

SERFF Tracking Number: NALF-126601108 State: Arkansas
Filing Company: National Life Insurance Company State Tracking Number: 45517
Company Tracking Number: 8852(0610)
TOI: L071 Individual Life - Whole Sub-TOI: L071.101 Fixed/Indeterminate Premium - Single Life
Product Name: Life Insurance Application
Project Name/Number: Life Insurance Application/8852(0610)

Filing at a Glance

Company: National Life Insurance Company

Product Name: Life Insurance Application

TOI: L071 Individual Life - Whole

Sub-TOI: L071.101 Fixed/Indeterminate
Premium - Single Life

Filing Type: Form

SERFF Tr Num: NALF-126601108 State: Arkansas

SERFF Status: Closed-Approved-
Closed State Tr Num: 45517

Co Tr Num: 8852(0610)

State Status: Approved-Closed

Reviewer(s): Linda Bird

Authors: Susan Carey, Laurie
Trombly, Michelle Goodwin, Susan
Preedom

Disposition Date: 04/28/2010

Date Submitted: 04/27/2010

Disposition Status: Approved-
Closed

Implementation Date Requested:

Implementation Date:

State Filing Description:

General Information

Project Name: Life Insurance Application

Project Number: 8852(0610)

Requested Filing Mode: Review & Approval

Explanation for Combination/Other:

Submission Type: New Submission

Overall Rate Impact:

Filing Status Changed: 04/28/2010

Deemer Date:

Submitted By: Laurie Trombly

Filing Description:

Today we submit for your consideration a new application that will be used with a previously approved Whole Life policy and a previously approved Indexed Flexible Premium Adjustable Benefit life policy. This new application will only be used when the two policies are sold together. This application does not replace any previously approved application currently in use by our company.

Status of Filing in Domicile: Pending

Date Approved in Domicile:

Domicile Status Comments: Filed to Vermont
on 4-16-10.

Market Type: Individual

Group Market Size:

Group Market Type:

Explanation for Other Group Market Type:

State Status Changed: 04/28/2010

Created By: Laurie Trombly

Corresponding Filing Tracking Number:

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Form 8852(0610) will be used with the following previously approved policies and only when the two policy types are sold together:

- 8310AR(0306), Limited Pay Whole Life. Approved on March 28, 2006
- 8311AR(0306), Limited Pay Whole Life. Unisex. Approved on March 28, 2006
- 8385AR(0606), Indexed Flexible Premium Adjustable Benefit Life Insurance. Approved on January 9, 2007
- 8386AR(0606), Indexed Flexible Premium Adjustable Benefit Life Insurance. Unisex. Approved on January 9, 2007.

The submitted form scores 58.3 on the Flesch Readability Scale.

Company and Contact

Filing Contact Information

Laurie Trombly, Senior Policy Forms Analyst LTrombly@nationallife.com
 One National Life Drive 802-229-3614 [Phone]
 Montpelier, VT 05604 802-229-3743 [FAX]

Filing Company Information

National Life Insurance Company	CoCode: 66680	State of Domicile: Vermont
One National Life Drive	Group Code: -99	Company Type:
Montpelier, VT 05604	Group Name:	State ID Number:
(802) 229-3333 ext. [Phone]	FEIN Number: 03-0144090	

Filing Fees

Fee Required? Yes
 Fee Amount: \$50.00
 Retaliatory? Yes
 Fee Explanation: Vermont charges \$50 for this same filing.
 Per Company: No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
National Life Insurance Company	\$50.00	04/27/2010	35988764

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Correspondence Summary

Dispositions

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

SERFF Tracking Number: NALF-126601108 *State:* Arkansas
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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		Yes
Supporting Document	Life & Annuity - Acturial Memo		No
Form	Life Insurance Application		Yes

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Form Schedule

Lead Form Number: 8852(0610)

Schedule Item Status	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
	8852(0610)	Application/Life Insurance Enrollment Application Form		Initial		58.300	8852.pdf

