

SERFF Tracking Number: GRWE-126601307 State: Arkansas  
Filing Company: Great-West Life & Annuity Insurance Company State Tracking Number: 45514  
Company Tracking Number: J445REVAPP4  
TOI: L08 Life - Other Sub-TOI: L08.000 Life - Other  
Product Name: J445app4  
Project Name/Number: COLI APPS/

## Filing at a Glance

Company: Great-West Life & Annuity Insurance Company

Product Name: J445app4

SERFF Tr Num: GRWE-126601307 State: Arkansas

TOI: L08 Life - Other

SERFF Status: Closed-Approved- Closed State Tr Num: 45514

Sub-TOI: L08.000 Life - Other

Co Tr Num: J445REVAPP4

State Status: Approved-Closed

Filing Type: Form

Reviewer(s): Linda Bird

Author: Alicia Uttley

Disposition Date: 04/28/2010

Date Submitted: 04/27/2010

Disposition Status: Approved-Closed

Implementation Date Requested: On Approval

Implementation Date:

State Filing Description:

## General Information

Project Name: COLI APPS

Status of Filing in Domicile: Not Filed

Project Number:

Date Approved in Domicile:

Requested Filing Mode:

Domicile Status Comments: Exempt in state of domicile

Explanation for Combination/Other:

Market Type: Individual

Submission Type: New Submission

Group Market Size:

Overall Rate Impact:

Group Market Type:

Filing Status Changed: 04/28/2010

Explanation for Other Group Market Type:

State Status Changed: 04/28/2010

Deemer Date:

Created By: Alicia Uttley

Submitted By: Alicia Uttley

Corresponding Filing Tracking Number:

Filing Description:

Revised Application for Flexible Premium Adjustable Life Insurance, Form J445app4

## Company and Contact

### Filing Contact Information

Alicia Uttley, Compliance Analyst

alicia.uttley@gwl.com

8515 E. Orchard Rd.

303-737-6793 [Phone]

8T2

303-737-5434 [FAX]

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Greenwood Village , CO 80110

**Filing Company Information**

Great-West Life & Annuity Insurance Company CoCode: 68322 State of Domicile: Colorado  
 8515 East Orchard Road Group Code: 769 Company Type:  
 Greenwood Village, CO 80111 Group Name: State ID Number:  
 (303) 737-3992 ext. [Phone] FEIN Number: 84-0467907

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**Filing Fees**

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

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Great-West Life & Annuity Insurance Company	\$50.00	04/27/2010	35973693

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## Correspondence Summary

### Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Linda Bird	04/28/2010	04/28/2010

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## Disposition

Disposition Date: 04/28/2010

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		No
Supporting Document	Cover Letter		No
Form	Application for Flexible Premium Adjustable Life Insurance		Yes

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## Form Schedule

**Lead Form Number: J445revapp4**

Schedule Item Status	Form Number	Form Type Form Name	Action	Action Specific Data	Readability	Attachment
	J445app4	Application/ Enrollment Form Application for Flexible Premium Adjustable Life Insurance	Revised	Replaced Form #: J445app4 Previous Filing #: 45472		J445app4.pdf

**GENERAL INFORMATION**

This page must be completed for all cases.

"Insured" whenever used in this application, means "the life proposed for insurance."

**INSURED**

**OWNER OF POLICY (IF OTHER THAN INSURED)**

Name: \_\_\_\_\_

Home Address: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Business Address: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Phone #: Day ( ) \_\_\_\_\_ - \_\_\_\_\_

Evening ( ) \_\_\_\_\_ - \_\_\_\_\_

Birth Date: \_\_\_/\_\_\_/\_\_\_ SS #: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Place of Birth: \_\_\_\_\_

Name: \_\_\_\_\_

Business Address: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Phone #: Day ( ) \_\_\_\_\_ - \_\_\_\_\_

