

SERFF Tracking Number: AEMN-126410384 State: Arkansas
Filing Company: RiverSource Life Insurance Company State Tracking Number: 44823
Company Tracking Number: 134851AR
TOI: L06I Individual Life - Variable Sub-TOI: L06I.002 Single Life - Flexible Premium
Product Name: Life Insurance
Project Name/Number: Life/DI 2010 Application/134851

Filing at a Glance

Company: RiverSource Life Insurance Company

Product Name: Life Insurance

SERFF Tr Num: AEMN-126410384 State: Arkansas

TOI: L06I Individual Life - Variable

SERFF Status: Closed-Approved-
Closed State Tr Num: 44823

Sub-TOI: L06I.002 Single Life - Flexible
Premium

Co Tr Num: 134851AR

State Status: Approved-Closed

Filing Type: Form

Reviewer(s): Linda Bird

Authors: Debbie Berg, Bonnie
Foley, Jeff Pederson, Susan
Schmidt

Disposition Date: 02/17/2010

Date Submitted: 02/11/2010

Disposition Status: Approved-
Closed

Implementation Date Requested: On Approval

Implementation Date:

State Filing Description:

General Information

Project Name: Life/DI 2010 Application

Status of Filing in Domicile: Not Filed

Project Number: 134851

Date Approved in Domicile:

Requested Filing Mode: Review & Approval

Domicile Status Comments: Forms will be
submitted in domicile state of Minnesota on
02/22/2010.

Explanation for Combination/Other:

Market Type: Individual

Submission Type: New Submission

Group Market Size:

Overall Rate Impact:

Group Market Type:

Filing Status Changed: 02/17/2010

Explanation for Other Group Market Type:

State Status Changed: 02/17/2010

Deemer Date:

Created By: Debbie Berg

Submitted By: Debbie Berg

Corresponding Filing Tracking Number:

Filing Description:

RE: Submission of 3 Application Forms

RiverSource Life Insurance Company

Individual Life Insurance Form Filing

SERFF Tracking Number:	AEMN-126410384	State:	Arkansas
Filing Company:	RiverSource Life Insurance Company	State Tracking Number:	44823
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TOI:	L06I Individual Life - Variable	Sub-TOI:	L06I.002 Single Life - Flexible Premium
Product Name:	Life Insurance		
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- ..Form 134851 - Individual Life and Disability Income Insurance Application
- ..Form 133081 - Insurance Application Supplement - Part Two
- ..Form 132263 - AdvanceSource Accelerated Benefit Rider Application

The new Life and DI application forms referenced above are submitted for review and approval by your department. We plan to implement use of these application forms in the 2nd quarter of 2010.

The submission contains no unusual or possibly controversial items from the standpoint of normal company or industry standards. The form structure of the new application forms has been modified to remove the Medical history/Underwriting questions from the base application and place them into a separate form titled, "Insurance Application Supplement - Part Two." The application process will be completed in the following manner:

- Form 134851 - Base application used for all product sales.
.....Will be completed with the advisor and client present.
- Form 133081 - Application supplement used for all product sales.
.....Will be completed separately from the base application via a telephone interview by someone other than the agent.
- Form 132263 - Rider application used in addition to base application for selecting an AdvanceSource Rider.
.....Will be completed with the advisor and client present.

Clients will provide additional information for those questions answered in the affirmative during the telephone interview which will be reflected in Section E of Form 133081. A copy of the entire form will be included as part of the issued policy.

In order to satisfy client signature requirements for the application supplement - Form 133081, a voice signature process will be used. Applicants will have the choice of opting out of the voicemail signature process but not out of the telephone interview. There is disclosure language in the Authorization and Disclosure section of base application Form 134851 about the voice signature consent or alternatively using a written signature.

The three new forms will replace two previously approved or pending application forms as follows:

New Form...	Replaces..	Filing Status..	Status Date.....	File No.
134851.....	134803.....	approved.....	07/24/2008.....	39689
133081.....	134803 and 132173.....	As listed above and below.		
132263.....	132173.....	Approved.....	04/17/2009.....	42104

- Other minor changes to the application forms include:
- Updated the Life Insurance Plan and Riders section to reflect current products.

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- Removed the Arbitration agreement section from any versions that previously included it.
- Overall format and layout changes throughout.
- Text revision intended to clarify questions or instructions.

The new application forms will be used to apply for previously approved life and/or disability income insurance policies/products. A Forms List of those policies to which the application will be attached is provided in supporting documents. The application forms are exempt from state and NAIC Readability requirements because they are used with variable life policies subject to SEC jurisdiction.

Material that may change is indicated by brackets on the submitted specimens. A Statement of Variability describing the bracketed items is attached in supporting documents. The specimens have also been annotated to easily match the bracketed items to the explanations in the Statement of Variability.

To the best of our knowledge, these forms comply with the laws and regulations of Arkansas. Any applicable certifications as required by your state are provided as supporting documents.

Thank you for your consideration of this filing. Please feel free to call or send me an email if there is any assistance I can provide to facilitate your review.

Debbie L. Berg, Senior Contract Analyst
612-671-2965
debbie.berg@ampf.com

Company and Contact

Filing Contact Information

Debbie Berg, Sr. Contract Analyst
9550 Ameriprise Financial Center
H22/9550
Minneapolis, MN 55474

debbie.berg@ampf.com
612-671-2965 [Phone]
612-671-3866 [FAX]

Filing Company Information

RiverSource Life Insurance Company
9550 Ameriprise Financial Center
H22/9550
Minneapolis, MN 55474
(612) 671-2465 ext. [Phone]

CoCode: 65005
Group Code: 4
Group Name:
FEIN Number: 41-0823832

State of Domicile: Minnesota
Company Type: Life
State ID Number:

SERFF Tracking Number: AEMN-126410384 State: Arkansas
Filing Company: RiverSource Life Insurance Company State Tracking Number: 44823
Company Tracking Number: 134851AR
TOI: L061 Individual Life - Variable Sub-TOI: L061.002 Single Life - Flexible Premium
Product Name: Life Insurance
Project Name/Number: Life/DI 2010 Application/134851

Filing Fees

Fee Required? Yes
Fee Amount: \$125.00
Retaliatory? Yes
Fee Explanation: AR filing fee is \$20 for each form filed separately from policy - 3 x 20 = \$60

MN filing fee is \$125 per filing.

Used retaliatory fee of \$125.00

Per Company: No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
RiverSource Life Insurance Company	\$125.00	02/11/2010	34141163

SERFF Tracking Number: AEMN-126410384 State: Arkansas
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TOI: L061 Individual Life - Variable Sub-TOI: L061.002 Single Life - Flexible Premium
Product Name: Life Insurance
Project Name/Number: Life/DI 2010 Application/134851

Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Linda Bird	02/17/2010	02/17/2010

SERFF Tracking Number: *AEMN-126410384* *State:* *Arkansas*
Filing Company: *RiverSource Life Insurance Company* *State Tracking Number:* *44823*
Company Tracking Number: *134851AR*
TOI: *L06I Individual Life - Variable* *Sub-TOI:* *L06I.002 Single Life - Flexible Premium*
Product Name: *Life Insurance*
Project Name/Number: *Life/DI 2010 Application/134851*

Disposition

Disposition Date: 02/17/2010

Implementation Date:

Status: Approved-Closed

Comment:

Rate data does NOT apply to filing.

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Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification		Yes
Supporting Document	Application		Yes
Supporting Document	Life & Annuity - Acturial Memo		No
Supporting Document	Forms List		Yes
Supporting Document	Statement of Variability		Yes
Form	Life and Disability Income Insurance Application		Yes
Form	Insurance Application Supplement - Part Two		Yes
Form	AdvanceSource Accelerated Benefit Rider Application		Yes

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Form Schedule

Lead Form Number: 134851

Schedule Item Status	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
	134851	Application/ Enrollment Form	Life and Disability Income Insurance Application	Initial		0.000	134851 Life-DI Application.pdf
	133081	Application/ Enrollment Form	Insurance Application Supplement - Part Two	Initial		0.000	133081 - App Supplement.pdf
	132263	Application/ Enrollment Form	AdvanceSource Accelerated Benefit Rider Application	Initial		0.000	132263 - ASR Application.pdf

Life and Disability Income Insurance Application

3.

Client ID



Always complete Section A.

Section A Insured Information

Insured's Phone Numbers Day Evening

1. Insured: Is Insured the Owner? Yes No If you answered "No" complete this page and Section C on Page 2.

Citizenship: U.S. Other If Other, Insured is: Resident Alien with Green Card Nonresident Alien

Insured's Name (First, Middle Initial and Last Name) Male Female

Birth Date (MMDDYYYY) State of Birth or Country of Birth U.S. Social Security Number

Driver's License (DL) Number DL State of Issuance Occupation

Employer Name Individual Income \$ Net Worth \$ Household Income \$

If this is a Succession Protector or Succession Select product, complete the Second Insured Sections H and I on Pages 10 and 11.

2. Coverage Questions

IT IS IMPORTANT THAT ANSWERS ARE TRUE, ACCURATE AND COMPLETE. ANY UNTRUE, INACCURATE OR INCOMPLETE INFORMATION COULD AFFECT YOUR INSURANCE COVERAGE.

- a. In the past 12 months, has the insured been hospitalized, placed in hospice care, or been advised by a health care professional to be hospitalized or placed in hospice care on either an inpatient or outpatient basis for any reason other than normal pregnancy? Yes No
- b. In the past 12 months, has the insured received treatment or advice from a health care professional for heart disease, chest pain, stroke, cancer (except basal cell carcinoma), kidney failure, liver failure or unexplained weight loss? Yes No
- c. Has the insured ever used tobacco or nicotine in any form? Yes No Date of last use (MMYYYY)
- d. Personal Physician or Primary Care Provider (Check here if none.)

