

SERFF Tracking Number: WDMM-126692087 State: Arkansas  
Filing Company: Woodmen of the World Life Insurance Society State Tracking Number: 46037  
Company Tracking Number: REVISED LIFE APPS 5055 R-3/10, 601 R-3/10, 943 R-3/10, 956 R-3/10  
TOI: L08 Life - Other Sub-TOI: L08.000 Life - Other  
Product Name: Revised Life App 5055 R-3/10 & Related Forms  
Project Name/Number: /

## Filing at a Glance

Company: Woodmen of the World Life Insurance Society

Product Name: Revised Life App 5055 R-3/10 & SERFF Tr Num: WDMM- State: Arkansas

Related Forms 126692087

TOI: L08 Life - Other SERFF Status: Closed-Approved- State Tr Num: 46037  
Closed

Sub-TOI: L08.000 Life - Other Co Tr Num: REVISED LIFE APPS State Status: Approved-Closed  
5055 R-3/10, 601 R-3/10, 943 R-  
3/10, 956 R-3/10

Filing Type: Form

Reviewer(s): Linda Bird  
Author: Lee Ann Anderson Disposition Date: 06/25/2010  
Date Submitted: 06/24/2010 Disposition Status: Approved-  
Closed

Implementation Date Requested: On Approval

Implementation Date:

State Filing Description:

## General Information

Project Name:

Status of Filing in Domicile: Authorized

Project Number:

Date Approved in Domicile:

Requested Filing Mode:

Domicile Status Comments: Approved in  
domicile by Interstate Insurance Product  
Commission on 6-21-10

Explanation for Combination/Other:

Market Type: Individual

Submission Type: New Submission

Group Market Size:

Overall Rate Impact:

Group Market Type:

Filing Status Changed: 06/25/2010

Explanation for Other Group Market Type:

State Status Changed: 06/25/2010

Deemer Date:

Created By: Lee Ann Anderson

Submitted By: Lee Ann Anderson

Corresponding Filing Tracking Number:

Filing Description:

The attached forms are being submitted for your review and approval. These forms were previously filed and approved by your Department on May 10, 2010 (SERFF Filing #WDMM-126590160). These forms have not yet been used by Woodmen therefore the form numbers will not be changed. These forms have been revised to be consistent with changes required upon filing these forms with the Interstate Insurance Product Commission. The changes that have

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been made are listed below.

#### APPLICATION FORM 5055 R-3/10

- Added to item A under Lodge Membership (Section 5) the wording “Assign to “Active” Lodge Number \_\_\_\_\_ State \_\_\_\_\_”.
- Under the Benefits & Riders section of Lodge Membership (Section 5), “Accelerated Benefit Rider” has been changed to “Accelerated Death Benefit Rider”.
- Replaced the wording “ever” with the wording “in the past 5 years” in question B under Applicant Waiver Rider under Life Insurance (Section 7).
- Revised question 8 under Medical (Section 14) to read “If “Yes”, indicate due date and if any complications of pregnancy have been diagnosed by a member of the medical profession.”
- Under Premium Deposit (Section 18), the option for Credit Card has been removed.

#### MEDICAL SUPPLEMENTARY STATEMENT FORM 601 R-3/10

Question 8 under the Medical section has been revised to read “If “Yes”, indicate due date and if any complications of pregnancy have been diagnosed by a member of the medical profession.”

#### ADMINISTRATIVE SUPPLEMENTARY STATEMENT FORM 943 R-3/10

Revised question B under Applicant Waiver Rider (Section 5) by replacing “ever” with “in the past 5 years”.

#### UNDERWRITING SUPPLEMENTARY STATEMENT FORM 956 R-3/10

The heading of Travel (Section 6) has been revised by deleting the wording “age 16 and over”.

These forms will be used with life certificates approved by your department. These forms will be produced in both paper and electronic form. The electronic form may have an electronic signature. Individually licensed field representatives will solicit both the paper and electronic forms. The forms are not intended for Internet use.

Application for Life Insurance and Membership Form 5055 R-3/10 is a fully underwritten application which will be used to apply for a new certificate, to reinstate a certificate, and to change an existing certificate. However, only one of these transactions can be done per application form.

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Supplementary Statements, Form 601 R-3/10, Form 943 R-3/10, and Form 956 R-3/10 will be used with Application Form 5055 R-3/10. The completion of a supplementary statement is required when, during the underwriting process, it is learned that on the original application an answer to a question was omitted or a question was answered "yes" but details were not given. The applicable proposed insured will be required to complete only the corresponding question(s) on the appropriate supplementary statement. We do not require the completion of the entire form.

The enclosed forms are submitted in final print and are subject to only minor modification in paper stock, ink, border, company logo, and adaptation to electronic media and computer printing.

## Company and Contact

### Filing Contact Information

Lee Ann Anderson, Senior Compliance Analyst landerson@woodmen.org  
 1700 FARNAM STREET 402-661-6206 [Phone]  
 OMAHA, NE 68102 402-449-7732 [FAX]

### Filing Company Information

Woodmen of the World Life Insurance Society CoCode: 57320 State of Domicile: Nebraska  
 1700 FARNAM STREET Group Code: Company Type:  
 OMAHA, NE 68102 Group Name: State ID Number:  
 (402) 271-7279 ext. [Phone] FEIN Number: 47-0339250

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## Filing Fees

Fee Required? Yes  
 Fee Amount: \$200.00  
 Retaliatory? No  
 Fee Explanation: \$50.00 per form x 4 = \$200.00  
 Per Company: No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Woodmen of the World Life Insurance Society	\$200.00	06/24/2010	37491706

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## Correspondence Summary

### Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Linda Bird	06/25/2010	06/25/2010

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## Disposition

Disposition Date: 06/25/2010

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
Form	Application for Life Insurance and Membership		Yes
Form	Medical Supplementary Statement		Yes
Form	Administrative Supplementary Statement		Yes
Form	Underwriting Supplementary Statement		Yes

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## Form Schedule

### Lead Form Number:

Schedule Item Status	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
	Form 5055 R-3/10	Application/ Enrollment Form	Application for Life Insurance and Membership	Initial		52.300	5055 R-3-10 Revised.pdf
	Form 601 R-3/10	Other	Medical Supplementary Statement	Initial		53.300	601 R-3-10 Revised.pdf
	Form 943 R-3/10	Other	Administrative Supplementary Statement	Initial		53.100	943 R-3-10 Revised.pdf
	Form 956 R-3/10	Other	Underwriting Supplementary Statement	Initial		55.600	956 R-3-10 Revised.pdf

**WOODMEN OF THE WORLD LIFE INSURANCE SOCIETY**  
**1700 Farnam Street Omaha, Nebraska 68102**

APPLICATION FOR INDIVIDUAL  
 LIFE INSURANCE AND  
 MEMBERSHIP

New Certificate Number:  This Change to Affect Certificate Number:

Field Representative Code: 123456  New Certificate  Reinstatement  Change Existing Certificate  Term Conversion

**1 PROPOSED INSURED (The insured is the applicant owner unless otherwise designated in Section 3.)**

First	Middle Initial	Last	Suffix	Social Security Number
John	K	Woodmen		123-45-6789

