

SERFF Tracking Number: MCHX-G126918095 State: Arkansas  
 Filing Company: OM Financial Life Insurance Company State Tracking Number: 47378  
 Company Tracking Number: LAPP 1001 (11-10)  
 TOI: L08 Life - Other Sub-TOI: L08.000 Life - Other  
 Product Name: LAPP 1001 (11-10) Indiv Life Application - OM Fina  
 Project Name/Number: LAPP 1001 (11-10) Indiv Life Application - OM Financial Life Insurance Company/LAPP 1001 (11-10) Indiv Life Application - OM Financial Life Insurance Company

## Filing at a Glance

Company: OM Financial Life Insurance Company

Product Name: LAPP 1001 (11-10) Indiv Life Application - OM Fina SERFF Tr Num: MCHX-G126918095 State: Arkansas  
 TOI: L08 Life - Other SERFF Status: Closed-Approved-Closed State Tr Num: 47378

Sub-TOI: L08.000 Life - Other Co Tr Num: LAPP 1001 (11-10) State Status: Approved-Closed  
 Filing Type: Form Reviewer(s): Linda Bird  
 Author: SPI McHughConsulting Disposition Date: 11/30/2010  
 Date Submitted: 11/23/2010 Disposition Status: Approved-Closed

Implementation Date Requested: On Approval Implementation Date:  
 State Filing Description:

## General Information

Project Name: LAPP 1001 (11-10) Indiv Life Application - OM Financial Life Insurance Company Status of Filing in Domicile: Pending

Project Number: LAPP 1001 (11-10) Indiv Life Application - OM Financial Life Insurance Company Date Approved in Domicile:  
 Requested Filing Mode: Review & Approval Domicile Status Comments:  
 Explanation for Combination/Other: Market Type: Individual  
 Submission Type: New Submission Group Market Size:  
 Overall Rate Impact: Group Market Type:  
 Filing Status Changed: 11/30/2010 Explanation for Other Group Market Type:  
 State Status Changed: 11/30/2010

Deemer Date: Created By: SPI McHughConsulting  
 Submitted By: SPI McHughConsulting Corresponding Filing Tracking Number:  
 Filing Description:

RE: Filing on Behalf of OM Financial Life Insurance Company  
 New Life Insurance Application, LAPP 1001 (11-10)  
 Paramedical Supplement to Application, LAPP 1002 (11-10)  
 Supplemental Questionnaire, Arthritis, ADMIN 4939 (11-10);  
 Supplemental Questionnaire, Aviation, ADMIN 4945 (11-10);

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Financial Life Insurance Company

Supplemental Questionnaire, Back Disorders, ADMIN 4940 (11-10);  
Supplemental Questionnaire, Childrens, ADMIN 4948 (11-10);  
Supplemental Questionnaire, Citizenship, LAPP 1003 (11-10);  
Supplemental Questionnaire, Climbing, ADMIN 4943 (11-10);  
Supplemental Questionnaire, Diabetes, ADMIN 4941 (11-10);  
Supplemental Questionnaire, Disability Income, LAPP 1006 (11-10);  
Supplemental Questionnaire, Diving, ADMIN 4944 (11-10);  
Supplemental Questionnaire, Gliding, Hang Gliding, Ultra Lighting, ADMIN 4947 (11-10);  
Supplemental Questionnaire, Growths, Cysts, Tumors, ADMIN 4942 (11-10);  
Supplemental Questionnaire, Hypertension, LAPP 1005 (11-10);  
Supplemental Questionnaire, Military, ADMIN 4938 (11-10);  
Supplemental Questionnaire, Motorsports, ADMIN 4936 (11-10);  
Supplemental Questionnaire, Musculoskeletal, LAPP 1004 (11-10);  
Supplemental Questionnaire, Parachuting, ADMIN 4946 (11-10);  
Supplemental Questionnaire, Residence and Travel, ADMIN 4937 (11-10)

Dear Commissioner Bradford:

McHugh Consulting Resources, Inc. has been requested to file the enclosed forms on behalf of OM Financial Life Insurance Company. We have provided an authorization letter for your files.

The above captioned life application, paramedical form, and supplemental questionnaires to the life application are attached for your review and approval. These forms are new and do not replace any forms on file with the Department.

These forms will also be available electronically so that they may be printed from a computer by an insurance producer for completion and signature.

The first contracts these forms are intended to be used with are the Flexible Premium, Adjustable Death Benefit, Universal Life Insurance Policy with Index Interest Option, OM IUL (1-09), approved on 12/8/2008, State Tracking # 41001, by the Department, and also the Flexible Premium, Adjustable Death Benefit, Universal Life Insurance Policy with Index Features, OM HCV IUL (3-08), approved on 8/18/2008, State Tracking # 39653, by the Department.

The forms are in final printed format subject only to changes in formatting, font style, margins, page numbers, ink and paper stock. Printing standards will never be less than those required by law.

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Thank you for your time and consideration of this filing. If you should have any questions regarding this filing, please do not hesitate to contact me at the telephone or fax numbers shown below.

Sincerely,

Tim Hager  
 Compliance Project Specialist  
 McHugh Consulting Resources, Inc.  
 215-230-7960  
 mcr@mchughconsulting.com

## Company and Contact

### Filing Contact Information

Tim Hager, Compliance Project Specialist mcr@mchughconsulting.com  
 McHugh Consulting Resources, Inc. 215-230-7960 [Phone]  
 2005 South Easton Road, Suite 207 215-230-7961 [FAX]  
 Doylestown, PA 18901

### Filing Company Information

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

OM Financial Life Insurance Company	CoCode: 63274	State of Domicile: Maryland
1001 Fleet Street	Group Code: 2598	Company Type:
Baltimore, MD 21202	Group Name:	State ID Number:
(410) 895-0091 ext. [Phone]	FEIN Number: 52-6033321	

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## Filing Fees

Fee Required?	Yes
Fee Amount:	\$2,375.00
Retaliatory?	Yes
Fee Explanation:	
Per Company:	No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
OM Financial Life Insurance Company	\$2,375.00	11/23/2010	42241344

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## Correspondence Summary

### Dispositions

Status	Created By	Created On	Date Submitted
Approved- Closed	Linda Bird	11/30/2010	11/30/2010

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## Disposition

Disposition Date: 11/30/2010

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	Submission Letter		Yes
Supporting Document	Authorization Letter		Yes
Supporting Document	Statement of Variability - LAPP 1001 (11-10)		Yes
Supporting Document	Statement of Variability - LAPP 1002 (11-10)		Yes
Form	Life Insurance Application		Yes
Form	Paramedical Supplement to Application		Yes
Form	Supplemental Questionnaire, Arthritis		Yes
Form	Supplemental Questionnaire, Aviation		Yes
Form	Supplemental Questionnaire, Back Disorders		Yes
Form	Supplemental Questionnaire, Childrens		Yes
Form	Supplemental Questionnaire, Citizenship		Yes
Form	Supplemental Questionnaire, Climbing		Yes
Form	Supplemental Questionnaire, Diabetes		Yes
Form	Supplemental Questionnaire, Disability Income		Yes
Form	Supplemental Questionnaire, Diving		Yes
Form	Supplemental Questionnaire, Gliding, Hang Gliding, Ultra Lighting		Yes
Form	Supplemental Questionnaire, Growths, Cysts, Tumors		Yes
Form	Supplemental Questionnaire, Hypertension		Yes
Form	Supplemental Questionnaire, Military		Yes
Form	Supplemental Questionnaire, Motorsports		Yes
Form	Supplemental Questionnaire, Musculoskeletal		Yes
Form	Supplemental Questionnaire, Parachuting		Yes
Form	Supplemental Questionnaire, Residence and Travel		Yes

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## Form Schedule

### Lead Form Number: LAPP 1001 (11-10)

Schedule Item Status	Form Number	Form Type Form Name	Action	Action Specific Data	Readability	Attachment
	LAPP 1001 (11-10)	Application/Life Insurance Enrollment Form	Initial		61.500	std LAPP 1001 (11-10) Life App-11_16_10.PDF
	LAPP 1002 (11-10)	Application/Paramedical Enrollment Form Supplement to Application	Initial		60.900	std, LAPP 1002 (11-10) Paramed-10_26_10.PDF
	ADMIN 4939 (11-10)	Application/Supplemental Enrollment Form Arthritis Questionnaire,	Initial		68.090	std, Arthritis ADMIN 4939 (11-10)-10_26_10.PDF
	ADMIN 4945 (11-10)	Application/Supplemental Enrollment Form Aviation Questionnaire,	Initial		67.300	std, Aviation ADMIN 4945 (11-10)-10_26_10.PDF
	ADMIN 4940 (11-10)	Application/Supplemental Enrollment Form Questionnaire, Back Disorders	Initial		61.200	std, Back Dis ADMIN 4940 (11-10)-10_26_10.PDF
	ADMIN 4948 (11-10)	Application/Supplemental Enrollment Form Childrens Questionnaire,	Initial		62.400	std, Child ADMIN 4948 (11-10)-10_26_10.PDF

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LAPP 1003 (11-10)	Application/ Supplemental Enrollment Questionnaire, Form Citizenship	Initial	63.700	std, Citiz LAPP 1003 (11-10)-10_26_10.PDF
ADMIN 4943 (11-10)	Application/ Supplemental Enrollment Questionnaire, Form Climbing	Initial	66.400	std, Climbing ADMIN 4943 (11-10)-10_26_10.PDF
ADMIN 4941 (11-10)	Application/ Supplemental Enrollment Questionnaire, Form Diabetes	Initial	62.600	std, Diab ADMIN 4941 (11-10)-10_26_10.PDF
LAPP 1006 (11-10)	Application/ Supplemental Enrollment Questionnaire, Form Disability Income	Initial	68.400	std, DI LAPP 1006 (11-10)-10_26_10.PDF
ADMIN 4944 (11-10)	Application/ Supplemental Enrollment Questionnaire, Diving Form	Initial	63.800	std, Div ADMIN 4944 (11-10)-10_26_10.PDF
ADMIN 4947 (11-10)	Application/ Supplemental Enrollment Questionnaire, Form Gliding, Hang Gliding, Ultra Lighting	Initial	69.000	std, GHU ADMIN 4947 (11-10)-10_26_10.PDF
ADMIN 4942 (11-10)	Application/ Supplemental Enrollment Questionnaire, Form Growths, Cysts, Tumors	Initial	67.400	std, GCT ADMIN 4942 (11-10)-10_26_10.PDF
LAPP 1005 (11-10)	Application/ Supplemental Enrollment Questionnaire, Form Hypertension	Initial	63.000	std, Hypert LAPP 1005 (11-10)-

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					10_26_10.PD F
ADMIN 4938 (11- 10)	Application/ Supplemental Enrollment Questionnaire, Form Military	Initial	68.800	std, Military ADMIN 4938 (11-10)- 10_26_10.PD F	
ADMIN 4936 (11- 10)	Application/ Supplemental Enrollment Questionnaire, Form Motorsports	Initial	63.100	std, Motor ADMIN 4936 (11-10)- 10_26_10.PD F	
LAPP 1004 (11-10)	Application/ Supplemental Enrollment Questionnaire, Form Musculoskeletal	Initial	61.200	std, Musculo LAPP 1004 (11-10)- 10_26_10.PD F	
ADMIN 4946 (11- 10)	Application/ Supplemental Enrollment Questionnaire, Form Parachuting	Initial	68.590	std, Para ADMIN 4946 (11-10)- 10_26_10.PD F	
ADMIN 4937 (11- 10)	Application/ Supplemental Enrollment Questionnaire, Form Residence and Travel	Initial	60.400	std, Travel ADMIN 4937 (11-10)- 10_26_10.PD F	

# Life Insurance Application

LAPP 1001 (11-10)

OM Financial Life Insurance Company Home Office: Baltimore, Maryland  
 [Administrative Office: P.O. Box 81497; Lincoln, NE 68501-81497]

## PART I (Page [1] of [9])

For anyone proposed to be insured: if you have any questions or concerns about any of the contents of this form or the insurance coverage, or wish to discuss the insurance coverage, contact our home office at [800 445-6758].

### PRIMARY INSURED

Name (First, M.I., Last)							
Home Address				City	State	Zip	
Social Security No.	Sex	Marital Status	Date of Birth	Place of Birth	Height (ft., in.)	Weight (lbs.)	
Driver's License Number and Issue State			Other Identification Number (if Driver's License not used):			State/Province and Country of Issue:	
Type of Identification:		ID Number					
Currently Employed? <input type="checkbox"/> Yes <input type="checkbox"/> No	[Employer]			[Occupation and Duties]		[No. of Years With Current Employer]	
[Earned Annual Income]			Email Address				
Daytime Phone Number		Evening Phone Number		Cell Phone Number		Best Time To Call	

### [OTHER INSURED

Name (First, M.I., Last)					Relationship to Primary Insured		
Home Address				City	State	Zip	
Social Security No.	Sex	Marital Status	Date of Birth	Place of Birth	Height (ft., in.)	Weight (lbs.)	
Driver's License Number and Issue State			Other Identification Number (if Driver's License not used):			State/Province and Country of Issue:	
Type of Identification:		ID Number					
Currently Employed? <input type="checkbox"/> Yes <input type="checkbox"/> No	[Employer]			[Occupation and Duties]		[No. of Years With Current Employer]	
[Earned Annual Income]			Email Address				
Daytime Phone Number		Evening Phone Number		Cell Phone Number		Best Time To Call	

### [OWNER(S)

UNLESS OTHERWISE INSTRUCTED, THE OWNER WILL BE THE PRIMARY INSURED

**IF THIS APPLICATION IS FOR CORPORATE OWNED LIFE INSURANCE, THE EMPLOYEE HAS NO OWNERSHIP RIGHTS.  
 A secondary addressee may be named to receive notice of possible lapse in coverage. (Required in FL, ME, VT)**

Name (First, M.I., Last)					Relationship to Primary Insured		
Home Address				City	State	Zip	
Social Security or Tax I.D. No.		Date of Birth		Email Address			
Driver's License Number and Issue State			Other Identification Number (if Driver's License not used):			State/Province and Country of Issue:	
Type of Identification:		ID Number					
Currently Employed? <input type="checkbox"/> Yes <input type="checkbox"/> No	[Employer]			[Occupation and Duties]		[No. of Years With Current Employer]	
[Earned Annual Income]			Email Address				
Daytime Phone Number		Evening Phone Number		Cell Phone Number		Best Time To Call	



Life Insurance Application Part I (Page [2] of [9])

SECONDARY ADDRESSEE

To receive notice of possible lapse in coverage. (Required in FL, ME, VT)

Name (First, M.I., Last)		Relationship to Primary Insured and/or Owner		
Home Address		City	State	Zip

BENEFICIARY DESIGNATION – Primary Insured

For each beneficiary, list full name, address, relationship to primary insured and % share. If this application is for corporate owned life insurance, fill in the employer's information

Primary Beneficiary(ies)

Full Name	Relationship to Primary Insured	%

Contingent Beneficiary(ies)

Full Name	Relationship to Primary Insured	%

BENEFICIARY DESIGNATION – Other Insured

Unless otherwise instructed, the beneficiary for other persons proposed to be insured will be the Owner.