Evening ( ) \_\_\_\_\_ - \_\_\_\_\_

Relationship to Insured: \_\_\_\_\_

Owner's SS # or Tax ID #: \_\_\_\_\_

See attached Schedule of Insureds

**POLICY INFORMATION**

Life Insurance or Premium Applied for:

Total Face Amount: \$ \_\_\_\_\_

Initial Periodic Premium Amount: \$ \_\_\_\_\_

Mode of Payment: \_\_\_\_\_

**Premium Payor** (Owner, unless otherwise indicated):

Name: \_\_\_\_\_

Address: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Death Benefit Option (Please check one):**

Level Death

Coverage Plus

**REPLACEMENT**

Do you have any existing insurance policies or annuity contracts? .....  Yes  No  
Will the policy applied for result in any insurance or annuity contract in this or any other Company being lapsed, surrendered, reduced, subjected to substantial borrowing, or changed to paid-up, extended term or automatic premium loan? .....  Yes  No

If yes, details: \_\_\_\_\_

Company Name: \_\_\_\_\_

Policy Number: \_\_\_\_\_

**BENEFICIARY**

Beneficiary: \_\_\_\_\_  
(Please Print Full Name)

Contingent Beneficiary: \_\_\_\_\_  
(Please Print Full Name)

Relationship to Insured: \_\_\_\_\_

Relationship to Insured: \_\_\_\_\_

If corporate owned please choose one of the following:

- Employer**
- Trust created by the Employer**
- Trust created by the Insured**

If the employer is the beneficiary, the employer certifies, represents and warrants that:

- a.** The employer has a lawful and substantial economic interest in the life, health and safety of each proposed insured;
- b.** The services of each such proposed insured are such that the employer expects to realize either:
  - A substantial monetary gain through the continued life of the proposed insured; or
  - A substantial monetary loss in the event of the proposed insured's death.
- c.** Per the requirements set forth in I.R.C.§101(j), the insured:
  - had "compensation" in excess of the IRC § 414(q) limitation, as adjusted annually for inflation; or
  - is among the highest paid 35% of all employees, determined in accordance with the rules of IRC § 105(h); or
  - is an owner of 5% or more of the employer at any time during the year (or was in the preceding year); or
  - is among the top 5 highest paid officers of the company

Additionally, in order to comply with IRC§101(j), employers must obtain positive written consent from employees that the employer may insure their life. This consent must disclose that the corporation will reside as beneficiary of the policy death benefit and the maximum amount of insurance that may be issued on their life. This information must be obtained PRIOR to the issue of any policy. Failure to do so may result in adverse tax consequences.

Please sign below stating you have read and understand the above conditions.

\_\_\_\_\_  
**Employer Name (Please Print)**

\_\_\_\_\_  
**Title**

**X**  
\_\_\_\_\_  
**Employer Signature**

\_\_\_\_\_  
**Date**

**CITIZENSHIP STATUS**

Is each individual named on this application a citizen of the United States? .....  **Yes**  **No**

Please answer the following question for each insured that is a Non-U.S. Citizen:

Does the employee reside in the United States with a permanent resident visa? .....  **Yes**  **No**

**If No, please provide visa information for all Non-U.S. Citizens.**

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

## SIGNATURE

I declare and agree that: 1) All statements and answers to questions made in this application and any supplement to it are true and complete to the best of my knowledge and belief. The information I have provided will be taken into consideration for and will serve as the basis of any contract of insurance based on this application. 2) No information or answer to any question will be deemed communicated to or binding on Great-West Life & Annuity Insurance Company (The Company) unless set out in this application. 3) Only the president, a vice president or the secretary of The Company is authorized to change or waive any terms of this application or any contract of insurance issued.

Any policy issued based on this application shall not take effect until delivered and the first premium paid to The Company, provided no change has taken place in the insurability of the Insured after the application, and any supplement to it is completed, and all proposed Insureds are still living.