Life Insurance Application

Agency Location and No.: _____ Policy No.: _____ Policy No.: _____

Product Name: LifeSelect

Part A - Proposed Insured Information

1. Name <i>(print first, middle, last)</i>	2. Place of Birth - State/Country	3. Date of Birth	4. Issue at Age
5. Home Address <i>(If mailing address different, provide in Remarks)</i>			
6. Sex <input type="checkbox"/> M <input type="checkbox"/> F	7. Social Sec. #	8. Telephone #'s and best time to call H () W () C ()	
9. Are you a citizen of <input type="checkbox"/> USA <input type="checkbox"/> Other Country _____		Type of VISA _____	Alien Registration #: _____
10. Employer Name & Address <i>(street, city, state and zip)</i>	11a. Driver's License #		11b. State
	12a. Occupation <i>(w/specific duties)</i>		
12b. Are you actively at work at the customary workplace, doing the usual duties and functions required by the position during the normal work hours and weekly period? <input type="checkbox"/> Yes <input type="checkbox"/> No* *Reason: _____			

Part B - Policy Information

1. Amount: a. LifeBuilder \$ _____ 2. a. Term Rider Plan <i>(LifeBuilder only)</i> _____ 3. Premium Information Planned Periodic Premium: a. LifeBuilder \$ _____ Cash with Application: c. LifeBuilder \$ _____ 4. Premium Frequency <input type="checkbox"/> Annual <input type="checkbox"/> Semi-Annual <input type="checkbox"/> Quarterly <input type="checkbox"/> Single Premium <input type="checkbox"/> COM <i>(Complete #5)</i> 5. <input type="checkbox"/> I authorize the Company to draft monthly payments from my account. <i>(Attach a void check/deposit slip)</i> <input type="checkbox"/> Checking <input type="checkbox"/> Draft on the: <input type="checkbox"/> Savings <input type="checkbox"/> 1st <input type="checkbox"/> 15th <input type="checkbox"/> Money Market <input type="checkbox"/> 8th <input type="checkbox"/> 22nd 6. Automatic Payment of Premium <input type="checkbox"/> Yes <input type="checkbox"/> No 7. Send premium notices to: <input type="checkbox"/> Owner <input type="checkbox"/> Proposed Insured <input type="checkbox"/> Other: <i>(Name, Street, City, State & Zip)</i> _____ _____ 8. Use of Dividends: <i>(LifeBuilder only. Choose only one.)</i> <input type="checkbox"/> Additions <input type="checkbox"/> Internal Paid-Up Insurance	b. Ultra Select \$ _____ b. Amount \$ _____ b. Ultra Select \$ _____ d. Ultra Select \$ _____ 9. Universal Life Death Benefit Option <i>(Ultra Select only)</i> <input type="checkbox"/> A - Level <input type="checkbox"/> B - Increasing 10. Definition of Life Insurance Test <i>(Ultra Select only)</i> <input type="checkbox"/> Guideline Premium Test (GPT) <input type="checkbox"/> Cash Value Accumulation Test (CVAT) 11. Additional Benefits and Amounts: <input type="checkbox"/> Accelerated Benefits (ABR) <input type="checkbox"/> Waiver of Premiums (WP) \$ _____ <i>(Annual Premium Waived)</i> <input type="checkbox"/> Other: _____ 12. Identify the source of funds for premium payment <input type="checkbox"/> Income/Savings <input type="checkbox"/> Home equity <input type="checkbox"/> Payment by third party <input type="checkbox"/> Loan/Premium Finance <input type="checkbox"/> Other: _____
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Part C - Beneficiary Information (Complete if Insured is owner; otherwise the beneficiary will be the owner.)

(Provide full names, addresses, date of birth and relationship to Insured)

Primary: _____ Secondary: _____

Part D - Current Policy Information about the Proposed Insured

<input type="checkbox"/> NONE IN FORCE Type: B=Business G=Group P=Personal				
Company Name	Type	Total in Force \$	Total with WP \$	Total ADB \$

Part E - Owner Information (Check one if other than Insured and complete questions 1 & 2.)

Individual (Other than Insured):

(Legal Name & Relationship): _____ Date of Birth: _____ ,
while living; thereafter

(Legal Name & Relationship): _____ Date of Birth: _____
while living; thereafter

(check one) the insured or Estate of the last survivor of the named owners.

Note: If neither box is checked, the final owner will be the estate of the last survivor of the named owners.