EXISTING INSURANCE

		Primary Insured	Other Insured
1.	Will this life insurance, if issued, replace or change any existing life insurance, mortgage life insurance, or annuity? Amount being replaced \$ _____	qY qN	qY qN
2.	Has any person proposed to be insured had any insurance application declined, postponed, rescinded or been offered rated or modified life insurance, or refused for renewal or reinstatement? If "Yes," please provide details:	qY qN	qY qN
3.	Does the proposed owner or any person proposed to be insured have any life insurance or annuity in force or pending, including mortgage life insurance, life insurance sold or assigned to a life settlement, viatical or secondary market provider? If "Yes," please provide details below	qY qN	qY qN

List existing personal and business life insurance or annuity coverage.

q There is no existing coverage.

Insurance Company	Type of Policy	Policy/Certificate Number	Life Insurance or Annuity	Accidental Death Benefit Amount	Year Issued	Replacing	1035
						q	q
						q	q
						q	q



## Life Insurance Application Part I (Page [3] of [9])

<b>STATEMENT OF INTENT</b>		This section must be completed by the owner and all persons applying for life insurance with this application	
It is the Company's policy that life insurance should only be purchased to provide protection to those with an insurable interest in the life (lives) of the insured(s). The Company will not knowingly participate in life insurance sales motivated by a possible sale of life insurance contracts to a secondary market or participation of investors in life insurance death benefits.			
1.	Are you financing or refinancing a mortgage and/or home equity loan or contemplating the use of any kind of mortgage financing strategy in connection with the purchase of or the payment of premiums on the life insurance policy? (If "Yes," please complete the Premium Financing questionnaire.)	<input type="checkbox"/> Y	<input type="checkbox"/> N
2.	Will you borrow money to pay the premium for the life insurance being applied for or have someone else pay these premiums for you in return for you assigning part or all of the policy values to someone else?	<input type="checkbox"/> Y	<input type="checkbox"/> N

<b>[LIFE INSURANCE INFORMATION]</b>			
[Product Name]	[Amount of Insurance] [\$ _____ ]	[Initial Premium] [\$ _____ ]	[Planned Premium] [\$ _____ ]
[TERM: <input type="checkbox"/> Level <input type="checkbox"/> Decreasing]	[Term Period (Number of years):]	[Premium Guarantee Period:]	
[UNIVERSAL LIFE: Death Benefit Option: <input type="checkbox"/> Option A-Level <input type="checkbox"/> Option B-Increasing]	[Life Insurance Qualification Test: <input type="checkbox"/> Guideline Premium <input type="checkbox"/> Cash Value Accumulation If not indicated, Guideline Premium Test will be used.]		
<input type="checkbox"/> Nontobacco <input type="checkbox"/> Tobacco]	[For Fixed Indexed Products Only: Initial Allocation Percentage (if not completed, [[100%] will be allocated to the [100% Par Index Interest Option]] [140% Par Index Interest Option _____%] [100% Par Index Interest Option _____%] [Fixed Interest Option _____%]]		
[Payment Mode: (For bank draft, complete Bank Draft Plan Authorization, and initial payment required.) <input type="checkbox"/> Annual <input type="checkbox"/> Semi-Annual <input type="checkbox"/> Quarterly <input type="checkbox"/> Monthly Bank Draft <input type="checkbox"/> Bi-Weekly Bank Draft <input type="checkbox"/> Payroll Deduction <input type="checkbox"/> Other _____]		[Payment in Exchange for Conditional Receipt] [\$ _____ ]	
[Credit Card (See instructions Page for Current Company Practice) <input type="checkbox"/> Visa <input type="checkbox"/> MasterCard]	[Account Number] [ _____ ]	[Expiration Date] [ _____ ]	[Signature to Authorize Credit Card Charge] [ _____ ]
No coverage will be effective except in accordance with the terms of the conditional receipt and unless the full initial modal premium payment is submitted with the application.]			

<b>[ADDITIONAL BENEFITS]</b>			
Subject to state availability. Certain restrictions may apply.			
<b>[PRIMARY INSURED]</b>		<b>[OTHER INSURED]</b>	
<input type="checkbox"/> Disability Income Rider		<input type="checkbox"/> Disability Income Rider	
Class: _____ Monthly Payout: \$ _____ <input type="checkbox"/> 3 Month Waiting Period, 2 Year Benefit <input type="checkbox"/> 6 Month Waiting Period, 5 Year Benefit]		Class: _____ Monthly Payout: \$ _____ <input type="checkbox"/> 3 Month Waiting Period, 2 Year Benefit <input type="checkbox"/> 6 Month Waiting Period, 5 Year Benefit]	
<input type="checkbox"/> Disability Income Accident Rider		<input type="checkbox"/> Disability Income Accident Rider	
Monthly Payout: \$ _____ <input type="checkbox"/> 3 Month Waiting Period, 2 Year Benefit <input type="checkbox"/> 6 Month Waiting Period, 5 Year Benefit]		Monthly Payout: \$ _____ <input type="checkbox"/> 3 Month Waiting Period, 2 Year Benefit <input type="checkbox"/> 6 Month Waiting Period, 5 Year Benefit]	
<input type="checkbox"/> Accelerated Benefit Rider]			
<input type="checkbox"/> Accidental Death Benefit Rider]	[Amount: \$ _____]		
<input type="checkbox"/> Critical Illness / Condition <sup>(PA)</sup> / Specified Medical Condition Rider <sup>(MA)</sup> ]	[Amount: \$ _____]	[Supplemental questionnaire required.]	
<input type="checkbox"/> Return of Premium Rider:	<input type="checkbox"/> 50% <input type="checkbox"/> 100%		
<input type="checkbox"/> Ultimate Income Option Rider	Initial Lump Sum: \$ _____ Monthly Income of: \$ _____ for _____ years. Final Lump Sum: \$ _____]	[Illustration Required. ]]	

## Life Insurance Application Part I (Page [4] of [9])

<b>[ADDITIONAL BENEFITS (continued)]</b>		
Subject to state availability. Certain restrictions may apply.		
<input type="checkbox"/> Other Insured Rider	Amount: \$ _____	
<input type="checkbox"/> Child Rider	Amount: \$ _____	Supplemental questionnaire required.]
<input type="checkbox"/> (UL Only) Waiver of Monthly Deduction Rider]		
<input type="checkbox"/> (Term Only) Waiver of Premium Rider]		
<input type="checkbox"/> Other: _____ ]		

PERSONAL HISTORY QUESTIONS			
		Primary Insured	Other Insured
1.	Is any person proposed to be insured a citizen or permanent resident of the United States? If "No," please complete W8ben form and the Citizenship Questionnaire.	qY qN	qY qN
2.	Has any person proposed to be insured traveled or resided outside the United States or Canada within the past 2 years or plan to travel outside the United States or Canada in the next two years? (not required in FL and MA); If you answered "Yes," to question 2, please complete the Residence and Travel Questionnaire.	qY qN	qY qN
3.	Has anyone proposed to be insured ever been convicted of, pending trial or currently on probation or parole on any felony and/or misdemeanor crime offense? If "Yes," please provide details below.	qY qN	qY qN
4.	Has anyone proposed to be insured ever sought or received treatment, advice, counseling for the use of or is currently using any narcotic, barbiturate, stimulant, amphetamine, hallucinogenic, street, alcohol, or prescription drug? If "Yes," please provide details below.	qY qN	qY qN
5.	In the past 10 years has anyone proposed to be insured been convicted of driving under the influence of alcohol or drugs, reckless driving, a motor vehicle moving violation, or any other type of DWI/DUI, or had a driver's license suspended or revoked? If "Yes," please provide details below.	qY qN	qY qN
6.	Within the past 7 years has anyone proposed to be insured filed for bankruptcy? If "Yes," please provide details below.	qY qN	qY qN
7.	In the past 5 years has anyone proposed to be insured participated in ballooning, bungee jumping, cliff diving, hang gliding, motorized racing, boat racing, parachuting, mountain or rock climbing, skin or scuba diving, rodeo, snowmobiling, competitive skiing, or any other similar activity or avocation or does anyone proposed to be insured plan to participate in any of these or any other similar activity or avocation? If "Yes," please complete the appropriate questionnaire.	qY qN	qY qN
8.	In the past 5 years has anyone proposed to be insured flown as a pilot, student pilot, or crew member of an aircraft or plan to? If "Yes," please complete the Aviation Questionnaire.	qY qN	qY qN
[9.	In the past 24 months, has anyone proposed to be insured had any of the following life events: <input type="checkbox"/> Marriage <input type="checkbox"/> Divorce <input type="checkbox"/> Birth of Child <input type="checkbox"/> Adoption If "Yes," to Birth of Child or Adoption, please provide details and complete Children's Questionnaire.	qY qN	qY qN]

**Provide full name, address, and phone number of primary medical provider.**

For Pennsylvania applicants, do NOT provide primary medical provider information for a medical consultation or informational visit concerning AIDS or AIDS related complex (ARC)

Primary Insured does not have a primary medical provider.

Medical Provider Name		Date Last Seen
Medical Provider Address	City, State, Zip	Medical Provider Phone Number
Reason and Results of Last Visit		

**Life Insurance Application PART II (Page [5] of [9])****Provide full name, address, and phone number of primary medical provider.**

For Pennsylvania applicants, do NOT provide primary medical provider information for a medical consultation or informational visit concerning AIDS or AIDS related complex (ARC)

 **Other Insured does not have a primary medical provider.**

Medical Provider Name		Date Last Seen
Medical Provider Address	City, State, Zip	Medical Provider Phone Number
Reason and Results of Last Visit		

**MEDICAL HISTORY QUESTIONS**

Please complete part II of the Life Insurance Application unless to be completed by Paramedical Examiner.		Primary Insured	Other Insured
1.	Has the person proposed for insurance ever (a) received care or had treatment for, or (b) been advised by a physician or health care provider to seek treatment for, or (c) consulted with a health care provider regarding:		
a)	Coronary artery disease, heart attack, congenital heart disease or defect, cardiomyopathy, chest pain, or any heart disease; high blood pressure, high cholesterol, heart murmur, palpitations, or any other disorder of the heart or blood vessels; had any coronary bypass surgery, coronary angioplasty, coronary stent, heart valve replacement, or any other heart related treatments, or any abnormality of the brain? If "Yes," please provide details below.	qY qN	qY qN
b)	Any circulatory disease, stroke, TIA, aneurysm, or any other disorder of the veins or arteries? If "Yes," please provide details below.	qY qN	qY qN
c)	Any breathing or respiratory disorders, Chronic Obstructive Pulmonary Disease (COPD), asthma, bronchitis, pleurisy, tuberculosis, sleep apnea, emphysema, sarcoidosis, or cystic fibrosis? If "Yes," please provide details below.	qY qN	qY qN
d)	Diabetes, thyroid, disorder of the immune system, anemia, blood disorder, disorder of the glands, or any other disorders? If "Yes," please provide details below.	qY qN	qY qN
e)	Cancer, growths, tumors, or cysts? If "Yes," please provide details below and complete the questionnaire.	qY qN	qY qN
f)	Depression, bipolar disorder, schizophrenia, anxiety, dementia, Alzheimer's, Parkinson's, demyelinating disease, multiple sclerosis, Huntington's, hydrocephalus, quadriplegia, paraplegia, any other type of paralysis, any other physical, psychiatric or emotional disorder, stress, or any other mental, nervous disease or disorder? If "Yes," please provide details below.	qY qN	qY qN
g)	Jaundice, intestinal bleeding, ulcer, hernia, hepatitis, gastritis, colitis, diverticulitis, recurrent indigestion or any disease or disorder of the liver, stomach, pancreas, or intestines? If "Yes," please provide details below.	qY qN	qY qN
h)	Kidney disease, albumin, blood or pus in urine, renal disease, dialysis, stone or any disease or disorder of the kidneys, bladder, prostate, urinary, breasts, or reproductive systems? If "Yes," please provide details below.	qY qN	qY qN
i)	Arthritis, neuritis, rheumatism, gout, or any disease, disorder or injury to the muscles (includes strains and sprains), tendons, bones, back or joints, nerves, knees, wrists or other joints? If "Yes," please provide details below.	qY qN	qY qN
j)	Any dizziness, vertigo, fainting, seizures, recurrent headache, or speech defect? If "Yes," please provide details below.	qY qN	qY qN
k)	Any disease or disorder of the skin, lymph glands, eyes, ears, nose or throat? If "Yes," please provide details below.	qY qN	qY qN
n)	Any mental or physical disorder or disease not mentioned above? If "Yes," please provide details below.	qY qN	qY qN