Doctor or Clinic Name Date Last Seen (MMYYYY)

Street Address

City State Zip Phone

3. Premium Submitted

Do not include any premium with this application if you:

- answered "Yes" to 2a or 2b of Section A, or
- answered "Yes" to 2a or 2b of Section H on Page 10, or
- are applying for death benefits totaling over \$1,000,000.

No money paid with this application Money paid with this application \$.

If one check is submitted for multiple products, please specify the dollar amount to each product.

4.

2.



3. Complete Sections B, C and D if applicable.

Section B Juvenile Insurance [(Complete if insured is under age 15.)]

3.

Did the advisor see this child? Yes No

Is there similar insurance in force or applied for on all siblings? Yes No If no, why?

Amount of life insurance already in force on the person responsible for child's primary support \$ _____ . _____

Signature of Parent or Legal Guardian

Signature of Witness

Date(MMDDYYYY)

9.

X _____ X _____

Section C Owner Information

1. **Owner** (If Owner is different from insured as shown on Page 1)

Individual — Name (First, Middle Initial and Last Name)

U.S. Social Security Number Birth Date (MMDDYYYY) Male Female

Citizenship: U.S. Other _____ If Other, Insured is: Resident Alien with Green Card Nonresident Alien

Relationship to Insured

Trust — Name of Trust

Revocable — Grantor's TIN _____ Irrevocable — Trust's TIN _____

Name of Trustee Date of Trust (MMDDYYYY)

Address of Trustee

Business or Other Entity — Name

TIN _____ Relationship to Insured _____

2. **Successor Owner:** Does the Owner wish to designate a Successor Owner? Yes No

If Yes, Successor Owner's Name Relationship to Owner

3.

Section D Business Insurance [(Complete if insurance is for business purposes.)]

Type of Business: Sole Proprietorship S Corporation Partnership C Corporation LLC

Type of Business Insurance: Buy/Sell Business Debt Protection Split Dollar Key Person Executive Bonus/GEBA Deferred Compensation (nongovernmental) Other _____

5.

6.



Complete Sections E and F for all life insurance products.

Section E Existing Life Insurance or Annuities

INSURED: Do you have any other **annuities** or **life insurance** currently in force or applied for? Yes No
If marked **Yes**, you must complete all details in the grid below, even if the existing policy is not being replaced. If a policy will be replaced, all state specific replacement forms must be completed.

Company	Policy Number	Type	Amount	ADB Amount	Being Replaced
					<input type="radio"/> Yes <input type="radio"/> No
					<input type="radio"/> Yes <input type="radio"/> No
					<input type="radio"/> Yes <input type="radio"/> No
					<input type="radio"/> Yes <input type="radio"/> No

Use Section K (on Page 12) if you have additional insurance coverage information to document.

You must check "Yes" to "Being Replaced" if:

- There is any possibility that the new RiverSource Life Insurance Company (RiverSource Life) policy will replace another policy, even if it is not yet certain.
- Premium payments will be discontinued on an existing policy or if the existing policy is surrendered, reduced, annuitized or otherwise terminated, in part or in full.
- A policy has been applied for with another company and that policy is not or will not be accepted.

Important Notice: In some states you must submit the "Important Notice: Replacement of Life Insurance or Annuities" (Form 200084) whenever the client has existing insurance or annuities, even if there is no replacement involved. Use the "eForms Manager" tool to determine if the form applies in your state.

Life External Replacements: If a 1035 Exchange to the RiverSource Life policy will be requested, the 1035 Exchange Request (Form 30062) must also be completed.

Life Internal Replacements: If "Being Replaced" is checked "Yes" and you are replacing a RiverSource Life policy, by signing this application, the existing RiverSource Life policy(s) listed above will be surrendered upon underwriting approval unless you inform us otherwise.

The cash value should be: applied to the new RiverSource Life policy returned to the owner.

Section F Agreement to Sell, Transfer or Assign Life Insurance

Any "party" to the application is defined as the insured, owner or any beneficiary. "Third Party" is defined as a viatical settlement entity, life settlement entity, insurance company, other secondary market provider or premium financing entity.

1. Agreements or Incentives — Has any Party to the application:

- Entered, or made plans to enter, into any agreement or contract to sell or assign the ownership of, or a beneficial interest in, the applied for policy; or
- Been promised or agreed to by any person that they will be given, or have been given, any inducement, fee or compensation as an incentive to purchase the applied for policy; or
- Received, or will receive, from any person any inducement, fee or compensation as incentive to purchase the applied for policy? Yes No

2. Prior Transactions — Has any Party to the application ever:

- Sold, transferred or assigned any life insurance policy to a Third Party; or
- Received any inducement, fee or compensation as an incentive to purchase, sell, transfer or assign any life insurance policy? Yes No

For any "Yes" responses to 1 or 2 above, provide details regarding any agreements, incentives or prior transactions.



Complete Section G1 for term life insurance products.

Section G1 Life Insurance Plan Information: Term Insurance

1. Life Insurance Plan

- a. Level Term Plans: 20-Year 15-Year 10-Year
Insured Amount \$ _____
- b. Income Protection Life Plans: Term to Age 60 Term to Age 65 Term to Age 67
Monthly Death Benefit Amount is \$ _____
- c. Other _____ Insured Amount \$ _____

2. Riders/Options

- Level Term
- Waiver of Premium
 - Accidental Death Benefit of \$ _____
 - Children's Insurance Rider (CIR) Units _____ — Provide details for CIR in Section J on Page 11.
- Income Protection Life
- Waiver of Premium
 - Cost of Living Adjustment
 - Other _____

3. Life Insurance Premiums

Annual Scheduled Premium
\$ _____ . _____

- a. Bank Authorization (BA): Monthly Quarterly
 New BA Authorization (Complete Form 200517.)
 Add to Existing BA with Account Number _____ 8.
- b. Systematic Payment Option (SPO) (Complete Form 200517.)
- c. Direct Bill: Quarterly Semiannual Annual
- d. Card billing: MasterCard American Express Visa
Frequency (not available for initial payment): Monthly Quarterly Semiannually Annually
Card Number _____ Expires _____

e. Other: _____

4. Life Insurance Beneficiary — Term Insurance

- Option A: Beneficiary is: Insured's designated spouse, if living, otherwise the beneficiaries are the living lawful children of the insured and they will receive equal shares of the proceeds.
Insured's Spouse's Full Name _____
- Option B: Beneficiary is: Insured's designated spouse, if living, otherwise, the beneficiaries are the lawful children of the insured and they will receive equal shares of the proceeds; provided, however, that if a child of the insured has died before the insured, the share which the child would have received if he/she survived the insured will be paid to his/her living lawful children in equal shares.
Insured's Spouse's Full Name _____
- Option C: Other Designation: Name and relationship to the insured (and percentage each beneficiary will receive, if applicable) _____



Complete Section G2 for universal life and Succession Protector products.

Section G2 Life Insurance Plan Information: Universal Life and Succession Protector

1. Life Insurance Plan Information

Insured Amount \$ Purpose of Insurance

- 10. Foundations Universal Life (FUL) must select Option 1 or 2 for this plan:
- Death Benefit Option 1 (Level)
- Death Benefit Option 2 (Variable)
- Succession Protector (SP)
- Foundations Protector (FP)
- Other

2. Riders

- Foundations Universal Life or Foundations Protector
- Accelerated Benefit Rider for Terminal Illness
- AdvanceSource Rider — Complete AdvanceSource Rider application.
- 11. Waiver of Monthly Deduction (FUL only)
- Waiver of Specified Premium — Monthly Specified Premium \$
- Accidental Death Benefit of \$ (FUL only)
- Children's Insurance Rider (CIR) Units (FUL only) — Provide details for CIR in Section J on Page 12.
- Automatic Increase Benefit Rider (FUL only): 2% 3% 4% 5% 6% 7% 8%
Succession Protector:
- Four Year Term of \$
- Policy Split Option
- Other

3. Life Insurance Premiums

Annual Scheduled Premium Lump-Sum Amount to Be Paid on Delivery of Policy
\$. \$.

- a. Bank Authorization (BA): Monthly Quarterly
- New BA Authorization (Complete Form 200517)
- Add to Existing BA with Account Number 8.
b. Systematic Payment Option (SPO) (Complete Form 200517.)
c. Direct Bill: Quarterly Semiannual Annual
d. Other 7.

4. Life Insurance Beneficiary — Universal Life Insurance

- 3. Do not complete for Succession Protector. Provide Survivorship Beneficiary Designation in Section H, Page 10.
- Option A: Beneficiary is: Insured's designated spouse, if living, otherwise the beneficiaries are the living lawful children of the insured and they will receive equal shares of the proceeds.
Insured's Spouse's Full Name
- Option B: Beneficiary is: Insured's designated spouse, if living, otherwise, the beneficiaries are the lawful children of the insured and they will receive equal shares of the proceeds; provided, however, that if a child of the insured has died before the insured, the share which the child would have received if he/she survived the insured will be paid to his/her living lawful children in equal shares.
Insured's Spouse's Full Name
- Option C: Other Designation: Name and relationship to the insured (and percentage each beneficiary will receive, if applicable)



Complete Section G3 for variable universal life and Succession Select insurance products.

Section G3 Life Insurance Plan Information: Variable Universal Life and Succession Select

1. Life Insurance Plan

For variable products, complete item 5 below AND investment option Form 33034 OR Portfolio Navigator Program Enrollment Form 402048.

