

SERFF Tracking Number: NAWS-126543268 State: Arkansas
Filing Company: National Western Life Insurance Company State Tracking Number: 45249
Company Tracking Number: 01-9063-10
TOI: L09I Individual Life - Flexible Premium Sub-TOI: L09I.001 Single Life
Adjustable Life
Product Name: Application for Individual Life Insurance
Project Name/Number: Application for Individual Life Insurance/01-9063-10

Filing at a Glance

Company: National Western Life Insurance Company

Product Name: Application for Individual Life Insurance SERFF Tr Num: NAWS-126543268 State: Arkansas

TOI: L09I Individual Life - Flexible Premium SERFF Status: Closed-Approved- State Tr Num: 45249
Adjustable Life Closed

Sub-TOI: L09I.001 Single Life Co Tr Num: 01-9063-10 State Status: Approved-Closed
Filing Type: Form Reviewer(s): Linda Bird

Author: Stephanie Foskitt Disposition Date: 03/25/2010

Date Submitted: 03/24/2010 Disposition Status: Approved-Closed

Implementation Date Requested: On Approval

Implementation Date:

State Filing Description:

General Information

Project Name: Application for Individual Life Insurance

Project Number: 01-9063-10

Requested Filing Mode: Review & Approval

Explanation for Combination/Other:

Submission Type: New Submission

Overall Rate Impact:

Filing Status Changed: 03/25/2010

Deemer Date:

Submitted By: Stephanie Foskitt

Filing Description:

Arkansas Department of Insurance

Life and Health Compliance

1200 West Third Street

Little Rock, Arkansas 72201-1904

Status of Filing in Domicile: Authorized

Date Approved in Domicile:

Domicile Status Comments: This form is deemed exempt by our state of domicile, Colorado, under Bulletin B-4.1.

Market Type: Individual

Group Market Size:

Group Market Type:

Explanation for Other Group Market Type:

State Status Changed: 03/25/2010

Created By: Stephanie Foskitt

Corresponding Filing Tracking Number:

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Project Name/Number: Application for Individual Life Insurance/01-9063-10

Re: Application for Individual Life Insurance, 01-9063-10
National Western Life Insurance Company, NAIC 66850, FEIN 84-0467208

To Whom It May Concern:

Please find attached the above captioned form submitted to your state for formal approval. This form will not replace any previously approved forms. This form is deemed exempt by our state of domicile, Colorado, under Bulletin B-4.1. This filing contains no unusual or possibly controversial items from normal industry standards.

Form 01-9063-10, Application for Individual Life Insurance, will be used to issue previously approved flexible premium life insurance product, 01-1143-07 approved for use in Arkansas on June 6, 2007 as SERFF filing number NAWS-125173610. We may also use this application to issue other life insurance products as developed and submitted for approval in the future.

Thank you for your time and consideration in this matter. If you have any questions or need more information, please feel free to contact me by email at SFoskitt@NationalWesternLife.com or by phone at 512-719-1563.

Sincerely,
Stephanie Foskitt
Contract Compliance Analyst

We reserve the right to change the format of this form without changing any of the language. Printing standards will never be less than those required by your state.

Company and Contact

Filing Contact Information

Stephanie Foskitt, Contract Compliance Analyst SFoskitt@NationalWesternLife.com
National Western Life Insurance Company 512-719-1563 [Phone]
850 East Anderson Lane 512-719-8522 [FAX]
Austin, TX 78752

Filing Company Information

National Western Life Insurance Company CoCode: 66850 State of Domicile: Colorado
850 East Anderson Lane Group Code: -99 Company Type:
Austin, TX 78752-1602 Group Name: State ID Number:
(512) 836-1010 ext. [Phone] FEIN Number: 84-0467208

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Filing Fees

Fee Required? Yes
Fee Amount: \$50.00
Retaliatory? No
Fee Explanation: \$50 per application x 1 application = \$50 total
Per Company: No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
National Western Life Insurance Company	\$50.00	03/24/2010	35119302

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Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Linda Bird	03/25/2010	03/25/2010

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Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification		Yes
Supporting Document	Application		No
Supporting Document	Health - Actuarial Justification		No
Supporting Document	Outline of Coverage		No
Supporting Document	Cover Letter		Yes
Form	Application for Individual Life Insurance		Yes