**Life Insurance Application Part II (Page [6] of [9])**

<b>MEDICAL HISTORY QUESTIONS (Continued)</b>			
		<b>Primary Insured</b>	<b>Other Insured</b>
2.	Has anyone proposed to be insured ever tested positive for exposure to the HIV (Human Immunodeficiency Virus) infection or been diagnosed as having ARC (AIDS-Related Complex) or AIDS (Acquired Immune Deficiency) caused by the HIV infection or other sickness or condition derived from such infection? If "Yes," please provide details in the Additional Information section.	qY qN	qY qN
3.	Is anyone proposed to be insured currently bedridden or confined to any hospital, nursing home, or other medical facility? If "Yes," please provide details in the Additional Information section.	qY qN	qY qN
4.	In the past 10 years, has anyone proposed to be insured:		
	a) Been hospitalized or had surgery? If "Yes," please provide details in the Additional Information section.	qY qN	qY qN
	b) Had any electrocardiograms, x-rays, laboratory tests, treatments, or procedures? If "Yes," please provide details in the Additional Information section.	qY qN	qY qN
	c) Been recommended to have any test, treatment, surgery or other procedure which has not been performed? If "Yes," please provide details in the Additional Information section.	qY qN	qY qN
	d) Received medical care for any illness, disease, or injury that is not included in other answers? If "Yes," please provide details in the Additional Information section.	qY qN	qY qN
5.	In the past 12 months, has any person proposed to be insured consulted a medical physician for chronic cough, unexplained weight loss, fatigue, unexplained gastrointestinal bleeding, shortness of breath or chest pain? If "Yes," please provide details in the Additional Information section.	qY qN	qY qN
6.	Has any grandparent parent, brother, or sister of anyone proposed to be insured died from or had any occurrence of mental illness, cancer, heart disease, diabetes, or any hereditary disease prior to age 60 or attempted suicide? If "Yes," please provide details in the Additional Information section.	qY qN	qY qN
7.	Has anyone proposed to be insured ever used tobacco in any form? If "Yes," Type(s) of tobacco product(s) used: _____ Frequency of use: _____ Date(s) of last use _____.	qY qN	qY qN
[8.	Within the past 10 years has anyone proposed to be insured made a claim or received benefits for disability or workman's compensation as a result of a sickness or injury? If "Yes," please provide details in the Additional Information section and complete the Disability Income Questionnaire.	qY qN	qY qN]
[9.	In the past 5 years, has anyone proposed to be insured been diagnosed with and/or treated by a member of the medical profession for:		
	a) Any of the following conditions for which anyone proposed to be insured has not fully recovered: any disorder or impairment of the eyes or ears; deformity or pain of the spine, neck, back, arms, hands, legs, feet or joints, including muscles and bones; or any connective tissue disease or auto-immune disorder? If "Yes," please provide details in the Additional Information section.	qY qN	qY qN
	b) Migraines or any type of reproductive disease or disorder, including complications due to pregnancy? If "Yes," please provide details in the Additional Information section.	qY qN	qY qN]
[10.	In the past 6 months, has anyone proposed to be insured been working full-time with a minimum of 30 hours per week and performing all duties of the regular occupation in the usual and customary way? If "No," please provide details in the Additional Information section.	qY qN	qY qN]





Life Insurance Application Part III (Page [8] of [9])

**AUTHORIZATION**

I (We) have read the questions and answers on this application. I (We) certify that the statements made in this application are: complete; true; and correctly recorded and are subject to the applicable **FRAUD WARNING** notice. **I (We) agree that: a copy of this application will form a part of any life insurance contract issued; and that no agent can pass on insurability or modify any life insurance contract issued by the Company. I (We) also agree that, except as provided in this application's Conditional Receipt, if issued, no insurance will take effect unless and until both of the following conditions are satisfied during each proposed insured's lifetime and while each proposed insured's health is as stated in this application: (1) the life insurance contract is delivered to and accepted by the Owner; and (2) the full initial premium for the mode of payment chosen is paid at our Home Office.** I (We) acknowledge that I (we) have received, read and understand the notices required by the Medical Information Bureau, and the Federal Fair Credit Reporting Act regarding investigative consumer reports. I (We) understand that if requested, I (we) may inspect or obtain a copy of this report.

In order to evaluate my application for life insurance, I (We) authorize any licensed physician, medical practioner, hospital, clinic, the Veterans Administration, laboratory or other medical or medically related facility, the Medical Information Bureau, Inc., insurance companies, a consumer reporting agency, prescription records, Pharmacy Benefit Manager, and my employer to give to OM Financial Life Insurance Company, its reinsurers, or other designee, medical and other information which may be pertinent to the evaluation regarding me or any member of my family who is applying for life insurance.

I (We) understand such information may concern my (our): physical history, condition and treatment, including drug or alcohol abuse or mental health information protected by Federal law; general character, habits, reputation, mode of living; financial status, income; occupation; avocations, sports, hobbies and aviation activities.

I (We) also authorize OM Financial Life Insurance Company to obtain an investigative consumer report on me and/or any member of my family who is also applying for life insurance. I (We) understand that I am (we are) entitled to be interviewed by any consumer reporting agency which may be requested to prepare such a report as long as I (we) can reasonably be contacted during normal business hours.

Check here if interview is requested:

[I (We) understand that if my coverage includes the Accelerated Benefit Rider and I am later diagnosed with a terminal illness, terminal condition, or specified medical condition as defined in the rider, I may receive up to [50%] of the life insurance death benefit. Since I would receive a portion of my benefits early, the amount payable at my death will be reduced. There is no premium charged for this rider. I (We) understand that receipt of benefits may be taxable, and that OM Financial Life Insurance Company recommends consultation with a tax advisor prior to exercising this benefit.]

I (We) authorize OM Financial Life Insurance Company and/or its reinsurer(s); or other designee to release information in my (our) file to other insurance companies to which I (we) may apply for life or health insurance coverage or to which a claim may be submitted.

This Authorization will be valid from the date signed for a period of 24 months unless revoked in writing by me (us) and delivered to OM Financial Life Insurance Company. A photographic copy of this Authorization will be as valid as the original; I (we), or any of my (our) representatives are entitled to receive a copy of this Authorization. Failure to sign or revocation of this authorization may impair the ability of a regulated insurance agency to evaluate claims or process applications and may be a basis for denying an application or claim for benefits.

I (We) understand that the information obtained by use of this Authorization will be used to determine eligibility for insurance and/or benefits.

**[For any fixed index life insurance issued, I (We) understand that I am (we are) purchasing fixed indexed life insurance. I (We) have received a copy of the indexed disclosure material for the fixed indexed life insurance applied for. I (We) understand that while the values of this life insurance may be affected by an external index, the life insurance does not directly participate in any stock, bond, or equity investments and that any values shown, other than guaranteed minimum values, are not guarantees, promises, or warranties.]**

**[CERTIFICATION:** I (We) certify, under penalties of perjury, that I am (we are) the person(s) identified in this application, I am a (we are) U.S. Citizen(s) or resident(s) of the U.S. (includes U.S. resident aliens) and that the taxpayer identification number(s) is (are) correct. I (We) understand that federal law requires all financial institutions to obtain identity information in order to verify my (our) identity(ies) and I (we) authorize its use for this purpose. This information includes, but is not limited to, the name(s), residential address(es), date(s) of birth, Social Security or taxpayer identification number(s); and any other information necessary to sufficiently verify identity(ies). I (we) understand that failure to provide this information could result in the application being rejected. Third party sources may be used to verify the information provided. ]

**FRAUD 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**

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

Signed at (City and State)	Date
Signature of Primary Insured Age 15 or More	
Signature(s) of Additional Insured(s) Age 15 or More	
Signature of Owner(s) (If not the Primary Insured or if Primary Insured is less than Age 18)	



Life Insurance Application Part III (Page [9] of [9])

AGENT CERTIFICATION

1) I have asked the questions contained in this application of the proposed Insured(s) and Owner and duly recorded the answers; 2) to the best of my knowledge there is nothing affecting the insurability of any persons proposed for insurance as stated in this application; 3) if the initial premium was paid with the application, I have remitted it to OM Financial Life Insurance Company and delivered a Conditional Receipt to the Owner; 4) if Disclosure Statements are required by the state, I have given them to the applicant; 5) I have witnessed the signatures on this application; 6) I have verified the identity of the Primary Insured, Other Insured, and Owner, if other than the Primary Insured, through examination of a state or federal government photo identification card provided by the Primary Insured, Other Insured and/or Owner, such as a driver's license or passport.

To the best of my knowledge, this application  does replace  does not replace existing life insurance, mortgage life insurance, or annuities.

If so, will this replacement be considered a 1035 exchange?  Yes  No

I certify that the indexed disclosure material has been presented to the Applicant. A copy was provided to the Applicant. I have not made statements which differ in any significant manner from this material. I have not made any promises or guarantees about the future value of any non-guaranteed elements.

Signature of Agent/Producer		Print Agent/Producer Name		Date
Agent /Producer OMFLIC Number	Agent/Producer State License Number (FL)	Agent/Producer Phone Number	Agent/Producer Fax Number	
Agent Email Address				
[If Bank Representative:]	[Name of Financial Institution]	[Branch Number]	[Employee Number]	

**Paramedical Supplement To Life Insurance Application (Page [1] of [3])**

OM Financial Life Insurance Company Home Office: [Baltimore, Maryland]

Administrative Office: [P.O. Box 81497; Lincoln, NE 68501-81497 ]

If you have any questions or concerns about any of the contents of this form or the insurance coverage, or wish to discuss the insurance coverage, contact our home office at [800 445-6758].

Name of Interviewer (First, M.I., Last)	Does the Interviewer know the Proposed Insured? <input type="checkbox"/> Yes <input type="checkbox"/> No	If "Yes," How does the Interviewer know the Proposed Insured?
Name of Examiner If Different From Interviewer (First, M.I., Last)	Does the Medical Examiner know the Proposed Insured? <input type="checkbox"/> Yes <input type="checkbox"/> No	If "Yes," How does the Medical Examiner know the Proposed Insured?
Information Source: <input type="checkbox"/> Proposed Insured <input type="checkbox"/> Other Name: _____ Relationship to Proposed Insured: _____ Is Proposed Insured Unable to Provide the information? <input type="checkbox"/> Yes <input type="checkbox"/> No If "Yes," please provide details in Additional Information section.		
Date of Interview	Time of Interview	<input type="checkbox"/> AM <input type="checkbox"/> PM

PROPOSED INSURED			
Name (First, M.I., Last)			
Home Address	City	State	Zip
Social Security No.	Date of Birth	Sex	
Driver's License Number and Issue State	Other Identification Number (if Driver's License not used):	State/Province and Country of Issue:	
Type of Identification: _____	ID Number _____		

MEDICAL HISTORY QUESTIONS		
If any answer to the following questions is "Yes," please provide details in the space provided on page 3.		
	Yes	No
1. Has the person proposed for insurance ever (a) received care or had treatment for, or (b) been advised by a physician or health care provider to seek treatment for, or (c) consulted with a health care provider regarding:		
a) Coronary artery disease, heart attack, congenital heart disease or defect, cardiomyopathy, chest pain, or any heart disease; high blood pressure, high cholesterol, heart murmur, palpitations, or any other disorder of the heart or blood vessels; had any coronary bypass surgery, coronary angioplasty, coronary stent, heart valve replacement, or any other heart related treatments, or any abnormality of the brain? If "Yes," please provide details below.	<input type="checkbox"/>	<input type="checkbox"/>
b) Any circulatory disease, stroke, TIA, aneurysm, or any other disorder of the veins or arteries? If "Yes," please provide details below.	<input type="checkbox"/>	<input type="checkbox"/>
c) Any breathing or respiratory disorders, Chronic Obstructive Pulmonary Disease (COPD), asthma, bronchitis, pleurisy, tuberculosis, sleep apnea, emphysema, sarcoidosis, or cystic fibrosis? If "Yes," please provide details below.	<input type="checkbox"/>	<input type="checkbox"/>
d) Diabetes, thyroid, disorder of the immune system, anemia, blood disorder, disorder of the glands, or any other disorders? If "Yes," please provide details below.	<input type="checkbox"/>	<input type="checkbox"/>
e) Cancer, growths, tumors, or cysts? If "Yes," please provide details below and complete the questionnaire.	<input type="checkbox"/>	<input type="checkbox"/>
f) Depression, bipolar disorder, schizophrenia, anxiety, dementia, Alzheimer's, Parkinson's, demyelinating disease, multiple sclerosis, Huntington's, hydrocephalus, quadriplegia, paraplegia, any other type of paralysis, any other physical, psychiatric or emotional disorder, stress, or any other mental, nervous disease or disorder? If "Yes," please provide details below.	<input type="checkbox"/>	<input type="checkbox"/>
g) Jaundice, intestinal bleeding, ulcer, hernia, hepatitis, gastritis, colitis, diverticulitis, recurrent indigestion or any disease or disorder of the liver, stomach, pancreas, or intestines? If "Yes," please provide details below.	<input type="checkbox"/>	<input type="checkbox"/>
h) Kidney disease, albumin, blood or pus in urine, renal disease, dialysis, stone or any disease or disorder of the kidneys, bladder, prostate, urinary, breasts, or reproductive systems? If "Yes," please provide details below.	<input type="checkbox"/>	<input type="checkbox"/>