**I certify under penalty of perjury that the Social Security or tax identification number listed on this application is correct.**

Signed at \_\_\_\_\_ this \_\_\_\_ day of \_\_\_\_\_ year \_\_\_\_\_  
City and State

\_\_\_\_\_  
Name of Proposed Insured (Please Print)

**X** \_\_\_\_\_  
Signature of Proposed Insured

**X** \_\_\_\_\_  
Witness

**X** \_\_\_\_\_  
Signature of Owner

# AGENT'S REPORT

1. Purpose of Insurance: \_\_\_\_\_
2. Annual earned income before taxes: \$ \_\_\_\_\_  
Above based on:  Insured's Statement  Other
3. Does the applicant have existing life insurance policies or annuity contracts? .....  Yes  No
4. Do you have reason to believe the life insurance applied for will replace any insurance or annuity with us or any other company? .....  Yes  No

If yes, details: \_\_\_\_\_

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

Agent's Declaration - I certify that I have asked and have fully recorded the proposed Insured's answers to all questions in this application. I know nothing that is material to the insurability of this life that has not been recorded herein.

\_\_\_\_\_ **X** \_\_\_\_\_  
Date Signature of Agent

Print Agent's Name: \_\_\_\_\_

Agent's License Number: \_\_\_\_\_

Phone #: ( ) - \_\_\_\_\_

Agency/Institution: \_\_\_\_\_

Office: \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_

Agent Name: \_\_\_\_\_

Agent Signature: \_\_\_\_\_

Agency/Institution: \_\_\_\_\_

Office: \_\_\_\_\_

Address: \_\_\_\_\_

**Agent Share %:** \_\_\_\_\_

Agent Name: \_\_\_\_\_

Agent Signature: \_\_\_\_\_

Agency/Institution: \_\_\_\_\_

Office: \_\_\_\_\_

Address: \_\_\_\_\_

**Agent Share %:** \_\_\_\_\_

Agent Name: \_\_\_\_\_

Agent Signature: \_\_\_\_\_

Agency/Institution: \_\_\_\_\_

Office: \_\_\_\_\_

Address: \_\_\_\_\_

**Agent Share %:** \_\_\_\_\_

Agent Name: \_\_\_\_\_

Agent Signature: \_\_\_\_\_

Agency/Institution: \_\_\_\_\_

Office: \_\_\_\_\_

Address: \_\_\_\_\_

**Agent Share %:** \_\_\_\_\_

Agent Name: \_\_\_\_\_

Agent Signature: \_\_\_\_\_

Agency/Institution: \_\_\_\_\_

Office: \_\_\_\_\_

Address: \_\_\_\_\_

**Agent Share %:** \_\_\_\_\_

Agent Name: \_\_\_\_\_

Agent Signature: \_\_\_\_\_

Agency/Institution: \_\_\_\_\_

Office: \_\_\_\_\_

Address: \_\_\_\_\_

**Agent Share %:** \_\_\_\_\_

### INSURED'S PERSONAL AND MEDICAL INFORMATION PART A

Name: \_\_\_\_\_ Occupation: \_\_\_\_\_

Total life insurance in force: \$ \_\_\_\_\_ Driver's License #: \_\_\_\_\_ State: \_\_\_\_\_

- 1. Have you applied for insurance in the past 6 months? .....  Yes  No
- 2. Have you ever been refused life insurance?.....  Yes  No
- 3. During the past 12 months have you used tobacco or nicotine products in any form? .....  Yes  No

**During the past three years have you:**

- 4. Flown as a private pilot or do you contemplate flying as a student pilot or crew member?  
(If yes, please complete the aviation questionnaire.).....  Yes  No
- 5. Participated in or do you contemplate participating in any sport such as racing (automobile, snowmobile, motorcycle, boat), scuba diving, hang gliding, mountain or rock climbing?  
(If yes, please complete the applicable sports questionnaire.).....  Yes  No
- 6. **In the past three years**, have you been charged with driving under the influence of alcohol or drugs (DUI), or have you had your driver's license suspended or revoked?.....  Yes  No
- 7. **In the past 10 years**, have you been medically advised that you have, or received any type of treatment for positive test for Human Immunodeficiency Virus (HIV), Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC)? .....  Yes  No