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Form Schedule

Lead Form Number: 01-9063-10

Schedule Item Status	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
	01-9063-10	Application/ Enrollment Form	Application for Individual Life Insurance	Initial		53.000	01-9063-10.pdf

I. PRIMARY INSURED (Please Print Clearly Using Black Ink)

Name of Proposed Insured (First, Middle, Last) _____ Date of Birth (mm/dd/yyyy) _____ Age _____ Place of Birth (State and Country) _____
 Male Female Marital Status Married Single Widowed Divorced Tobacco Use Tobacco Free

Home Address (number and street) _____ City _____ State _____ Zip _____
 Social Security Number or Tax ID _____ Drivers License Number and State _____ Home Phone Number _____
 Best time and place to call
 Home AM PM
 Work AM PM

Citizenship U.S. Citizen Foreign National
 If Non US Citizen: Type of Visa _____ Exp date _____ Country of Citizenship _____

Current Employer _____ Occupation and Duties _____ Work Phone Number _____
 Employer Address (number and street) _____ City _____ State _____ Zip _____

II. COVERAGE APPLIED FOR

Plan of Insurance (Name of Product) _____ Face Amount \$ _____
 Riders: Accelerated Benefit Rider (Not available in all states)

III. PREMIUMS

Single Premium \$ _____
 Modal Premium: 5 pay \$ _____ to be paid: Annual Semi-annual Quarterly Monthly
 10 pay
 Method: Direct Billing Bank Draft Other _____
 Amount collected with application: \$ _____
 Source of Premium: Salary Savings Investments 1035 Exchange Loan (premium financing) Other (specify) _____

IV. OWNERSHIP INFORMATION (Complete only if Owner is other than the Proposed Insured)

Owner / Applicant / Trust Name _____ Date of Birth (mm/dd/yyyy) _____ SSN / TIN _____
 Phone Number _____ Relationship to Proposed Insured _____
 Address (number and street) _____ City _____ State _____ Zip Code _____
 If the owner is a trust, please submit the Trust Information Form.

V. BENEFICIARY INFORMATION (If percentages are not given, the shares will be divided equally)

Primary Beneficiaries		
Full Name	Relationship	% Share
1. _____	_____	_____
2. _____	_____	_____
3. _____	_____	_____
Contingent Beneficiaries		
Full Name	Relationship	% Share
1. _____	_____	_____
2. _____	_____	_____
3. _____	_____	_____

VI. OTHER COVERAGE AND REPLACEMENT

1. Does the Proposed Insured have any existing life insurance or annuity policies with this company or any other company? (If yes provide details in #5)..... Yes No
 2. Is this policy intended to replace any existing life insurance or annuity with this company or any other? Yes No
(If yes, please submit appropriate state replacement forms and provide company name and details in #5)
 3. Is the Proposed Owner or Proposed Insured considering using funds from an existing policy or contract to pay premiums on the Policy being applied for? (If Yes, complete the appropriate state replacement forms and provide company name and details in #5).... Yes No
 4. Company Policy Number Type of Coverage Amt of Coverage To be Replaced 1035 Exchange
- | | | | | | |
|--|--|--|--|--|--|
| | | | | | |
| | | | | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| | | | | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| | | | | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| | | | | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |

VII. HEIGHT AND WEIGHT

What is your height? _____ ft _____ in: What is your weight? _____ Lbs

VIII. MEDICAL HISTORY QUESTIONS (If any question in Section VIII is answered yes, no coverage can be issued.)

1. Have you ever been diagnosed by a member of the medical profession or tested positive for Human Immunodeficiency Virus (AIDS virus) or Acquired Immune Deficiency Syndrome (AIDS)? Yes No
2. Do you have any impairment, whether physical or mental, for which you need or receive assistance or supervision in performing normal activities of daily living such as bathing, dressing, eating, toileting, or taking medications?..... Yes No
3. Do you use a walker, wheelchair, motorized scooter or any medical appliance such as oxygen, respirator, or dialysis machine, or have a defibrillator implanted? Yes No
4. Have you had or been advised by a member of the medical profession to have, an organ transplant, or have you been medically diagnosed as having a terminal illness or life expectancy of 12 months or less? Yes No
5. Are you currently hospitalized, confined to a bed or nursing facility, residing in an assisted living facility or receiving hospice care? Yes No
6. Have you ever been diagnosed, treated, tested positive for, or been given medical advice by a member of the medical profession for a disease or disorder such as:
 - a. Congestive heart failure, cardiomyopathy, cirrhosis of the liver, liver failure, kidney (renal) failure, end stage kidney disease, chronic kidney disease or renal insufficiency? Yes No
 - b. Alzheimer’s disease, dementia, memory loss, mental incapacity, schizophrenia, manic depression, bipolar disorder, brain disease, Lou Gehrig’s disease (ALS), Huntington’s disease, muscular dystrophy, cystic fibrosis, multiple sclerosis or multiple myeloma? Yes No
 - c. Any 2 or more of the following: insulin dependent diabetes, coronary artery disease (including heart attack), stroke or transient ischemic attack (TIA), carotid artery disease, heart valve replacement, or had multiple strokes or TIA’s? Yes No
7. Have you:
 - a. Been diagnosed, treated, tested positive for, or been given medical advice by a member of the medical profession for diabetes prior to age 20? Yes No
 - b. Taken insulin prior to age 40? Yes No
 - c. Ever been treated for insulin shock or diabetic coma? Yes No
 - d. Been hospitalized two or more times for any diabetic complications within the last 2 years? Yes No
8. Within the past 3 years have you been diagnosed by a member of the medical profession with leukemia, lymphoma, melanoma or any internal cancer, or received chemotherapy, radiation or had surgery for any cancer (other than basal or squamous cell cancer of the skin)? Yes No
9. Other than basal cell or squamous cell cancer of the skin, have you ever had more than one occurrence of any cancer, a recurrence of any cancer, or an amputation caused by cancer or any other disease, or are you currently being treated for cancer? Yes No

VIII. MEDICAL HISTORY QUESTIONS CONTINUED (If any question in Section VIII is answered yes, no coverage can be issued.)

10. Within the past 2 years have you:
- a. Been diagnosed or treated by a member of the medical profession for, been hospitalized for, taken or been prescribed medication for: Chronic Obstructive Pulmonary or Lung disease (COPD/COLD), emphysema, chronic bronchitis, respiratory failure, chronic hepatitis, liver disease, angina, stroke, transient ischemic attack (TIA), Hodgkin's disease, cerebral palsy, Parkinson's disease, grand mal epilepsy, systemic lupus (SLE) disease, or do you have paralysis of 2 or more extremities? Yes No
 - b. Been diagnosed or treated by a member of the medical profession for, or been hospitalized for: Heart disease, heart attack, uncontrolled high blood pressure, heart or circulatory surgery, including coronary artery bypass, angioplasty, cardiac or vascular stent placement, pacemaker or pacemaker replacement, heart valve replacement, abdominal aortic aneurysm, or any procedure to improve the circulation to the heart, brain or extremities? Yes No
 - c. Been confined three or more times to a hospital, nursing facility, convalescent care facility, assisted living facility, or mental care facility? Yes No
 - d. Been declined for life, health or long term care insurance? Yes No
11. Within the past 5 years have you:
- a. Been convicted of a felony or are you currently incarcerated, on parole, or probation?..... Yes No
 - b. Been treated for or been advised to have treatment for alcohol or drug use, or attempted suicide?..... Yes No
12. Within the last 3 years have you been convicted of operating a vehicle while intoxicated, impaired or under the influence or for reckless driving? Yes No

IX. ADDITIONAL INFORMATION

13. Are you taking any medication for any impairment or disease listed in section VIII? Yes No
14. In the last 12 months, have you used any tobacco or nicotine products, such as cigarettes, pipes or cigars, snuff, chewing tobacco, or a nicotine delivery device such as a patch, gum or lozenge? Yes No
15. Have you applied for life insurance with any other insurance companies in the last 2 years? Yes No
16. Do you believe that this life insurance policy is appropriate for your financial situation based on your income, net worth, available funds and retirement considerations?..... Yes No

Each of the undersigned: Declares that all answers in this application are true and complete to the best of their knowledge and belief, and understands that: (a) all statements and answers in this application will be relied upon by the Company to determine insurability and to issue the policy; (b) no information will be considered given to the Company unless it is stated in the application; (c) the agent does not have the Company's authorization to accept risk, pass on insurability, or make, void, waive, or change any conditions or provisions in the application, policy or receipt, as applicable; and (d) a material misrepresentation may void the policy during the contestable period. This policy will take effect when: (1) the application is approved at National Western's Office in Austin, Texas; (2) National Western delivers the policy; (3) the initial premium has been paid; and (4) each of the prior three conditions is satisfied while the proposed insureds are alive and their health and insurability are as described herein.

