	42.87	7	13.18	12	8.26	17	6.25
3	29.01	8	11.70	13	7.73	18	5.98
4	22.08	9	10.55	14	7.28	19	5.75
5	17.92	10	9.63	15	6.89	20	5.53
The amount of monthly payment for other periods will be furnished on request.							

OPTION 2 TABLE											
Monthly payments are shown for each \$1,000 of proceeds. Age is the age last birthday of the payee when the first installment is payable.											
Number of Years Certain											
None						10 years					
Age	Male	Female	Age	Male	Female	Age	Male	Female	Age	Male	Female
46	3.83	3.61	66	5.85	5.31	46	3.81	3.61	66	5.64	5.20
47	3.88	3.66	67	6.03	5.47	47	3.86	3.65	67	5.79	5.34
48	3.94	3.71	68	6.23	5.63	48	3.92	3.70	68	5.94	5.48
49	4.01	3.76	69	6.44	5.81	49	3.98	3.75	69	6.10	5.63
50	4.07	3.82	70	6.66	6.00	50	4.04	3.81	70	6.26	5.79
51	4.14	3.88	71	6.90	6.20	51	4.11	3.86	71	6.43	5.96
52	4.21	3.94	72	7.15	6.43	52	4.18	3.92	72	6.60	6.13
53	4.29	4.01	73	7.42	6.67	53	4.25	3.99	73	6.78	6.32
54	4.37	4.08	74	7.70	6.93	54	4.33	4.05	74	6.96	6.51
55	4.46	4.15	75	8.01	7.21	55	4.41	4.12	75	7.15	6.71
56	4.55	4.22	76	8.34	7.51	56	4.49	4.20	76	7.33	6.91
57	4.64	4.31	77	8.69	7.84	57	4.58	4.27	77	7.52	7.12
58	4.75	4.39	78	9.07	8.20	58	4.68	4.36	78	7.71	7.33
59	4.85	4.48	79	9.47	8.58	59	4.78	4.44	79	7.89	7.54
60	4.97	4.58	80	9.90	9.00	60	4.88	4.53	80	8.07	7.76
61	5.09	4.68	81	10.36	9.45	61	4.99	4.63	81	8.25	7.97
62	5.23	4.79	82	10.85	9.94	62	5.11	4.73	82	8.42	8.17
63	5.37	4.91	83	11.37	10.47	63	5.23	4.84	83	8.59	8.37
64	5.52	5.04	84	11.92	11.04	64	5.36	4.96	84	8.74	8.56
65	5.68	5.17	85	12.52	11.66	65	5.50	5.08	85	8.89	8.73

Values were calculated using the Annuity 2000 Mortality Table, male or female, and 3.0% interest per year. Satisfactory proof of the age and sex of the payee is required. The amount of monthly payments for other ages and certain periods will be furnished on request.



# **INVESTORS HERITAGE**

*Life Insurance Company*

TO OBTAIN INFORMATION, MAKE A CLAIM, OR MAKE A COMPLAINT

Call us toll-free:

**1.800.422.2011**

Or write to us:

**INVESTORS HERITAGE LIFE INSURANCE COMPANY  
PO BOX 717  
FRANKFORT KY 40602-0717**

Or email us:

**[ihlic@investorsheritage.com](mailto:ihlic@investorsheritage.com)**

## **WHOLE LIFE INSURANCE POLICY**

Proceeds payable at death of insured and prior to the maturity date;  
Cash surrender value payable on the maturity date;  
Premiums payable for amount and period stated in policy schedule;  
Non-participating - no dividends.

**APPLICATION FOR  
INDIVIDUAL LIFE INSURANCE AND ANNUITY**

**INVESTORS HERITAGE** *Life Insurance Company*

PO Box 717 • Frankfort, KY 40602-0717 • Phone: 800.422.2011 • Fax: 502.875.7084  
E-mail: investorsheritage@ihlic.com • www.investorsheritage.com

PRINT USING BLACK INK. ALL SECTIONS MUST BE COMPLETED.