## Paramedical Supplement To Life Insurance Application (Cont'd) (page [2] of [3])

MEDICAL HISTORY QUESTIONS (Continued)		Yes	No
1. Has the person proposed for insurance ever (a) received care or had treatment for, or (b) been advised by a physician or health care provider to seek treatment for, or (c) consulted with a health care provider regarding (Continued):			
i)	Arthritis, neuritis, rheumatism, gout, or any disease, disorder or injury to the muscles (includes strains and sprains), tendons, bones, back or joints, nerves, knees, wrists or other joints? If "Yes," please provide details below.	q	q
j)	Any dizziness, vertigo, fainting, seizures, recurrent headache, or speech defect? If "Yes," please provide details below.	q	q
k)	Any disease or disorder of the skin, lymph glands, eyes, ears, nose or throat? If "Yes," please provide details below.	q	q
n)	Any mental or physical disorder or disease not mentioned above? If "Yes," please provide details below.	q	q
2. Has anyone proposed to be insured ever tested positive for exposure to the HIV (Human Immunodeficiency Virus) infection or been diagnosed as having ARC (AIDS-Related Complex) or AIDS (Acquired Immune Deficiency) caused by the HIV infection or other sickness or condition derived from such infection? If "Yes," please provide details in the Additional Information section.		q	q
3. Is anyone proposed to be insured currently bedridden or confined to any hospital, nursing home, or other medical facility? If "Yes," please provide details in the Additional Information section.		q	q
4. In the past 10 years, has anyone proposed to be insured:			
a)	Been hospitalized or had surgery? If "Yes," please provide details in the Additional Information section.	q	q
b)	Had any electrocardiograms, x-rays, laboratory tests, treatments, or procedures? If "Yes," please provide details in the Additional Information section.	q	q
c)	Been recommended to have any test, treatment, surgery or other procedure which has not been performed? If "Yes," please provide details in the Additional Information section.	q	q
d)	Received medical care for any illness, disease, or injury that is not included in other answers? If "Yes," please provide details in the Additional Information section.	q	q
5. In the past 12 months, has any person proposed to be insured consulted a medical physician for chronic cough, unexplained weight loss, fatigue, unexplained gastrointestinal bleeding, shortness of breath or chest pain? If "Yes," please provide details in the Additional Information section.		q	q
6. Has any grandparent parent, brother, or sister of anyone proposed to be insured died from or had any occurrence of mental illness, cancer, heart disease, diabetes, or any hereditary disease prior to age 60 or attempted suicide? If "Yes," please provide details in the Additional Information section.		q	q
7. Has anyone proposed to be insured ever used tobacco in any form? If "Yes," Type(s) of tobacco product(s) used: _____ Frequency of use: _____ Date(s) of last use _____.		q	q
[8. Within the past 10 years has anyone proposed to be insured made a claim or received benefits for disability or workman's compensation as a result of a sickness or injury? If "Yes," please provide details in the Additional Information section and complete the Disability Income Questionnaire.		q	q]
[9. In the past 5 years, has anyone proposed to be insured been diagnosed with and/or treated by a member of the medical profession for:			
a)	Any of the following conditions for which anyone proposed to be insured has not fully recovered: any disorder or impairment of the eyes or ears; deformity or pain of the spine, neck, back, arms, hands, legs, feet or joints, including muscles and bones; or any connective tissue disease or auto-immune disorder? If "Yes," please provide details in the Additional Information section.	q	q
b)	Migraines or any type of reproductive disease or disorder, including complications due to pregnancy? If "Yes," please provide details in the Additional Information section.	q	q]
[10. In the past 6 months, has anyone proposed to be insured been working full-time with a minimum of 30 hours per week and performing all duties of the regular occupation in the usual and customary way? If "No," please provide details in the Additional Information section.		q	q]

# Paramedical Supplement To Life Insurance Application (Cont'd) (page [3] of [3])

## MEDICAL HISTORY QUESTIONS (Continued)

Check here if Proposed Insured does not have a primary medical provider.

For Pennsylvania applicants, do NOT provide primary medical provider information for a medical consultation or informational visit concerning AIDS or AIDS related complex (ARC).

11. Primary Medical Provider's Name and Address: \_\_\_\_\_  
\_\_\_\_\_

Date and Reason Last Consulted: \_\_\_\_\_  
\_\_\_\_\_

What treatment was given or medication prescribed? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

### ADDITIONAL INFORMATION

Give details of "Yes" answers. State question number and include where appropriate: diagnosis, date, duration, names and addresses of all attending physicians and medical facilities

Question	Detail

### CERTIFICATION

I have read the questions and answers on this Paramedical Supplement to the life insurance application and certify that the statements made in this Paramedical Supplement to the life insurance application are: complete; accurate; and correctly recorded and are subject to the applicable **FRAUD WARNING** notice in the life insurance application. I agree that a copy of this Paramedical Supplement to the life insurance application will form a part of any life insurance contract issued; and that no agent or medical examiner can pass on insurability or modify any life insurance contract issued by OM Financial Life Insurance Company.

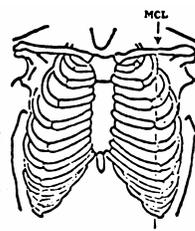
I certify, under penalties of perjury, that I am the person identified in this Paramedical Supplement to the life insurance application, I am a U.S. Citizen or resident of the U.S. (includes U.S. resident aliens) and that the taxpayer identification number is correct. I understand that federal law requires all financial institutions to obtain identity information in order to verify my identity and I authorize its use for this purpose. This information includes, but is not limited to, the name, residential address, date of birth, Social Security or taxpayer identification number; and any other information necessary to sufficiently verify my identity. I understand that failure to provide this information could result in the application being rejected. Third party sources may be used to verify the information provided.

Signed at (City and State)	Date
Witness (Medical Examiner)	
Signature of Proposed Insured Age 15 or More; Otherwise the Parent or Guardian of Proposed Insured	

Paramedical Supplement To Life Insurance Application (Cont'd)

Medical Examiner's Report

Males Only:						
14.	a)	Height (in shoes) ft. in.	Weight (clothed) Lbs.	Chest (Full Inspiration) in.	Chest (Forced Expiration) in.	Abdomen, at Umbilicus in.
	b)	Did you weigh? qY qN		Did you measure? qY qN		
	c)	Is appearance unhealthy or older than stated age? qY qN				
15.	Blood Pressure:	1 <sup>st</sup> Reading		2 <sup>nd</sup> Reading		3 <sup>rd</sup> Reading
	Systolic					
	Diastolic 5 <sup>th</sup> Phase					
16.	Pulse (Answer All columns):	At Rest		After Exercise		3 Minutes Later
	Rate					
	Irregularities per min.					
17.	Heart: Is there any:					
	Enlargement:	qY	qN	Dyspnea:	qY	qN
	Murmur(s):	qY	qN	Edema:	qY	qN
		Murmur 1	Murmur 2			
	Murmur location			Indicate:		
	Transmitted	q	q			
	Localized	q	q			
	Constant	q	q			
	Inconstant	q	q	Apex by: X		
	Systolic	q	q	Murmur area by: ⊗		
	Diastolic	q	q	Point of greatest intensity by: ○		
	Presystolic	q	q	Transmission by: ⊕		
	Soft (Gr. 1-2)	q	q			
	Mod. (Gr. 3-4)	q	q			
	Loud (Gr. 5-6)	q	q	In your opinion, is murmur organic or functional?		
	After Exercise:					
	Increased	q	q			
	Unchanged	q	q	If organic, your diagnosis: _____		
	Decreased	q	q			
18.	Is there, on examination, any abnormality of the following (circle applicable item and give details).					
	a)	Eyes, ears, nose, mouth, pharynx? (If vision or hearing is markedly impaired, indicate degree and correction)			qY	qN
	b)	Skin (incl. scars); lymph nodes; varicose veins or peripheral arteries?			qY	qN
	c)	Nervous system (includes reflexes, gait, paralysis)?			qY	qN
	d)	Respiratory system?			qY	qN
	e)	Abdomen (include scars)?			qY	qN
	f)	Genitourinary system (include prostate)?			qY	qN
	g)	Endocrine system (include spine, joints, amputation, deformities)?			qY	qN
	h)	Musculoskeletal system (include spine, joints, amputation, deformities)?			qY	qN
19.	a)	Are there any hernias? qY qN		b) Any hemorrhoids? qY qN		
20.	Are you aware of any additional medical history? (A confidential report may be forwarded to the medical director)					



Record any additional information here: it will be considered strictly confidential. Anything regarding habits, character, residence, history or physical condition which may have a bearing on the risk will be appreciated:

Name of person who requested you make this examination:  
 Place Examined: q Your Office q Proposed Insured's q Home or q Office  
 Date Examined: \_\_\_\_\_ Time: \_\_\_\_\_ am/pm

Signature of Medical Examiner		
Address	City	ZIP
<b>HOME OFFICE USE ONLY:</b>	Fee Paid \$	

# MEDICAL SUPPLEMENTAL QUESTIONNAIRE TO APPLICATION ARTHRITIS

OM Financial Life Insurance Company

First Name	MI	Last Name
------------	----	-----------

1. Which form of arthritis do you suffer from? (i.e., Rheumatoid Arthritis, osteoarthritis, etc.) \_\_\_\_\_  
\_\_\_\_\_
2. When was this condition first diagnosed? \_\_\_\_\_  
\_\_\_\_\_
3. Have you had any x-rays or other investigations?  Yes  No  
If YES, please provide details, including dates of investigations and results. \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_
4. Regarding your symptoms / disability:
  - a. Please describe your symptoms: \_\_\_\_\_  
\_\_\_\_\_
  - b. When did symptoms first occur? \_\_\_\_\_
  - c. How frequently do symptoms occur? (i.e., how often in the last 12 months) \_\_\_\_\_  
\_\_\_\_\_
  - d. Which of your joints are affected? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_
  - e. Are your activities restricted in any way?  Yes  No  
If YES, please provide details: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_
  - f. Do you use a cane or other mobility aids?  Yes  No  
If YES, please provide details: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_
5. Have you had an operation for this condition, or is an operation being considered?  Yes  No  
If YES, please provide date(s) and full details, including names of hospital and consultant / surgeon: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Bar Code

# MEDICAL SUPPLEMENTAL QUESTIONNAIRE TO APPLICATION: ARTHRITIS (Continued)

6. Please provide details of your treatment. Include names of medication (i.e., Ibuprofen, Naprosyn, etc.), dosage and how often taken. Include details of any injections.
- a. Currently: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_
- b. In the past: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_
- c. Have you ever taken steroids? (i.e., Betnesol, Ledercort, Prednesol, etc.)     Yes     No  
 If YES, please provide details: \_\_\_\_\_  
 \_\_\_\_\_
7. Regarding the monitoring of your condition:
- a. Who is in charge of your follow-up? \_\_\_\_\_
- b. How often do you attend follow-ups? \_\_\_\_\_
- c. When was your last consultation or follow-up? \_\_\_\_\_
8. Have you lost time from work with this condition?     Yes     No  
 If YES, please provide details, including dates and duration of time off work: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_
9. Please provide any additional information on your condition which you feel will be helpful in processing your application: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

I have read the questions and answers on this supplemental questionnaire to the life insurance application and certify that the statements made in this questionnaire are: complete, accurate, and correctly recorded and are subject to the applicable **FRAUD WARNING** notice in the life insurance application. I agree a copy of this supplemental questionnaire to the life insurance application will form a part of any life insurance contract issued, and that no agent can pass on insurability or modify any life insurance contract issued by OM Financial Life Insurance Company.

I certify, under penalties of perjury, that I am the person identified in this supplemental questionnaire. I understand that federal law requires all financial institutions to obtain identity information in order to verify my identity and I authorize its use for this purpose. This information includes, but is not limited to, the name, residential address, date of birth, Social Security or taxpayer identification number, and any other information necessary to sufficiently verify my identity. I understand that failure to provide this information could result in the life insurance application being rejected. Third party sources may be used to verify the information provided.

Signed at (City and State)	Date
Signature of Proposed Insured Age 15 or More	
Signature of Owner(s) (If Proposed Insured is less than Age 18)	

Bar Code

# AVOCATIONS SUPPLEMENTAL QUESTIONNAIRE TO APPLICATION AVIATION

## OM Financial Life Insurance Company

First Name	MI	Last Name
------------	----	-----------

1. In which of the following capacities do you fly? (check all that apply)

- |   |   |
|---|---|
| <input type="checkbox"/> Aerial Photography | <input type="checkbox"/> Helicopter Crew        |
| <input type="checkbox"/> Airline Crew       | <input type="checkbox"/> Police Work            |
| <input type="checkbox"/> Airline Pilot      | <input type="checkbox"/> Private Pilot          |
| <input type="checkbox"/> Armed Services     | <input type="checkbox"/> Survey Work            |
| <input type="checkbox"/> Construction Work  | <input type="checkbox"/> Test Pilot             |
| <input type="checkbox"/> Crop Spraying      | <input type="checkbox"/> Other (specify): _____ |
| <input type="checkbox"/> Flight Instruction |   |

No flying duties (if you have no flying duties, you do not need to complete the rest of this questionnaire.)

2. Do you anticipate that your flying will be of a different nature in the future?  Yes  No

If YES, provide details: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

3. Please provide the make and model of the aircraft that you usually fly: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

4. Hours flown:

- a) Number of hours flown to date: \_\_\_\_\_  
b) Number of flights to date: \_\_\_\_\_  
c) Future hours intended per year: \_\_\_\_\_  
d) Future number of flights intended per year: \_\_\_\_\_

5. Certificates held: (check all that apply)

- |                                     |   |
|-------------------------------------|---|
| <input type="checkbox"/> Student    | <input type="checkbox"/> Airline Transport        |
| <input type="checkbox"/> Private    | <input type="checkbox"/> Flight Instruction       |
| <input type="checkbox"/> Commercial | <input type="checkbox"/> Instrument Flight Rating |

Bar Code

# AVOCATIONS SUPPLEMENTAL QUESTIONNAIRE TO APPLICATION: AVIATION (Continued)

6. Have you ever had your license revoked or been grounded?     Yes     No

If YES, provide details: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

7. Do you engage in aerobatic flight, stunt flying or racing?     Yes     No

If YES, provide details: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

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Signed at (City and State)	Date
Signature of Proposed Insured Age 15 or More	
Signature of Owner(s) (If Proposed Insured is less than Age 18)	

Bar Code

# MEDICAL SUPPLEMENTAL QUESTIONNAIRE TO APPLICATION BACK DISORDERS

OM Financial Life Insurance Company

First Name	MI	Last Name
------------	----	-----------

1. Please state the precise diagnosis, if known: \_\_\_\_\_  
\_\_\_\_\_
2. When was this condition first diagnosed? \_\_\_\_\_  
\_\_\_\_\_
3. Have you had any x-rays or other investigations?     Yes     No  
If YES, please provide details, including dates of investigations and results: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_
4. Regarding your symptoms / disability:
  - a. Please describe your symptoms: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_
  - b. When did symptoms first occur? \_\_\_\_\_
  - c. How frequently do symptoms occur? (i.e., how often in the last 12 months) \_\_\_\_\_  
\_\_\_\_\_
  - d. Are your activities restricted in any way?     Yes     No  
If YES, please provide details: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_
  - e. Do you use a cane or other mobility aids?     Yes     No  
If YES, please provide details: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_
5. Have you had an operation for this condition, or is an operation being considered?     Yes     No  
If YES, please provide date(s) and full details, including names of hospital and consultant / surgeon: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Bar Code

# MEDICAL SUPPLEMENTAL QUESTIONNAIRE TO APPLICATION: BACK DISORDERS (Continued)

6. Please provide details of your treatment. Include names of medication (i.e., Ibuprofen, Naprosyn, etc.), dosage and how often taken. Include details of any physical therapy.

a. Currently: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

b. In the past: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

7. Regarding the monitoring of your condition:

a. Who is in charge of your follow-up? \_\_\_\_\_

b. How often do you attend follow-ups? \_\_\_\_\_

c. When was your last consultation or follow-up? \_\_\_\_\_

8. Have you lost time from work with this condition?     Yes         No

If YES, please provide details, including dates and duration of time off work: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

9. Please provide any additional information on your condition which you feel will be helpful in processing your application: \_\_\_\_\_

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

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Signature of Owner(s) (If Proposed Insured is less than Age 18)	

Bar Code

# MEDICAL SUPPLEMENTAL QUESTIONNAIRE TO APPLICATION CHILDREN'S INSURANCE

## OM Financial Life Insurance Company

First Name	MI	Last Name
------------	----	-----------

Name of Primary Insured's Child	Birth Date	Sex	Height	Weight	Social Security Number	Relationship to Primary Insured	Name of Physician

1. Has any child ever had, been treated for, or been diagnosed with any Neurological, Psychiatric, or cardiovascular disorders?