Insured Amount \$ _____ Purpose of Insurance _____

Variable Universal Life (VUL)* Succession Select (SS)* Other _____

*Must select Option 1 or 2 for this plan: Death Benefit Option 1 (Level) Death Benefit Option 2 (Variable)

2. Riders

Variable Universal Life

- Accelerated Benefit Rider for Terminal Illness
- AdvanceSource Rider — Complete AdvanceSource Rider application.
- Waiver of Monthly Deduction
- Waiver of Specified Premium — Monthly Specified Premium \$ _____
- Accidental Death Benefit of \$ _____
- Children's Insurance Rider (CIR) Units _____ Provide details for CIR in Section J on Page 12.
- Automatic Increase Benefit Rider: 2% 3% 4% 5% 6% 7% 8%

Succession Select

- Four Year Term of \$ _____
- Policy Split Option \$ _____
- Other _____

3. Life Insurance Premiums

Annual Scheduled premium _____ Lump-Sum Amount to Be Paid on Delivery of Policy
\$ _____ . _____ \$ _____ . _____

- a. Bank Authorization (BA): Monthly Quarterly
 - New BA Authorization (Complete Form 200517.)
 - Add to Existing BA with Account Number _____
- b. Systematic Payment Option (SPO) (Complete Form 200517.)
- c. Direct Bill: Quarterly Semiannual Annual

d. Other _____

4. Life Insurance Beneficiary — Variable Universal Life

Do not complete for Succession Select. Provide Survivorship Beneficiary Designation in Section H, Page 10.

- Option A: Beneficiary is: Insured's designated spouse, if living, otherwise the beneficiaries are the living lawful children of the insured and they will receive equal shares of the proceeds.

Insured's Spouse's Full Name _____

- Option B: Beneficiary is: Insured's designated spouse, if living, otherwise, the beneficiaries are the lawful children of the insured and they will receive equal shares of the proceeds; provided, however, that if a child of the insured has died before the insured, the share which the child would have received if he/she survived the insured will be paid to his/her living lawful children in equal shares.

Insured's Spouse's Full Name _____

- Option C: Other Designation: Name and relationship to the insured (and percentage each beneficiary will receive, if applicable) _____

Continued on next page...



Section G3 Life Insurance Plan Information (continued)

5. Variable Universal Life and Succession Select Information — Check each of the following below to indicate your acknowledgement: (Also, complete [investment option allocation Form 33034] or [Portfolio Navigator Program Enrollment Form 402048].) **8.**

- Adequate Information.** You have received the current prospectuses for the policy applied for and any funds involved.
- Purpose.** You agree that this variable type of insurance is in accord with your insurance and financial objectives.
- Variable values.** You understand that the amount of Death Benefit and Policy Value can both increase and decrease; however, the Death Benefit will never be less than any Guaranteed Minimum Death Benefit.
- Fees and Charges.** The fees and charges have been explained to you and are also explained in detail in the policy.

6. Consent for Delivery of Initial Prospectuses on CD-ROM

- Yes — By checking this box, I acknowledge that I have chosen to receive and have received the initial product and fund prospectuses on computer readable compact disk ("CD"). See details of Consent for Delivery in Section M on Page 13.

12.

3.



Complete Section G4a for disability income insurance products.

Section G4a Disability Income Plan Information

1. Disability Income Insurance Plan

Base Monthly Benefit

\$ [] . []

Insured's Occupation Class:

- 1A 2A 3A 3M
- 4A 4M 5A 5M

Waiting Period:

- 30 days 60 days 90 days
- 180 days 365 days

8.

Submit [Application Supplement Form 33507] (available on DI Illustration System).

Duration of Benefit: 1 year 3 year 5 years to age 65 to age 67

Premium Pattern: Level Step Rate

Disability Provision:

13.

- Occupation Classes 1A, 2A, 3A & 3M Income Protection Plus with 2 Years Occupation Protection (IPP-2)
- Occupation Classes 4A, 4M, 5A & 5M Income Protection Plus with 5 Years Occupation Protection (IPP-5)
- Occupation Classes 4A & 5A Income Protection Plus (IPP)
- Occupation Classes 4A, 4M, 5A & 5M Income Protection with Residual Benefits (IPTr)
- Occupation Classes 3A, 4A, 4M, 5A & 5M Income Protection (IPMod)

Group Rate Options — Please indicate below ONLY if either of the following applies to this application.

- Employer Plan Coverage Unisex Rates Multiple Case Discount (see online reference materials for all qualification details)

2. Disability Income Insurance Riders

Social Benefits Rider \$ [] per month with Waiting Period of [] days

10.

Supplemental Income Rider \$ [] per month and benefit paid up through month [] with [] day waiting period

Cost of Living Adjustment Maximum (classes 2A, 3A, 3M, 4A, 4M, 5A, and 5M)
Maximum: 3% 4% 5% 6% 7% 8% 9% 10%

Future Purchase Option \$ [] Pool Amount

Other []

Continued on next page...



Section G4a Disability Underwriting Information (continued)

3. Disability Income Insurance Premiums

Annual Premium \$ [] . []

a. Bank Authorization (BA): Monthly Quarterly

New BA Authorization (Complete [Form 200517].)

Add to Existing BA with Account Number [] 8.

b. Special Payment Option SPO (Systematic Payout) Complete [Form 200517]

c. Direct Bill: Quarterly Semiannual Annual

d. Card Billing: MasterCard American Express Visa

Frequency (not available for initial payment): Monthly Quarterly Semiannually Annually

Card Number [] Expires []

e. Other []

3. [! Complete Section G4b for business overhead expense products.]

Section G4b Business Overhead Expense Protection Plan Information

1. Business Overhead Expense Protection Insurance Plan

(Cannot be applied for without personal disability income protection in force or applied for with RiverSource Life or other company.)

3. [Complete Disability Underwriting Information Section G4c.]

Monthly Benefit \$ [] 8.

Submit Application [Supplement Form 33507] (available on DI Illustration System)

Insured's Occupation Class: 3A 3M 4A 4M 5A 5M

Waiting Period: 30 days 60 days 90 days

Benefit Pattern: Level Increasing

Multiple DI Case Discount (See online reference materials for all qualification details.)

2. Business Overhead Expense Protection Insurance Premiums

Annual Premium \$ []

a. Bank Authorization (BA): Monthly Quarterly

New BA Authorization (Complete [Form 200517].) 8.

Add to Existing BA with Account Number []

b. Special Payment Option SPO (Systematic Payout) Complete [Form 200517]

c. Direct Bill: Quarterly Semiannual Annual

d. Card Billing: MasterCard American Express Visa

Frequency (not available for initial payment): Monthly Quarterly Semiannually Annually

Card Number [] Expires []

e. Other []



3. Complete Section G4c for disability income and business overhead expense products.

Section G4c Disability Underwriting Information

1. Are you currently actively employed? Yes No

a. If yes, number of hours per week Number of weeks per year

b. Self-employed? Yes No

i. Date business began (MMDDYYYY)

ii. Type of business or industry

2. Occupational Duties

a. Provide a complete description of your job duties. Include a percentage of time spent on each task.

7. [Empty text box for job duties description]

b. Do you manage or supervise others? Yes No

If yes, what percent of duties are supervisory? % Number of employees

c. Provide any professional designations or educational degrees you hold which are specific to your occupation.

3. Any contemplated change in occupation?

Yes No If yes, explain:

4. Previous occupation if changed in the past five years

5. Amount of unearned income \$ Source

6. Is the Insured a member of a State, Public, or Federal Retirement System?

Yes No If yes, which one?

7. Is the Insured eligible for or does the insured have any disability income insurance through his/her employer?

a. Short-term: Yes No at \$ per month for months and day waiting period

b. Long-term: Yes No at \$ per month for months and day waiting period

c. If yes to b., is the group long-term disability integrated with Social Security? Yes No

d. Will the insured's employer be paying the premiums for the RiverSource Life disability insurance? Yes No

e. Is the insured eligible for benefits from a required state Cash Sickness disability program? Yes No

8. Existing Disability Income Insurance (all DI applicants must complete)

Insured: Do you have any other disability insurance currently in force or applied for? Yes No

If yes, you must complete all details in the grid below even if the existing policy is not being replaced. If a policy will be replaced, all state specific replacement forms must be completed.

Table with 7 columns: Company, Policy Number, Type, Insurance Amount/Monthly Income, DI Years Payable, Being Replaced. Includes a 7. marker in the left margin.

Use Section K (on Page 12) if you have additional insurance coverage information to document.

You must check "Yes" to "Being Replaced" if:

- There is any possibility that the new RiverSource Life policy will replace another policy, even if it is not yet certain.
Premium payments will be discontinued on an existing policy or if the existing policy is surrendered, reduced, annuitized or otherwise terminated, in part or in full.
A policy has been applied for with another company and that policy is not or will not be accepted.



Complete Section H for Succession Protector and Succession Select life insurance products.

Section H Second Insured

Insured's Phone Number:

Day Evening

1. Insured:

Citizenship: U.S. Other If Other, insured is: Resident Alien with Green Card Nonresident Alien

Insured's Name (First, Middle Initial and Last Name) Male Female

Relationship to primary insured

Birth Date (MMDDYYYY) State of Birth or Country of Birth U.S. Social Security Number

Driver's License (DL) Number DL State of Issuance

Occupation Employer Name

Individual Income Net Worth Household Income
\$ \$ \$

2. Coverage Questions

IT IS IMPORTANT THAT ANSWERS ARE TRUE, ACCURATE AND COMPLETE. ANY UNTRUE, INACCURATE OR INCOMPLETE INFORMATION COULD AFFECT YOUR INSURANCE COVERAGE.

a. In the past 12 months, has the insured been hospitalized, placed in hospice care, or been advised by a health care professional to be hospitalized or placed in hospice care on either an inpatient or outpatient basis for any reason other than normal pregnancy? Yes No

b. In the past 12 months, has the insured received treatment or advice from a health care professional for heart disease, chest pain, stroke, cancer (except basal cell carcinoma), kidney failure, liver failure or unexplained weight loss? Yes No

c. Has the insured ever used tobacco or nicotine in any form? Yes No Date of last use (MMYYYY)

d. Personal Physician or Primary Care Provider (Check here if none.)
Doctor or Clinic Name Date Last Seen

Street Address

City State Zip Phone

3. Survivorship Beneficiary Designation

Name and relationship to insured (and percentage each beneficiary will receive, if applicable)



Complete Section I for Succession Protector and Succession Select life insurance products.