1. PROPOSED INSURED / PROPOSED ANNUITANT										
Name (First, Middle Initial, Last)										
Birth Date	Month	Day	Year	State/Country of Birth	<input type="checkbox"/> Male <input type="checkbox"/> Female	Height:	ft.	in.	Weight:	lbs.
Primary Mailing Address			City			State		Zip Code		
Social Security Number					E-mail Address					
Phone Number (     )			<input type="checkbox"/> Home <input type="checkbox"/> Work <input type="checkbox"/> Mobile		Phone Number (     )			<input type="checkbox"/> Home <input type="checkbox"/> Work <input type="checkbox"/> Mobile		
2. SECONDARY ADDRESSEE										
(Provide name and mailing address of person to receive grace and lapse notification on behalf of the Proposed Insured.)										
Secondary Addressee Name (First, Middle Initial, Last)										
Mailing Address			City			State		Zip Code		
3. BENEFICIARY INFORMATION										
Primary Beneficiary Name (First, Middle Initial, Last)				Social Security Number		% Benefit if not equal		Relationship to Proposed Insured		
Contingent Beneficiary Name (First, Middle Initial, Last)				Social Security Number		% Benefit if not equal		Relationship to Proposed Insured		
4. OWNER (If other than Proposed Insured / Annuitant)										
Name (First, Middle Initial, Last)						Birth Date	Month	Day	Year	
Social Security Number			Relationship to Proposed Insured			Phone Number (     )		<input type="checkbox"/> Home <input type="checkbox"/> Work <input type="checkbox"/> Mobile		
Mailing Address			City		State		Zip Code		E-mail Address	
5. INSURANCE AND ANNUITY INFORMATION										
Mark plans applying for:										
<input type="checkbox"/> Single Premium Whole Life Insurance				Face Amount		\$ _____				
<input type="checkbox"/> 10 Pay Whole Life Insurance				Face Amount		\$ _____				
<input type="checkbox"/> Single Premium Immediate Annuity			<input type="checkbox"/> Qualified <input type="checkbox"/> Non-Qualified		Single Premium		\$ _____			
Annual payments for 10 years or until the annuitant's death, whichever is earlier. <i>SPIA only available with the 10 Pay Whole Life Insurance.</i>						Premium Submitted with application \$ _____				
6. RIDER INFORMATION										
Mark riders applying for:										
<input type="checkbox"/> Accelerated Death Benefit Rider			<input type="checkbox"/> Yes <input type="checkbox"/> No		Automatically included unless "NO" is marked.					
<input type="checkbox"/> Other _____										

**7. HEALTH INFORMATION**

If any question in this section is answered "Yes", no coverage can be issued.  
 If height & weight exceeds the maximum allowed for this product, no coverage can be issued.

1. Do you need assistance with the normal activities of daily living (eating, bathing, dressing, taking medications, etc.) or are you currently hospitalized, confined to a bed or nursing facility or receiving hospice care? .....  Yes  No
2. Have you been diagnosed with Diabetes prior to age 20 or taken insulin injections prior to age 40? Have you ever been treated for insulin shock, diabetic coma or hospitalized two or more times for diabetic complications within the last 18 months? .....  Yes  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)? .....  Yes  No
4. Have you had or been medically advised to have an organ transplant, hospice care, or been diagnosed as having a terminal medical condition that is expected to result in death within the next 12 months? .....  Yes  No
5. Have you ever been medically diagnosed, treated or taken medication for: congestive heart disease, cardiomyopathy, end stage kidney (renal) disease, kidney (renal) insufficiency, chronic kidney disease (including dialysis), kidney or liver failure, Alzheimer's disease, dementia, Lou Gehrig's disease (ALS), schizophrenia, bipolar disorder, or brain disease? .....  Yes  No
6. In the last 5 years have you been convicted of a felony or are you currently on probation, been treated or advised by a medical professional to have treatment for alcohol, drugs or medication abuse? .....  Yes  No
7. Within the past 3 years have you been diagnosed with leukemia, lymphoma, melanoma or internal cancer or have you had more than one occurrence of any cancer in your lifetime (excluding basal or squamous cell skin cancer), had a recurrence of any cancer, or are you currently being treated for cancer, had an amputation caused by cancer or an amputation caused by any disease? .....  Yes  No
8. Within the past 2 years have you:
  - a. Been medically diagnosed, treated or taken medication for: angina, chronic hepatitis, cirrhosis, liver disease, Hodgkin's disease, chronic obstructive pulmonary or lung disease (COPD/COLD), emphysema, chronic bronchitis, respiratory failure, or required oxygen to assist in breathing? .....  Yes  No
  - b. Been diagnosed as having, been treated for or hospitalized for: heart disease, heart attack, peripheral vascular disease, heart or vascular surgery (including coronary artery bypass, angioplasty, stent placement (cardio or vascular), pacemaker or replacement pacemaker, heart valve replacement, abdominal aortic aneurysm, or any procedure to improve circulation to the heart, brain or extremities, neuromuscular disease (including multiple sclerosis, cerebral palsy, muscular dystrophy, Parkinson's disease), systematic lupus (SLE) or paralysis of two or more extremities? .....  Yes  No
  - c. Been medically diagnosed, treated or taken medication for stroke, transient ischemic attack (TIA), or been diagnosed as having uncontrolled high blood pressure? .....  Yes  No
  - d. Been confined more than twice to a hospital, nursing facility, convalescent care facility, assisted living facility, mental facility or hospice care? .....  Yes  No
  - e. Been convicted of operating a motor vehicle while intoxicated, impaired or reckless driving? .....  Yes  No
  - f. Been declined or postponed for life or health insurance? .....  Yes  No
  - g. Attempted suicide? .....  Yes  No