Street Address (Residence of Proposed Insured) Apt/Unit #  
 1234 Main Street

City	State	Zip
Omaha	NE	68102

Mailing Address is the same as above Street Address  
 Mailing Address if Different from Residence City State Zip

Sex	Date of Birth (MM/DD/YYYY)	Age Now	Rating Age	Birth State/Country	Telephone Day (402) 231-1234
M	11/01/1974	35	35	NE	Eve (402) 123-4321

**2 PROPOSED ADULT APPLICANT (Complete only if proposed insured is age 0 - 15.)**

First	Middle Initial	Last	Suffix	Social Security Number
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Street Address (Residence of Proposed Adult Applicant) Apt/Unit #

City	State	Zip	Occupation and Duties
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Mailing Address is the same as above Street Address  
 Mailing Address if Different from Residence City State Zip

Sex	Date of Birth (MM/DD/YYYY)	Telephone Day	Relationship to Proposed Insured (If Legal Guardian, submit copy of Letters of Guardianship)
		Eve	

**OWNERSHIP TYPE If no ownership type is checked, the proposed adult applicant will be the controller of the certificate.**

**PROPOSED ADULT APPLICANT IS CONTROLLER** - The youth insured will be the owner of the certificate. The adult applicant will retain control over the certificate until the youth insured reaches the age of majority. The applicant controller can exercise all rights in the certificate, except for the right of assignment, on behalf of the youth insured until the youth insured reaches the age of majority.

**PROPOSED ADULT APPLICANT IS OWNER** - The adult applicant will be the owner of the certificate. The adult applicant will have the right to exercise all rights in the certificate.

**3 PROPOSED APPLICANT OWNER (Complete only if different than proposed insured. Not applicable if the proposed insured is age 0-15.)**

Owner is:  Individual, different than proposed insured  Partnership  Corporation  Trust  Other

Name	Social Security No./Tax ID No.
------	--------------------------------

Street Address (Residence if Individual)	Apt./Unit #	State & Date of Trust/Corporation/Partnership
		Mo. Day Year

City	State	Zip
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Mailing Address is the same as above Street Address  
 Mailing Address if Different from Street Address City State Zip

Sex	Date of Birth (MM/DD/YYYY)	Telephone Day	Relationship to Proposed Insured
		Eve	

**4 PROPOSED JOINT APPLICANT OWNER (Complete only if different than proposed insured. Not applicable if the proposed insured is age 0-15.)**

Joint Owner is:  Individual, different than proposed insured  Partnership  Corporation  Trust  Other

Name \_\_\_\_\_ Social Security No./Tax ID No. \_\_\_\_\_

Street Address (Residence if Individual) \_\_\_\_\_ Apt./Unit # \_\_\_\_\_ State & Date of Trust/Corporation/Partnership  
 Mo. \_\_\_\_\_ Day \_\_\_\_\_ Year \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Mailing Address is the same as above Street Address

Mailing Address if Different from Street Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Sex	Date of Birth (MM/DD/YYYY)	Telephone Day Eve	Relationship to Proposed Insured
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Check here if more than two owners. Complete a Supplementary Statement for additional owners.

**5 LODGE MEMBERSHIP (Applies to proposed insured.)**

- A.  New Member - Assign to "Active" Lodge Number \_\_\_\_\_ 1 \_\_\_\_\_ State \_\_\_\_\_ NE \_\_\_\_\_
- B.  Current Member - No Lodge Change
- C.  Current Member - New Lodge Number \_\_\_\_\_ State \_\_\_\_\_ (Do Not Transfer Existing Certificates)
- D.  Current Member - New Lodge Number \_\_\_\_\_ State \_\_\_\_\_ (Transfer All Existing Certificates)

**6 TYPE OF CHANGE OR TERM CONVERSION**

Certificate Number(s) to change or convert: \_\_\_\_\_

**CONVERSION**

- Convert \$ \_\_\_\_\_ of certificate or rider  Retain \$ \_\_\_\_\_ as term insurance
- Exercise Additional Insurance Option/Guaranteed Insurability Rider option  
 Note: Flexible Life increases **ONLY** available as a result of AIO Rider attached to Flexible Life.
- Convert to a new product
- Increase existing Adjustable Life certificate number \_\_\_\_\_ **BY** \$ \_\_\_\_\_
- Increase existing Adjustable Life certificate number \_\_\_\_\_ so that the **total face amount** will be \$ \_\_\_\_\_

**CHANGE**

- 90 day change
- Consider for possible rate reduction/removal
- Consider for non-tobacco classification
- Decrease **TO** \$ \_\_\_\_\_
- Purchase paid-up insurance with refunds on deposit
- Increase existing Adjustable Life certificate number \_\_\_\_\_ **BY** \$ \_\_\_\_\_
- Increase existing Adjustable Life certificate number \_\_\_\_\_ so that the **total face amount** will be \$ \_\_\_\_\_
- Change from Exclude to Include (Adjustable Life & Flexible Life only)
- Change from Include to Exclude (Adjustable Life & Flexible Life only)

**7 LIFE INSURANCE**

Kind of Basic Certificate Applied For: No Lapse GUAR UL (NLGUL) Amount \$ 50,000

**Adjustable Life & Flexible Life Only (Choose One)**  Include Cash Value  Exclude Cash Value

**For No Lapse Guarantee Universal Life Only**

Planned Premium payable to certificate anniversary following age: **(Choose One)**  80  100  120

**BENEFITS & RIDERS**

Additional Insurance Option/Guaranteed Insurability Rider . . . . .  Add Amount \$ \_\_\_\_\_  
(Not available for No Lapse Guarantee Universal Life)  Reduce **TO** Amount \$ \_\_\_\_\_

Remove

Accidental Death Benefit Rider (Amount calculated by the Home Office). . .  Add Amount \$ \_\_\_\_\_

Reduce **TO** Amount \$ \_\_\_\_\_

Remove

Disability Income Rider . . . . .  Reduce **TO** Amount \$ \_\_\_\_\_

Remove

Accelerated Death Benefit Rider (included unless "No" checked here) . . .  No  Add  Remove

Applicant Waiver Rider . . . . .  Add  Remove  
(Youth Applications Only - Proposed Insured Age 0-15)

Applicant's Certificate Number \_\_\_\_\_ **Applicant must be a member of Woodmen and age 16-55.**

A. Is the applicant currently working at least 30 hours per week and performing his/her regular duties of employment?  Yes  No  
If "No", give details. \_\_\_\_\_

B. In the past 5 years has the applicant filed for disability benefits or been compensated for a disabling condition? . . .  Yes  No  
If "Yes", give details. \_\_\_\_\_

C. Is the applicant currently taking any medications? . . . . .  Yes  No  
If "Yes", state name of drug and condition requiring it. \_\_\_\_\_

**ADDITIONAL BENEFITS & RIDERS AVAILABLE FOR TRADITIONAL LIFE ONLY**

Kind of Term Rider: \_\_\_\_\_ . . . . .  Add Amount \$ \_\_\_\_\_

Reduce **TO** Amount \$ \_\_\_\_\_

Remove

Waiver of Premium Rider . . . . .  Add  Remove

Automatic Premium Loan Provision . . . . .  Add  Remove

**ADDITIONAL BENEFITS & RIDERS AVAILABLE FOR UNIVERSAL LIFE ONLY**

Waiver of Monthly Deduction Rider . . . . .  Add  Remove

2X Waiver of Monthly Deduction Rider . . . . .  Remove

Cost of Living Adjustment Rider . . . . .  Remove

Waiver of Premium Rider on Adjustable Life Increases only  
(original certificate must be issued prior to 9/88) . . . . .  Add  Remove