If you answered yes to questions 1-7, provide details: \_\_\_\_\_

### INSURED'S PERSONAL AND MEDICAL INFORMATION PART B

Height: \_\_\_\_\_ Weight: \_\_\_\_\_

- 1. Do you have a personal physician? If yes, please provide name and address:.....  Yes  No
- 2. Please provide date last seen, reason seen and results: \_\_\_\_\_
- 3. Have any members of your immediate family died before age 60? .....  Yes  No
- 4. Are you currently taking any medication(s)?.....  Yes  No
- 5. Have you ever been hospitalized? (If yes, give details below including date(s) and reason(s).) .....  Yes  No

**Within the past 10 years, has a member of the medical profession diagnosed you as having or treated you for any of the following:**

- 6. Any permanent disease or disorder, including those requiring medical or surgical intervention of the heart, lungs, liver, kidneys, gastrointestinal system?.....  Yes  No
- 7. Elevated blood pressure, stroke, paralysis, or any chronic or progressive disease or disorder of the brain, spinal cord or central nervous system? .....  Yes  No
- 8. Blood disorders including chronic anemia? .....  Yes  No
- 9. Diabetes, cancer or malignancy?.....  Yes  No
- 10. Treatment for alcohol or drug use, or have you been medically advised to do so? .....  Yes  No
- 11. Any counseling or treatment for mental, nervous or emotional disorders? .....  Yes  No
- 12. Any physical impairments or diseases not listed above? .....  Yes  No

If you answered yes to questions 1-12, provide details: \_\_\_\_\_



## FRAUD WARNINGS

**[California:** For your protection, California law requires the following to appear on this form: Any person who knowingly presents false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

**Colorado:** 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 policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado division of insurance within the department of regulatory agencies.

**District of Columbia, Maine, Tennessee and Virginia:** It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance benefits.

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

**Kentucky:** 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.

**Massachusetts, Oregon and Vermont:** Any person who knowingly and with the intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which may be a crime and subjects such person to criminal and civil penalties.

**New Jersey:** Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

**Washington:** 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.

**All Other States:** Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim 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 and subjects such person to criminal and civil penalties.]

**Notice of Insurance Information  
Practices and Notice Regarding  
Medical Information Bureau**

This is to inform you that, as part of our procedure for processing your application, an investigative consumer report may be prepared whereby information is obtained through personal interviews with your business associates, friends, or others with whom you are acquainted. This inquiry includes information as to your character, general reputation, personal characteristics, financial information and mode of living. 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. You have the right to access information upon written request. You may request correction, amendment or deletion of any information which you believe to be inaccurate.

In connection with your application for insurance you may receive a telephone call from an authorized person to obtain some personal and financial information. You may be assured that the information is considered confidential and will be used to assess your eligibility for insurance. The interview normally takes from five to ten minutes and will be conducted at a time convenient for you. In the event you are not in when the interviewer calls, the interviewer will leave his or her name and telephone number so that you can return the call at no charge to you and supply the necessary information.

Inquiries on the above notices should be addressed to:

[Great-West Life & Annuity Insurance Company  
Department 690, P.O. Box 1700  
Denver, CO 80201]

Information regarding your insurability will be treated as confidential. The Company, or its reinsurers, may, however, make a brief report thereon to the Medical Information Bureau, a non-profit membership organization of life insurance companies, which operates an information exchange on behalf of its members. If you apply to another Bureau member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, the Bureau, upon request, will supply such company with the information it may have in its file.