Section I Existing Life Insurance or Annuities

SECOND INSURED: Do you have any other **annuities** or **life insurance** currently in force or applied for? Yes No
If marked **Yes**, you must complete all details in the grid below even if the existing policy is not being replaced.
If a policy will be replaced, all state specific replacement forms must be completed.

Company	Policy Number	Type	Amount	ADB Amount	Being Replaced
					<input type="radio"/> Yes <input type="radio"/> No
					<input type="radio"/> Yes <input type="radio"/> No
					<input type="radio"/> Yes <input type="radio"/> No
					<input type="radio"/> Yes <input type="radio"/> No

Use Section K (on Page 12) if you have additional insurance coverage information to document.

You must check "Yes" to "Being Replaced" if:

- There is any possibility that the new RiverSource Life policy will replace another policy, even if it is not yet certain.
- Premium payments will be discontinued on an existing policy or if the existing policy is surrendered, reduced, annuitized or otherwise terminated, in part or in full.
- A policy has been applied for with another company and that policy is not or will not be accepted.

Important Notice: In some states you must submit the "Important Notice: Replacement of Life Insurance or Annuities" (Form 200084) whenever the client has existing insurance or annuities, **even if there is no replacement involved. Use the "eForms Manager" tool to determine if the form applies in your state.**

Life External Replacements: If a 1035 Exchange to the RiverSource Life policy will be requested, the 1035 Exchange Request (Form 30062) must also be completed.

Life Internal Replacements: If "Being Replaced" is checked "Yes" and you are replacing a RiverSource Life policy, by signing this application, the existing RiverSource Life policy(s) listed above will be surrendered upon underwriting approval unless you inform us otherwise.

The cash value should be: applied to the new RiverSource Life policy returned to the owner.

2.

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3.

- Complete Section J for Children’s Insurance Rider.
- Complete Section K for additional information for all products.

Section J Children’s Insurance Rider Information

1. Name(s) of child(ren) to be covered by rider (must be under age 19 and unmarried):

Name (First, Full Middle, Last)	Birth Date (MMDDYYYY)	Sex	Physical/Mental Abnormalities at Birth?
<input type="text"/>	<input type="text"/>	<input type="radio"/> Male <input type="radio"/> Female	<input type="radio"/> Yes <input type="radio"/> No
<input type="text"/>	<input type="text"/>	<input type="radio"/> Male <input type="radio"/> Female	<input type="radio"/> Yes <input type="radio"/> No
<input type="text"/>	<input type="text"/>	<input type="radio"/> Male <input type="radio"/> Female	<input type="radio"/> Yes <input type="radio"/> No
<input type="text"/>	<input type="text"/>	<input type="radio"/> Male <input type="radio"/> Female	<input type="radio"/> Yes <input type="radio"/> No

7.

2. Has anyone listed above received treatment for any disease, physical or mental condition in the past five years?

Yes No

3. Is this insurance intended to replace any existing insurance and/or annuity? Yes No

4. If “Yes” was checked for 1, 2 or 3 above, explain here:

5. Are there any children under the age of 19 and unmarried not listed above? Yes No

If “Yes” list name:

Birth Date (MMDDYYYY)

Reason for exclusion

Section K Notes

(Include details to any “Yes” answers for any additional replacement information.)

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5.

Page 12 of 16

6.

A (5/10) ●



Review Disclosures and Notices in Sections L, M, N and O.

Section L Credit or Charge Card Billing

(Not available for initial premium payment. Available with term and disability income insurance products only.)

- By signing for card billing, you authorize RiverSource Life Insurance Company to bill your card account for the insurance premiums and frequency indicated in Sections G1, G2, G3 and G4a and you understand that payments will be automatically billed to your card account.
- You understand that RiverSource Life Insurance Company may receive updated card account information from your card company.
- You understand you may discontinue this payment at any time. The arrangement will remain in effect until you notify RiverSource Life Insurance Company in writing to cancel it, allowing reasonable time to act on your cancellation. Any such notification shall be effective only with respect to entries initiated after receipt of and reasonable time to act upon such notification, usually 15 days.
- RiverSource Life Insurance Company reserves the right to terminate this agreement at any time upon 30 days written notification.

Section M Consent for Delivery of Initial Prospectuses on CD-ROM

I understand that I have the right to receive the prospectuses in paper format, which has been offered to me.

- I have access to and understand how to use the hardware and software that are necessary to view the prospectuses (see CD label for operating requirements).
- I understand that, in order to retain paper copies of the prospectuses, I must either:
 - A. Print the prospectuses found on the CD, incurring any printing costs myself; or
 - B. Request the prospectuses in paper form free of charge by calling Customer Service toll-free at 1 (800) 333-3437.
- I understand that all future prospectus updates and supplements will be provided to me in paper form unless I sign up for online document delivery on the My Financial Accounts website at Ameriprise.com.

Section N Universal Life/Variable Universal Life/Succession Protector/Succession Select products

If you have applied for the type of insurance, you understand and acknowledge that (1) a projection of future death benefits and policy values will be provided upon written request; (2) surrender charges may apply in certain circumstances; (3) no-lapse guarantee or death benefit guarantee features as applicable to the type of insurance applied for have been adequately described to you and may involve premium in excess of your scheduled premium; and (4) interest at rates in excess of the guaranteed interest rate will accrue on any policy value/fixed account value at rates determined by the company and at the company's discretion. These rates will be based on various factors including, but not limited to, the interest rate environment, returns earned on investments backing these policies, the rates currently in effect for new and existing company policies, product design, competition, and the company's revenues and expenses.

**Section O State Fraud Notices****14.** For Applicants in **Arkansas, Louisiana and Rhode Island** only:

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

For Applicants in **Colorado** only:

It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policy holder or claimant for the purpose of defrauding or attempting to defraud the policy holder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance with the Department of Regulatory Agencies.

For Applicants in **District of Columbia** only:

WARNING: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits, if false information materially related to a claim was provided by the applicant.

For Applicants in **Kentucky** only:

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act which is a crime.

For Applicants in **New Mexico** only:

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

For Applicants in **Ohio** only:

Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

For Applicants in **Oklahoma** only:

WARNING: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes a claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

For Applicants in **Tennessee** and **Washington** only:

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

For Applicants in **Texas** only:

Any person who, with intent to defraud or knowing that he/she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement, commits insurance fraud, which is a crime and subjects the person to civil and criminal penalties.

Life and Disability Income Insurance Application

Agreement and Signature

Agreement: By signing this application, you acknowledge that you understand and agree with all of the following terms and conditions.

Identification and Verification: We are required by law to obtain certain personal information from you that will be used by us to verify your identity. If you do not provide us with the information, we may not be able to issue you a policy or rider. If we are unable to verify your identity, we reserve the right to withdraw your application, rescind your policy and/or rider or take such other steps as we deem reasonable.

Conditional Insurance Coverage Prior to Policy Delivery: You agree that an Insured for life or disability insurance will be covered prior to policy delivery only when all of the following requirements have been met:

- The owner has paid the full first premium, according to the frequency of modal premium payment selected, for all insurance applied for in this application (any check or draft for that payment must be honored by the bank); and
- The premium has not been returned by the company; and
- The Insured has submitted all medical and other information required by the company's written underwriting rules; and
- The Insured is insurable on the Effective Date, as defined below, under the company's written underwriting rules, for the plan of insurance and amount of insurance at the premium rate applied for with no modification. "Effective Date" as used herein means the later of: (a) the date of this application; or (b) the date of completion of the company's paramedical/medical examinations, the company's medical information gathering interview; and any other information as required by the company's written underwriting rules.

In cases where the Insured is not insurable for the plan of insurance, amount of insurance, or at the premium rate applied for, coverage begins if and when the company insures that person under a policy accepted by the owner in writing and any additional premium has been paid.

For disability coverage, all disability policies specified to be discontinued in this application must also be discontinued before coverage will begin; (this limitation is subject to the incontestability provision in the policy.)

Amount of Life Insurance Coverage: If coverage begins prior to delivery of the policy under the conditions described above and death of an Insured occurs prior to delivery of the policy, the amount of life insurance coverage on each Insured will be the total requested for that person by this application and any other applications for life insurance on the Insured being considered by the company, up to a maximum of \$500,000. Except as limited by this agreement, any coverage provided will be under the terms of the policy or rider applied for.

Amount of Disability Insurance Coverage: If conditional coverage begins prior to delivery of the policy under the conditions described above and a disability of the insured begins prior to delivery of the policy, the disability coverage monthly benefit on the Insured will be the lesser of (1) \$3,500 of monthly benefit, (2) the monthly benefit applied for in this application, or (3) the maximum monthly benefit based on the company's written underwriting rules. Coverage on the Insured for this monthly benefit will be provided under the terms of the policy or rider until the first of the following to occur: (1) benefits paid and payable total \$500,000 or (2) the Insured is no longer eligible for benefits under the terms of the policy or rider because the Insured is no longer disabled or the maximum benefit period has been reached. When the first of (1) or (2) occur, all benefits will cease and coverage under this agreement and the policy will cease.

Company's Responsibilities: You understand that:

Only the officers of the company have the authority to decide on insurability and risk classification and to bind the company to insure a proposed Insured. The officers of the company are the President, Vice President, Secretary and Assistant Secretary;

If a policy does not go into effect, the company's sole liability will be to refund any premium paid, plus interest if required by law;

No change in or waiver of anything in this application or alteration of an insurance policy or rider is binding unless it is in writing and signed by an officer of the company; and

By accepting a policy, the owner ratifies any changes to this application entered at any time on the Home Office Endorsement form attached to the policy (*not applicable in Maryland, Missouri, New Hampshire, New Jersey, Pennsylvania and West Virginia*). However, the owner must sign a separate written document for any change in type of plan, amount, benefits or Insured's risk classification.