**8 REFUND OPTION**

Unless specifically stated otherwise in your contract, if no option, more than one option, or an unavailable option is checked, refunds will be:

- left with Woodmen at interest on renewable Term and No Lapse Guarantee Universal Life
- used to buy paid-up additions on Whole Life and Youth Term, or
- used as additional premium on Adjustable Life and Flexible Life

Available for Traditional Life Only	Available for Adjustable Life & Flexible Life Only	Available for No Lapse Guarantee Universal Life Only
<input type="checkbox"/> Cash <input type="checkbox"/> Paid-up additions <input type="checkbox"/> Left with Woodmen at interest <input type="checkbox"/> Apply to reduce annual premium (Not available with Pre-Authorized Collection)	<input type="checkbox"/> Cash <input type="checkbox"/> Used as Additional Premium For Adjustable Life and Flexible Life, after maximum cash value (Choose One): <input type="checkbox"/> Paid in cash <input type="checkbox"/> Used to purchase additional insurance <input type="checkbox"/> Left with Woodmen at interest	<input type="checkbox"/> Cash <input checked="" type="checkbox"/> Left with Woodmen at interest

**9 BENEFICIARY**

- ◆ For **reinstatements, changes and increases in face amounts**: Completion of this section will revoke all previous beneficiary designations for this certificate.
- ◆ For **term conversions**: Completion of this section will apply only to the new certificate issued as a result of this application. Previous beneficiary designations for any existing certificate or any portion of existing certificate(s) not converted as a result of this application will remain in effect and will not be revoked. If the beneficiary is to be changed for any existing certificate(s), please submit Beneficiary Change Form 181.
- ◆ For **Additional Insurance Option/Guaranteed Insurability Rider** option exercised to increase the face amount: Completion of this section will revoke all previous beneficiary designations for this certificate.
- ◆ For **new certificate issued as a result of exercising Additional Insurance Option/Guaranteed Insurability Rider** option: Completion of this section will apply to the new certificate only. Previous beneficiary designations for any existing certificate(s) will remain in effect and will not be revoked. If the beneficiary is to be changed for any existing certificate(s), please submit Beneficiary Change Form 181.

**PRIMARY BENEFICIARY**

Name	City	State	Relationship	Age or Date of Birth	Social Security No./ Tax ID Number
Joseph Woodmen	Omaha	NE	Brother	45	123-66-6666

**ALTERNATE BENEFICIARY**

Name	City	State	Relationship	Age or Date of Birth	Social Security No./ Tax ID Number

**UNLESS OTHERWISE STATED IN WRITING, THE FOLLOWING CONDITIONS APPLY**

- The death benefit, when paid to all surviving primary beneficiaries, is paid equally in one sum.
- If there are no surviving primary beneficiaries, the death benefit is paid equally in one sum to all surviving alternate beneficiaries.
- The beneficiary will have the right to change the method by which the death benefit is paid after the death of the insured.

**10 TOBACCO USAGE (Applies to proposed insured age 18 and over.)**

In the past **12 months**, has the proposed insured used tobacco/nicotine in any form, such as cigarettes, pipes, cigars, snuff or chewing tobacco OR smoking cessation products such as nicotine patches or nicorette gum? . . . . .  Yes  No

A. If "Yes", indicate date last used: mo. \_\_\_\_\_ yr. \_\_\_\_\_ Indicate form(s) used: \_\_\_\_\_  
If cigarettes, how many packs per day? \_\_\_\_\_ If cigars, indicate quantity and frequency: \_\_\_\_\_

B. If "No", has the proposed insured used tobacco/nicotine in any form OR smoking cessation products in the last **36 months**? . . . . .  Yes  No

**11 OCCUPATION (Applies to proposed insured age 16 and over.)**

Occupation and Duties Teacher	Annual Income (Nearest \$10,000) 50000	How Long in Present Occupation? 10y
Name of Employer and Nature of Business Abc High School	Address of Business 123 Education Street	Previous Occupation

**12 NONMEDICAL (Applies to proposed insured age 14 and over.)**

A. Does the proposed insured have a current driver's license/permit?  
 No, explain why no license/permit: \_\_\_\_\_

Yes, Driver's License/Permit Number: 234567 State: NE

B. Is the proposed insured currently a United States citizen? If "No", provide permanent resident card number:  Yes  No

C. Has the proposed insured ever had a license/permit suspended or revoked? . . . . .  Yes  No

D. Has the proposed insured had any moving traffic violations or traffic accidents within the past three years? . . . . .  Yes  No

E. Has the proposed insured been convicted of or pled guilty or no contest to driving while intoxicated or under the influence of a narcotic drug? . . . . .  Yes  No

F. Has the proposed insured been convicted of or pled guilty or no contest to a crime within the past 10 years, or is the proposed insured currently awaiting trial for any crime? . . . . .  Yes  No

G. Is the proposed insured currently on probation or parole? . . . . .  Yes  No

H. Is the proposed insured a member of the U.S. Armed Services or active reserve? . . . . .  Yes  No  
If "Yes", has the proposed insured been alerted of possible deployment? If "Yes", give details below. . . . .  Yes  No

**If any question C-H has been answered "Yes", give dates and full details.**

\_\_\_\_\_

I. Within the next 12 months, does the proposed insured intend to travel or reside outside of the U.S., Canada or any U.S. territories? If "Yes", submit details on Form 956. . . . .  Yes  No

J. In the past 3 years has the proposed insured participated in aviation as a pilot, crew member or student – to include sky diving, hang gliding, ballooning, ultralight, and other sky sports – or intends to within the next 2 years? If "Yes", submit an Aviation Questionnaire. . . . .  Yes  No

K. In the past 3 years has the proposed insured participated in racing of any type, skin or scuba diving, boxing, ultimate fighting or mountain climbing – or intends to within the next 2 years? If "Yes", submit an Avocation Questionnaire . . . . .  Yes  No

**13 YOUTH INFORMATION (Applies to proposed insured age 0-15.)**

A. Does the child live with the natural or adoptive parent(s)? If "No", explain why . . . . .  Yes  No

\_\_\_\_\_

B. Does the child have brothers and/or sisters?  Yes  No (If "Yes", indicate amount of coverage carried on each child and their ages.) \_\_\_\_\_

C. Indicate amount of insurance carried by Father \$ \_\_\_\_\_  
Indicate amount of insurance carried by Mother \$ \_\_\_\_\_

**14 MEDICAL**

Applies to proposed insured. If proposed insured is age 0-15, questions 1 through 9 are to be answered by whoever has the best knowledge of the child's health history. (Usually the person with whom the child resides.)