Yes    No

If YES, please provide details: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

2. Has any child ever had, been treated for, or been diagnosed with Muscular Dystrophy, Cerebral Palsy, or Cystic Fibrosis, internal cancer or leukemia?

Yes    No

If YES, please provide details: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

3. Has any child ever had, been treated for, or been diagnosed with Respiratory disorders; Acquired Immune Deficiency Syndrome (AIDS), AIDS related Complex (ARC), or tested positive for Acquired Immune Deficiency Syndrome; or organ transplant?

Yes    No

If YES, please provide details: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

4. Has any child ever had, been treated for, or been diagnosed with Diabetes or disorder of the endocrine system?

Yes    No

If YES, please provide details: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Bar Code

# MEDICAL SUPPLEMENTAL QUESTIONNAIRE TO APPLICATION: CHILDREN'S INSURANCE (Continued)

5. Has any child ever had, been treated for, or been diagnosed with any disease, illness or disorder not listed in questions 1-4?  
 Yes    No

If YES, please provide details: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

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Bar Code

# SUPPLEMENTAL QUESTIONNAIRE TO APPLICATION CITIZENSHIP

## OM Financial Life Insurance Company

First Name	MI	Last Name	Country of Birth
------------	----	-----------	------------------

1. Are you a U.S. Citizen?  Yes  No

If No:

a. How long have you been in the U.S.? \_\_\_\_\_

b. How long do you plan on staying in the U.S.? \_\_\_\_\_

c. Are you planning to apply for U.S. citizenship?  Yes  No If Yes, when? \_\_\_\_\_

Please provide proof of identification (**CATEGORY 4 ONLY**). Provide information on two forms of identification from the list provided at the end of this form. The two forms of identification must be from different issuing agencies.

### Document 1 (Must Have Recent Photo)

### Document 2

Document Type: \_\_\_\_\_

Document Number (if any): \_\_\_\_\_

Issue Date: \_\_\_\_\_

Expiration Date (if any): \_\_\_\_\_

2. Do you have a passport?  Yes  No

If Yes, please provide: Issuing Authority (Country): \_\_\_\_\_

Issue Date: \_\_\_\_\_

Passport Number: \_\_\_\_\_

Expiration Date: \_\_\_\_\_

3. In the U.S. do you: 1. Own Property?  Yes  No

2. Have Business Interests?  Yes  No

3. Have an investment/banking relationship?  Yes  No

4. Are you employed by a U.S. based company and travel to the U.S. at least once each year?  Yes  No

If Yes, approximately how many times do you travel to the U.S. per year? \_\_\_\_\_

4. Do you have an Immigration Card?  Yes  No

If Yes, please provide: Immigration Card #: \_\_\_\_\_

Card Color: \_\_\_\_\_

Date Issued: \_\_\_\_\_

Expiration Date: \_\_\_\_\_

If No, what is your current immigration status: \_\_\_\_\_

5. Do you have a Visa issued by the U.S. Department of State?  Yes  No

If Yes, please provide: Visa Type: \_\_\_\_\_

Visa Number: \_\_\_\_\_

Date Issued: \_\_\_\_\_

Expiration Date: \_\_\_\_\_

If No, what is your current Visa status: \_\_\_\_\_

Bar Code

# SUPPLEMENTAL QUESTIONNAIRE TO APPLICATION: CITIZENSHIP (Cont'd)

6. Please provide a form of individual U.S. tax identification (SSN or ITIN) or a W-8BEN form that certifies foreign status.  
 q SSN: \_\_\_\_\_ q ITIN: \_\_\_\_\_ q W-8BEN (please attach completed form).
7. Do you plan on returning to visit your home country? q Yes q No  
 If Yes: When: \_\_\_\_\_  
 For how long: \_\_\_\_\_  
 Do you plan on returning to the U.S.? q Yes q No  
 If Yes, when: \_\_\_\_\_
8. How often do you return to your home country? \_\_\_\_\_
9. Do you travel, visit or reside in any other country other than the U.S. and your home country? q Yes q No  
 If Yes, when, where and how often: \_\_\_\_\_
10. Do you ever plan to return to live in your home country or any other country other than the U.S.? q Yes q No  
 If Yes, when and where: \_\_\_\_\_
11. Do the beneficiaries listed on the application live in the U.S.? q Yes q No  
 If No, please provide a form of individual U.S. tax identification (SSN or ITIN) or a W-8BEN form that certifies foreign status (please attach completed form) for each beneficiary listed on the application.

**Acceptable Forms of Proof of Identity**

- |   |                                      |
|---|--------------------------------------|
| 1. USCIS Photo Identification*          | 7. National Identification Card**    |
| 2. Visa from U.S. Department of State   | 8. U.S. State Identification Card    |
| 3. U.S. Driver's License                | 9. Foreign Voter's Registration Card |
| 4. U.S. Military Identification Card    | 10. Civil Birth Certificate***       |
| 5. Foreign Driver's License             | 11. Medical Records****              |
| 6. Foreign Military Identification Card | 12. School Records****               |

\* United States Citizenship and Immigration Services.  
 \*\* Must be current, and contain individual's name, photograph, address, date of birth, and expiration date.  
 \*\*\* Expiration date not applicable.  
 \*\*\*\* ONLY Valid for dependents under 14 years of age; under 18 years of age if a student.

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Signature of Owner(s) (If Proposed Insured is less than Age 18)	

Bar Code

# AVOCATIONS SUPPLEMENTAL QUESTIONNAIRE TO APPLICATION CLIMBING

## OM Financial Life Insurance Company

First Name	MI	Last Name
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1. How many years have you been climbing? \_\_\_\_\_
2. How often do you climb? \_\_\_\_\_
3. Are you the member of a climbing club?     Yes     No
4. In which of the following areas do you climb? (Check All That Apply)
  - North America – Mt. McKinley
  - North America – elsewhere (Specify): \_\_\_\_\_
  - Alps (Europe)
  - Africa
  - Himalayas / Karakoram
  - Other Areas (Specify): \_\_\_\_\_
5. Nature of climbing – please give details of:
  - a. Type of terrain (i.e , rock, snow / ice, artificial climbing walls): \_\_\_\_\_
  - b. Degree of difficulty:     Easy     Moderate     Difficult     Severe  
If SEVERE, indicate maximum technical rate (4a, 4b...7b, 7c): \_\_\_\_\_
  - c. Maximum height reached by climbing: \_\_\_\_\_
  - d. Season(s) of the year when you climb: \_\_\_\_\_
6. What proportion of your climbing is on routes protected by climbing bolts? \_\_\_\_\_
7. Do you ever climb alone or without a rope?     Yes     No  
If Yes, please state how often, location, and degree of difficulty: \_\_\_\_\_  
\_\_\_\_\_
8. Do you plan to go on any overseas expeditions in the next 2 years?     Yes     No  
If Yes, please give full details, including area, length of expedition and frequency of trips \_\_\_\_\_  
\_\_\_\_\_

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Bar Code

# MEDICAL SUPPLEMENTAL QUESTIONNAIRE TO APPLICATION DIABETES

## OM Financial Life Insurance Company

First Name	MI	Last Name
------------	----	-----------

1. When were you first diagnosed with diabetes? \_\_\_\_\_
2. Regarding your treatment:
  - a. Do you take oral medication?     Yes     No  
If YES, please state the name of the tablets, dosage, (including number of times daily): \_\_\_\_\_
  - b. Do you take insulin?     Yes     No  
If YES, please state type of insulin and dosage (including number of times daily): \_\_\_\_\_  
\_\_\_\_\_
  - c. Has your treatment been changed in the last 2 years?     Yes     No  
If YES, please provide full details: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_
3. Do you follow a strict diet?     Yes     No
4. Regarding the monitoring of your condition:
  - a. Please provide the name and address of the doctor or clinic supervising your treatment: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_
  - b. How often do you attend monitoring? \_\_\_\_\_
  - c. What is the date you were last monitored? \_\_\_\_\_
  - d. How often do you test your blood or urine for glucose? \_\_\_\_\_
  - e. Please indicate your usual blood glucose reading:  
 Blood Glucose:     Below 145     146-165     166-200     Over 200  
 Urine Glucose:     Negative     +     ++     +++ or more
  - f. Please provide the dates and results of your last two HbA1c (glycosylated hemoglobin) tests, if known: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_
5. Since your treatment began, have you ever been in a diabetic (hyperglycemic) or insulin (hypoglycemic) coma?     Yes     No  
If YES, please provide full details, including date(s): \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Bar Code

# MEDICAL SUPPLEMENTAL QUESTIONNAIRE TO APPLICATION: DIABETES (Continued)

6. Have you ever had any of the following:

- |   |       |      |
|---|-------|------|
| a. Problems with your eyes?                   | q Yes | q No |
| b. High blood pressure?                       | q Yes | q No |
| c. Heart or circulatory trouble?              | q Yes | q No |
| d. Albumin or protein in your urine?          | q Yes | q No |
| e. Numbness or tingling in your feet or legs? | q Yes | q No |

If YES to any of the above, please provide full details: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

7. Have you lost time from work due to diabetes or associated conditions? q Yes      q No

If YES, please provide details including dates and duration of time off work: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

8. Please provide any additional information on your condition which you feel will be helpful in processing your application: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

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Bar Code

# SUPPLEMENTAL QUESTIONNAIRE TO APPLICATION DISABILITY INCOME

## OM Financial Life Insurance Company

First Name	MI	Last Name
------------	----	-----------

1. What is your principal occupation? \_\_\_\_\_  
§ Please give a short description of your duties and responsibilities \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
§ Please provide the name of your employer \_\_\_\_\_  
§ Hours worked per week \_\_\_\_\_  
§ How long have you worked at this occupation? \_\_\_\_\_
2. What are your other occupations, if any? \_\_\_\_\_  
\_\_\_\_\_  
§ Please give a short description of your duties and responsibilities \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
§ Please provide the name of your employer \_\_\_\_\_  
§ Hours worked per week \_\_\_\_\_
3. Do you work from an office in your home?     Yes     No (if no, proceed to question 4)  
§ If yes, please answer the following:  
§ How many hours do you work each week?
  - In total \_\_\_\_\_
  - In your office \_\_\_\_\_
  - Away from your office \_\_\_\_\_§ What duties of your occupation are performed away from your office? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_
4. What is your earned annual income from your principal occupation (last year's W-2)?  
\$ \_\_\_\_\_  
§ If self-employed, what is your net annual income from your principal occupation (last year's tax return)?  
\$ \_\_\_\_\_

Bar Code

# SUPPLEMENTAL QUESTIONNAIRE TO APPLICATION: DISABILITY INCOME (Continued)

5. Have you ever been denied Disability Income coverage or been disabled?     Yes     No

(if yes, please provide details): \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

6. Have you ever collected Worker's Compensation?     Yes     No

(if yes, please provide details): \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

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# AVOCATIONS SUPPLEMENTAL QUESTIONNAIRE TO APPLICATION DIVING

## OM Financial Life Insurance Company

First Name	MI	Last Name
------------	----	-----------

1. Diving experience and qualifications:
  - a. When and where did you learn to dive? \_\_\_\_\_
  - b. Are you an active member of a diving club? (i.e., PADI, etc.)     Yes     No
  - c. Do you hold any diving qualifications?     Yes     No
  - d. If Yes, please list: Which diving qualifications do you hold? \_\_\_\_\_
  - e. What is the average number of dives per year that you have undertaken in the last 3 years? \_\_\_\_\_
  - f. What is the maximum depth you have reached by diving? \_\_\_\_\_
2. Intended diving in future:
  - a. How many dives do you plan to make each year? \_\_\_\_\_
  - b. To what depth will you usually dive? \_\_\_\_\_
  - c. Will you use mixed gas equipment? (i.e., Nitrox, Trimix, Heliox)     Yes     No
  - d. Do you ever dive to a depth of 165 feet (50 meters) or more?     Yes     No  
If YES, please state how often and under what conditions: \_\_\_\_\_
  - e. Do you ever dive unaccompanied?     Yes     No  
If YES, please state how often and under what conditions: \_\_\_\_\_
3. Please give details of the location of your diving, including countries and whether deep sea, coastal waters, lakes, rivers, etc.: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_
4. Purpose of dives:
  - a. For what purpose do you dive? (i.e., photography, marine biology, etc.) \_\_\_\_\_
  - b. Do you participate in any of the following? (check all that apply)  

<input type="checkbox"/> Wreck diving (observation, salvage, photography or exploration)	<input type="checkbox"/> Ice diving
<input type="checkbox"/> Cave or pot hole diving	<input type="checkbox"/> Diving at high altitudes (i.e., mountain lakes)
<input type="checkbox"/> Treasure trove diving	<input type="checkbox"/> Depth record attempts

  
For all checked, please give full details, including how often: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_
  - c. Do you ever dive for profit?     Yes     No