**8. ADDITIONAL INFORMATION**

Proposed Insured's Driver's License Number	State of Issue
1. Have you used nicotine or tobacco based products in the past 12 months? ..... <input type="checkbox"/> Yes <input type="checkbox"/> No	
2. Have you applied for life insurance with any other company in the past two years? ..... <input type="checkbox"/> Yes <input type="checkbox"/> No	
3. Are you taking medication for any impairment listed in Section 7 Health Information? ..... <input type="checkbox"/> Yes <input type="checkbox"/> No	

**9. OTHER INSURANCE / REPLACEMENT INFORMATION**

1. Does Proposed Insured now have any life insurance or annuity (includes personal, business or group life) (a) in force or applications pending with any company? or (b) which will be replaced, changed, or borrowed against because of this application?  
 Yes  No Provide details to "Yes" answers below and submit appropriate replacement forms.

2. Name of Company	Date of Issue	Life Amount	Personal/Business	Accidental Death Amount	To be replaced?
			<input type="checkbox"/> Personal <input type="checkbox"/> Business		<input type="checkbox"/> Yes <input type="checkbox"/> No
			<input type="checkbox"/> Personal <input type="checkbox"/> Business		<input type="checkbox"/> Yes <input type="checkbox"/> No
			<input type="checkbox"/> Personal <input type="checkbox"/> Business		<input type="checkbox"/> Yes <input type="checkbox"/> No
			<input type="checkbox"/> Personal <input type="checkbox"/> Business		<input type="checkbox"/> Yes <input type="checkbox"/> No
			<input type="checkbox"/> Personal <input type="checkbox"/> Business		<input type="checkbox"/> Yes <input type="checkbox"/> No

If there is additional insurance beyond those listed, please provide on a separate sheet of paper.

**10. AGREEMENT & AUTHORIZATION**

I have read the completed application. I am not currently taking and I am not under the influence of any medications or drugs that would affect my ability to fully understand and to fully and accurately complete this application. I agree that this application will be the basis for, and will become part of, the policy that is issued. The above representations are true to the best of my knowledge and belief. I agree the policy shall not be in effect until it has been issued by Investors Heritage Life Insurance Company ("the Company") and the initial premium has been paid. I understand that the information on this application will be relied upon to determine insurability and that incorrect information may result in coverage being voided, subject to the policy's incontestability provision. I understand that the agent has no authority to approve the application, change the policy or waive any policy provisions. I understand no insurance will be effective until the date stated in the policy and all eligibility requirements are met. I understand that the USA Patriot Act requires all financial institutions, including insurance companies, to verify the identity of their customers. I am providing my name, address, date of birth and taxpayer identification number to allow verification of identity. I understand the verification process may include the use of third-party sources to verify the information provided. I am not being paid cash and have not been promised services as an inducement to enter into this application for life insurance. The purpose of this insurance application is not to sell or assign it to any type of viatical settlement, senior settlement, or life settlement company. I acknowledge receipt of a copy of the Information Practices Notice, MIB Pre-Notice and Fair Credit Reporting Act Notice.

**Any person who knowingly presents a false statement in an application for insurance may be guilty of a criminal offense and subject to penalties under state law.**

I authorize any physician, medical practitioner, hospital, medical care facility, the Veteran's Administration, insurance company, MIB, Inc., pharmacy manager, pharmacy, insurance laboratory, a consumer reporting agency, my employer or any other person or organization that has any record of information about me to give Investors Heritage Life Insurance Company, its reinsurers or its authorized representatives, information about my health, other insurance coverage, employment, age, general character, finances, participation in hazardous activities, medical care or advice about any physical or mental condition, including information about drugs, alcoholism, or other information Investors Heritage Life Insurance Company requires to determine insurability or eligibility of benefits. I further authorize the sources listed above, except MIB, Inc., to give such information to a consumer reporting agency acting on behalf of Investors Heritage Life Insurance Company. This authorization may be revoked; however, it may not be revoked during the contestability period of the policy or to the extent the company has taken action in reliance on this authorization. Notice or revocation may be sent, in writing, to the Company at its administrative office address. 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 30 months from the date signed.

**11. SIGNATURES OF PROPOSED INSURED / OWNER**

X) \_\_\_\_\_ X) \_\_\_\_\_  
 Signature of Proposed Insured Signature of Owner if other than Proposed Insured

Signed at \_\_\_\_\_ On \_\_\_\_\_  
 (City, State) (Month, Day, Year)

12. AGENT'S STATEMENT AND SIGNATURE

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(s) by viewing a state issued driver's license, state issued I.D. card, military I.D. card, Permanent U.S. Resident Card (Green Card), passport or other government issued picture I.D. card.

I certify that the Owner, Proposed Insured or any person or entity is not being paid cash or promised services as an inducement to enter into this insurance transaction and that this insurance transaction will not be sold or assigned for any type of viatical settlement, senior settlement, life settlement or any other secondary market.