Any insurance provided by this agreement will be subject to the conditions and terms of the policy applied for.

Qualified Plans Only: You certify that the Owner is qualified under Section 401(a) of the United States Internal Revenue Code. This policy or rider will be issued based on representations by you that the Plan is qualified.

Adequate Information: You have received the RiverSource Life Insurance Company (RiverSource Life) Insurance Products Disclosure. You understand and agree that the company will use and release information about you as described in the attached RiverSource Life Insurance Products Disclosure. You may inform us not to use information for certain marketing purposes described in the RiverSource Life Insurance Products Disclosure.

Voice Signature: The medical portion of your application will be completed via telephone interview. At the end of the interview you will have the opportunity to provide your verbal consent to sign the medical portion of your application using an electronic voice signature. Upon providing your electronic voice signature, the information gathered during the telephone interview will become part of your insurance application and will be subject to the terms of the Declaration section below. Your consent to sign the medical portion of your application using electronic voice signature may be withdrawn at any time during the telephone interview. If you withdraw your consent or choose not to utilize the electronic voice signature, we will contact you to obtain a written signature. You may obtain a non-electronic version of your telephone interview and voice signature by sending a signed written request containing your full name and date of birth to: RiverSource Life Insurance Company, 70100 Ameriprise Financial Center, Attention Insurance Underwriting, Minneapolis, MN 55474.

Declaration: You declare that all answers provided are true, accurate and complete; and you understand that all your answers will be a basis for our underwriting analysis for any policy and/or rider issued and that any untrue, inaccurate or incomplete information could result in the denial of any claims made and/or the rescission of any policy and/or rider issued. You also acknowledge that you have received a copy of this agreement and receipt for any premium paid with this application.

Authorization and Certification

By your signature below, the owner authorizes the Medical Information Bureau, employer, and consumer reporting agency having information about you and your minor children to give that information to RiverSource Life or its reinsurer. You understand that you have the right to request a personal interview if an investigative consumer report is obtained. You understand that RiverSource Life will use this information to determine eligibility for insurance and benefits. You agree that a photographic copy of this authorization will be as valid as the original, and that this authorization will be valid for 30 months from the date shown below (24 months in CT, KY, ND, NM, OK, WV and WY).

Social Security or Taxpayer Identification Number (TIN) Certification as required by Form W-9 of the Internal Revenue Service (IRS)

Under penalties of perjury, you certify that:

15.

1. The number shown on this form is your correct taxpayer identification number, and
2. You are not subject to backup withholding because: (a) you are exempt from backup withholding, or (b) you have not been notified by the IRS that you are subject to backup withholding as a result of a failure to report all interest or dividends, or (c) the IRS has notified you that you are no longer subject to backup withholding, and
3. You are a U.S. citizen or other U.S. person (defined below).

Definition of a U.S. Person. For federal tax purposes, you are considered a U.S. Person if you are:

- An individual who is a U.S. citizen or U.S. resident alien,
- A partnership, corporation, company, or association created or organized in the United States or under the law of the United States,
- An estate (other than a foreign estate), or
- A domestic trust (as defined in Regulations section 301.7701-7).

Form W-9 Instructions are available upon request or on irs.gov.

Certification Instructions — You must cross out item 2 above if you have been notified by the IRS that you are currently subject to backup withholding because you have failed to report all interest and dividends on your tax return.

The IRS does not require your consent to any provision of this document other than certifications required to avoid backup withholding.

You acknowledge that you or your authorized representative have received a copy of this agreement and signature section of the application.

Signatures (Insureds under age 15 need not sign.)

Insured's Name (Print) _____ Signed on Date (MMDDYYYY) _____ State _____

Insured's Signature (base plan)

Second Insured's Signature

9.

Owner's Signature (other than Insured)

Parent/Legal Guardian's Signature (for Insureds under age 15)

Receipt — All checks must be completed in full and be made payable to the company (not to the advisor).

Received from _____ the sum of \$ _____ . _____ with this application.

Advisor's Report

Is Insured related to advisor Yes No if yes, give relationship _____

You certify that you personally requested the information in this application and witnessed its signing and received any money that was paid. You also certify that you truly and accurately recorded on the application the information supplied by the applicant. You are not aware of anything detrimental to the risk that is not recorded in this application. You certify that, to the best of your knowledge and belief, the information provided in this application regarding replacement of existing insurance and annuities is true and accurate.

16.

Team ID _____ Advisor's Signature _____ 9. _____ Advisor Number _____

Comp % _____ Area Office Number _____ Phone Number _____ Ext. _____

Advisor's Name _____

Recommending Advisor Information Is this transaction based on a recommendation by an Ameriprise Financial Advisor? Yes No
If yes, provide the Recommending Advisor Name and ID below if different than Advisor listed above.

Advisor's Number _____ Name _____

It is assumed the Recommending Advisor and Advisor listed above are the same, if the Recommending Advisor is not identified.

Co-Advisor Information

Team ID _____ Advisor's Signature _____ 9. _____ Advisor Number _____

Comp % _____ Area Office Number _____ Phone Number _____ Ext. _____

Client Copy — Do Not Submit to Corporate Office

RiverSource Life Insurance Company, 70100 Ameriprise Financial Center, Minneapolis, MN 55474

Life and Disability Income Insurance Application

Agreement and Signature

Agreement: By signing this application, you acknowledge that you understand and agree with all of the following terms and conditions.

Identification and Verification: We are required by law to obtain certain personal information from you that will be used by us to verify your identity. If you do not provide us with the information, we may not be able to issue you a policy or rider. If we are unable to verify your identity, we reserve the right to withdraw your application, rescind your policy and/or rider or take such other steps as we deem reasonable.

Conditional Insurance Coverage Prior to Policy Delivery: You agree that an Insured for life or disability insurance will be covered prior to policy delivery only when all of the following requirements have been met:

- The owner has paid the full first premium, according to the frequency of modal premium payment selected, for all insurance applied for in this application (any check or draft for that payment must be honored by the bank); and
- The premium has not been returned by the company; and
- The Insured has submitted all medical and other information required by the company's written underwriting rules; and
- The Insured is insurable on the Effective Date, as defined below, under the company's written underwriting rules, for the plan of insurance and amount of insurance at the premium rate applied for with no modification. "Effective Date" as used herein means the later of: (a) the date of this application; or (b) the date of completion of the company's paramedical/medical examinations, the company's medical information gathering interview; and any other information as required by the company's written underwriting rules.

In cases where the Insured is not insurable for the plan of insurance, amount of insurance, or at the premium rate applied for, coverage begins if and when the company insures that person under a policy accepted by the owner in writing and any additional premium has been paid.

For disability coverage, all disability policies specified to be discontinued in this application must also be discontinued before coverage will begin; (this limitation is subject to the incontestability provision in the policy.)

Amount of Life Insurance Coverage: If coverage begins prior to delivery of the policy under the conditions described above and death of an Insured occurs prior to delivery of the policy, the amount of life insurance coverage on each Insured will be the total requested for that person by this application and any other applications for life insurance on the Insured being considered by the company, up to a maximum of \$500,000. Except as limited by this agreement, any coverage provided will be under the terms of the policy or rider applied for.

Amount of Disability Insurance Coverage: If conditional coverage begins prior to delivery of the policy under the conditions described above and a disability of the insured begins prior to delivery of the policy, the disability coverage monthly benefit on the Insured will be the lesser of (1) \$3,500 of monthly benefit, (2) the monthly benefit applied for in this application, or (3) the maximum monthly benefit based on the company's written underwriting rules. Coverage on the Insured for this monthly benefit will be provided under the terms of the policy or rider until the first of the following to occur: (1) benefits paid and payable total \$500,000 or (2) the Insured is no longer eligible for benefits under the terms of the policy or rider because the Insured is no longer disabled or the maximum benefit period has been reached. When the first of (1) or (2) occur, all benefits will cease and coverage under this agreement and the policy will cease.

Company's Responsibilities: You understand that:

Only the officers of the company have the authority to decide on insurability and risk classification and to bind the company to insure a proposed Insured. The officers of the company are the President, Vice President, Secretary and Assistant Secretary;

If a policy does not go into effect, the company's sole liability will be to refund any premium paid, plus interest if required by law;

No change in or waiver of anything in this application or alteration of an insurance policy or rider is binding unless it is in writing and signed by an officer of the company; and

By accepting a policy, the owner ratifies any changes to this application entered at any time on the Home Office Endorsement form attached to the policy (*not applicable in Maryland, Missouri, New Hampshire, New Jersey, Pennsylvania and West Virginia*). However, the owner must sign a separate written document for any change in type of plan, amount, benefits or Insured's risk classification.

Any insurance provided by this agreement will be subject to the conditions and terms of the policy applied for.

Qualified Plans Only: You certify that the Owner is qualified under Section 401(a) of the United States Internal Revenue Code. This policy or rider will be issued based on representations by you that the Plan is qualified.

Adequate Information: You have received the RiverSource Life Insurance Company (RiverSource Life) Insurance Products Disclosure. You understand and agree that the company will use and release information about you as described in the attached RiverSource Life Insurance Products Disclosure. You may inform us not to use information for certain marketing purposes described in the RiverSource Life Insurance Products Disclosure.

Voice Signature: The medical portion of your application will be completed via telephone interview. At the end of the interview you will have the opportunity to provide your verbal consent to sign the medical portion of your application using an electronic voice signature. Upon providing your electronic voice signature, the information gathered during the telephone interview will become part of your insurance application and will be subject to the terms of the Declaration section below. Your consent to sign the medical portion of your application using electronic voice signature may be withdrawn at any time during the telephone interview. If you withdraw your consent or choose not to utilize the electronic voice signature, we will contact you to obtain a written signature. You may obtain a non-electronic version of your telephone interview and voice signature by sending a signed written request containing your full name and date of birth to: RiverSource Life Insurance Company, 70100 Ameriprise Financial Center, Attention Insurance Underwriting, Minneapolis, MN 55474.