Bar Code

# AVOCATIONS SUPPLEMENTAL QUESTIONNAIRE TO APPLICATION: DIVING (Continued)

5. Medical:

a. When were you last medically examined for diving purposes? \_\_\_\_\_

b. Were any restrictions imposed?     Yes         No

If YES, please give full details: \_\_\_\_\_

\_\_\_\_\_

c. Have you ever suffered any illness or injury due to diving?     Yes         No

If YES, please give full details: \_\_\_\_\_

\_\_\_\_\_

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Bar Code

# AVOCATIONS SUPPLEMENTAL QUESTIONNAIRE TO APPLICATION GLIDING, HANG GLIDING, and ULTRA LIGHTING

OM Financial Life Insurance Company

First Name	MI	Last Name
------------	----	-----------

1. How many years have you been gliding, hang gliding or ultra-lighting? \_\_\_\_\_

2. Are you a member of an affiliated association or club?  Yes  No

3. Are you an instructor?  Yes  No

4. Do you hold any certificates?  Yes  No

If YES, please list: \_\_\_\_\_

5. Do you hold a pilot rating for cross-country or higher?  Yes  No

If YES, provide details: \_\_\_\_\_

6. **EXPERIENCE:**

**Gliding**

a) What type of glider do you fly? (i.e., unpowered, self-sustaining or self-launching) \_\_\_\_\_

b) Number of hours flown to date: \_\_\_\_\_

c) Number of flights to date: \_\_\_\_\_

d) Future hours intended per year: \_\_\_\_\_

e) Future number of launches intended per year: \_\_\_\_\_

**Hang Gliding**

a) Where do you hang glide? \_\_\_\_\_

b) Which method of launching do you use? \_\_\_\_\_

c) Number of hours flown to date: \_\_\_\_\_

d) Number of flights to date: \_\_\_\_\_

e) Future hours intended per year: \_\_\_\_\_

f) Future number of flights intended per year: \_\_\_\_\_

**Ultra-Lighting**

a) Number of hours flown to date: \_\_\_\_\_

b) Number of flights to date: \_\_\_\_\_

c) Future hours intended per year: \_\_\_\_\_

d) Future number of flights intended per year: \_\_\_\_\_

Do you have experience flying other aircraft?  Yes  No

If YES, provide details: \_\_\_\_\_

Do you expect to fly your aircraft for reasons other than pleasure? (i.e., crop-spraying, inspection)  Yes  No

If YES, provide details: \_\_\_\_\_

Bar Code

# AVOCATIONS SUPPLEMENTAL QUESTIONNAIRE TO APPLICATION: GLIDING, HANG GLIDING, and ULTRA LIGHTING (Continued)

7. Do you expect to participate in any form of competition, record attempts, or prototype testing?     Yes     No  
If YES, provide details: \_\_\_\_\_
8. Have you been involved in any accident causing injury to yourself or significant damage to your aircraft?     Yes     No  
If YES, provide details: \_\_\_\_\_
- \_\_\_\_\_

I have read the questions and answers on this supplemental questionnaire to the life insurance application and certify that the statements made in this questionnaire are: complete, accurate, and correctly recorded and are subject to the applicable **FRAUD WARNING** notice in the life insurance application. I agree a copy of this supplemental questionnaire to the life insurance application will form a part of any life insurance contract issued, and that no agent can pass on insurability or modify any life insurance contract issued by OM Financial Life Insurance Company.

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Signed at (City and State)	Date
Signature of Proposed Insured Age 15 or More	
Signature of Owner(s) (If Proposed Insured is less than Age 18)	

Bar Code

# MEDICAL SUPPLEMENTAL QUESTIONNAIRE TO APPLICATION GROWTHS, CYSTS, and TUMORS

OM Financial Life Insurance Company

First Name	MI	Last Name
------------	----	-----------

1. When was the growth, cyst, lump or tumor first discovered? \_\_\_\_\_
2. In which part of the body was it located? \_\_\_\_\_
3. Please state your diagnosis, if known: \_\_\_\_\_
4. Has the growth been removed?

NO – please provide:

a. Details of investigations which have been carried out, including date(s) and results of tests: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

b. Details of any proposed treatment or surgery: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

YES – please provide:

c. Date of removal: \_\_\_\_\_

d. Method of removal (i.e., local anesthetic, cryosurgery, operation with general anesthetic, etc.): \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

e. Name of surgeon, general practitioner, consultant, hospital or clinic: \_\_\_\_\_  
\_\_\_\_\_

f. What treatment have you had following removal? (i.e., tablets, radiotherapy, chemotherapy, etc.) \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

g. Have you been given any information regarding outlook / prognosis?     Yes     No

If YES, please provide details: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

5. Are you still having follow ups?     Yes     No

If YES, please state how often: \_\_\_\_\_

If NO, when were you discharged from follow up? \_\_\_\_\_

Bar Code

# MEDICAL SUPPLEMENTAL QUESTIONNAIRE TO APPLICATION: GROWTHS, CYSTS and TUMORS (Continued)

6. Have you lost time from work with this condition?     Yes     No  
 If YES, please provide details, including dates and duration of time off work: \_\_\_\_\_

\_\_\_\_\_

7. Please provide any additional information on your condition which you feel will be helpful in processing your application:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

I have read the questions and answers on this supplemental questionnaire to the life insurance application and certify that the statements made in this questionnaire are: complete, accurate, and correctly recorded and are subject to the applicable **FRAUD WARNING** notice in the life insurance application. I agree a copy of this supplemental questionnaire to the life insurance application will form a part of any life insurance contract issued, and that no agent can pass on insurability or modify any life insurance contract issued by OM Financial Life Insurance Company.

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Signed at (City and State)	Date
Signature of Proposed Insured Age 15 or More	
Signature of Owner(s) (If Proposed Insured is less than Age 18)	

Bar Code

# MEDICAL SUPPLEMENTAL QUESTIONNAIRE TO APPLICATION HYPERTENSION

## OM Financial Life Insurance Company

First Name	MI	Last Name
------------	----	-----------

1. When was your high blood pressure first diagnosed? \_\_\_\_\_
2. Why was your blood pressure measured at that particular time i.e. routine examination, do to symptoms, etc.? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_
3. Do you know what your blood pressure readings were at diagnosis?     Yes     No  
If YES, please provide details \_\_\_\_\_  
\_\_\_\_\_
4. Have you had an EKG, x-ray, blood lipid test or other investigations?     Yes     No  
If YES, please provide details including dates of investigations and results.  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_
5. Please provide details of your treatment; include names of medication, dosage, and how often it is taken (i.e. Moduretic, Navidrex, Aldomet, Inderal, Tenoretic, Tenomin, Trasicor, etc.,.  
    Currently: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
    In the past: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_
6. Regarding the monitoring of your condition:  
    Who is in charge of your follow-up? \_\_\_\_\_  
    How often do you attend follow-ups? \_\_\_\_\_  
    When was your last follow-up? Please provide details of your blood pressure reading at that time, if known. \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Bar Code

# MEDICAL SUPPLEMENTAL QUESTIONNAIRE TO APPLICATION: HYPERTENSION (Continued)

7. Have any abnormalities ever been found in your urine? (i.e. protein, blood, etc.)     Yes     No

If YES, please provide date(s) and full details. \_\_\_\_\_

\_\_\_\_\_

8. Have you lost time off work with this condition? (i.e. weeks)     Yes     No

If YES, please provide details including dates and duration of time off work \_\_\_\_\_

\_\_\_\_\_

Please provide any additional information on your condition which you feel will be helpful in processing your application. \_\_\_\_\_

\_\_\_\_\_

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Signed at (City and State)	Date
Signature of Proposed Insured Age 15 or More	
Signature of Owner(s) (If Proposed Insured is less than Age 18)	

Bar Code

# SUPPLEMENTAL QUESTIONNAIRE TO APPLICATION MILITARY

## OM Financial Life Insurance Company

First Name	MI	Last Name
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1. Are you currently a member of any military service, active or inactive?     Yes     No
2. Branch of service:     Army     Navy     Marines     Air Force     Coast Guard     Other \_\_\_\_\_
3. Current duty status:  Active     Active Reserve     Inactive Reserve     National Guard     ROTC     Other \_\_\_\_\_
4. Current rank: \_\_\_\_\_
5. Current unit: \_\_\_\_\_
6. Military occupational specialty: \_\_\_\_\_
7. Address of Current unit: \_\_\_\_\_
8. Current assignment: \_\_\_\_\_
9. Are you receiving any supplemental or hazardous duty pay based on your duties or assignment?     Yes     No  
If YES, please give details: \_\_\_\_\_  
\_\_\_\_\_
10. Have you been informed or are you aware that:
  - a. You and/or your unit will be transferred overseas?     Yes     No  
If YES, where? \_\_\_\_\_
  - b. You will be transferred to a new unit?     Yes     No
  - c. You or your unit will be alerted for duty (if currently in Reserve or National Guard)?     Yes     No

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Signed at (City and State)	Date
Signature of Proposed Insured Age 15 or More	
Signature of Owner(s) (If Proposed Insured is less than Age 18)	

Bar Code

# AVOCATIONS SUPPLEMENTAL QUESTIONNAIRE TO APPLICATION MOTORSPORTS (Including Motor Cycle and Speed Boating)

## OM Financial Life Insurance Company

First Name	MI	Last Name

1. Type of vehicle or vehicles that you race, including make and model:  
 Type of Car: \_\_\_\_\_  
 Type of Motorcycle: \_\_\_\_\_  
 Type of Boat: \_\_\_\_\_  
 Other: \_\_\_\_\_
2. What is your engine displacement and horsepower? \_\_\_\_\_
3. What type of racing do you participate in and do you plan on changing classes in the future? \_\_\_\_\_
4. How long have you been competing? \_\_\_\_\_
5. What type of license do you hold? \_\_\_\_\_
6. Do you have any affiliation with any racing organizations? \_\_\_\_\_
7. Are you an amateur or professional driver/rider? \_\_\_\_\_
8. What are the number of events that you participate in per year, and the average length of the events (laps/miles or kilometers/ time)?  
 a. Current year: \_\_\_\_\_  
 b. Previous year: \_\_\_\_\_  
 c. Planned for next year: \_\_\_\_\_
9. Do you participate or intend to participate in any of the following:  
 a. Testing of prototypes:     Yes     No  
 b. Record attempts:         Yes     No  
 If YES, please give details: \_\_\_\_\_
10. What is your average speed and top speed attained? \_\_\_\_\_
11. Have you been involved in any accident causing injury to yourself or a third party?     Yes     No  
 If YES, please give details: \_\_\_\_\_

I have read the questions and answers on this supplemental questionnaire to the life insurance application and certify that the statements made in this questionnaire are: complete, accurate, and correctly recorded and are subject to the applicable **FRAUD WARNING** notice in the life insurance application. I agree a copy of this supplemental questionnaire to the life insurance application will form a part of any life insurance contract issued, and that no agent can pass on insurability or modify any life insurance contract issued by OM Financial Life Insurance Company.

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Signed at (City and State)	Date
Signature of Proposed Insured Age 15 or More	
Signature of Owner(s) (If Proposed Insured is less than Age 18)	

Bar Code

# MEDICAL SUPPLEMENTAL QUESTIONNAIRE TO APPLICATION MUSCULOSKELETAL

## OM Financial Life Insurance Company

First Name	MI	Last Name
------------	----	-----------

1. What is/are your condition(s)? \_\_\_\_\_
2. What is/was the diagnosis of your condition, and/or what surgical procedure or investigation did you undergo? \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_
3. What is the approximate date when you last experienced problems or symptoms relating to this condition? \_\_\_\_\_
4. Have you had any procedures or surgery for this condition?     Yes     No  
 Date of the last procedure or surgery \_\_\_\_\_  
 Name and Address of Treatment Facility and Name of Treating Medical Personnel \_\_\_\_\_  
 \_\_\_\_\_
5. Are you awaiting a procedure or surgery for this condition?     Yes     No
6. Have you used a cane or any other mobility aid within the last 2 years?     Yes     No
7. Are your daily activities restricted in any way?     Yes     No
8. Have you been unable to work in the last 12 months because of this condition?     Yes     No  
 If YES, please give dates and duration of the absences \_\_\_\_\_  
 \_\_\_\_\_
9. Have you taken any corticosteroid medication for this condition within the last 2 years?     Yes     No

I have read the questions and answers on this supplemental questionnaire to the life insurance application and certify that the statements made in this questionnaire are: complete, accurate, and correctly recorded and are subject to the applicable **FRAUD WARNING** notice in the life insurance application. I agree a copy of this supplemental questionnaire to the life insurance application will form a part of any life insurance contract issued, and that no agent can pass on insurability or modify any life insurance contract issued by OM Financial Life Insurance Company.

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Signed at (City and State)	Date
Signature of Proposed Insured Age 15 or More	
Signature of Owner(s) (If Proposed Insured is less than Age 18)	

Bar Code

# AVOCATIONS SUPPLEMENTAL QUESTIONNAIRE TO APPLICATION PARACHUTING

## OM Financial Life Insurance Company

First Name	MI	Last Name
------------	----	-----------

1. Are you involved in parachuting as a member of the armed services?     Yes     No
2. Are you a member of a parachuting association or an affiliated club?     Yes     No  
 If YES, please provide details: \_\_\_\_\_  
 \_\_\_\_\_
3. Static Line Jumps:
  - a) How many years have you been participating in static line jumping? \_\_\_\_\_
  - b) Number of jumps completed to date: \_\_\_\_\_
  - c) Future number of jumps intended per year: \_\_\_\_\_
  - d) Do you intend to participate in any free-fall jumps?     Yes     No  
 If YES, please provide details, including the number of jumps intended per year: \_\_\_\_\_  
 \_\_\_\_\_
4. Free Fall Jumps:
  - a) How many years have you been participating in free-fall jumping? \_\_\_\_\_
  - b) Number of jumps completed to date: \_\_\_\_\_
  - c) Future number of jumps intended per year: \_\_\_\_\_
- (5) Do you expect to participate in any parachuting competitions or record attempts?     Yes     No  
 If YES, please give full details, including the nature of jumps (i.e., static line or free-fall): \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

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Signed at (City and State)	Date
Signature of Proposed Insured Age 15 or More	
Signature of Owner(s) (If Proposed Insured is less than Age 18)	

Bar Code

# SUPPLEMENTAL QUESTIONNAIRE TO APPLICATION RESIDENCE and TRAVEL

## OM Financial Life Insurance Company

First Name	MI	Last Name
------------	----	-----------

Please provide details of previous and future foreign travel, including holidays and short business trips.