Purpose of Insurance \_\_\_\_\_

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

This application signed and dated at \_\_\_\_\_, \_\_\_\_\_.  
City State

X) \_\_\_\_\_  
Licensed Agent's Signature Date

\_\_\_\_\_  
Agent's Printed Name Agent's Code Number Agent's Phone Number

X) \_\_\_\_\_  
Second Licensed Agent's Signature Date

\_\_\_\_\_  
Agent's Printed Name Agent's Code Number Agent's Phone Number

SERFF Tracking Number: IHLI-126872052 State: Arkansas  
 Filing Company: Investors Heritage Life Insurance Company State Tracking Number: 47284  
 Company Tracking Number: PUR-10 PAY WL  
 TOI: L071 Individual Life - Whole Sub-TOI: L071.101 Fixed/Indeterminate Premium - Single Life  
 Product Name: Ten Pay Whole Life Product  
 Project Name/Number: PUR-10 PAY WL

## Supporting Document Schedules

**Item Status:** **Status Date:**

**Satisfied - Item:** Flesch Certification

**Comments:**

Compliance Certificaton and Readability Certification attached.

**Attachments:**

AR Compliance Certification WL10pay.pdf  
 Readability Certification WL10.pdf

**Item Status:** **Status Date:**

**Satisfied - Item:** Application

**Comments:**

Attached is the application form that will be used to apply for this whole life product. Form ICC10-PURAPP (4-2010) was approved in June, 2010 and Form ICC10-PURAPP-REV (9-2010) is being filed with this filing as a revised application. I have included a list of the minor changes that were made to the application for reference.

**Attachments:**

ICC10-PURAPP-REV 9-2010-LTR.pdf  
 ICC10-PURAPP (4-2010).pdf  
 Changes Made to ICC10 PURAPP.pdf



# INVESTORS HERITAGE *Life Insurance Company*

PO Box 717 Frankfort KY 40602-0717

1-800-422-2011

investorsheritage@ihlic.com

## **Certificates of Compliance**

Re: Forms: ICC10-WL10-AR (9-2010) & ICC10-PURAPP-REV (9-2010)

I hereby certify that the submitted forms listed above meets all applicable Arkansas requirements including the requirements of Rule and Regulation 19 and the requirements of Rule and Regulation 49.

I also hereby certify that the submitted forms listed above meets with the applicable readability requirements of the Arkansas Code.

I also certify that the Consumer Information Notice as required by ACA 23-79-138 is attached to every policy at policy issue.

Julie A. Hunsinger, FSA, MAAA  
Vice President & Chief Actuary

November 10, 2010

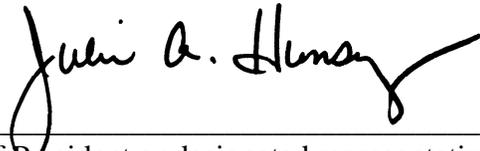
**READABILITY CERTIFICATION**

**INVESTORS HERITAGE LIFE INSURANCE COMPANY**  
**SERFF Tracking Number IHLI-126872052**  
**NAIC Number 64904**

I have reviewed or supervised the preparation of the forms listed below and certify that the forms comply with the applicable readability requirements of Arkansas Code.

Form Number	Description	Flesch Score
ICC10-WL10-AR (9-2010)	Ten Pay Whole Life Policy	50.3
ICC10-PURAPP-REV (9-2010)	Application	52.4

November 10, 2010  
Date



\_\_\_\_\_  
Signature of President or designated representative

Julie Hunsinger, FSA, MAAA  
Name of Person signing above

\_\_\_\_\_  
Vice President & Chief Actuary  
Title of person signing above



**7. HEALTH INFORMATION**

If any question in this section is answered "Yes", no coverage can be issued.  
 If height & weight exceeds the maximum allowed for this product, no coverage can be issued.