Declaration: You declare that all answers provided are true, accurate and complete; and you understand that all your answers will be a basis for our underwriting analysis for any policy and/or rider issued and that any untrue, inaccurate or incomplete information could result in the denial of any claims made and/or the rescission of any policy and/or rider issued. You also acknowledge that you have received a copy of this agreement and receipt for any premium paid with this application.



Authorization and Certification

By your signature below, the owner authorizes the Medical Information Bureau, employer, and consumer reporting agency having information about you and your minor children to give that information to RiverSource Life or its reinsurer. You understand that you have the right to request a personal interview if an investigative consumer report is obtained. You understand that RiverSource Life will use this information to determine eligibility for insurance and benefits. You agree that a photographic copy of this authorization will be as valid as the original, and that this authorization will be valid for 30 months from the date shown below (24 months in CT, KY, ND, NM, OK, WV and WY).

15.

Social Security or Taxpayer Identification Number (TIN) Certification as required by Form W-9 of the Internal Revenue Service (IRS) Under penalties of perjury, you certify that:

1. The number shown on this form is your correct taxpayer identification number, and
2. You are not subject to backup withholding because: (a) you are exempt from backup withholding, or (b) you have not been notified by the IRS that you are subject to backup withholding as a result of a failure to report all interest or dividends, or (c) the IRS has notified you that you are no longer subject to backup withholding, and
3. You are a U.S. citizen or other U.S. person (defined below).

Definition of a U.S. Person. For federal tax purposes, you are considered a U.S. Person if you are:

- An individual who is a U.S. citizen or U.S. resident alien,
- A partnership, corporation, company, or association created or organized in the United States or under the law of the United States,
- An estate (other than a foreign estate), or
- A domestic trust (as defined in Regulations section 301.7701-7).

Form W-9 Instructions are available upon request or on irs.gov.

Certification Instructions — You must cross out item 2 above if you have been notified by the IRS that you are currently subject to backup withholding because you have failed to report all interest and dividends on your tax return.

The IRS does not require your consent to any provision of this document other than certifications required to avoid backup withholding.

You acknowledge that you or your authorized representative have received a copy of this agreement and signature section of the application.

Signatures (Insureds under age 15 need not sign.)

Insured's Name (Print)	Signed on Date (MMDDYYYY)	State
<input type="text"/>	<input type="text"/>	<input type="text"/>

Insured's Signature (base plan)	Second Insured's Signature
<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>

9.

Owner's Signature (other than Insured)	Parent/Legal Guardian's Signature (for Insureds under age 15)
<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>

Receipt — All checks must be completed in full and be made payable to the company (not to the advisor).

Received from the sum of \$. with this application.

Advisor's Report

Is Insured related to advisor Yes No if yes, give relationship

You certify that you personally requested the information in this application and witnessed its signing and received any money that was paid. You also certify that you truly and accurately recorded on the application the information supplied by the applicant. You are not aware of anything detrimental to the risk that is not recorded in this application. You certify that, to the best of your knowledge and belief, the information provided in this application regarding replacement of existing insurance and annuities is true and accurate.

Team ID	Advisor's Signature	Advisor Number
<input type="text"/>	<input checked="" type="checkbox"/>	<input type="text"/>

Comp %	Area Office Number	Phone Number	Ext.
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

Advisor's Name

Recommending Advisor Information Is this transaction based on a recommendation by an Ameriprise Financial Advisor? Yes No
If yes, provide the Recommending Advisor Name and ID below if different than Advisor listed above.

Advisor's Number Name

It is assumed the Recommending Advisor and Advisor listed above are the same, if the Recommending Advisor is not identified.

Co-Advisor Information

Team ID	Advisor's Signature	Advisor Number
<input type="text"/>	<input checked="" type="checkbox"/>	<input type="text"/>

Comp %	Area Office Number	Phone Number	Ext.
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

Corporate Office Copy — Submit to Corporate Office

Insurance Application Supplement — Part II

Full Name Date of Birth (MMDDYYYY) Last Four Digits of SSN

Section A Primary Care Provider

1. Name and address of your personal physician or primary care provider? (If none, so state)

2. Date last consulted

3. Reason last consulted

4. What treatment was given or medication prescribed?

7.

Section B Height and Weight

1. What is your height (feet, inches)? 2. What is your weight (pounds)?

3. Have you had any change in weight of more than 10 pounds in the past year? Yes No (If yes, how much did you lose/gain and what was the cause?)

7.

Section C Medical Information

For any YES answers, provide diagnoses, treatments, medications, dates, durations, and names and addresses of medical professionals and medical facilities in Section E on Page 3.

1. Have you ever been advised of, treated for, tested for or diagnosed by a medical professional with:

- a. Disorder of the eyes, ears, nose or throat? Yes No
- b. Tumor, cancer or lymph node disorder? Yes No
- c. Stroke or TIA (transient ischemic attack), memory loss, Alzheimer's or other form of dementia? Yes No
- d. Seizures, epilepsy, fainting, dizziness, imbalance, falls or tremors? Yes No
- e. Parkinson's disease, muscular dystrophy, Huntington's disease, motor neuron disease, ALS (Lou Gehrig's disease) or multiple sclerosis? Yes No
- f. Ataxia, myasthenia gravis, post-polio syndrome, paralysis or numbness? Yes No
- g. Shortness of breath, persistent hoarseness or cough, asthma, emphysema, tuberculosis, sarcoidosis, or other disorder of the lung or breathing? Yes No
- h. Sleep apnea or sleep disorder? Yes No
- i. Chest pain, heart attack, coronary artery disease, congestive heart failure, cardiomyopathy, palpitation or heart rhythm disturbance, heart murmur, high blood pressure, or other disorder of the heart or heart valves? Yes No
- j. Peripheral vascular disease or disorder of the blood vessels? Yes No

4.

Continued...next page

**Section C Medical Information (continued)**

- k. Ulcer, colitis, diverticulitis, abdominal pain, recurrent indigestion, or other disorder of the intestines, stomach, esophagus, colon or pancreas? Yes No
- l. Liver disorder, cirrhosis or hepatitis? Yes No
- m. High blood sugar, diabetes or thyroid disorder? Yes No
- n. Sugar, protein or blood in urine; or any disorder of the kidney or bladder? Yes No
- o. Disorder of the prostate or reproductive organs? Yes No
- p. Complications with a current or prior pregnancy, or are you currently pregnant? (females only) Yes No
- q. Sciatica, neuropathy, arthritis, gout, lupus, or other disorder of the joints, connective tissue, spine, back or neck? Yes No
- r. Osteoporosis, fractures, fibromyalgia, unusual or chronic fatigue, or disorder of the bones or muscles? Yes No
- s. Skin disorder or allergies? Yes No
- t. Anemia, bleeding or clotting disorder, or other disorder of the blood or bone marrow? Yes No
- u. Anxiety, stress, depression or other mental health condition? Yes No
- v. Dysthymia? Yes No

2. Other than listed above, within the past five years have you:

- a. Had any mental or physical disorder? Yes No
- b. Had a checkup, consultation, illness, injury or surgery; or been a patient in a hospital, clinic or other medical facility? Yes No
- c. Had an electrocardiogram, treadmill stress test, thallium stress test, angiogram, heart catheterization or echocardiogram? Yes No
- d. Had an MRI, CT scan, X-ray, mammogram, ultrasound, biopsy or other diagnostic test? Yes No
- e. Been advised to have any diagnostic test, surgery, consultation or appointment with a doctor, medical practitioner or any other type of health care provider which has not been completed? Yes No

Section D Additional Medical and Underwriting Information**Provide the requested details in Section E on Page 3.**

1. Are you currently using any prescription medication not already listed? (If yes, provide medication, dosage and reason prescribed) Yes No
2. In the past five years, have you used tobacco or nicotine in any form? (If yes, what is/was used, amount and date last used) Yes No
3. Do you currently consume alcohol? (If yes, provide amount and frequency) Yes No
4. Have you ever been treated for or been advised to be treated for alcohol dependency, addiction or abuse? (If yes, provide treatment details and dates) Yes No
5. Have you ever used marijuana, cocaine, heroin or amphetamines; or other narcotics, stimulants, sedatives, hallucinogens or prescription drugs not prescribed to you by a physician? (If yes, provide details and date last used) Yes No
6. Have you ever been treated for or been advised to be treated for drug dependency, addiction or abuse? (If yes, what drug or substance and treatment details and dates) Yes No
7. Have you ever been diagnosed or received treatment by a health care provider for AIDS (Acquired Immune Deficiency Syndrome) or ARC (AIDS-Related Complex) or have you ever had a positive HIV (Human Immunodeficiency Virus) test? (If yes, date of last consultation, test or treatment) Yes No
8. Is there any family history of cancer, diabetes, heart, kidney or neurologic disease? (If yes, provide disorder, relationship and age at diagnosis) Yes No

Continued...next page



Section D Additional Medical and Underwriting Information (continued)

Provide the requested details in Section E on Page 3.

- 9. During the past five years have you flown, or do you contemplate flying as a pilot, student pilot or crew member? (If yes, indicate date of last participation) Yes No
- 10. During the past five years have you participated in or do you contemplate participating in motorcycle riding, racing (automobile, snowmobile, motorcycle or boat), skin/scuba diving, skydiving, hang-gliding or other similar activities? (If yes, indicate activity and date of last participation) Yes No
- 11. During the past five years have you had your driver's license revoked or suspended, received a moving violation or been cited for a DUI (driving under the influence) or DWI (driving while intoxicated)? (If yes, provide type of violation or citation and when received) Yes No
- 12. Are you a citizen of the United States? (If no, of what country are you a citizen?) Yes No
- 13. Do you have any current plans to travel outside of the United States? (If yes, provide where, when and duration of travel) Yes No
- 14. Have you ever had an application for insurance declined, postponed or modified in any way? (If yes, provide date, company name and reason) Yes No
- 15. Have you ever requested or received a pension, benefits, or payment because of an injury, sickness or disability? (If yes, provide dates and reason) Yes No

Section E DETAILS — Provide Details as Requested Above

7.