Proposed Insured: Authorizes any licensed physician, medical practitioner, hospital, other health care provider, insurance company or the MIB, Inc., formerly known as Medical Information Bureau, or other organization or person to give any information about me or my mental or physical health to the Company and/or its authorized agents to determine my eligibility for life insurance coverage. The Company may disclose such information to its reinsurers and the MIB, Inc. National Western or its reinsurers may also release such information to other life or health insurance companies to whom an application for insurance or to whom a claim for benefits is submitted. This authorization also applies to any member of my family proposed for coverage in the application and is valid for 2 years after the date shown below. A photocopy of this form is as valid as the original. I may have a copy of this form upon request.

Each of the undersigned acknowledges receipt of the Notice under the Fair Credit Reporting Act (Consumer Report Notice), MIB Disclosure Notice, and Notice of Information Practices (if applicable).

FRAUD WARNING: ANY PERSON WHO KNOWINGLY PRESENTS A FALSE STATEMENT IN AN APPLICATION FOR INSURANCE MAY BE GUILTY OF A CRIMINAL OFFENSE AND SUBJECT TO PENALTIES UNDER STATE LAW.

Signed at _____ Date _____
City and State

Signature of Proposed Insured (parent if age 17 or less)

Signature of Owner if other than Proposed Insured
(If a Trust, signature of trustee)
(If business or corporation, officer, other than Proposed insured, and Title)

Agent Name (please print)

License No.

Signature of Agent

AGENT REPORT

1. How long have you known the Proposed Insured? _____ Are you related? Yes No If yes, How? _____
2. Did you personally see the Proposed Insured(s) and complete the application in his and/or her presence? Yes No
If No, please explain: _____
3. Are you aware of any information about any of the Proposed Insured(s) that might affect his/her insurability? Yes No
If Yes, give details: _____
4. Will the policy applied for replace or change any existing life insurance or annuity? Yes No
5. Do you have any knowledge or reason to believe:
 - a. that the Proposed Insured or Owner is considering assigning or transferring any rights or interest in this policy to an unrelated third party such as a Life Settlement company, Viatical, Investor, trust, bank, lending institution or other third party? Yes No
 - b. that any of the initial or future premiums will be borrowed, loaned or otherwise financed? Yes No
 - c. that the Proposed Insured or Owner has taken or been offered any incentive, financial or other, or been offered free insurance as an inducement to purchase this policy? Yes No

I certify that:

- a. the insurance being applied for is suitable for the Proposed Insured's needs and financial objectives
- b. the consumer notices were delivered to the Proposed Insured or Owner;
- c. all questions on the application were asked of each Proposed Insured, and the answers were recorded as given, prior to the application being signed;
- d. the temporary insurance agreement was explained fully and (if applicable), the receipt was given.
- e. the answers given in this application and Agent's Report are complete and accurate to the best of my knowledge and belief

Date _____ Agent Signature _____ Print Agent Name _____

Licensed agent(s) to receive commissions (please print)

Name of Agent	Agent No.	Percent of commission	Agent phone #	Agent Email address
1. _____	_____	_____	_____	_____
2. _____	_____	_____	_____	_____
3. _____	_____	_____	_____	_____

TEMPORARY INSURANCE AGREEMENT & RECEIPT

This agreement shall be void if altered or modified. • Premium checks must be made payable to National Western Life.

Proposed Insured _____ Amount Paid \$ _____ Application Date _____

Subject to all terms and conditions of the insurance policy applied for in this application, this Temporary Insurance Agreement & Receipt (TIA) provides Temporary Insurance in the amount of the lesser of: (a) the amount of insurance applied for; or (b) \$50,000 on each proposed insured; or (c) \$250,000 in the aggregate for all insureds listed on the application. This Temporary Insurance will take effect on the effective date and end as defined below.

I have read this Temporary Insurance Agreement & Receipt and it has been explained to me by the agent. I understand and agree to all conditions and limitations. Proposed owner's signature _____ Date _____

I explained and witnessed the signing of this Agreement.

01-9058-09 Receipt Agent's signature _____ Date _____

Temporary Insurance will take effect on the date that the following four requirements are met: (1) the application is fully completed, including any amendments required by National Western; (2) the initial premium has been paid; and (3) all medical exams or tests required by National Western are completed; and (4) as of the date of this Agreement, the proposed insured must be insurable at standard rates for the type and amount of insurance applied for.