1. Do you need assistance with the normal activities of daily living (eating, bathing, dressing, taking medications, etc.) or are you currently hospitalized, confined to a bed or nursing facility or receiving hospice care? .....  Yes  No
2. Have you been diagnosed with Diabetes prior to age 20 or taken insulin injections prior to age 40? Have you ever been treated for insulin shock, diabetic coma or hospitalized two or more times for diabetic complications within the last 18 months? .....  Yes  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)? .....  Yes  No
4. Have you had or been medically advised to have an organ transplant, hospice care, or been diagnosed as having a terminal medical condition that is expected to result in death within the next 12 months? .....  Yes  No
5. Have you ever been medically diagnosed, treated or taken medication for: congestive heart disease, cardiomyopathy, end stage kidney (renal) disease, kidney (renal) insufficiency, chronic kidney disease (including dialysis), kidney or liver failure, Alzheimer's disease, dementia, Lou Gehrig's disease (ALS), schizophrenia, bipolar disorder, or brain disease? .....  Yes  No
6. In the last 5 years have you been convicted of a felony or are you currently on probation, been treated or advised by a medical professional to have treatment for alcohol, drugs or medication abuse? .....  Yes  No
7. Within the past 3 years have you been diagnosed with leukemia, lymphoma, melanoma or internal cancer or have you had more than one occurrence of any cancer in your lifetime (excluding basal or squamous cell skin cancer), had a recurrence of any cancer, or are you currently being treated for cancer, had an amputation caused by cancer or an amputation caused by any disease? .....  Yes  No
8. Within the past 2 years have you:
  - a. Been medically diagnosed, treated or taken medication for: angina, chronic hepatitis, cirrhosis, liver disease, Hodgkin's disease, chronic obstructive pulmonary or lung disease (COPD/COLD), emphysema, chronic bronchitis, respiratory failure, or required oxygen to assist in breathing? .....  Yes  No
  - b. Been diagnosed as having, been treated for or hospitalized for: heart disease, heart attack, peripheral vascular disease, heart or vascular surgery (including coronary artery bypass, angioplasty, stent placement (cardio or vascular), pacemaker or replacement pacemaker, heart valve replacement, abdominal aortic aneurysm, or any procedure to improve circulation to the heart, brain or extremities, neuromuscular disease (including multiple sclerosis, cerebral palsy, muscular dystrophy, Parkinson's disease), systematic lupus (SLE) or paralysis of two or more extremities? .....  Yes  No
  - c. Been medically diagnosed, treated or taken medication for stroke, transient ischemic attack (TIA), or been diagnosed as having uncontrolled high blood pressure? .....  Yes  No
  - d. Been confined more than twice to a hospital, nursing facility, convalescent care facility, assisted living facility, mental facility or hospice care? .....  Yes  No
  - e. Been convicted of operating a motor vehicle while intoxicated, impaired or reckless driving? .....  Yes  No
  - f. Been declined or postponed for life or health insurance? .....  Yes  No
  - g. Attempted suicide? .....  Yes  No

**8. ADDITIONAL INFORMATION**

Proposed Insured's Driver's License Number	State of Issue
1. Have you used nicotine or tobacco based products in the past 12 months? ..... <input type="checkbox"/> Yes <input type="checkbox"/> No	
2. Have you applied for life insurance with any other company in the past two years? ..... <input type="checkbox"/> Yes <input type="checkbox"/> No	
3. Are you taking medication for any impairment listed in Section 7 Health Information? ..... <input type="checkbox"/> Yes <input type="checkbox"/> No	

**9. OTHER INSURANCE / REPLACEMENT INFORMATION**

1. Does Proposed Insured now have any life insurance or annuity (includes personal, business or group life) (a) in force or applications pending with any company? or (b) which will be replaced, changed, or borrowed against because of this application?  
 Yes  No Provide details to "Yes" answers below and submit appropriate replacement forms.

2. Name of Company	Date of Issue	Life Amount	Personal/Business	Accidental Death Amount	To be replaced?
			<input type="checkbox"/> Personal <input type="checkbox"/> Business		<input type="checkbox"/> Yes <input type="checkbox"/> No
			<input type="checkbox"/> Personal <input type="checkbox"/> Business		<input type="checkbox"/> Yes <input type="checkbox"/> No
			<input type="checkbox"/> Personal <input type="checkbox"/> Business		<input type="checkbox"/> Yes <input type="checkbox"/> No
			<input type="checkbox"/> Personal <input type="checkbox"/> Business		<input type="checkbox"/> Yes <input type="checkbox"/> No
			<input type="checkbox"/> Personal <input type="checkbox"/> Business		<input type="checkbox"/> Yes <input type="checkbox"/> No

If there is additional insurance beyond those listed, please provide on a separate sheet of paper.

**10. AGREEMENT & AUTHORIZATION**

I have read the completed application. I am not currently taking and I am not under the influence of any medications or drugs that would affect my ability to fully understand and to fully and accurately complete this application. I agree that this application will be the basis for, and will become part of, the policy that is issued. The above representations are true to the best of my knowledge and belief. I agree the policy shall not be in effect until it has been issued by Investors Heritage Life Insurance Company ("the Company") and the initial premium has been paid. I understand that the information on this application will be relied upon to determine insurability and that incorrect information may result in coverage being voided, subject to the policy's incontestability provision. I understand that the agent has no authority to approve the application, change the policy or waive any policy provisions. I understand no insurance will be effective until the date stated in the policy and all eligibility requirements are met. I understand that the USA Patriot Act requires all financial institutions, including insurance companies, to verify the identity of their customers. I am providing my name, address, date of birth and taxpayer identification number to allow verification of identity. I understand the verification process may include the use of third-party sources to verify the information provided. I am not being paid cash and have not been promised services as an inducement to enter into this application for life insurance. The purpose of this insurance application is not to sell or assign it to any type of viatical settlement, senior settlement, or life settlement company. I acknowledge receipt of a copy of the Information Practices Notice, MIB Pre-Notice and Fair Credit Reporting Act Notice.