Continued...next page

5.

6.

A (05/10) ●

2.



DOC0404133081

Section E DETAILS — DETAILS — Provide Details as Requested Above (continued)

An additional sheet of paper may be attached if necessary.

7.

I declare that all the answers provided are true, accurate and complete; and I understand that all of my answers will be a basis for the company's underwriting analysis for any policy and/or rider issued and that any untrue, inaccurate or incomplete information could result in the denial of any claims made and/or the rescission of any policy and/or rider issued.

9.

Signature of Proposed Insured (Parent/Legal Guardian for Insured under age 18)

Interview Date

X

133081

5.

6.

A (05/10) ●

RiverSource Life Insurance Company 70100 Ameriprise Financial Center Minneapolis, MN 55474



16. AdvanceSourceSM Accelerated Benefit Rider Application



3. ⓘ This rider is not available for policies with Death Benefit Option 2

Client ID

Part 1 Accelerated Benefit Insured (Insured) and Owner Information

1. Insured: Is Insured the Owner? Yes No Owner if other than Insured:
Insured's Name:

Part 2 Rider Specified Amount and Monthly Benefit Percent

Rider Specified Amount: \$
Monthly Benefit Percent: 1% 2% 3% If nothing chosen, it will be 1%.

Part 3 Protection Against Unintended Lapse or Termination

I, the owner, understand that I have the right to designate at least one person other than myself to receive written notice of lapse or termination of the policy while this rider is attached. I understand that such notice will not be sent until 30 days after the rider charge is due and unpaid.
 1. I elect (complete information below)
 2. I DO NOT elect to designate a person to receive such notice If nothing chosen, it will be election 2.
Name
Home Address:
City State ZIP code

Part 4 Insurance Coverage Information (Insured)

1. Are you covered by Medicaid? Yes No
2. Do you currently have, or have you had during the last twelve months, another long-term care, accident, sickness, health or medical insurance policy or certificate in force (including a health care service contract or health maintenance organization contract)? Yes No
3. Do you intend to replace any of your long-term care, accident, sickness, health or medical coverage with the coverage applied for? Yes No
4. Do you have any other life insurance policies or annuity contracts currently in force that provide similar long-term care coverage? Yes No
5. Have you ever been denied coverage for a long-term care rider or policy? If yes, provide details: Yes No
7.

Details for "YES" answers to insurance coverage information (Questions 2-4)

Company	Policy/Certificate No.	Type and Amount	Currently in force? If no, provide date of lapse	Being Replaced?
			<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No
			<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No
			<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No
			<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No

3. Sign on page 3

4. © 2010 RiverSource Life Insurance Company. All rights reserved.



Part 6 Agreement & Acknowledgement

16.

I agree as follows: I, the owner, am applying for an acceleration of life insurance death benefits under the AdvanceSource Accelerated Benefit rider that will become part of the life insurance policy. I, the owner, understand that this application will form part of the basis of coverage under the policy and that coverage for this rider will take effect on the Date shown under Policy Data. I understand that this rider covers only the Accelerated Benefit Insured who is the base insured person named in the policy. The statements and answers in this application from the Accelerated Benefit Insured and the owner are true and complete to the best of my(our) knowledge and belief.

Caution: If any answers from the Accelerated Benefit Insured or the owner on this application are incorrect or untrue, RiverSource Life Insurance Company has the right to deny benefits or rescind your rider.

17.

Acknowledgement: I have received and reviewed the rider Outline of Coverage, the life insurance illustration along with the rider supplemental report and the Long-Term Care Insurance Potential Rate Increase Disclosure. I have also received and reviewed the following forms (if required by law in the state in which this rider is delivered): Replacement Notice and Shopper's Guide to Long-Term Care Insurance.

Disclosure: The receipt of Accelerated Benefits may or may not be taxable. You should consult your tax advisor as to the taxation of any Accelerated Benefits.

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance may be subject to state fraud penalties. Refer to the life insurance application for your state's specific fraud disclosure, if applicable.

I acknowledge that this rider has a pre-existing condition limitation. No coverage will be provided for illness, injury, or other pre-existing condition until 6 months after this rider has become effective.

9.

Insured's Signature

Insured's Name (Print)

X

Owner's Signature (if other than Insured)

Date (MMDDYYYY)

X

Advisor's Report

15.

List all long-term care, accident, sickness, health or medical insurance policies that you have sold to the applicant:

In force:

Sold in the past five years that are no longer in force:

Company	Policy/Certificate No.	Type and Amount	Company	Policy/Certificate No.	Type and Amount

You certify that you personally requested the information in this application and witnessed its signing and received any money that was paid. You also certify that you truly and accurately recorded on the application the information supplied by the applicant. You are not aware of anything detrimental to the risk that is not recorded in this application. To the best of your knowledge and belief, the information provided in this application regarding replacement of existing insurance is true and accurate.

Advisor's Signature

Advisor Number

X

9.

<i>SERFF Tracking Number:</i>	<i>AEMN-126410384</i>	<i>State:</i>	<i>Arkansas</i>
<i>Filing Company:</i>	<i>RiverSource Life Insurance Company</i>	<i>State Tracking Number:</i>	<i>44823</i>
<i>Company Tracking Number:</i>	<i>134851AR</i>		
<i>TOI:</i>	<i>L061 Individual Life - Variable</i>	<i>Sub-TOI:</i>	<i>L061.002 Single Life - Flexible Premium</i>
<i>Product Name:</i>	<i>Life Insurance</i>		
<i>Project Name/Number:</i>	<i>Life/DI 2010 Application/134851</i>		

Supporting Document Schedules

	Item Status:	Status Date:
<p>Satisfied - Item: Flesch Certification</p> <p>Comments: The application forms are exempt from state and NAIC Readability requirements because they are used with variable life policies subject to SEC jurisdiction.</p> <p>Attachments: AR CH 19 CERT 134851.pdf AR GTY NOTICE.pdf ARNOTIC2.pdf</p>		
<p>Satisfied - Item: Application</p> <p>Comments: The submitted forms are applications and are attached in the Form Schedule.</p>		
<p>Satisfied - Item: Forms List</p> <p>Comments: Policies to which the application forms will be attached is on the attached Forms List.</p> <p>Attachment: AR Forms List.pdf</p>		
<p>Satisfied - Item: Statement of Variability</p> <p>Comments: The attached Statement of Variability provides specific detail regarding items bracketed as variable.</p> <p>Attachment: Statement of Variability 134851, 133081, 132263.pdf</p>		

STATE OF ARKANSAS
Life and Disability Income Application
CERTIFICATION OF COMPLIANCE

Forms: **134851 Life and Disability Income Application Form**
 133081 Insurance Application Supplement - Part Two
 132263 AdvanceSource Accelerated Benefit Rider Application

We certify that the above forms being submitted meet the provisions of Rules 19 of the Arkansas Insurance Department Rules and Regulations as well as all applicable requirements of the Department.

I, Jack R. Kispert, Assistant Secretary of RiverSource Life Insurance Company, further certify that I am familiar with the applicable laws, rules and regulations of the State of Arkansas, and that to the best of my knowledge, information and belief, all forms submitted with this letter are in compliance in all respects with the provisions of the Insurance Laws, Rules and Regulations of the State of Arkansas.



RiverSource Life Insurance Company
Jack R. Kispert, Assistant Secretary

Date: January 25, 2010

Limitations and Exclusions under the Arkansas Life and Disability Insurance Guaranty Association Act

Residents of this state who purchase life insurance, annuities, or health and accident insurance should know that the insurance companies licensed in this state to write these types of insurance are members of the Arkansas Life and Health Insurance Guaranty Association ("Guaranty Association"). The purpose of the Guaranty Association is to assure that policy and contract owners will be protected within certain limits, in the unlikely event that a member insurer becomes financially unable to meet its obligations. If this should happen, the Guaranty Association will assess its other member insurance companies for the money to pay the claims of policy owners who live in this state, and, in some cases, to keep coverage in force. The valuable extra protection provided by the member insurers through the Guaranty Association is not unlimited, however. And, as noted in the box below, this protection is not a substitute for consumers' care in selecting insurance companies that are well managed and financially stable.

DISCLAIMER

The Arkansas Life and Health Insurance Guaranty Association ("Guaranty Association") may not provide coverage for this policy. If coverage is provided, it may be subject to substantial limitations or exclusions and require continued residency in this state. You should not rely on coverage by the Guaranty Association in purchasing an insurance policy or contract.

Coverage is NOT provided for your policy or contract or any portion of it that is not guaranteed by the insurer or for which you have assumed the risk, such as non-guaranteed amounts held in a separate account under a variable life or variable annuity contract.

Insurance companies or their agents are required by law to provide you with this notice. However, insurance companies and their agents are prohibited by law from using the existence of the Guaranty Association to induce you to purchase any kind of insurance policy.

The Arkansas Life and Health Insurance Guaranty Association
c/o The Liquidation Division
1023 West Capitol
Little Rock, Arkansas 72201

Arkansas Insurance Department
1200 West Third Street
Little Rock, Arkansas 72201-1904

The state law that provides for this safety-net is called the Arkansas Life and Health Insurance Guaranty Association Act ("Act"). Below is a brief summary of the Act's coverages, exclusions and limits. This summary does not cover all provisions of the Act; nor does it in any way change anyone's rights or obligations under the Act or the rights or obligations of the Guaranty Association.

COVERAGE

Generally, individuals will be protected by the Guaranty Association if they live in this state and hold a life, annuity or health insurance contract or policy, or if they are insured under a group insurance contract issued by a member insurer. The beneficiaries, payees or assignees of policy or contract owners are protected as well, even if they live in another state.

