

SERFF Tracking Number: IHLI-126879382 State: Arkansas  
 Filing Company: Investors Heritage Life Insurance Company State Tracking Number: 47220  
 Company Tracking Number: PUR-SPIA  
 TOI: A05I Individual Annuities- Immediate Non- Variable Sub-TOI: A05I.000 Annuities - Immediate Non-variable  
 Product Name: Single Premium Immediate Annuity  
 Project Name/Number: PUR SPIA/SPIA

## Filing at a Glance

Company: Investors Heritage Life Insurance Company

Product Name: Single Premium Immediate Annuity SERFF Tr Num: IHLI-126879382 State: Arkansas

TOI: A05I Individual Annuities- Immediate Non- Variable SERFF Status: Closed-Approved- Closed State Tr Num: 47220

Sub-TOI: A05I.000 Annuities - Immediate Non- variable Co Tr Num: PUR-SPIA State Status: Approved-Closed

Filing Type: Form

Reviewer(s): Linda Bird

Authors: Julie Hunsinger, Karen Jones, Brad Shepherd

Disposition Date: 11/08/2010

Date Submitted: 11/04/2010

Disposition Status: Approved-Closed

Implementation Date Requested: On Approval

Implementation Date:

State Filing Description:

## General Information

Project Name: PUR SPIA

Project Number: SPIA

Requested Filing Mode: Review & Approval

Status of Filing in Domicile: Pending

Date Approved in Domicile:

Domicile Status Comments: Filed in KY as part of a compact filing 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: 11/08/2010

Explanation for Other Group Market Type:

State Status Changed: 11/08/2010

Deemer Date:

Created By: Karen Jones

Submitted By: Karen Jones

Corresponding Filing Tracking Number:

Filing Description:

We are submitting the attached form for your consideration for approval. This form has not previously been filed in the state of Arkansas and does not replace any current form. This form is submitted in final print format. This contract will not be marketed with illustrations.

ICC10-SPIA-AR (9-2010) is a single premium immediate annuity contract that satisfies the requirements for such

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contracts under the Internal Revenue Code of the United States. Income to the annuitant is in the form of ten annual payments, payable during the lifetime of the annuitant. The first payment is made on the contract date. Income payments are determined at issue and remain fixed for the duration of the contract. The contract will be available to the general public in both the qualified and non-qualified markets. This contract contains no unique features. The contract cannot be surrendered and has no cash surrender value. Annuity benefits may not be commuted. Issue ages are 50 – 85. Reserves are determined by discounting future income payments using the appropriate valuation interest rate and mortality tables as set forth in the Standard Valuation Law in effect.

Application Form ICC10-PURAPP-REV (9-2010) will be used to apply for the annuity. This revised application form replaces form ICC10-PURAPP (4-2010) which was approved in Arkansas on 06/18/2010, SERFF Tracking No. IHLI-126652310. The revised application form is being filed along with the 10 pay whole live product under a separate SERFF 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]

## Filing Fees

Fee Required? Yes  
 Fee Amount: \$50.00  
 Retaliatory? No  
 Fee Explanation: \$50.00 Annuity Contract  
 Per Company: No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
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SERFF Tracking Number: IHLI-126879382 State: Arkansas  
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Investors Heritage Life Insurance Company \$50.00 11/04/2010 41546733

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## Correspondence Summary

### Dispositions

Status	Created By	Created On	Date Submitted
Approved- Closed	Linda Bird	11/08/2010	11/08/2010

*SERFF Tracking Number:* IHLI-126879382      *State:* Arkansas  
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*Product Name:* Single Premium Immediate Annuity  
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## **Disposition**

Disposition Date: 11/08/2010

Implementation Date:

Status: Approved-Closed

Comment:

Rate data does NOT apply to filing.

*SERFF Tracking Number:* IHLI-126879382      *State:* Arkansas  
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<b>Schedule</b>	<b>Schedule Item</b>	<b>Schedule Item Status</b>	<b>Public Access</b>
<b>Supporting Document</b>	Flesch Certification		Yes
<b>Supporting Document</b>	Application		Yes
<b>Supporting Document</b>	Life & Annuity - Acturial Memo		No
<b>Form</b>	Single Premium Immediate Annuity Contract		Yes

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## Form Schedule

**Lead Form Number: ICC10-SPIA-AR (9-2010)**

Schedule Item Status	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
	ICC10-SPIA-AR (9-2010)	Policy/Contract	Single Premium Immediate Annuity Contract Certificate	Initial		54.900	ICC10-SPIA-AR (9-2010).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 annuity specified in the contract schedule to the owner. Payment is subject to the provisions on this and the following pages of this contract.

This contract is a legal contract between you and us. It is issued in consideration of the application and the payment of the single premium on or before the date of contract delivery.

## PLEASE READ YOUR CONTRACT 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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**RIGHT TO EXAMINE CONTRACT.** You may return this contract 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.

## SINGLE PREMIUM IMMEDIATE ANNUITY CONTRACT

Income payable during annuitant's lifetime with a maximum of ten (10) annual payments;  
Non-participating - no dividends.

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DEFINITIONS	3
GENERAL PROVISIONS	4

**CONTRACT SCHEDULE  
SINGLE PREMIUM IMMEDIATE ANNUITY CONTRACT**

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**CONTRACT NUMBER:** ..... 991151  
**ANNUITANT:** ..... John Doe  
**OWNER:** ..... John Doe  
**CONTRACT DATE:** ..... October 1, 2010  
**ISSUE AGE:** ..... 55  
**SEX:** ..... Male  
**SINGLE PREMIUM:** ..... \$ 2,640.00  
**ANNUITY PAYMENT:** ..... \$ 50,000  
**DATE OF FIRST ANNUITY PAYMENT:** .....  
**DATE OF LAST ANNUITY PAYMENT:** .....  
**FREQUENCY OF ANNUITY PAYMENTS:** ..... Annually

**SCHEDULE OF ANNUITY PAYMENTS**

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Annual payments begin on October 1, 2010 and will continue during the lifetime of the annuitant for a maximum of ten (10) payments.