Upon receipt of a request from you, the Bureau will arrange disclosure of any information it may have in your file. If you question the accuracy of information in the Bureau's file, you may contact the Bureau and seek a correction in accordance with the procedures set forth in the federal Fair Credit Reporting Act. The address of the Bureau's information office is:

[MIB, Inc.  
50 Braintree Hill Park, Suite 400  
Braintree, MA 02184-8734  
Phone: 866-692-6901 (TTY 866-346-3642)]

The Company, or its reinsurers, may also release information in its file to other life insurance companies to whom you may apply for life or health insurance, or to whom a claim for benefits may be submitted.

THIS STANDARD DISCLOSURE IS  
REQUIRED OF ALL LIFE INSURANCE  
PROVIDERS. BE ASSURED THAT  
GREAT-WEST'S BUSINESS PRACTICES  
MEET THE HIGHEST INDUSTRY  
STANDARDS.

**Please keep this form for your records**

SERFF Tracking Number: GRWE-126601307 State: Arkansas  
Filing Company: Great-West Life & Annuity Insurance Company State Tracking Number: 45514  
Company Tracking Number: J445REVAPP4  
TOI: L08 Life - Other Sub-TOI: L08.000 Life - Other  
Product Name: J445app4  
Project Name/Number: COLI APPS/

## Supporting Document Schedules

	Item Status:	Status Date:
<b>Satisfied - Item:</b> Flesch Certification <b>Comments:</b> <b>Attachment:</b> ar compliance cert J445app4.pdf		

	Item Status:	Status Date:
<b>Bypassed - Item:</b> Application <b>Bypass Reason:</b> Not applicable. Application filing. <b>Comments:</b>		

	Item Status:	Status Date:
<b>Satisfied - Item:</b> Cover Letter <b>Comments:</b> <b>Attachment:</b> AR Letter 4.27.10.pdf		

**STATE OF ARKANSAS  
INSURANCE DEPARTMENT**

**CERTIFICATE OF COMPLIANCE**

**RE: Application for Flexible Premium Adjustable Life Insurance, Form J445app4**

We hereby certify that the guidelines established in Arkansas Rule and Regulation 19 have been reviewed and the forms designated above comply with these guidelines.

We hereby certify that the above policy forms meet the minimum Flesch Reading Ease Test score requirements.

Great-West Life & Annuity Insurance Company



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Susan Gile

Vice President, Individual Markets Operation

April 27, 2010

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Date



8515 East Orchard Road  
Greenwood Village, CO 80111 Tel. (303) 737-3000  
Address mail to: P.O. Box 1700, Denver, CO 80201  
[www.gwla.com](http://www.gwla.com)

April 27, 2010

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

NAIC #769-68322

**RE: Individual Life Insurance Submission  
Revised Application for Flexible Premium Adjustable Life Insurance, Form J445app4**

We are resubmitting the above referenced application for your review and approval. The attached application will replace form J445app4 previously approved in your state on April 22, 2010 under SERFF tracking # GRWE-126592857, AR state tracking # 45472. The previously approved form J445app4 was not issued. It has been revised to more closely correspond with IRC § 101 (j) whereby employers must obtain positive written consent from employees that the employer may insure their life.

This application contains a score in excess of 40 using the Flesch Reading Ease Test.

We are exempt from filing in Colorado, our state of domicile, pursuant to Regulation 5-92. Colorado requires a fee to be paid each February 28th based on our Company's direct written premium. If appropriate, a retaliatory fee has been paid in your state in conjunction with your annual premium tax return.

We reserve the right at any time to make non-material changes to these forms, including (but not limited to) paper stock, type face (but not font size) and page layout made necessary by unavoidable changes.

To the best of our knowledge, this submission complies with your state laws and regulations. We look forward to your approval. Should you have any questions, please call me on our toll-free number, (800) 537-2033, ext 75829 or via email at [Tanya.gonzales@gwl.com](mailto:Tanya.gonzales@gwl.com)

Sincerely,

A handwritten signature in black ink that reads 'Tanya D. Gonzales'. The signature is written in a cursive, flowing style.

Tanya D. Gonzales  
Manager, Individual Markets