EXCLUSIONS FROM COVERAGE

However, persons owning such policies are NOT protected by the Guaranty Association if:

- They are eligible for protection under the laws of another state (this may occur when the insolvent insurer was incorporated in another state whose guaranty association protects insureds who live outside that state);
- The insurer was not authorized to do business in this state;
- Their policy or contract was issued by a nonprofit hospital or medical service organization, an HMO, a fraternal benefit society, a mandatory state pooling plan, a mutual assessment company or similar plan in which the policy or contract owner is subject to future assessments, or by an insurance exchange.

The Guaranty Association also does NOT provide coverage for:

- Any policy or contract or portion thereof which is not guaranteed by the insurer or for which the owner has assumed the risk, such as non-guaranteed amounts held in a separate account under a variable life or variable annuity contract;
- Any policy of reinsurance (unless an assumption certificate was issued);
- Interest rate yields that exceed an average rate;
- Dividends and voting rights and experience rating credits;
- Credits given in connection with the administration of a policy by a group contract holder;
- Employers' plans to the extent they are self-funded (that is, not insured by an insurance company, even if an insurance company administers them);
- Unallocated annuity contracts (which give rights to group contractholders, not individuals);
- Unallocated annuity contracts issued to/in connection with benefit plans protected under Federal Pension Benefit Corporation ("FPBC")(whether the FPBC is yet liable or not);
- Portions of an unallocated annuity contract not owned by a benefit plan or a government lottery (unless the owner is a resident) or issued to a collective investment trust or similar pooled fund offered by a bank or other financial institution);
- Portions of a policy or contract to the extent assessments required by law for the Guaranty Association are preempted by State or Federal law;
- Obligations that do not arise under the policy or contract, including claims based on marketing materials or side letters, riders, or other documents which do not meet filing requirements, or claims for policy misrepresentations, or extra-contractual or penalty claims;
- Contractual agreements establishing the member insurer's obligations to provide book value accounting guarantees for defined contribution benefit plan participants (by reference to a portfolio of assets owned by a nonaffiliate benefit plan or its trustees).

LIMITS ON AMOUNT OF COVERAGE

The Act also limits the amount the Guaranty Association is obligated to cover: The Guaranty Association cannot pay more than what the insurance company would owe under a policy or contract. Also, for any one insured life, the Guaranty Association will pay a maximum of \$300,000 - no matter how many policies and contracts there were with the same company, even if they provided different types of coverages. Within this overall \$300,000 limit, the Association will not pay more than \$300,000 in health insurance benefits, \$300,000 in present value of annuity benefits, or \$300,000 in life insurance death benefits or net cash surrender values - again, no matter how many policies and contracts there were with the same company, and no matter how many different types of coverages. There is a \$1,000,000 limit with respect to any contract holder for unallocated annuity benefits, irrespective of the number of contracts held by the contract holder. These are limitations for which the Guaranty Association is obligated before taking into account either its subrogation and assignment rights or the extent to which those benefits could be provided out of the assets of the impaired or insolvent insurer.

RiverSource Life Insurance Company
70100 Ameriprise Financial Center
Minneapolis, MN 55474

John Doe
XXXX-XXXXXXXX

Questions Regarding Your Policy?

If you have questions regarding your policy, you may contact the following:

RiverSource Life Insurance Company
Policyowner Service Department
70100 Ameriprise Financial Center
Minneapolis, MN 55474

Tele: 1-800-862-7919 (Hours are 7 am - 8 pm Central Standard time)

Representative Name: John Smith

Representative Address: Ameriprise Financial Services
1234 Main Street
Little Rock, AR 72204

If we at RiverSource Life Insurance Company fail to provide you with reasonable and adequate service, you should feel free to contact:

Arkansas Insurance Department
Consumer Services Division
1200 West Third Street
Little Rock, AR 72201-1904

Tele: 1-800-852-5494

Forms List - Previously Approved Base Policies - State of Arkansas

Individual Life-DI Application 134851 and Insurance Application Supplement 133081 will be issued with all of the previously approved policy forms listed below.

AdvanceSourceSM ABR Application 132263 will only be included with those policies issued with an approved ABR Rider Form 132172.

The following base policies will use all 3 new application forms - 134851, 133081 and 132263:

Description	Form Number	Status	Approval Date	State/SERFF File #
Life Insurance Policy Forms				
Variable Universal Life (VUL) ABR Rider	30061-AR 132172-AR	approved Approved	06/16/1998 04/17/2009	42104
Foundations universal life (FUL) ABR Rider	30080C 132172-AR	approved Approved	10/08/2002 04/17/2009	42104
Foundations Protector universal life (FP) ABR Rider	133078-AR 132172-AR	approved Approved	12/15/2005 04/17/2009	42104

The following base policies will use these 2 new application forms - 134851 and 133081:

Description	Form Number	Status	Approval Date	State/SERFF File #
Life Insurance Policy Forms				
Succession Select Survivorship Life	30090C	approved	02/20/2001	
Succession Protector Survivorship Life	134581-AR	approved	09/27/2006	33766
Term Insurance - 10 Year	30480A-AR	approved	09/02/2003	
Term Insurance - 15 & 20 Year	30470A-AR	approved	09/02/2003	
Disability Income Insurance				
Disability Income Insurance IPP 2	30200G	Approved	06/25/2007	36199
Disability Income Insurance IPP 5	30203G	Approved	06/26/2007	36204
Disability Income Insurance IP Plus	30205G	Approved	06/26/2007	36205
Disability Income Insurance IP Tr	30207G	Approved	06/26/2007	36203
Disability Income Insurance IP Mod	30208G	Approved	06/26/2007	36201
Disability Income Insurance BOE	30209C	Approved	07/11/1994	

RiverSource Life Insurance Company Statement of Variability

Form 134851 - Base Application
Form 133081 - Application Supplement
Form 132263 - Rider Application

Brackets have been placed around various items in the forms in order to indicate that they are variable and subject to change by us as explained below.

- Formatting may change due to future changes in typestyle and/or electronic generation of the forms. However, any adaptation we make will not involve changes to text without any necessary prior approval and will always meet or exceed the requirements of your state.
- We reserve the right to correct typographical errors.

All Forms

1. **RiverSource Life Address, Service Phone.** Will insert the current home office address and service telephone number for RiverSource Life.
2. **Bar Code and identifier number.** The spacing, typestyle and ink color appearance may change. Or use of the bar code may be discontinued as an identifier.
3. **Instructional symbols and text notes.** These are instructional symbols on the form. The company may change the symbols at some point in time. The text is bracketed for future instruction clarification needs to assist both advisors and applicants in completing the application.
4. **Copyright statement.** Bracketed in case copyright year changes with future application updates of variable items.
5. **Page numbers.** If due to changing or expanding lines of text to allow more or less room, the page numbers may be adjusted.
6. **Version letter/print date.** Will be changed if any future changes are made to items bracketed as variable. The range will be A - Z except never "B, I, O, Q, or S." The date range will also use 1-12 for the months and the last two numbers of a year, from 2010 to future years.
7. **Lines of text** throughout. If more or less text lines are needed, we may adjust the number of text lines in these sections.
8. **Service form names or numbers** referenced throughout. If the form number or name changes for any referenced service form.
9. **Signature marker.** The symbol and bold line used to denote that a signature is required is slightly different between the three forms dependent on the system used to produce the form. In the event the symbol is unified to one look, we may change the look of the symbol.

Form 134851 - Life and Disability Income Insurance Application

See items 1 - 8 listed under All Forms.

10. Section G1 - 1. **Life Insurance Plan.**
Section G2 - 1. **Life Insurance Plan Information.**
Section G3 - 1. **Term Insurance.**
These are bracketed in case the product names are changed, if additional products are available or discontinued in the future. Any new products would be filed with your department, if required, for prior approval.
11. Section G1 - 2. **Riders/Options.**
Section G2 - 2. **Riders.**
Section G3 - 2. **Riders.**
Section G4a - 2. **Disability Income Insurance Riders.**
These are bracketed in the event the product or rider names are changed, increase percentage option is changed or added, if riders are not offered for new issues of the policy or if additional products are available or discontinued in the future. Any new products or riders would be filed with your department, if required, for prior approval.
12. Sections G1 - 6 and N. **Consent for Delivery of Initial Prospectuses on CD-ROM.** This is bracketed for three reasons: 1) The Company decides to no longer offer this service, this provision will be removed; 2) bracketed also in the event that this language is removed and placed into a separate acknowledgement form for applicants to sign; and 3) bracketed to allow for text change within this provision to clarify or add additional language relating to consenting to receiving a CD ROM.
13. Section G4a - 1. **Disability Income Insurance Plan - Disability Provision.** Bracketed in case the Occupation Classes need to be revised and/or in case the product names are changed, if additional products are available or discontinued in the future. Any new products would be filed with your department, if required, for prior approval.

14. Section M. **State Fraud notices.** Bracketed in case additional state fraud warnings are added or if existing fraud notices are no longer required or are revised.
15. **TIN Certification.** For possible changes to Federal TIN certification required language.
16. **Advisor's Report.** This section is attached to the application for convenience to the agent and is not subject to review and approval. The information may change as needed to identify the selling agent, pay compensation, verify replacement of coverage, add notes from the agent, etc.

Form 133081 - Insurance Application Supplement - Part II

See items 1 - 8 listed under All Forms.

Form 132263 - AdvanceSourcesm Accelerated Benefit Rider Application

See items 1 - 8 listed under All Forms.

15. **Advisor's Report.** This section is attached to the application for convenience to the agent and is not subject to review and approval. The information may change as needed to identify the selling agent, pay compensation, verify replacement of coverage, add notes from the agent, etc.
16. **Name of Rider.** Will insert the marketing name of rider and if the marketing name changes, will update this section. This includes any text where the marketing name is used.
17. Part 6 - **Acknowledgement.** This is bracketed in the event other documents are created or discontinued, or the names of these documents change.