**Any person who knowingly presents a false statement in an application for insurance may be guilty of a criminal offense and subject to penalties under state law.**

I authorize any physician, medical practitioner, hospital, medical care facility, the Veteran's Administration, insurance company, MIB, Inc., pharmacy manager, pharmacy, insurance laboratory, a consumer reporting agency, my employer or any other person or organization that has any record of information about me to give Investors Heritage Life Insurance Company, its reinsurers or its authorized representatives, information about my health, other insurance coverage, employment, age, general character, finances, participation in hazardous activities, medical care or advice about any physical or mental condition, including information about drugs, alcoholism, or other information Investors Heritage Life Insurance Company requires to determine insurability or eligibility of benefits. I further authorize the sources listed above, except MIB, Inc., to give such information to a consumer reporting agency acting on behalf of Investors Heritage Life Insurance Company. This authorization may be revoked; however, it may not be revoked during the contestability period of the policy or to the extent the company has taken action in reliance on this authorization. Notice or revocation may be sent, in writing, to the Company at its administrative office address. 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 30 months from the date signed.

**11. SIGNATURES OF PROPOSED INSURED / OWNER**

X) \_\_\_\_\_ X) \_\_\_\_\_  
 Signature of Proposed Insured Signature of Owner if other than Proposed Insured

Signed at \_\_\_\_\_ On \_\_\_\_\_  
 (City, State) (Month, Day, Year)

12. AGENT'S STATEMENT AND SIGNATURE

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(s) by viewing a state issued driver's license, state issued I.D. card, military I.D. card, Permanent U.S. Resident Card (Green Card), passport or other government issued picture I.D. card.

I certify that the Owner, Proposed Insured or any person or entity is not being paid cash or promised services as an inducement to enter into this insurance transaction and that this insurance transaction will not be sold or assigned for any type of viatical settlement, senior settlement, life settlement or any other secondary market.

Purpose of Insurance \_\_\_\_\_

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

This application signed and dated at \_\_\_\_\_, \_\_\_\_\_.  
City State

X) \_\_\_\_\_  
Licensed Agent's Signature Date

\_\_\_\_\_  
Agent's Printed Name Agent's Code Number Agent's Phone Number

X) \_\_\_\_\_  
Second Licensed Agent's Signature Date

\_\_\_\_\_  
Agent's Printed Name Agent's Code Number Agent's Phone Number

**APPLICATION FOR  
INDIVIDUAL LIFE INSURANCE AND ANNUITY**

**INVESTORS HERITAGE** *Life Insurance Company*

PO Box 717 • Frankfort, KY 40602-0717 • Phone: 800.422.2011 • Fax: 502.875.7084  
E-mail: investorsheritage@ihlic.com • www.investorsheritage.com

PRINT USING BLACK INK. ALL SECTIONS MUST BE COMPLETED.

1. PROPOSED INSURED / PROPOSED ANNUITANT										
Name (First, Middle Initial, Last)										
Birth Date	Month	Day	Year	State/Country of Birth	<input type="checkbox"/> Male <input type="checkbox"/> Female	Height:	ft.	in.	Weight:	lbs.
Primary Mailing Address			City			State		Zip Code		
Social Security Number					E-mail Address					
Phone Number (      )			<input type="checkbox"/> Home <input type="checkbox"/> Work <input type="checkbox"/> Mobile		Phone Number (      )			<input type="checkbox"/> Home <input type="checkbox"/> Work <input type="checkbox"/> Mobile		
2. SECONDARY ADDRESSEE										
(Provide name and mailing address of person to receive grace and lapse notification on behalf of the Proposed Insured.)										
Secondary Addressee Name (First, Middle Initial, Last)										
Mailing Address			City			State		Zip Code		
3. BENEFICIARY INFORMATION										
Primary Beneficiary Name (First, Middle Initial, Last)				Social Security Number		% Benefit if not equal		Relationship to Proposed Insured		
Contingent Beneficiary Name (First, Middle Initial, Last)				Social Security Number		% Benefit if not equal		Relationship to Proposed Insured		
4. OWNER (If other than Proposed Insured / Annuitant)										
Name (First, Middle Initial, Last)						Birth Date	Month	Day	Year	
Social Security Number			Relationship to Proposed Insured			Phone Number (      )		<input type="checkbox"/> Home <input type="checkbox"/> Work <input type="checkbox"/> Mobile		
Mailing Address			City		State		Zip Code		E-mail Address	
5. INSURANCE AND ANNUITY INFORMATION										
Mark plans applying for:										
<input type="checkbox"/> Single Premium Whole Life Insurance				Face Amount		\$ _____				
<input type="checkbox"/> Flexible Premium Adjustable Universal Life Insurance				Face Amount		\$ _____				
<input type="checkbox"/> Single Premium Immediate Annuity				Single Premium		\$ _____		<input type="checkbox"/> Qualified <input type="checkbox"/> Non-Qualified		
Annual payments for 10 years or until the annuitant's death, whichever is earlier. <i>SPIA only available with the Flexible Premium Adjustable Universal Life Insurance.</i>										
6. RIDER INFORMATION										
Mark riders applying for:										
<input type="checkbox"/> Accelerated Death Benefit Rider		<input type="checkbox"/> Yes <input type="checkbox"/> No		Automatically included unless "NO" is marked.						
<input type="checkbox"/> Other	_____									