Business Entity:

(Full Legal Name): _____ , a (State): _____ ,

Corporation Limited Partnership Limited Liability Company or General Partnership, or its successors, if any;
otherwise the final owner will be the insured.

Trust: (Current Trustee(s)) _____ , trustee(s) under the
(Trust Name) _____

trust between said trustee(s) and (Trustor/Grantor) _____ , as heretofore or
hereafter amended, or the successors in said trust, while trust is existent; otherwise the final owner will be the insured.

1. Owner Taxpayer ID No.: _____ Owner Daytime Telephone #: () _____

2. Owner Complete Address: _____

Part F - General Information about the Proposed Insured (If 'Yes', provide details in Remarks on page 3)

1. Have you used any type of product containing nicotine within the last 24 months? _____ Yes No

Product Type: _____ Frequency: _____ Date Last Used: _____

2. Have you ever applied for life, health, or disability insurance or reinstatement of same, which was declined, postponed,
rated or modified in any way? _____ Yes No

3. Are you or have you entered into a written agreement to become a member of a military organization? _____ Yes No

4. Have you ever been convicted of a felony or misdemeanor? _____ Yes No

5. Have you had any moving vehicle violations in the last 3 years, or a suspended license or a DUI conviction in the last
5 years? _____ Yes No

6. Have there been any bankruptcy proceedings against you within the last 7 years? _____ Yes No

7. Within the past 6 months have you applied for or do you currently have any applications pending for life or disability
insurance? _____ Yes No

8. Have you been offered any cash incentive or other consideration (such as free insurance) as an inducement to apply
for or become an insured under this life insurance policy, or have you been involved in any discussions about the
possible sale or transfer of this policy to an unrelated third party, such as (but not limited to) a life settlement company
or investor group? _____ Yes No

(If 'Yes', to questions 9-11 complete form 1480, Avocation, Aviation & Foreign Travel Supplemental Application)

9. Within the last 3 years, have you participated in or do you intend to participate in any type of racing; scuba, skin,
sport or sky diving; competition sport; parachuting or hang gliding; BASE or bungee cord jumping; big game hunting;
mountain climbing; cave exploring; rodeos or snowmobiling? _____ Yes No

10. Do you participate in any aviation activity other than as a fare paying passenger? _____ Yes No

11. Do you intend to travel or reside outside of the USA for more than 2 weeks in a year? _____ Yes No

Part G - Replacement Information (If 'Yes', Replacement forms must be provided; list company name and policy numbers).

1. Do you have any existing life insurance policies or annuity contracts? _____ Yes No

2. Has there been or will there be a lapse, surrender, replacement, reissue, conversion, or change to reduce amount,
premium, or period of coverage of any existing life, disability or annuity contract if the applied for policy or rider is issued?

Ultra Select Yes No

LifeBuilder Yes No

3. Will there be any substantial borrowing on any life insurance policy if the applied for policy or rider is issued?

List Company Name(s) and Policy Number(s) Ultra Select Yes No

LifeBuilder Yes No

Part H - Health History of the Proposed Insured (Complete Part H if money was collected with this application or an NL exam is not being done.) **Provide details, dates, and results for any 'Yes' answer to questions 2-10 in Remarks.**