1. **Physician or medical facility that has the proposed insured's most complete and current medical records:**  

Dr. Thomas Shepard			(402) 322-3241
Physician/Facility Name		Phone Number	
111 Medical Street	Omaha	NE	68102
Address	City	State	Zip
Date Last Seen	10/15/2009	Reason For Visit	Annual Check-up
  
2. **Has the proposed insured had or ever been diagnosed, treated, tested positive for or been given medical advice by a member of the medical profession for any disease or disorder of the:** YES NO
  - A. Brain or Nervous System – such as epilepsy, paralysis or mental illness – to include treatment or counseling for depression or anxiety? . . . . . A.  YES  NO
  - B. Respiratory System – such as emphysema, bronchitis, asthma or sleep apnea– to include disorders of the eyes, ears, nose or throat? . . . . . B.  YES  NO
  - C. Circulatory System – such as high blood pressure, chest pain, heart attack, heart surgery, heart murmur, stroke, or phlebitis? . . . . . C.  YES  NO
  - D. Digestive or Urinary Tract Systems – such as ulcer, colitis, hepatitis, kidney infection, kidney stones, protein, blood or sugar in the urine – to include diabetes and thyroid disorders? . . . . . D.  YES  NO
  - E. Musculoskeletal System – such as arthritis, gout, back disorders, or any connective tissue disorders? . . . . . E.  YES  NO
  - F. Reproductive System – such as prostate, testes, breasts, ovaries or uterus disorders? . . . . . F.  YES  NO
  - G. Immune System – such as lupus, multiple sclerosis or scleroderma except those related to the Human Immunodeficiency Virus?. . . . . G.  YES  NO
  
3. **Has the proposed insured ever:**
  - A. Been diagnosed or treated for cancer or tumor of any kind? . . . . . A.  YES  NO
  - B. Had or been advised to have any surgical operation? . . . . . B.  YES  NO
  - C. Been treated or received counseling for alcohol use, alcoholism or drug addiction? If "Yes", submit an Alcohol & Drug Questionnaire . . . . . C.  YES  NO
  - D. Used narcotics, barbiturates, excitant drugs, hallucinogens or tranquilizers without a prescription by a physician? If "Yes", submit an Alcohol & Drug Questionnaire . . . . . D.  YES  NO
  
4. **Has the proposed insured been diagnosed by a member of the medical profession or tested positive for Human Immunodeficiency Virus (AIDS Virus) or Acquired Immune Deficiency Syndrome (AIDS)?** . . . . . 4.  YES  NO
  
5. **At any time in the past five years, has the proposed insured been treated or diagnosed by a medical professional with any other illness or injury not mentioned above?** . . . . . 5.  YES  NO
  
6. **During the past five years has the proposed insured:**
  - A. Consulted, been examined by, treated by or received diagnostic tests (e.g., X-rays, ECG, or blood studies except those tests related to the Human Immunodeficiency Virus (AIDS Virus)) from a physician, hospital, clinic or similar institution? . . . . . A.  YES  NO
  - B. Received a pension, applied for or been compensated for disability? If "Yes", please explain . . . . . B.  YES  NO
  - C. Had an application for life, health, accident or disability insurance declined, postponed, rated up or modified? If "Yes", please explain what action was taken and why . . . . . C.  YES  NO
  
7. **Does the proposed insured take medication, use medical assistive devices or equipment (e.g. CPAP, oxygen)?** If "Yes", state the name of the drug or describe the device and condition requiring it. . . . . 7.  YES  NO
  
8. **Is the proposed insured now pregnant?** If "Yes", indicate due date and if any complications of this pregnancy have been diagnosed by a member of the medical profession. . . . . 8.  YES  NO
  
9. A. **Proposed Insured's Height:** 6 ft. 0 in. **Weight:** 210 lbs.  
 B. Has weight changed more than 15 pounds in the past year? If "Yes", indicate how much and by what means: B.  YES  NO

**14 MEDICAL, Continued**

**If any question 2-8 has been answered "Yes", give full details below:**

Question Number	Diagnosis	Treatment/ Medication	Dates From/To	Name, Address & Phone Number Of Health Care Professional/Facility

If more space is needed for Medical details, include an additional page, signed and dated.

**15 FAMILY HISTORY (Applies to proposed insured.)**

- A. Has a parent or sibling been diagnosed or treated by a member of the medical profession for cardiovascular disease or cancer prior to age 60? . . . . .  Yes  No  
 If "Yes", give details \_\_\_\_\_
- B. Did death of a parent or sibling occur prior to age 60 due to cardiovascular disease or cancer? . . . . .  Yes  No

**16 REPLACEMENT** The proposed applicant is the insured, unless an adult applicant (youth application) or an owner other than the proposed insured is designated. Submit replacement forms, if required.

- A. Does the proposed applicant have any existing life insurance or annuity contracts? . . . . .  Yes  No
- B. Will any existing life or annuity contracts be replaced if the proposed certificate is issued? . . . . .  Yes  No
- C. Will a 1035 exchange be involved? (If "Yes", submit Form 1035 for companies other than Woodmen.) . . . . .  Yes  No
- If B or C is answered "Yes", provide policy number and company information below for the policy being replaced.

Policy Number	Company Name	Address	City	State	Zip

**17 INSURANCE NOW IN FORCE OR APPLIED FOR**

List all policies currently in force or applied for on the **proposed insured** not described in Section 16. **If none, check here.**

Company Name	Policy Number	Kind	Life Insurance Amount	Accidental Death Amount	Year Issued

**18 PREMIUM DEPOSIT**

1. Cash/Cash Equivalent Amount: \$ \_\_\_\_\_ (Submit Cash Receipt)
2. Refunds on Deposit Amount: \$ \_\_\_\_\_
3. Cash Surrender Value Amount: \$ \_\_\_\_\_
4. Check Amount: \$ 100.00
5. Express Check Amount: \$ \_\_\_\_\_
6. No Premium Deposit Has Been Made
- Total Amount To Be Applied: \$ 100.00 Premium and \$ 12.00 Fraternal Dues As Payment for 12 Months.

Payor Name: \_\_\_\_\_ Relationship to Proposed Insured: \_\_\_\_\_

If 1-5 is selected on an application for a new certificate, give conditional receipt to applicant; if 2, 3, or 5 is selected, also submit proper authorization.

P.A.C. authorizations, List Bill, and 1035 exchange requests to companies other than Woodmen are NOT premium deposits for RECEIPT AND CONDITIONAL INSURANCE AGREEMENT purposes.

**Advance Premiums:** \$ \_\_\_\_\_ No future payments until advance premium depleted.

Max Out at issue for Adjustable Life & Flexible Life only

**For Conversions Only** – Any credits should be applied as follows:

Additional Premium for Traditional Life     Premium for Universal Life     Refund any credits

**19 FOR ADJUSTABLE LIFE & FLEXIBLE LIFE ONLY**

If the premium paid at issue or at any time thereafter would cause the certificate to be classified as a modified endowment contract (MEC) because the premium exceeds the amount allowed by the Internal Revenue Code (IRC), I choose one of the following:

- Allow the certificate to become a MEC (excess premium is added to the certificate's cash value).
- Not allow the certificate to become a MEC by placing the excess premium paid at issue or at any time thereafter into an advance premium fund that earns interest. Interest earned will be reported annually to the IRS. Woodmen is authorized to automatically transfer money from the advanced premium fund to the certificate's cash value once a year. The amount transferred each year will not exceed the amount allowed by the IRC based on Woodmen's understanding of the requirements of the IRC.