- a. Within the last 2 years: \_\_\_\_\_  
 \_\_\_\_\_
- b. Within the next 2 years: \_\_\_\_\_  
 \_\_\_\_\_
2. Please give a brief description of your duties while traveling or residing abroad: \_\_\_\_\_  
 \_\_\_\_\_
3. Do you expect to visit non-urban areas?     Yes     No  
 If YES, please give details of:
  - a. Your accommodations: \_\_\_\_\_  
\_\_\_\_\_
  - b. The availability of medical facilities: \_\_\_\_\_  
\_\_\_\_\_
  - c. Your travel arrangements, e.g. light aircraft, boat, etc.: \_\_\_\_\_  
\_\_\_\_\_
4. Would you consider traveling to war zones or hazardous areas?     Yes     No  
 If YES, please give details: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

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Signature of Proposed Insured Age 15 or More	
Signature of Owner(s) (If Proposed Insured is less than Age 18)	

Bar Code

SERFF Tracking Number: MCHX-G126918095 State: Arkansas  
 Filing Company: OM Financial Life Insurance Company State Tracking Number: 47378  
 Company Tracking Number: LAPP 1001 (11-10)  
 TOI: L08 Life - Other Sub-TOI: L08.000 Life - Other  
 Product Name: LAPP 1001 (11-10) Indiv Life Application - OM Fina  
 Project Name/Number: LAPP 1001 (11-10) Indiv Life Application - OM Financial Life Insurance Company/LAPP 1001 (11-10) Indiv Life Application - OM Financial Life Insurance Company

## Supporting Document Schedules

	<b>Item Status:</b>	<b>Status Date:</b>
<b>Satisfied - Item:</b> Flesch Certification		
<b>Comments:</b>		
<b>Attachments:</b>		
AR Readability Certification.PDF		
Cert of Compliance Rule 19.PDF		
Certificate of Compliance 23-79-138 and R&R 49.PDF		
Certification of Compliance Bulletin 11-83.PDF		

	<b>Item Status:</b>	<b>Status Date:</b>
<b>Satisfied - Item:</b> Application		
<b>Comments:</b>		
Please see form schedule.		

	<b>Item Status:</b>	<b>Status Date:</b>
<b>Satisfied - Item:</b> Submission Letter		
<b>Comments:</b>		
<b>Attachment:</b>		
Indv, LAPP 1001 (11-10) MCR Submission Letter.PDF		

	<b>Item Status:</b>	<b>Status Date:</b>
<b>Satisfied - Item:</b> Authorization Letter		
<b>Comments:</b>		
<b>Attachment:</b>		
2010 MCR Vendor Authorization letter new address eff 2-11-2010.PDF		

	<b>Item Status:</b>	<b>Status</b>

SERFF Tracking Number: MCHX-G126918095 State: Arkansas  
Filing Company: OM Financial Life Insurance Company State Tracking Number: 47378  
Company Tracking Number: LAPP 1001 (11-10)  
TOI: L08 Life - Other Sub-TOI: L08.000 Life - Other  
Product Name: LAPP 1001 (11-10) Indiv Life Application - OM Fina  
Project Name/Number: LAPP 1001 (11-10) Indiv Life Application - OM Financial Life Insurance Company/LAPP 1001 (11-10) Indiv Life Application - OM Financial Life Insurance Company

**Date:**

**Satisfied - Item:** Statement of Variability - LAPP  
1001 (11-10)

**Comments:**

**Attachment:**

std, SOV LAPP 1001 (11-10)-10\_26\_10.PDF

**Item Status:**

**Status**

**Date:**

**Satisfied - Item:** Statement of Variability - LAPP  
1002 (11-10)

**Comments:**

**Attachment:**

std, SOV LAPP 1002 (11-10)-10\_28\_10.PDF

**STATE OF ARKANSAS**  
**READABILITY CERTIFICATION**

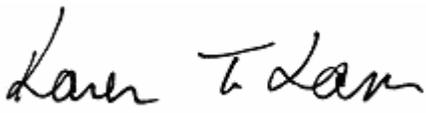
**COMPANY NAME:** OM Financial Life Insurance Company

This is to certify that the form(s) referenced below has achieved a Flesch Reading Ease Score as indicated below and complies with the requirements of Ark. Stat. Ann. Section 66-3251 through 66-3258, cited as the Life and Disability Insurance Policy Language Simplification Act.

<b>Form Number</b>	<b>Score</b>
LAPP 1001 (11-10)	61.5
LAPP 1002 (11-10)	60.9
ADMIN 4939 (11-10)	68.09
ADMIN 4945 (11-10)	67.3
ADMIN 4940 (11-10)	61.2
ADMIN 4948 (11-10)	62.4
LAPP 1003 (11-10)	63.7
ADMIN 4943 (11-10)	66.4
ADMIN 4941 (11-10)	62.6
LAPP 1006 (11-10)	68.4
ADMIN 4944 (11-10)	63.8
ADMIN 4947 (11-10)	69
ADMIN 4942 (11-10)	67.4
LAPP 1005 (11-10)	63
ADMIN 4938 (11-10)	68.8
ADMIN 4936 (11-10)	63.1

**STATE OF ARKANSAS**  
**READABILITY CERTIFICATION**

<b>Form Number</b>	<b>Score</b>
LAPP 1004 (11-10)	61.2
ADMIN 4946 (11-10)	68.59
ADMIN 4937 (11-10)	60.4

Signed:   
Name: Karen T. Lam  
Title: Assistant Vice President, Compliance Oversight  
Date: 11/23/2010

## Certificate of Compliance with Arkansas Rule and Regulation 19

Insurer: OM Financial Life Insurance Company

Form Number(s): LAPP 1001 (11-10) et al

I hereby certify that to the best of my knowledge and belief, the filing above meets all applicable Arkansas requirements including the requirements of Rule and Regulation 19.



\_\_\_\_\_  
Signature of Company Officer

Karen T. Lam

\_\_\_\_\_  
Name

Assistant Vice President – Compliance Oversight

\_\_\_\_\_  
Title

11/23/2010

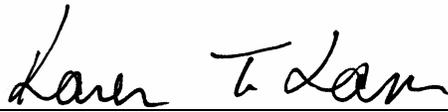
\_\_\_\_\_  
Date

**CERTIFICATE OF COMPLIANCE**

Insurer: OM Financial Life Insurance Company

Form Numbers: LAPP 1001 (11-10) et al

I hereby certify that the filing above meets all applicable Arkansas requirements including Regulation 49 (Life and Health Guaranty Fund Notice) and Ark. Code Ann. 23-79-138 and Bulletin 11-88 (Consumer Information Notice).



\_\_\_\_\_  
Signature of Company Officer

Karen T. Lam

\_\_\_\_\_  
Name

Assistant Vice President, Compliance  
Oversight

\_\_\_\_\_  
Title

11/23/2010

\_\_\_\_\_  
Date

**STATE OF ARKANSAS**

**Certification**

Name of Company: OM Financial Life Insurance Company

The above named company certifies that Life Insurance Application Form LAPP 1001 (11-10) has been reviewed and complies with Arkansas Insurance Department Guidelines identified in its Bulletin No. 11-83.



\_\_\_\_\_  
Signature

Karen T. Lam

\_\_\_\_\_  
Print or Type Name

Assistant Vice President – Compliance Oversight

\_\_\_\_\_  
Title

# McHugh Consulting Resources, Inc.

November 23, 2010

NAIC # 63274  
FEIN: 52-6033321

Jay Bradford  
Insurance Commissioner  
Arkansas Department of Insurance  
Compliance - Life and Health  
1200 West Third Street  
Little Rock, AR 72201-1904

**RE: Filing on Behalf of OM Financial Life Insurance Company**

- New Life Insurance Application, LAPP 1001 (11-10)
- Paramedical Supplement to Application, LAPP 1002 (11-10)
- Supplemental Questionnaire, Arthritis, ADMIN 4939 (11-10);
- Supplemental Questionnaire, Aviation, ADMIN 4945 (11-10);
- Supplemental Questionnaire, Back Disorders, ADMIN 4940 (11-10);
- Supplemental Questionnaire, Childrens, ADMIN 4948 (11-10);
- Supplemental Questionnaire, Citizenship, LAPP 1003 (11-10);
- Supplemental Questionnaire, Climbing, ADMIN 4943 (11-10);
- Supplemental Questionnaire, Diabetes, ADMIN 4941 (11-10);
- Supplemental Questionnaire, Disability Income, LAPP 1006 (11-10);
- Supplemental Questionnaire, Diving, ADMIN 4944 (11-10);
- Supplemental Questionnaire, Gliding, Hang Gliding, Ultra Lighting, ADMIN 4947 (11-10);
- Supplemental Questionnaire, Growths, Cysts, Tumors, ADMIN 4942 (11-10);
- Supplemental Questionnaire, Hypertension, LAPP 1005 (11-10);
- Supplemental Questionnaire, Military, ADMIN 4938 (11-10);
- Supplemental Questionnaire, Motorsports, ADMIN 4936 (11-10);
- Supplemental Questionnaire, Musculoskeletal, LAPP 1004 (11-10);
- Supplemental Questionnaire, Parachuting, ADMIN 4946 (11-10);
- Supplemental Questionnaire, Residence and Travel, ADMIN 4937 (11-10)

Dear Commissioner Bradford:

McHugh Consulting Resources, Inc. has been requested to file the enclosed forms on behalf of OM Financial Life Insurance Company. We have provided an authorization letter for your files.

The above captioned life application, paramedical form, and supplemental questionnaires to the life application are attached for your review and approval. These forms are new and do not replace any forms on file with the Department.

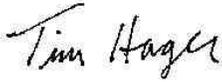
These forms will also be available electronically so that they may be printed from a computer by an insurance producer for completion and signature.

The first contracts these forms are intended to be used with are the Flexible Premium, Adjustable Death Benefit, Universal Life Insurance Policy with Index Interest Option, OM IUL (1-09), approved on 12/8/2008, State Tracking # 41001, by the Department, and also the Flexible Premium, Adjustable Death Benefit, Universal Life Insurance Policy with Index Features, OM HCV IUL (3-08), approved on 8/18/2008, State Tracking # 39653, by the Department.

The forms are in final printed format subject only to changes in formatting, font style, margins, page numbers, ink and paper stock. Printing standards will never be less than those required by law.

Thank you for your time and consideration of this filing. If you should have any questions regarding this filing, please do not hesitate to contact me at the telephone or fax numbers shown below.

Sincerely,

A handwritten signature in black ink that reads "Tim Hager". The signature is written in a cursive style with a large initial "T".

Tim Hager  
Compliance Project Specialist  
McHugh Consulting Resources, Inc.  
215-230-7960  
mcr@mchughconsulting.com



OLD MUTUAL  
1001 Fleet Street  
Baltimore, Maryland 21202  
PH 410.895.0100  
1.888.697.LIFE  
FX 410.895.0162  
www.omfn.com

January 1, 2010

NAIC Company Code: 63274

To: The Insurance Commissioner

Re: Authorization

This letter, or a copy thereof, will authorize the consulting firm of McHugh Consulting Resources, Inc., 2005 South Easton Road, Suite 207, Doylestown, PA 18901, to represent this Company in matters before the Insurance Department.

This Authorization shall be valid until revoked by us.

OM Financial Life Insurance Company

BY:

Karen T. Lam, FLMI, AIRC  
Assistant Vice President, Compliance Oversight

# Statement of Variability

Life Application Form Number: LAPP 1001 (11-10)

Variable Item	Need for Variability	Anticipated Frequency of Change	Anticipated Range
<b>Page 1</b>			
Company Administrative Address	Administrative office name and address may change to reflect the current name and address.  The section may be deleted as applicable to remove the Administrative Address from the document.	Currently, there is no anticipation of changing this item; moving the service center; or changing service center providers.	The range for this item is open to any city and state as applicable.
Page Number (this item applies to all pages on this form).	This number will change to reflect the number of pages printed.	Currently, there is no anticipation of changing this item.	N/A
Company Contact Number	May change if the contact number changes.	Currently, there is no anticipation of changing this item.	N/A

<b>Page 1, Primary Insured, Other Insured, and Owner(s) Sections</b>			
The following items will change with each Primary Insured, Other Insured and Owner(s)			
Name; Address, Social Security Number, Birth Date and Sex; Place of Birth; Driver's License Number and Issue State; Other Identification Number (if Driver's License not used); State/ Province and Country of Issue; Type of Identification, ID Number	These items vary according to each new application's Primary Insured, Other Insured, and Owner(s).	Varies on each application.	N/A
Marital Status  (not applicable to Owner(s) section)	This item varies according to each new applicant's marital status.  May choose to delete depending on the product applied for.	Varies on each application.	N/A
Height and Weight  (not applicable to Owner(s) section)	These items vary according to each new application's Primary and Other Insured.  These fields may be deleted if they are not applicable to the product being applied for.	Varies on each application.	N/A

Variable Item	Need for Variability	Anticipated Frequency of Change	Anticipated Range
<b>Page 1 (Continued), Primary Insured, Other Insured, and Owner(s) Sections (Continued)</b>			
Employment Information; Employer; Occupation and Duties; Number of Years with Current Employer; Earned Annual Income, Email Address; Daytime Phone Number; Evening Phone Number; Cell Phone Number; and Best Time to Call	<p>These items vary according to each new application's Primary Insured, Other Insured, and Owner(s).</p> <p>The entire section may be removed if not applicable to the product being applied for.</p>	Varies on each application.	N/A
<b>Page 1, Other Insured and Owner(s) Section</b> The entire section may be removed if it is not applicable to the product being applied for.			
<b>Page 2, Secondary Addressee Section</b>			
Secondary Addressee	<p>This item varies according to each new application and allows a secondary addressee be named to receive lapse notices.</p> <p>The entire section may be removed if not applicable to the state the application is taken in.</p> <p>This item is not variable in FL, ME, and VT.</p>	Varies on each application.	N/A
<b>Page 2, Beneficiary Designation – Primary Insured Section</b>			
Primary Beneficiary (ies) and Contingent Beneficiary(ies): Full Name; Relationship to Primary Insured; and Percentage Share of Life Insurance Proceeds	These items vary according to each new application's Primary and Contingent Beneficiary(ies).	Varies on each application.	N/A
<b>Page 3, Life Insurance Information Section</b>			
Product Name	This item varies according to the product the applicant is applying for.	Varies on each application.	The range for this item is open to the life insurance products sold by the company.
Amount of Insurance	This item varies according to the amount of insurance applied for by the Primary and/or Other Insured.	Varies on each application.	The range for this item is between \$1000 and \$30,000,000.