1. Height	Weight	lbs.	Change in last year	lbs.	Reason?	
<hr/>						
2. Are you taking any medication?						<input type="checkbox"/> Yes <input type="checkbox"/> No
3. Is your health impaired in any way?						<input type="checkbox"/> Yes <input type="checkbox"/> No
4. Have you ever applied for or received disability or worker's compensation from any source?						<input type="checkbox"/> Yes <input type="checkbox"/> No
5. At any time during the last 10 years have you:						
a. made the decision or been advised to reduce alcohol or drug intake, or used drugs not prescribed by a physician?						<input type="checkbox"/> Yes <input type="checkbox"/> No
b. been a member of a support group, such as AA or NA?						<input type="checkbox"/> Yes <input type="checkbox"/> No
6. At any time during the last 10 years have you been diagnosed or treated by a member of the medical profession or taken medication for:						
a. Chest Pain, Heart Murmur, Rheumatic Fever or Anemia	<input type="checkbox"/> Yes	<input type="checkbox"/> No			i. Eyes, Ears, Nose or Throat Disorder	<input type="checkbox"/> Yes <input type="checkbox"/> No
b. Habitual Cough, Asthma, Emphysema or Sleep Apnea	<input type="checkbox"/> Yes	<input type="checkbox"/> No			j. Brain, Nervous System Disorder or Headaches	<input type="checkbox"/> Yes <input type="checkbox"/> No
c. Ulcer, Jaundice or Chronic Indigestion	<input type="checkbox"/> Yes	<input type="checkbox"/> No			k. Spine, Bones, Muscles, Joints, Skin or Gland Disorder	<input type="checkbox"/> Yes <input type="checkbox"/> No
d. Stroke, Dizzy Spells, Epilepsy, Convulsions, Paralysis or Unconsciousness	<input type="checkbox"/> Yes	<input type="checkbox"/> No			l. Cancer, Polyp or Other Tumor	<input type="checkbox"/> Yes <input type="checkbox"/> No
e. Heart, Veins, Arteries, Blood or Blood Pressure Disorder	<input type="checkbox"/> Yes	<input type="checkbox"/> No			m. Gout, Arthritis, Back Pain or Back Disorder	<input type="checkbox"/> Yes <input type="checkbox"/> No
f. Lung or Respiratory Tract Disorder	<input type="checkbox"/> Yes	<input type="checkbox"/> No			n. High Blood Sugar or Diabetes	<input type="checkbox"/> Yes <input type="checkbox"/> No
g. Esophagus, Stomach, Intestinal, Rectum, Liver or Gall Bladder Disorder	<input type="checkbox"/> Yes	<input type="checkbox"/> No			o. Protein, Sugar, Casts, Pus or Blood in the Urine	<input type="checkbox"/> Yes <input type="checkbox"/> No
h. Kidney, Bladder, Prostate, Genito-Urinary Organs, Pelvic Organs or Breast Disease	<input type="checkbox"/> Yes	<input type="checkbox"/> No			p. Renal Colic or Kidney Stone	<input type="checkbox"/> Yes <input type="checkbox"/> No
i. Depression, Anxiety or any other Psychological Condition						<input type="checkbox"/> Yes <input type="checkbox"/> No
j. Alzheimer's or Dementia						<input type="checkbox"/> Yes <input type="checkbox"/> No
7. Within the past 10 years have you tested positive for exposure to the Human Immunodeficiency Virus (HIV), or has a physician or other medical professional diagnosed you as having Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC) or AIDS related conditions?						<input type="checkbox"/> Yes <input type="checkbox"/> No
8. Within the past 5 years have you:						
a. had x-rays, electrocardiograms or other diagnostic tests?						<input type="checkbox"/> Yes <input type="checkbox"/> No
b. been admitted to a hospital, or have you planned or been advised to enter a hospital for observation, operation or treatment of any kind?						<input type="checkbox"/> Yes <input type="checkbox"/> No
c. consulted any medical professional other than your personal physician?						<input type="checkbox"/> Yes <input type="checkbox"/> No
9. Do you have any pending appointments with any medical professional within the next 30 days?						<input type="checkbox"/> Yes <input type="checkbox"/> No
10. Has a parent or sibling been diagnosed or treated by a member of the medical profession for diabetes, cancer, heart disease, Huntington's Disease or polycystic kidney disease?						<input type="checkbox"/> Yes <input type="checkbox"/> No

11. Family History	Father	Mother	Sibling	Sibling
Age if alive	_____	_____	_____	_____
State of health	_____	_____	_____	_____
Age at death	_____	_____	_____	_____
Cause of death	_____	_____	_____	_____

12. Name and Address of Personal Physician (If none, so state)	Date last seen	Reason consulted & outcome

Part I - Remarks (Provide the details to any questions so requested. Attach additional pages if necessary.)

Section & Number:	Additional Information:
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Part J - Agreement & Authorization

The Applicant has received an illustration of the policy applied for, signed and returned the illustration with this application and the Soliciting Agent has presented the illustration and explained any non-guaranteed elements of the policy to the Applicant. Yes No

To the best of my knowledge and belief, the statements and answers given on this application are complete and true. They shall be a part of the contract of insurance if one is issued. The Applicant agrees to be bound by all statements and answers attested to in this Application.