**20 FUTURE BILLING**

Billing Method		Frequency
<input checked="" type="checkbox"/> New P.A.C. plan *	<input type="checkbox"/> Do Not Send Future Billing	<input type="checkbox"/> Annually
<input type="checkbox"/> Add to present P.A.C. plan (list one certificate number currently being paid on plan)	<input type="checkbox"/> Direct Bill	<input checked="" type="checkbox"/> Semiannually
<b>P.A.C. billing not available with refund option</b>	<input type="checkbox"/> Government Allotment (Military)	<input type="checkbox"/> Quarterly
<b>Apply To Reduce Annual Premium</b>	<input type="checkbox"/> List Bill *	<input type="checkbox"/> Monthly
CERTIFICATE NO. _____	Group Number: _____	
Payor's Name: _____	* Submit proper authorizations	
Bank Acct. No.: _____		
<b>For Universal Life Only</b>		
Planned Premium, excluding fraternal dues for selected frequency: \$ 100.00		

**21 PAYOR INFORMATION**

Proposed Insured     Adult Applicant     Applicant Owner     Joint Applicant Owner     Other (Complete below)

First \_\_\_\_\_ Middle Initial \_\_\_\_\_ Last \_\_\_\_\_ Suffix \_\_\_\_\_

Address \_\_\_\_\_ Apt/Unit # \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Relationship to Proposed Insured \_\_\_\_\_ Date of Birth (MM/DD/YYYY) \_\_\_\_\_ Social Security Number \_\_\_\_\_

**22 PARENT OR LEGAL GUARDIAN'S CONSENT**

**(To be completed ONLY when the proposed adult applicant is not a parent or legal guardian.)**

I, the parent or legal guardian, give my consent to this application on the child's life and the beneficiaries as designated.

I have received a copy of the "Notice Relating to the MIB (Medical Information Bureau)", "Notice Required Under the Fair Credit Reporting Act" and if applicable the "Notice of Information Practices".

**Certification Instructions** – You must cross out the language in item (2) within this box if the child has been notified by the IRS that the child is currently subject to backup withholding because of underreporting interest or dividends on a tax return.

Under penalties of perjury, I, the undersigned parent or legal guardian, certify:

- (1) the number shown on this application represents the correct Taxpayer Identification Number (TIN) of the proposed insured child AND
- (2) the same is not subject to backup withholding because: (a) the child is exempt from backup withholding, or (b) the child has not been notified by the IRS that he/she is subject to backup withholding as a result of a failure to report all interest or dividends, or (c) the IRS has notified the child that he/she is no longer subject to backup withholding, AND
- (3) the child is a United States person (including a United States resident alien).

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

\_\_\_\_\_  
Signature of Parent or Legal Guardian

\_\_\_\_\_  
Date

\_\_\_\_\_  
Relationship to the Proposed Insured  
(If Legal Guardian, submit copy of  
Letters of Guardianship)

**23 ACKNOWLEDGEMENT AND AGREEMENT**

The following statements must be read by or to the proposed insured and any proposed applicant owner or the proposed adult applicant:

I have received a copy of the "Notice Relating to the MIB (Medical Information Bureau)", "Notice Required Under the Fair Credit Reporting Act" and if applicable the "Notice of Information Practices".

The Accelerated Death Benefit Disclosure Statement has been given to me, the applicant owner, if applicable.

I have read this application. I represent that each of the answers and the information given therein is full, complete and true, to the best of my knowledge and belief, with the understanding that they shall be considered as representations and not warranties. I agree as follows:

- 1. Notice to or knowledge of any Field Representative or medical examiner as to information which relates to the proposed insured will not be notice to Woodmen unless it is in writing in this application.
- 2. Field Representatives do not have authority to (a) determine insurability; (b) change any terms of this application; (c) make or change a contract for Woodmen; (d) waive any rights or requirements of Woodmen. I understand that oral statements between the Field Representative and myself regarding such matters of limited authority are not binding on Woodmen unless accepted by Woodmen in writing.

I agree to be bound by the terms of this application and the life insurance certificate for which I am applying. I also agree to be bound by all obligations set forth in Woodmen's Articles of Incorporation and its Constitution and Laws and I acknowledge Woodmen's common bond and purpose.

**Applications for New Certificate:**

Except for coverage which may be provided in the RECEIPT AND CONDITIONAL INSURANCE AGREEMENT, no insurance will be in force because of this application until it has been approved and at least one monthly premium has been paid to Woodmen.

**Applications for Reinstatement, Change to Existing Certificate, or Term Conversion:**

I agree this application shall not be construed as extending temporary insurance coverage on the life of the proposed insured. Reinstatement of or change to existing insurance will be effective and coverage will commence on the date this application is approved in the Home Office of Woodmen.

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.

**Certification Instructions**-You must cross out the language in item (2) within this box if you (and/or the child) have been notified by the IRS that you (and/or the child) are currently subject to backup withholding because of underreporting interest or dividends on a tax return.

Under penalties of perjury, I, the undersigned applicant, certify:

- (1) the number(s) shown on this application represents my (and/or the child's) correct Taxpayer Identification Number (TIN) AND
- (2) I (and/or the child) am not subject to backup withholding because: (a) I (and/or the child) am exempt from backup withholding, or (b) I (and/or the child) have not been notified by the IRS that I (and/or the child) am subject to backup withholding as a result of a failure to report all interest or dividends, or (c) the IRS has notified me (and/or the child) that I (and/or the child) am no longer subject to backup withholding, AND
- (3) I (and/or the child) am a United States person (including a United States resident alien).

**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 Omaha NE  
City State

**By checking this box, I the proposed applicant, acknowledge this application was signed in a different state than the state in which I reside.**

John K Woodmen 04/01/2010  
Signature of Proposed Insured, Date  
if age 16 or older OR  
Signature of Proposed Adult Applicant

\_\_\_\_\_  
Signature of Proposed Applicant Owner Date  
if not Proposed Insured &  
Title if Trust/Corporation/Partnership

\_\_\_\_\_  
Signature of Proposed Joint Applicant Owner Date  
& Title if Trust/Corporation/Partnership

\_\_\_\_\_  
Signature of Proposed Joint Applicant Owner Date  
& Title if Trust/Corporation/Partnership

\_\_\_\_\_  
Signature of Proposed Joint Applicant Owner Date  
& Title if Trust/Corporation/Partnership

**24 FIELD REPRESENTATIVE'S CERTIFICATION** The proposed applicant is the insured, unless an adult applicant (youth application) or an owner other than the proposed insured is designated. Submit replacement forms, if required.

- 1. Were you present when this application was signed? (If "No", submit a full explanation with the application) . . .  Yes  No
- 2. Does the proposed applicant have any existing life insurance or annuity contracts? . . . . .  Yes  No
- 3. Do you have knowledge or reason to believe that replacement of existing insurance or annuities was or may be involved? (If "Yes", submit replacement forms, if required) . . . . .  Yes  No
- 4. Did you see the proposed insured when this application was written? (If "No", submit a full explanation with the application) . . . . .  Yes  No
- 5. I asked each question exactly as written and accurately recorded the information supplied in this application.