Temporary Insurance will end on the earliest of the following dates: (1) the date insurance begins under the policy applied for; (2) the date this application is cancelled or declined; or (3) 60 days have passed since the date of this application.

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**DETACH AND LEAVE WITH APPLICANT
(DO NOT SEND TO NATIONAL WESTERN)**

Date _____

NOTICE UNDER THE FAIR CREDIT REPORTING ACT. This is to inform you that, as part of our procedure for processing your application for insurance, an investigative consumer report may be prepared whereby information is obtained through personal interviews with your neighbors, friends, or others with whom you are acquainted. This inquiry includes information as to your character, general reputation, personal characteristics and mode of living. None of the information described in this paragraph will be used to establish, or aid in establishing, the proposed insured's sexual orientation. You have the right to make a written request within a reasonable period of time to receive additional, detailed information about the nature and scope of this investigation.

MIB DISCLOSURE NOTICE. Information regarding your insurability will be treated as confidential; however, we or our reinsurers may make a brief report thereon to the MIB, Inc., formerly known as Medical Information Bureau, a not-for-profit membership of insurance companies which operates an information exchange on behalf of its members. If you apply to another MIB member company for life or health insurance coverage, or a claim for benefits is submitted to such company, MIB, upon request, will supply such company with the information about you in its file. Upon receipt of a request from you, MIB will arrange disclosure of any information in your file. Please contact MIB at 866 692-6901 (TTY 866 346-3642). If you question the accuracy of information in MIB's file, you may contact MIB and seek a correction in accordance with the procedures set forth in the federal Fair Credit Reporting Act. The address of MIB's information office is 50 Braintree Hill Park, Suite 400, Braintree, Massachusetts 02184-8734. We or our reinsurers may also release information to other life or health insurance companies to whom you may (1) apply for life or health insurance, or (2) submit a claim for benefits. Information for consumers about MIB may be obtained on its website at www.mib.com.

NOTICE OF INFORMATION PRACTICES. Residents of Arizona, California, Connecticut, Georgia, Illinois, Maine, Massachusetts, Minnesota, Montana, New Mexico, Nevada, New Jersey, North Carolina, Ohio, Oregon and Virginia must be given and sign an Authorization to Obtain and Disclose Information and Notice of Information Practices [SU-6412(current version)]. New Mexico residents are to use SU-6412-NM(current version).

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Supporting Document Schedules

	Item Status:	Status Date:
<p>Satisfied - Item: Flesch Certification Comments: R&R 19 - not applicable to application filing. R&R 49 - not applicable to application filing. Flesch Certification - attached Consumer Information Notice - not applicable to application filing. Attachment: 01-9063-10 Officer Flesch Cert.pdf</p>		
<p>Bypassed - Item: Application Bypass Reason: The form submitted for approval is an application. Comments:</p>		
<p>Bypassed - Item: Outline of Coverage Bypass Reason: Not health insurance. Comments:</p>		
<p>Satisfied - Item: Cover Letter Comments: Attachment: AR 01-9063-10 Cover Letter.pdf</p>		

NATIONAL WESTERN LIFE INSURANCE COMPANY
FLESCH READING EASE TEST SCORE CERTIFICATE
Form Number 01-9063-10

I hereby certify the following:

1. The Flesch Reading Ease Test score is as indicated below.
2. The form is printed, except for specifications pages, schedules and tables, in not less than ten point type.
3. The number of words contained in the text is as indicated below.
4. The entire form was analyzed.

<u>Form No.</u>	<u>Flesch Score</u>	<u>Words</u>
01-9063-10	53	2,636


Paul D. Facey, FSA, MAAA, FCIA, FLMI
Senior Vice President and Chief Actuary

March 16, 2010

Date



March 24, 2010

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

Re: **Application for Individual Life Insurance, 01-9063-10**
National Western Life Insurance Company, NAIC 66850, FEIN 84-0467208

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Thank you for your time and consideration in this matter. If you have any questions or need more information, please feel free to contact me by email at SFoskitt@NationalWesternLife.com or by phone at 512-719-1563.

Sincerely,

A handwritten signature in cursive script that reads "SFoskitt".

Stephanie Foskitt
Contract Compliance Analyst

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