Variable Item	Need for Variability	Anticipated Frequency of Change	Anticipated Range
<b>Page 3 (Continued), Life Insurance Information Section (Continued)</b>			
Initial Premium	This item varies according to the Insured's premium class and the periodic payment mode selected at application.	Varies on each application.	The range for this item is open to the amount of initial premium paid for the payment mode selected.
Planned Premium	This item varies according to the Insured's premium class and the periodic payment mode selected at application.	Varies on each application.	The range for this item is open to the planned premiums and modes used by the company.
Term	<p>This item varies according to the term selected at application.</p> <p>This section may be removed if term insurance is not being applied for.</p>	Varies on each application.	<p>The range for this item may vary by any other premium class(es) added to this product or developed in the future.</p> <p>Currently, the range for this item is:</p> <ul style="list-style-type: none"> <li>• Level; or</li> <li>• Decreasing.</li> </ul>
Term and Guarantee Period	<p>This item varies according to the term periods offered by the company.</p> <p>This section may be removed if term insurance is not being applied for.</p>	Varies on each application.	The range for this item is between 1 and 30 years:
UL Death Benefit Options	<p>This item varies according to the death benefit option selected at application.</p> <p>This section may be removed if UL insurance is not being applied for.</p>	Varies on each application.	<p>The range for this item may vary by any other death benefit options added to this product or developed in the future.</p> <p>The range for this item is a choice between:</p> <ul style="list-style-type: none"> <li>• Option A - Level; or</li> <li>• Option B - Increasing.</li> </ul>
UL Life Insurance Qualification Test	<p>This item varies according to the life insurance qualification test selected at application</p> <p>This section may be removed if UL insurance is not being applied for.</p>	Varies on each application.	<p>The range for this item is a choice between the:</p> <ul style="list-style-type: none"> <li>• Guideline Premium Test; or</li> <li>• The Cash Value Accumulation Test.</li> </ul>
Premium Class	This item varies according to the premium class indicated on the application.	<p>Varies on each application. The current choices are:</p> <ul style="list-style-type: none"> <li>• Tobacco; or</li> <li>• Nontobacco.</li> </ul>	The range for this item may be any other premium classes added to the product or developed in the future.

Variable Item	Need for Variability	Anticipated Frequency of Change	Anticipated Range
<b>Page 3 (Continued), Life Insurance Information Section (Continued)</b>			
UL Initial Allocation % for Fixed Indexed Products	This item varies according to the allocation percentages selected at application.	Varies on each application. The current interest crediting options are: <ul style="list-style-type: none"> <li>• Fixed Interest Option;</li> <li>• The Fixed Index Interest Option;</li> <li>• The Fixed Index Interest Option with a participation rate; and/or</li> </ul>	The range for this item is any interest crediting option developed by the company.  The total percentages allocated must equal 100%.  The range for the participation rate is between 30% and 200%.
Payment Mode	This item varies according to the payment mode selected at application.	Varies on each application. The current payment modes are: <ul style="list-style-type: none"> <li>• Annual;</li> <li>• Semi-Annual;</li> <li>• Quarterly;</li> <li>• Monthly Bank Draft;</li> <li>• Bi-Weekly Bank Draft;</li> <li>• Payroll Deduction; or</li> <li>• Other.</li> </ul>	The range for this item is open to any mode made available by the company.
Payment in Exchange for Conditional Receipt	This item varies according to the payment made in exchange for the Conditional Insurance Receipt.  This section may be removed if a conditional receipt is not required for the product applied for.	Varies on each application.	The range for this item is the amount of premium paid at the time of application for conditional insurance coverage.
Credit Card Information	This item varies according to whether the first premium is made by credit card or not.  This section may be removed if credit card payments are not accepted for the product applied for.	Varies on each application.	The range for this item is any credit cards that may be accepted by the company.

Variable Item	Need for Variability	Anticipated Frequency of Change	Anticipated Range
<b>Page 3 (Continued), Life Insurance Information Section (Continued)</b>			
Credit Card Account Number, Credit Card Expiration Date, and Credit Card Signature to Authorize Credit Card Charge	<p>This item varies according to the credit card used for the transaction.</p> <p>This section may be removed if credit card payments are not accepted for the product applied for.</p>	Varies on each application.	N/A
<b>Page 3, Life Insurance Information Section</b> The entire section may be removed if it is not applicable to the product being applied for.			
<b>Page 3 (Continued), Additional Benefits Section</b>			
Primary and Other Insured Disability Income Rider	<p>These items vary according to whether the disability income rider is selected at application for either the Primary Insured, Other Insured, or both.</p> <p>This section may be removed if there are no riders used with the product applied for.</p>	Varies on each application.	The range for these items is selecting the rider or not selecting the rider.
Primary and Other Insured Disability Income Rider Class	<p>These items vary according to the Primary and Other Insured's class.</p> <p>This section may be removed if there are no riders used with the product applied for.</p>	Varies on each application.	Currently, the ranges for these items are any class as defined by the company's underwriting guidelines.
Primary and Other Insured Disability Income Rider Amount of Monthly Income	<p>These items vary according to the Primary and Other Insured's monthly income if this rider is selected at application.</p> <p>This section may be removed if there are no riders used with the product applied for.</p>	Varies on each application.	The ranges for these items are the amounts allowed under the rider.
Primary and Other Insured Disability Income Rider Waiting Period and Benefit Period	<p>These items vary according to the waiting and benefit period selected at application.</p> <p>This section may be removed if there are no riders used with the product applied for.</p>	Varies on each application.	The ranges for these items are the amounts allowed under the rider.

Variable Item	Need for Variability	Anticipated Frequency of Change	Anticipated Range
<b>Page 3 (Continued), Additional Benefits Section (Continued)</b>			
Primary and Other Insured Accident Only Disability Income Rider	<p>These items vary according to whether the disability income rider is selected at application.</p> <p>This section may be removed if there are no riders used with the product applied for.</p>	Varies on each application.	N/A
Primary and Other Insured Accident Only Disability Income Rider Amount of Monthly Income	<p>These items vary according to the Primary and Other Insured's monthly income if this rider is selected at application.</p> <p>This section may be removed if there are no riders used with the product applied for.</p>	Varies on each application.	The ranges for these items are the amounts allowed under the rider.
Primary and Other Insured Accident Only Disability Income Rider Waiting Period and Benefit	<p>These items vary according to the waiting and benefit period selected at application.</p> <p>This section may be removed if there are no riders used with the product applied for.</p>	Varies on each application.	The ranges for these items are the amounts allowed under the rider.
Primary Insured Accelerated Benefit Rider	<p>This item varies according to whether the rider is selected at application.</p> <p>This section may be removed if there are no riders used with the product applied for.</p> <p>If this rider is not offered with the product, paragraph 5 of the Authorization section on page 8 will also be removed.</p>	Varies on each application.	N/A
Primary Insured Accidental Death Benefit Rider	<p>This item varies according to whether the rider is selected at application.</p> <p>This section may be removed if there are no riders used with the product applied for.</p>	Varies on each application.	N/A

Variable Item	Need for Variability	Anticipated Frequency of Change	Anticipated Range
<b>Page 3 (Continued), Additional Benefits Section (Continued)</b>			
Primary Insured Accidental Death Benefit Rider Amount of ADB	This item varies according to whether the rider is selected at application.  This section may be removed if there are no riders used with the product applied for.	Varies on each application.	The range for this item is the amount allowed under the rider.
Primary Insured Critical Illness/Condition/ Specified Medical Condition Rider	This item varies according to whether the rider is selected at application or not.  This section may be removed if there are no riders used with the product applied for.	Varies on each application.	The range for this item is the amount allowed under the rider.
Primary Insured Return of Premium Rider	This item varies according to whether the rider is selected at application or not.  This section may be removed if there are no riders used with the product applied for.	Varies on each application.	The range for this item is the amount allowed under the rider.
Primary Insured Ultimate Income Rider	This item varies according to whether the rider is selected at application or not.  This section may be removed if there are no riders used with the product applied for.	Varies on each application.	N/A
<b>Page 4, Additional Benefits Section (Continued)</b>			
Other Insured Rider	This item varies according to whether the rider is selected at application or not.  This section may be removed if there are no riders used with the product applied for.	Varies on each application.	N/A
Other Insured Rider Amount	This item varies according to the amount of insurance selected at application if the Other Insured Rider is chosen.  This section may be removed if there are no riders used with the product applied for.	Varies on each application.	If the rider is selected, the range for this item is up to the amount of insurance selected for the Primary Insured.

Variable Item	Need for Variability	Anticipated Frequency of Change	Anticipated Range
<b>Page 4, Additional Benefits Section (Continued)</b>			
Primary Insured Child Rider	This item varies according to whether the rider is selected at application or not.  This section may be removed if there are no riders used with the product applied for.	Varies on each application.	The range for this item is the amount allowed under the rider.
Primary Insured Waiver of Monthly Deduction Rider (UL)	This item varies according to whether the rider is selected at application or not.  This section may be removed if there are no riders used with the product applied for.	Varies on each application.	N/A
Primary Insured Waiver of Premium Rider (Term)	This item varies according to whether the rider is selected at application or not.  This section may be removed if there are no riders used with the product applied for.	Varies on each application.	N/A
Other	This item varies according to whether there are any other riders approved and offered by the company but not currently listed on the application that are available with the product being applying for. These rider(s) name(s) may be written in.	Varies on each application.	The range for this is any approved rider that is available but not listed on the application.

**Page 4 (Continued), Additional Benefits Section (Continued)****Pages 3 and 4, Additional Benefits Section**

The entire section may be removed if it is not applicable to the product being applied for.

**Personal History Questions Section**

Personal History Questions	This section may be removed if there are no personal history questions required for the product applied for.	The responses to these questions vary on each application.	N/A
Personal History Questions, Question 9	This question may be removed if it is not required for the product being applied for.	Currently, there is no anticipation of removing this item.	N/A
Medical Provider Information – Primary Insured and Other Insured	These items vary by applicant.	Varies on each application.	N/A

Variable Item	Need for Variability	Anticipated Frequency of Change	Anticipated Range
<b>Page 7, Medical History Questions Section (Continued)</b>			
Medical History Questions, Question 8	This question may be removed if the disability income rider is not used with the product being applied for.	Currently, there is no anticipation of removing this item.	N/A
Medical History Questions, Question 9	This question may be removed it is not required for the product being applied for.	Currently, there is no anticipation of removing this item.	N/A
Medical History Questions, question 10	This question may be removed it is not required for the product being applied for.	Currently, there is no anticipation of removing this item.	N/A

<b>Page 8, Authorization Section</b>			
Accelerated Benefit Rider Disclosure (paragraph 5)	<p>This item may be removed if the rider is not used with the product applying for.</p> <p>If the rider option is removed from the Additional Benefits section on page 3, this disclosure would be removed.</p>	Currently, there is no anticipation of changing this item.	N/A

<b>Page 8 (Continued), Authorization Section (Continued)</b>			
Index UL Disclosure (paragraph 9)	This item may be removed if it is not required for the product applied for.	Currently, there is no anticipation of changing this item.	N/A
Certification (paragraph 10)	This item is variable to accommodate federal or state law changes.	Currently, there is no anticipation of changing this item.	N/A

# Statement of Variability

## Paramedical Supplement To Life Application Form Number: LAPP 1002 (11-10)

Variable Item	Need for Variability	Anticipated Frequency of Change	Anticipated Range
<b>Page 1</b>			
Company Administrative Address	Administrative office name and address may change to reflect the current name and address.  The section may be deleted as applicable to remove the Administrative Address from the document.	Currently, there is no anticipation of changing this item; moving the service center; or changing service center providers.	The range for this item is open to any city and state as applicable.
Page Number (this item applies to all pages on this form).	This number will change to reflect the number of pages printed.	Currently, there is no anticipation of changing this item.	N/A
Company Contact Number	May change if the contact number changes.	Currently, there is no anticipation of changing this item.	N/A

<b>Interviewer Section</b>			
The following items will change with each Proposed Insured			
Name of Interviewer; Interviewer Questions; Information Source; Date and Time of Interview	This item varies according to each new application's Proposed Insured.	Varies on each application.	N/A

<b>Page 1 (Continued), Proposed Insured Section</b>			
The following items will change with each Proposed Insured			
Name, Address, Social Security Number, Birth Date and Sex, Driver's License Number and Issue State; Other Identification Number (if Driver's License not used); State/Province and Country of Issue; Type of Identification, ID Number	This item varies according to each new application's Proposed Insured.	Varies on each application.	N/A

Variable Item	Need for Variability	Anticipated Frequency of Change	Anticipated Range
<b>Page 2, Medical History Questions Section (Continued)</b>			
Medical History Questions, Question 8	This question may be removed if the disability income rider is not used with the product being applied for.	Currently, there is no anticipation of removing this item.	N/A
Medical History Questions, Question 9	This question may be removed it is not required for the product being applied for.	Currently, there is no anticipation of removing this item.	N/A
Medical History Questions, question 10	This question may be removed it is not required for the product being applied for.	Currently, there is no anticipation of removing this item.	N/A
The above questions may also be revised or deleted to match the medical questions on the life application, LAPP 1001 (11-10)			

<b>Page 3, Medical History Questions Section (Continued)</b>			
Medical Provider Information – Primary Insured and Other Insured	These items vary by applicant.	Varies on each application.	N/A

<b>Page 4, Medical Examiner's Report</b>			
Height and Weight Blood Pressure Pulse Heart Abnormalities Hernias Additional medical history	These items vary according to each Proposed Insured.	Varies on each application.	N/A