Primary FR Code \_\_\_\_\_ %  
Secondary FR Code \_\_\_\_\_ %  
Third FR Code \_\_\_\_\_ %

Thomas K Smith 04/01/2010  
Field Representative's Signature Date

Thomas K Smith  
Field Representative's Name Printed

**WOODMEN OF THE WORLD LIFE INSURANCE SOCIETY**  
 **OMAHA WOODMEN LIFE INSURANCE SOCIETY**  
**1700 Farnam Street Omaha, Nebraska 68102**

CERTIFICATE NUMBER

MEDICAL  
 SUPPLEMENTARY  
 STATEMENT

New Certificate  Change Existing Certificate  
 Reinstatement  Term Conversion

Field Representative Code: 123456

**PROPOSED INSURED (The insured is the applicant owner unless otherwise designated.)**

First	Middle Initial	Last	Suffix
John	K	Woodmen	

Date of Birth (MM/DD/YYYY)	Social Security Number
11/01/1974	123-45-6789

**MEDICAL** Applies to proposed insured. If proposed insured is age 0-15, questions 1 through 9 are to be answered by whoever has the best knowledge of the child's health history. (Usually the person with whom the child resides.)

**1. Physician or medical facility that has the proposed insured's most complete and current medical records:**

Physician/Facility Name		Phone Number	
Address	City	State	Zip
Date Last Seen	Reason For Visit		

**2. Has the proposed insured had or ever been diagnosed, treated, tested positive for or been given medical advice by a member of the medical profession for any disease or disorder of the:**

- |   | YES                      | NO                       |
|---|--------------------------|--------------------------|
| A. Brain or Nervous System – such as epilepsy, paralysis or mental illness – to include treatment or counseling for depression or anxiety? . . . . .  | <input type="checkbox"/> | <input type="checkbox"/> |
| B. Respiratory System – such as emphysema, bronchitis, asthma or sleep apnea – to include disorders of the eyes, ears, nose or throat? . . . . .  | <input type="checkbox"/> | <input type="checkbox"/> |
| C. Circulatory System – such as high blood pressure, chest pain, heart attack, heart surgery, heart murmur, stroke, or phlebitis? . . . . .   | <input type="checkbox"/> | <input type="checkbox"/> |
| D. Digestive or Urinary Tract Systems – such as ulcer, colitis, hepatitis, kidney infection, kidney stones, protein, blood or sugar in the urine – to include diabetes and thyroid disorders? . . . . . | <input type="checkbox"/> | <input type="checkbox"/> |
| E. Musculoskeletal System – such as arthritis, gout, back disorders, or any connective tissue disorders? . . . . .  | <input type="checkbox"/> | <input type="checkbox"/> |
| F. Reproductive System – such as prostate, testes, breasts, ovaries or uterus disorders? . . . . .  | <input type="checkbox"/> | <input type="checkbox"/> |
| G. Immune System – such as lupus, multiple sclerosis or scleroderma except those related to the Human Immunodeficiency virus? . . . . .   | <input type="checkbox"/> | <input type="checkbox"/> |

**3. Has the proposed insured ever:**

- |   |    |                          |                                     |
|---|----|--------------------------|-------------------------------------|
| A. Been diagnosed or treated for cancer or tumor of any kind? . . . . .   | A. | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| B. Had or been advised to have any surgical operation? . . . . .  | B. | <input type="checkbox"/> | <input type="checkbox"/>            |
| C. Been treated or received counseling for alcohol use, alcoholism or drug addiction? If "Yes", submit an Alcohol & Drug Questionnaire . . . . .                                  | C. | <input type="checkbox"/> | <input type="checkbox"/>            |
| D. Used narcotics, barbiturates, excitant drugs, hallucinogens or tranquilizers without a prescription by a physician? If "Yes", submit an Alcohol & Drug Questionnaire . . . . . | D. | <input type="checkbox"/> | <input type="checkbox"/>            |

**4. Has the proposed insured been diagnosed by a member of the medical profession or tested positive for Human Immunodeficiency Virus (AIDS virus) or Acquired Immune Deficiency Syndrome (AIDS)? . . . . .**

4.  YES  NO

**5. At any time in the past five years, has the proposed insured been treated or diagnosed by a medical professional with any other illness or injury not mentioned above? . . . . .**

5.  YES  NO

**6. During the past five years has the proposed insured:**

- |  |    |                          |                          |
|--|----|--------------------------|--------------------------|
| A. Consulted, been examined by, treated by or received diagnostic tests (e.g., X-rays, ECG, or blood studies except those tests related to the Human Immunodeficiency Virus (AIDS Virus)) from a physician, hospital, clinic or similar institution? . . . . . | A. | <input type="checkbox"/> | <input type="checkbox"/> |
| B. Received a pension, applied for or been compensated for disability? If "Yes", please explain. . . . .   | B. | <input type="checkbox"/> | <input type="checkbox"/> |
| C. Had an application for life, health, accident or disability insurance declined, postponed, rated up or modified? If "Yes", please explain what action was taken and why . . . . .   | C. | <input type="checkbox"/> | <input type="checkbox"/> |

YES NO

7. **Does the proposed insured take medication, use medical assistive devices or equipment (e.g. CPAP, oxygen)?** If "Yes", state the name of the drug or describe the device and condition requiring it. . . . . 7.
8. **Is the proposed insured now pregnant?** If "Yes", indicate due date and if any complications of this pregnancy have been diagnosed by a member of the medical profession. . . . . 8.
9. A. **Proposed Insured's Height:** \_\_\_\_\_ ft. \_\_\_\_\_ in. **Weight:** \_\_\_\_\_ lbs.
- B. Has weight changed more than 15 pounds in the past year? If "Yes", indicate how much and by what means: B.

**If any question 2-8 has been answered "Yes", give full details below:**

Question Number	Diagnosis	Treatment/ Medication	Dates From/To	Name, Address & Phone Number Of Health Care Professional/Facility

If more space is needed for Medical details, include an additional page, signed and dated.

**I have read the answers written above. I ratify and agree to be bound by such answers and agree that they are true and complete to the best of my knowledge and belief. I agree they shall form part of this application.**

John K Woodmen

Signature of Proposed Insured,  
if age 16 or older OR  
Signature of Proposed Adult Applicant

04/01/2010

Date

WOODMEN OF THE WORLD LIFE INSURANCE SOCIETY

OMAHA WOODMEN LIFE INSURANCE SOCIETY

1700 Farnam Street Omaha, Nebraska 68102

Field Representative Code: 123456

CERTIFICATE NUMBER

[Empty box for Certificate Number]

ADMINISTRATIVE SUPPLEMENTARY STATEMENT

New Certificate  Change Existing Certificate

Reinstatement  Term Conversion

**PROPOSED INSURED (The insured is the applicant owner unless otherwise designated.)**

First	Middle Initial	Last	Suffix
John	K	Woodmen	

Date of Birth (MM/DD/YYYY)	Social Security Number
11/01/1974	123-45-6789

**1 CLARIFICATION OF PROPOSED INSURED'S NAME**

Please provide the correct full name.