**DEFINITIONS**

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**ATTAINED AGE**

The issue age of the annuitant plus the number of completed contract years.

**ANNUITANT**

The individual named as the annuitant in the contract schedule.

**ISSUE AGE**

Age on the annuitant's last birthday on or preceding the contract date.

**CONTRACT ANNIVERSARY**

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

**CONTRACT DATE**

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

**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 contract. 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 contract, 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 are representations and not warranties. No statement shall be used in defense of a claim under this contract unless it is contained in a written application that is attached to the contract when issued or delivered.

**SINGLE PREMIUM**

The single premium as shown in the contract schedule is due on the contract date. It is payable to us on or before the delivery of this contract. There is no coverage in effect until the single premium is paid. The single premium may be paid to our authorized agent who will provide a receipt. The receipt must be signed by the agent who received payment on our behalf.

**AUTHORITY TO CHANGE**

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

**INCONTESTABILITY**

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

No statement made by the owner or by the annuitant related to the annuitant'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 annuitant, and (b) a copy of such instrument has been given to the owner, the annuitant, or the beneficiary.

**MISSTATEMENT OF AGE OR SEX**

If the age or sex of the annuitant 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 annuitant.

**NON-PARTICIPATING**

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

## **OWNER**

The owner of this contract is the person or party designated to exercise the rights and receive the benefits of ownership. The annuitant 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 annuitant:

1. Assign this contract;
2. With our consent, make a change in this contract;
3. Transfer the ownership of this contract; and
4. Exercise other rights and receive other benefits as defined in this contract.

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

## **BENEFICIARY**

The beneficiary is as shown in the application. The beneficiary will receive proceeds, if any, payable at the death of the annuitant subject to any assignment made by you.

## **CHANGE OF OWNER OR BENEFICIARY**

You may change the designations of owner and beneficiary while the annuitant is alive. Any change is subject to the consent of an irrevocable beneficiary. Written request of change must be filed at our home office in a form acceptable to us. 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 contract by written request. We are not responsible for the validity or effect of any assignment of this contract. 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.

## **EVIDENCE OF SURVIVAL**

We may require proof that the annuitant is living before making any payment. We will not ask for this proof more than once in any twelve-month period.

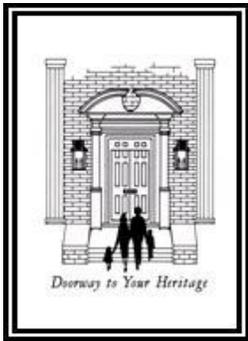
## **DEATH OF ANNUITANT**

No annuity payment will be made after the death of the annuitant.

## **TERMINATION**

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

1. The date of death of the annuitant;
2. The date on which the final annuity payment is made in accordance with the provisions of this contract.



# **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)**

## **SINGLE PREMIUM IMMEDIATE ANNUITY CONTRACT**

Income payable during annuitant's lifetime with a maximum of ten (10) annual payments;  
Non-participating - no dividends.

<i>SERFF Tracking Number:</i>	<i>IHLI-126879382</i>	<i>State:</i>	<i>Arkansas</i>
<i>Filing Company:</i>	<i>Investors Heritage Life Insurance Company</i>	<i>State Tracking Number:</i>	<i>47220</i>
<i>Company Tracking Number:</i>	<i>PUR-SPIA</i>		
<i>TOI:</i>	<i>A05I Individual Annuities- Immediate Non-Variable</i>	<i>Sub-TOI:</i>	<i>A05I.000 Annuities - Immediate Non-variable</i>
<i>Product Name:</i>	<i>Single Premium Immediate Annuity</i>		
<i>Project Name/Number:</i>	<i>PUR SPIA/SPIA</i>		

## Supporting Document Schedules

	<b>Item Status:</b>	<b>Status Date:</b>
<b>Satisfied - Item:</b> Flesch Certification		
<b>Comments:</b> Please see attached.		
<b>Attachments:</b> AR Compliance Certification.pdf Readability Certification SPIA.pdf		

	<b>Item Status:</b>	<b>Status Date:</b>
<b>Satisfied - Item:</b> Application		
<b>Comments:</b> Form ICC10-PURAPP (4-2010) was approved for use in Arkansas on June 18, 2010 which is the application to be used to apply for this annuity contract. Form ICC10-PURAPP-REV (9-2010) is being submitted to Arkansas and will replace the previously approved application. This form will be used to apply for this annuity contract once approved. Also attached is a summary of the changes that have been made to the application form.		
<b>Attachments:</b> ICC10-PURAPP (4-2010).pdf ICC10-PURAPP-REV 9-2010-LTR.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-SPIA-AR (9-2010)

I hereby certify that the submitted form 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 form 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 4, 2010

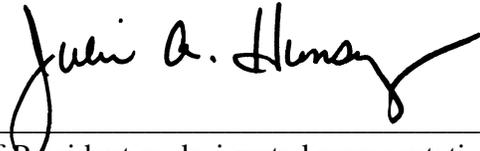
**READABILITY CERTIFICATION**

**INVESTORS HERITAGE LIFE INSURANCE COMPANY**  
**SERFF Tracking Number IHLI-126879382**  
**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 the state of Arkansas.

Form Number	Description	Flesch Score
ICC10-SPIA-AR (9-2010)	Single Premium Immediate Annuity Contract	54.9

November 2, 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

**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



**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

**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 \_\_\_\_\_.”