National Life Insurance Company (the Company) may make administrative corrections and changes to this application. These, if any, are noted on the "Application Amendment" page which is attached to the policy at issue. Acceptance of any policy issued on this application will ratify and will be notice of any such change made. If the laws where the application is made so require, any change of amount, age at issue, class of risk, plan of insurance or benefits must be ratified in writing.

The Agent taking this application has no authority to make, change or discharge any contract hereby applied for. The Agent may not extend credit on behalf of the Company. No statement made to or information acquired by any representative of the Company shall bind the Company unless set out in writing in this application.

The Company shall incur no liability under any policy issued on this application unless and until such policy is delivered to the Owner, and the first premium is paid prior to any change in the Proposed Insured's good health and insurability.

I, the Proposed Insured, authorize any physician, medical practitioner, hospital, clinic, or other medically related facility, insurer or reinsurer, the Medical Information Bureau, Inc. (MIB), consumer reporting agency, or employer having information as to diagnosis, treatment and prognosis of any physical or mental condition of me; any non-medical information of me; to give National Life Insurance Company, herein called National Life, or its authorized representative, any and all such information. I authorize National Life to request a copy of my driving record from the state motor vehicle department.

I authorize National Life to obtain an investigative consumer report. I understand that I am entitled to be interviewed by the consumer reporting agency that prepares any such report, as long as I can reasonably be contacted during normal business hours.

I wish to be interviewed if an investigative consumer report is prepared.

This information may be used to determine eligibility for life or health insurance or claims for benefits, and I authorize National Life to release any of this information to the MIB and/or Reinsurers and other life insurance companies in which I have insurance or from which I seek insurance or benefits.

I authorize National Life to redisclose the information to any person performing a business or legal function for its benefit; an attending physician for diagnostic or treatment purposes; government authorities to prevent insurance related illegal activities; persons conducting medical or statistical studies for National Life; persons having an authorization specifically permitting the redisclosure; and when required by law. In making this authorization, I waive any right to prohibit redisclosure to an affiliate of National Life where the redisclosure is related to the servicing of my policy.

This authorization shall remain valid for 30 months from the date shown below. I understand I have a right to receive a copy of this authorization. A copy of this authorization shall be as valid as the original. I acknowledge receipt of copies of the prenotifications relating to investigative consumer reports and the MIB.

AR - 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. **DC** - 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 may 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.

Part K - Owner's Taxpayer ID Number Certification

Under penalties of perjury, I certify that (1) the number shown on this application is my correct taxpayer identification number; (2) the IRS has never notified me that I am subject to backup withholding, or has notified me that I am no longer subject to such withholding or I am exempt from such withholding; and (3) I am a U.S. person (including a U.S. resident alien). You must cross out item 2 if you have been notified by the IRS that you are currently subject to backup withholding because of underreporting interest or dividends on your tax return.

Part L - Signatures

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

Signed at (City & State) _____ Date (mm/dd/yyyy) _____

Proposed Insured (Sign name in full)

Applicant (Sign name in full if other than Proposed Insured)

Soliciting Agent/Representative (Sign name in full)

Owner (If other than Applicant or Proposed Insured)

For Check-O-Matic Only (If Depositor other than Applicant/Owner)
Depositor (Exactly as it appears on bank records)

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Supporting Document Schedules

	Item Status:	Status Date:
Satisfied - Item: Flesch Certification		
Comments:		
Attachment: AR Readability.pdf		

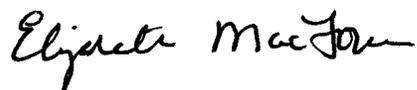
	Item Status:	Status Date:
Satisfied - Item: Application		
Comments: Application included under the form schedule tab.		

	Item Status:	Status Date:
Bypassed - Item: Life & Annuity - Acturial Memo		
Bypass Reason: N/A		
Comments:		

Arkansas Certification

This is to certify that the attached form number 8852(0610) has achieved a Flesch Reading Score of 58.3 and complies in all respects with the requirements of Arkansas Statute Annotated Section 66-3251 through 66-3258, cited as the Life and Disability Insurance Policy Language Simplification Act.

National Life Insurance Company



Elizabeth MacGowan
Vice President
Product Development

April 27, 2010

Date