**7. HEALTH INFORMATION**

1. Do you need assistance with the normal activities of daily living (eating, bathing, dressing, taking medications, etc.) or are you currently hospitalized, confined to a bed or nursing facility or receiving hospice care? .....  Yes  No
2. Have you been diagnosed with Diabetes prior to age 20 or taken insulin injections prior to age 40? Have you ever been treated for insulin shock, diabetic coma or hospitalized two or more times for diabetic complications within the last 18 months? .....  Yes  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)? .....  Yes  No
4. Have you had or been medically advised to have an organ transplant, hospice care, or been diagnosed as having a terminal medical condition that is expected to result in death within the next 12 months? .....  Yes  No
5. Have you ever been medically diagnosed, treated or taken medication for: congestive heart disease, cardiomyopathy, end stage kidney (renal) disease, kidney (renal) insufficiency, chronic kidney disease (including dialysis), kidney or liver failure, Alzheimer's disease, dementia, Lou Gehrig's disease (ALS), schizophrenia, bipolar disorder, brain disease or attempted suicide? .....  Yes  No
6. In the last 5 years have you been convicted of a felony or are you currently on probation, been treated or advised by a medical professional to have treatment for alcohol, drugs or medication abuse? .....  Yes  No
7. Within the past 3 years have you been diagnosed with leukemia, lymphoma, melanoma or internal cancer or have you had more than one occurrence of any cancer in your lifetime (excluding basal or squamous cell skin cancer), had a recurrence of any cancer, or are you currently being treated for cancer, had an amputation caused by cancer or an amputation caused by any disease? .....  Yes  No
8. Within the past 2 years have you:
  - a. Been medically diagnosed, treated or taken medication for: angina, chronic hepatitis, cirrhosis, liver disease, Hodgkin's disease, chronic obstructive pulmonary or lung disease (COPD/COLD), emphysema, chronic bronchitis, respiratory failure, or required oxygen to assist in breathing? .....  Yes  No
  - b. Been diagnosed as having, been treated for or hospitalized for: heart disease, heart attack, peripheral vascular disease, heart or vascular surgery (including coronary artery bypass, angioplasty, stent placement (cardio or vascular), pacemaker or replacement pacemaker, heart valve replacement, abdominal aortic aneurysm, or any procedure to improve circulation to the heart, brain or extremities, neuromuscular disease (including multiple sclerosis, cerebral palsy, muscular dystrophy, Parkinson's disease), systematic lupus (SLE) or paralysis of two or more extremities? .....  Yes  No
  - c. Been medically diagnosed, treated or taken medication for stroke, transient ischemic attack (TIA), or been diagnosed as having uncontrolled high blood pressure? .....  Yes  No
  - d. Been confined more than twice to a hospital, nursing facility, convalescent care facility, assisted living facility, mental facility or hospice care? .....  Yes  No
  - e. Been convicted of operating a motor vehicle while intoxicated, impaired or reckless driving? .....  Yes  No
  - f. Been declined or postponed for life or health insurance? .....  Yes  No

**8. ADDITIONAL INFORMATION**

Proposed Insured's Driver's License Number

State of Issue

1. Have you used nicotine or tobacco based products in the past 12 months? .....  Yes  No
2. Have you applied for life insurance with any other company in the past two years? .....  Yes  No
3. Are you taking medication for any impairment listed in Question 5 of Section 7 Health Information? ....  Yes  No

**9. OTHER INSURANCE / REPLACEMENT INFORMATION**

1. Does Proposed Insured now have any life insurance or annuity (includes personal, business or group life) (a) in force or applications pending with any company? or (b) which will be replaced, changed, or borrowed against because of this application?  
 Yes  No Provide details to "Yes" answers below and submit appropriate replacement forms.

2. Name of Company	Date of Issue	Life Amount	Personal/Business	Accidental Death Amount	To be replaced?
			<input type="checkbox"/> Personal <input type="checkbox"/> Business		<input type="checkbox"/> Yes <input type="checkbox"/> No
			<input type="checkbox"/> Personal <input type="checkbox"/> Business		<input type="checkbox"/> Yes <input type="checkbox"/> No
			<input type="checkbox"/> Personal <input type="checkbox"/> Business		<input type="checkbox"/> Yes <input type="checkbox"/> No
			<input type="checkbox"/> Personal <input type="checkbox"/> Business		<input type="checkbox"/> Yes <input type="checkbox"/> No
			<input type="checkbox"/> Personal <input type="checkbox"/> Business		<input type="checkbox"/> Yes <input type="checkbox"/> No

If there is additional insurance beyond those listed, please provide on a separate sheet of paper.