First	Middle Initial	Last	Suffix
John	K	Woodmen	

**2 CLARIFICATION OF PROPOSED APPLICANT'S NAME**

The proposed applicant's name on the application and the signature differ. Please print your correct name.

First	Middle Initial	Last	Suffix
-------	----------------	------	--------

**3 PROPOSED ADULT APPLICANT (Complete only if proposed insured is age 0 - 15.)**

First	Middle Initial	Last	Suffix	Social Security Number
-------	----------------	------	--------	------------------------

Street Address (Residence of Proposed Adult Applicant)	Apt/Unit #
--	------------

City	State	Zip	Occupation and Duties
------	-------	-----	-----------------------

Mailing Address is the same as above Street Address

Mailing Address if Different from Residence	City	State	Zip	Relationship to Proposed Insured (If Legal Guardian, submit copy of Letters of Guardianship)
---	------	-------	-----	--

Sex	Date of Birth (MM/DD/YYYY)	Telephone Day	Eve
-----	----------------------------	---------------	-----

**OWNERSHIP TYPE** If no ownership type is checked, the proposed adult applicant will be the controller of the certificate.

**PROPOSED ADULT APPLICANT IS CONTROLLER** - The youth insured will be the owner of the certificate. The adult applicant will retain control over the certificate until the youth insured reaches the age of majority. The applicant controller can exercise all rights in the certificate, except for the right of assignment, on behalf of the youth insured until the youth insured reaches the age of majority.

**PROPOSED ADULT APPLICANT IS OWNER** - The adult applicant will be the owner of the certificate. The adult applicant will have the right to exercise all rights in the certificate.

**4 PROPOSED JOINT APPLICANT OWNER (Complete only if different than proposed insured. Not applicable if the proposed insured is age 0-15.)**

Joint Owner is:  Individual, different than proposed insured  Partnership  Corporation  Trust  Other

Name	Social Security No./Tax ID No.
------	--------------------------------

Street Address (Residence if Individual)	Apt./Unit #	State & Date of Trust/Corporation/Partnership
		Mo. Day Year

City	State	Zip
------	-------	-----

Mailing Address is the same as above Street Address

Mailing Address if Different from Street Address	City	State	Zip
--	------	-------	-----

Sex	Date of Birth (MM/DD/YYYY)	Telephone Day	Eve	Relationship to Proposed Insured
-----	----------------------------	---------------	-----	----------------------------------

**4 PROPOSED JOINT APPLICANT OWNER, (Continued)**

Joint Owner is:  Individual, different than proposed insured  Partnership  Corporation  Trust  Other

Name \_\_\_\_\_ Social Security No./Tax ID No. \_\_\_\_\_

Street Address (Residence if Individual) \_\_\_\_\_ Apt./Unit # \_\_\_\_\_ State & Date of Trust/Corporation/Partnership \_\_\_\_\_  
 Mo. Day Year

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Mailing Address is the same as above Street Address

Mailing Address if Different from Street Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Sex	Date of Birth (MM/DD/YYYY)	Telephone Day Eve	Relationship to Proposed Insured
-----	----------------------------	----------------------	----------------------------------

**5 APPLICANT WAIVER RIDER (Youth Applications Only - Proposed Insured Age 0-15)**

Applicant Waiver Rider . . . . .  Add  Remove

Applicant's Certificate Number: \_\_\_\_\_ **Applicant must be a member of Woodmen and age 16-55.**

A. Is the applicant currently working at least 30 hours per week and performing his/her regular duties of employment?  Yes  No  
 If "No", give details. \_\_\_\_\_

B. In the past 5 years has the applicant filed for disability benefits or been compensated for a disabling condition? . . .  Yes  No  
 If "Yes", give details. \_\_\_\_\_

C. Is the applicant currently taking any medications? . . . . .  Yes  No  
 If "Yes", state name of drug and condition requiring it. \_\_\_\_\_

**6 REPLACEMENT** The proposed applicant is the insured, unless an adult applicant (youth application) or an owner other than the proposed insured is designated. Submit replacement forms, if required.

A. Does the proposed applicant have any existing life insurance or annuity contracts? . . . . .  Yes  No

B. Will any existing life or annuity contracts be replaced if the proposed certificate is issued? . . . . .  Yes  No

C. Will a 1035 exchange be involved? (If "Yes", submit Form 1035 for companies other than Woodmen.) . . . . .  Yes  No

If B or C is answered "Yes", provide policy number and company information below for the policy being replaced.

Policy Number	Company Name	Address	City	State	Zip

**7 INSURANCE NOW IN FORCE OR APPLIED FOR**

List all policies currently in force or applied for on the **proposed insured** not described in Section 6. **If none, check here.**

Company Name	Policy Number	Kind	Life Insurance Amount	Accidental Death Amount	Year Issued

**8 VERIFICATION OF STATE SIGNED**

The state in which I signed the application was: \_\_\_\_\_

**9 VERIFICATION OF THE DATE OF APPLICATION**

The date I signed the application was: \_\_\_\_\_

**10 FIELD REPRESENTATIVE'S CERTIFICATION**      The proposed applicant is the insured, unless an adult applicant (youth application) or an owner other than the proposed insured is designated. Submit replacement forms, if required.

- 1. Were you present when this application was signed? (If "No", submit a full explanation). . . . .  Yes  No
- 2. Does the proposed applicant have any existing life insurance or annuity contracts? . . . . .  Yes  No
- 3. Do you have knowledge or reason to believe that replacement of existing insurance or annuities was or may be involved? (If "Yes", submit replacement forms, if required) . . . . .  Yes  No
- 4. Did you see the proposed insured when this application was written? (If "No", submit a full explanation with the application). . . . .  Yes  No
- 5. I asked each question exactly as written and accurately recorded the information supplied in this application.

Field Representative's Signature	Date	Field Representative's Name Printed
----------------------------------	------	-------------------------------------

**I have read the answers written above. I ratify and agree to be bound by such answers and agree that they are true and complete to the best of my knowledge and belief. I agree they shall form part of this application.**

<i>John K Woodmen</i>	04/01/2010
Signature of Proposed Insured, if age 16 or older OR Signature of Proposed Adult Applicant	Date

Signature of Proposed Applicant Owner if not Proposed Insured & Title if Trust/Corporation/Partnership	Date
--	------

Signature of Proposed Joint Applicant Owner & Title if Trust/Corporation/Partnership	Date
---	------

Signature of Proposed Joint Applicant Owner & Title if Trust/Corporation/Partnership	Date
---	------

Signature of Proposed Joint Applicant Owner & Title if Trust/Corporation/Partnership	Date
---	------

**WOODMEN OF THE WORLD LIFE INSURANCE SOCIETY**  
 **OMAHA WOODMEN LIFE INSURANCE SOCIETY**  
1700 Farnam Street Omaha, Nebraska 68102

CERTIFICATE NUMBER

UNDERWRITING  
SUPPLEMENTARY  
STATEMENT

Field Representative Code: 123456

New Certificate     Change Existing Certificate  
 Reinstatement     Term Conversion

**PROPOSED INSURED (The insured is the applicant owner unless otherwise designated.)**

First John	Middle Initial K	Last Woodmen	Suffix
---------------	---------------------	-----------------	--------

Date of Birth (MM/DD/YYYY) 11/01/1974	Social Security Number 123-45-6789
--	---------------------------------------

**1 TOBACCO USAGE (Applies to proposed insured age 18 and over.)**

In the past **12 months**, has the proposed insured used tobacco/nicotine in any form, such as cigarettes, pipes, cigars, snuff or chewing tobacco OR smoking cessation products such as nicotine patches or nicorette gum? . . . . .  Yes  No

A. If "Yes", indicate date last used: mo. \_\_\_\_\_ yr. \_\_\_\_\_ Indicate form(s) used: \_\_\_\_\_  
If cigarettes, how many packs per day? \_\_\_\_\_ If cigars, indicate quantity and frequency: \_\_\_\_\_

B. If "No", has the proposed insured used tobacco/nicotine in any form OR smoking cessation products in the last **36 months**? . . . . .  Yes  No

**2 OCCUPATION (Applies to proposed insured age 16 and over.)**

Occupation and Duties	Annual Income (Nearest \$10,000)	How Long in Present Occupation?
Name of Employer and Nature of Business	Address of Business	Previous Occupation

**3 NONMEDICAL (Applies to proposed insured age 14 and over.)**

A. Does the proposed insured have a current driver's license/permit?  
 No, explain why no license/permit: \_\_\_\_\_  
 Yes, Driver's License/Permit Number: \_\_\_\_\_ State: \_\_\_\_\_

B. Is the proposed insured currently a United States citizen? If "No", provide permanent resident card number:  Yes  No

C. Has the proposed insured ever had a license/permit suspended or revoked? . . . . .  Yes  No

D. Has the proposed insured had any moving traffic violations or traffic accidents within the past three years? . . . . .  Yes  No

E. Has the proposed insured been convicted of or pled guilty or no contest to driving while intoxicated or under the influence of a narcotic drug? . . . . .  Yes  No

F. Has the proposed insured been convicted of or pled guilty or no contest to a crime within the past 10 years, or is the proposed insured currently awaiting trial for any crime? . . . . .  Yes  No

G. Is the proposed insured currently on probation or parole? . . . . .  Yes  No

H. Is the proposed insured a member of the U.S. Armed Services or active reserve? . . . . .  Yes  No  
If "Yes", has the proposed insured been alerted of possible deployment? If "Yes", give details below. . . . .  Yes  No

**If any question C-H has been answered "Yes", give dates and full details:**

I. Within the next 12 months, does the proposed insured intend to travel or reside outside of the U.S., Canada or any U.S. territories? If "Yes", complete Section 6 on this form . . . . .  Yes  No

J. In the past 3 years has the proposed insured participated in aviation as a pilot, crew member or student – to include sky diving, hang gliding, ballooning, ultralight, and other sky sports – or intends to within the next 2 years? If "Yes", submit an Aviation Questionnaire . . . . .  Yes  No

K. In the past 3 years has the proposed insured participated in racing of any type, skin or scuba diving, boxing, ultimate fighting or mountain climbing – or intends to within the next 2 years? If "Yes", submit an Avocation Questionnaire . . . . .  Yes  No

**4 YOUTH INFORMATION (Applies to proposed insured age 0-15.)**

- A. Does the child live with the natural or adoptive parent(s)? . . . . .  Yes  No  
If "No", explain why \_\_\_\_\_
- B. Does the child have brothers and/or sisters?  Yes  No (If "Yes", indicate amount of coverage carried on each child and their ages.)  
\_\_\_\_\_
- C. Indicate amount of insurance carried by Father \$ \_\_\_\_\_  
Indicate amount of insurance carried by Mother \$ \_\_\_\_\_

**5 FAMILY HISTORY (Applies to proposed insured.)**

- A. Has a parent or sibling been diagnosed or treated by a member of the medical profession for cardiovascular disease or cancer prior to age 60? . . . . .  Yes  No  
If "Yes", give details \_\_\_\_\_
- B. Did death of a parent or sibling occur prior to age 60 due to cardiovascular disease or cancer? . . . . .  Yes  No

**6 TRAVEL (Applies to proposed insured.)**

Please provide the following details for any travel plans you have to locations other than the United States (and its territories or Canada):

- 1. What country, or countries, do you plan on traveling to? \_\_\_\_\_
- 2. What city or cities do you plan to visit? \_\_\_\_\_
- 3. When do you plan on going? \_\_\_\_\_
- 4. How long do you plan on being there? \_\_\_\_\_
- 5. What is the purpose of the trip? \_\_\_\_\_
- 6. Will medical and sanitation facilities be accessible? \_\_\_\_\_

**Provide any additional information relating to the above questions that would be helpful in consideration of the application.**

**I have read the answers written above. I ratify and agree to be bound by such answers and agree that they are true and complete to the best of my knowledge and belief. I agree they shall form part of this application.**

*John K Woodmen*

04/01/2010

\_\_\_\_\_  
Signature of Proposed Insured,  
if age 16 or older OR  
Signature of Proposed Adult Applicant

\_\_\_\_\_  
Date

SERFF Tracking Number: WDM-126692087 State: Arkansas  
Filing Company: Woodmen of the World Life Insurance Society State Tracking Number: 46037  
Company Tracking Number: REVISED LIFE APPS 5055 R-3/10, 601 R-3/10, 943 R-3/10, 956 R-3/10  
TOI: L08 Life - Other Sub-TOI: L08.000 Life - Other  
Product Name: Revised Life App 5055 R-3/10 & Related Forms  
Project Name/Number: /

## Supporting Document Schedules

**Item Status:** **Status**  
**Date:**

**Satisfied - Item:** Flesch Certification

**Comments:**

**Attachments:**

Rule & Reg 19 Cftn-Revised Apps.pdf

Revised Apps Readability Cert with scores.pdf

**Item Status:** **Status**  
**Date:**

**Satisfied - Item:** Application

**Comments:**

Applications are new and are listed under the Form Schedule tab.

WOODMEN OF THE WORLD LIFE INSURANCE SOCIETY  
1700 Farnam Street, Omaha, Nebraska 68102

CERTIFICATION

I certify that to the best of my knowledge and belief the form(s) in this submission meets the provisions of Rule and Regulation 19 as well as all applicable requirements of the Arkansas Insurance Department.

June 24, 2010

\_\_\_\_\_  
Date

\_\_\_\_\_  
Vice President & Chief Actuary

Form(s):  
FORM 5055 R-3/10  
601 R-3/10  
943 R-3/10  
956 R-3/10

**WOODMEN OF THE WORLD/OMAHA WOODMEN LIFE INSURANCE SOCIETY  
1700 Farnam Street, Omaha, Nebraska 68102-2007**

**FLESCH CERTIFICATION**

<b><u>Form Number(s)</u></b>	<b><u>Description</u></b>	<b><u>Flesch Score</u></b>
5055 R-3/10	Application for Life Insurance and Membership	52.3
601 R-3/10	Medical Supplementary Statement	53.3
943 R-3/10	Administrative Supplementary Statement	53.1
956 R-3/10	Underwriting Supplementary Statement	55.6

I certify that these Flesch Index numbers are accurate in accordance with the published rules of application of the test.

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Randall P. Rotschafer  
Vice President and Chief Actuary