**10. AGREEMENT & AUTHORIZATION**

I have read the completed application. I am not currently taking and I am not under the influence of any medications or drugs that would affect my ability to fully understand and to fully and accurately complete this application. I agree that this application will be the basis for, and will become part of, the policy that is issued. The above representations are true to the best of my knowledge and belief. I agree the policy shall not be in effect until it has been issued by Investors Heritage Life Insurance Company ("the Company") and the initial premium has been paid. I understand that the information on this application will be relied upon to determine insurability and that incorrect information may result in coverage being voided, subject to the policy's incontestability provision. I understand that the agent has no authority to approve the application, change the policy or waive any policy provisions. I understand no insurance will be effective until the date stated in the policy and all eligibility requirements are met. I understand that the USA Patriot Act requires all financial institutions, including insurance companies, to verify the identity of their customers. I am providing my name, address, date of birth and taxpayer identification number to allow verification of identity. I understand the verification process may include the use of third-party sources to verify the information provided. I am not being paid cash and have not been promised services as an inducement to enter into this application for life insurance. The purpose of this insurance application is not to sell or assign it to any type of viatical settlement, senior settlement, or life settlement company. I acknowledge receipt of a copy of the Information Practices Notice, MIB Pre-Notice and Fair Credit Reporting Act Notice.

**Any person who knowingly presents a false statement in an application for insurance may be guilty of a criminal offense and subject to penalties under state law.**

I authorize any physician, medical practitioner, hospital, medical care facility, the Veteran's Administration, insurance company, MIB, Inc., pharmacy manager, pharmacy, insurance laboratory, a consumer reporting agency, my employer or any other person or organization that has any record of information about me to give Investors Heritage Life Insurance Company, its reinsurers or its authorized representative, information about my health, other insurance coverage, employment, age, general character, finances, participation in hazardous activities, medical care or advice about any physical or mental condition, including information about drugs, alcoholism, or other information Investors Heritage Life Insurance Company requires to determine insurability or eligibility of benefits. I further authorize the sources listed above, except MIB, Inc., to give such information to a consumer reporting agency acting on behalf of Investors Heritage Life Insurance Company. This authorization may be revoked; however, it may not be revoked during the contestability period of the policy or to the extent the company has taken action in reliance on this authorization. Notice or revocation may be sent, in writing, to the Company at its administrative office address. 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 30 months from the date signed.

**11. SIGNATURES OF PROPOSED INSURED / OWNER**

X) \_\_\_\_\_ X) \_\_\_\_\_  
 Signature of Proposed Insured Signature of Owner if other than Proposed Insured

Signed at \_\_\_\_\_ On \_\_\_\_\_  
 (City, State) (Month, Day, Year)

12. AGENT'S STATEMENT AND SIGNATURE

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(s) by viewing a state issued driver's license, state issued I.D. card, military I.D. card, Permanent U.S. Resident Card (Green Card), passport or other government issued picture I.D. card.

I certify that the Owner, Proposed Insured or any person or entity is not being paid cash or promised services as an inducement to enter into this insurance transaction and that this insurance transaction will not be sold or assigned for any type of viatical settlement, senior settlement, life settlement or any other secondary market.

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

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

Licensed Agent's Signature

\_\_\_\_\_  
Agent's Printed Name

\_\_\_\_\_  
Agent's Code Number

\_\_\_\_\_  
Agent's Phone Number

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

Second Licensed Agent's Signature

\_\_\_\_\_  
Agent's Printed Name

\_\_\_\_\_  
Agent's Code Number

\_\_\_\_\_  
Agent's Phone Number

**Changes Made to ICC10-PURAPP (4-2010)**

**New Form Number: ICC10-PURAPP REV (9-2010)**

- 1.) The form number has been changed to reflect the new revision date.
- 2.) Page 1, Section 5. Insurance and Annuity Information:
  - a. “Flexible Premium Adjustable Universal Life Insurance” has been replaced with “10 Pay Whole Life Insurance”.
  - b. *SPIA only available with the 10 Pay Whole Life Insurance.*
- 3.) Page 2, Section 7. Health Information:
  - a. Language added: “If any question in this section is answered “Yes”, no coverage can be issued. If height and weight exceeds the maximum allowed for this product, no coverage can be issued”.
  - b. Question g. added: “Attempted suicide? Yes/No”
- 4.) Page 2. Section 8. Additional Information:
  - a. #3. Language “Question 5 of” has been eliminated.
- 5.) Page 3. Section 10. Agreement & Authorization:
  - a. The word “representative” has been replaced with “representatives”.
- 6.) Page 4. Section 12. Agent’s Statement and Signature:
  - a. Language added: “Purpose of Insurance \_\_\_\_\_”
  - b. Language added: “This application is signed and dated at City \_\_\_\_\_ State \_\_\_\_\_.”