

SERFF Tracking Number: SFBL-126713978 State: Arkansas
Filing Company: Southern Farm Bureau Life Insurance company State Tracking Number: 46260
Company Tracking Number:
TOI: L04I Individual Life - Term Sub-TOI: L04I.213 Specified Age or Duration -
Fixed/Indeterminate Premium - Single Life
Product Name: 10 & 20 YLT Par Term Policy
Project Name/Number: 10 & 20 YLT Par Term Policy & Application/Form LT205

Filing at a Glance

Company: Southern Farm Bureau Life Insurance company

Product Name: 10 & 20 YLT Par Term Policy SERFF Tr Num: SFBL-126713978 State: Arkansas
TOI: L04I Individual Life - Term SERFF Status: Closed-Approved- State Tr Num: 46260
Closed

Sub-TOI: L04I.213 Specified Age or Duration - Co Tr Num: State Status: Approved-Closed
Fixed/Indeterminate Premium - Single Life
Filing Type: Form

Author: Hart Sullivan

Date Submitted: 07/20/2010

Reviewer(s): Linda Bird

Disposition Date: 07/22/2010

Disposition Status: Approved-
Closed

Implementation Date Requested: On Approval

Implementation Date:

State Filing Description:

General Information

Project Name: 10 & 20 YLT Par Term Policy & Application

Project Number: Form LT205

Requested Filing Mode:

Explanation for Combination/Other:

Submission Type: New Submission

Overall Rate Impact:

Filing Status Changed: 07/22/2010

Status of Filing in Domicile: Authorized

Date Approved in Domicile: 04/19/2010

Domicile Status Comments:

Market Type: Individual

Group Market Size:

Group Market Type:

Explanation for Other Group Market Type:

State Status Changed: 07/22/2010

Created By: Hart Sullivan

Corresponding Filing Tracking Number:

Deemer Date:

Submitted By: Hart Sullivan

Filing Description:

Form LT205 – Participating Non-Renewable Term Insurance Policy

Form L401-AR – Life Insurance Application

NAIC# 68896

Attached for your consideration are the above-referenced forms. Form LT205 will be part of our new portfolio of participating term insurance policies and will be used to issue the following:

--Non-Renewable Convertible Participating Term for 10 years with premiums level for 10 years; or

SERFF Tracking Number: SFBL-126713978 State: Arkansas
 Filing Company: Southern Farm Bureau Life Insurance company State Tracking Number: 46260
 Company Tracking Number:
 TOI: L041 Individual Life - Term Sub-TOI: L041.213 Specified Age or Duration - Fixed/Indeterminate Premium - Single Life
 Product Name: 10 & 20 YLT Par Term Policy
 Project Name/Number: 10 & 20 YLT Par Term Policy & Application/Form LT205

--Non-Renewable Convertible Participating Term for 20 years with premiums level for 20 years.

Premiums for each of these plans will be guaranteed at issue. These plans will be issued to males and females on a Tobacco, Non-Tobacco, Preferred Tobacco, Preferred Non-Tobacco and Super Preferred Non-Tobacco basis. The application to be used with this form will be Form L401-AR (5/10), which is attached with the specimen forms. This form, like the previous version of this form, will be used by the agent in electronic form. Your early consideration of this submission is greatly appreciated. Please let me know if you should have any questions regarding this form filing.

Company and Contact

Filing Contact Information

Hart Sullivan, hsullivan@sfbli.com
 1401 Livingston Lane 601-981-7422 [Phone] 1522 [Ext]
 Jackson, MS 39213 601-713-3071 [FAX]

Filing Company Information

Southern Farm Bureau Life Insurance company CoCode: 68896 State of Domicile: Mississippi
 1401 Livingston Lane Group Code: Company Type:
 Jackson, MS 39213 Group Name: State ID Number:
 (601) 981-7422 ext. [Phone] FEIN Number: 64-0283583

Filing Fees

Fee Required? No
 Retaliatory? No
 Fee Explanation:
 Per Company: No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Southern Farm Bureau Life Insurance company	\$0.00	07/20/2010	
Southern Farm Bureau Life Insurance company	\$70.00	07/21/2010	38192156

SERFF Tracking Number: SFBL-126713978 State: Arkansas
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Product Name: 10 & 20 YLT Par Term Policy
Project Name/Number: 10 & 20 YLT Par Term Policy & Application/Form LT205

Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved- Closed	Linda Bird	07/22/2010	07/22/2010

SERFF Tracking Number: SFBL-126713978 *State:* Arkansas
Filing Company: Southern Farm Bureau Life Insurance company *State Tracking Number:* 46260
Company Tracking Number:
TOI: L04I Individual Life - Term *Sub-TOI:* L04I.213 Specified Age or Duration -
Fixed/Indeterminate Premium - Single Life
Product Name: 10 & 20 YLT Par Term Policy
Project Name/Number: 10 & 20 YLT Par Term Policy & Application/Form LT205

Disposition

Disposition Date: 07/22/2010

Implementation Date:

Status: Approved-Closed

Comment:

Rate data does NOT apply to filing.

SERFF Tracking Number: SFBL-126713978 State: Arkansas
 Filing Company: Southern Farm Bureau Life Insurance company State Tracking Number: 46260
 Company Tracking Number:
 TOI: L041 Individual Life - Term Sub-TOI: L041.213 Specified Age or Duration -
 Fixed/Indeterminate Premium - Single Life
 Product Name: 10 & 20 YLT Par Term Policy
 Project Name/Number: 10 & 20 YLT Par Term Policy & Application/Form LT205

Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification		Yes
Supporting Document	Application		Yes
Supporting Document	Life & Annuity - Actuarial Memo		No
Form	Participating Non-Renewable Convertible Term Insurance Policy		Yes
Form	20 YLT Schedule Pg		Yes

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 Company Tracking Number:
 TOI: L041 Individual Life - Term Sub-TOI: L041.213 Specified Age or Duration - Fixed/Indeterminate Premium - Single Life
 Product Name: 10 & 20 YLT Par Term Policy
 Project Name/Number: 10 & 20 YLT Par Term Policy & Application/Form LT205

Form Schedule

Lead Form Number: Form LT205

Schedule Item Status	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
	Form LT205	Policy/Contractual Certificate	Participating Non-Renewable Convertible Term Insurance Policy	Initial		52.300	LT205_AR_Par_10YLT.pdf
	Schedule Pg for 20 YLT	Schedule Pages	20 YLT Schedule Pg	Initial			LT205_Par_20YLT_SchPg.pdf



SOUTHERN FARM BUREAU LIFE INSURANCE COMPANY

Jackson, Mississippi

[JOHN DOE]

Policy Number: [012345678L]

Participating Non-Renewable Convertible Term Insurance Policy

Southern Farm Bureau Life Insurance Company will pay the policy proceeds to the Beneficiary on receipt of Due Proof of the Insured's Death before the Expiry Date and while this policy is in force.

This policy is issued in consideration of the application and of the payment of premiums, and is subject to the provisions on this and the following pages. **This policy is a legal contract between the Policy Owner and the Company.**

30-DAY RIGHT TO EXAMINE POLICY

The Owner may return this policy to the Company or to its authorized agent within 30 days after receiving it for a full refund of premium. Upon return, this policy will be cancelled as of its Date of Issue.

IMPORTANT NOTICE

Please read this policy carefully! Notify the Company within 30 days of receipt if any information on the attached copy of the application or Schedule Page is not correct or complete.

Signed for the Company at its Home Office as of the Date of Issue.

[*Larry B. Wooten*]

[President]

[*J. Purvis*]

[Secretary]

To obtain information or make a complaint, you may contact us at the following:
Southern Farm Bureau Life Insurance Company, [1401 Livingston Lane, Jackson, MS 39213]
[1 (800) 457.9611]
[www.sfbli.com]

Non-Renewable Convertible Term Life Insurance - Payable at Death Before the Expiry Date
Premiums Payable As Shown on the Schedule Page
PARTICIPATING

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SECTION 3.	PREMIUMS AND REINSTATEMENT 3.1 Payment of Premiums 3.2 Method of Payment 3.3 Grace Period 3.4 Refund at Death 3.5 Reinstatement.
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SECTION 7.	BENEFICIARY 7.1 Successive Beneficiaries 7.2 Change of Beneficiary.
SECTION 8.	GENERAL PROVISIONS 8.1 Entire Contract 8.2 Modification of Contract 8.3 Incontestability 8.4 Suicide 8.5 Incorrect Age or Sex 8.6 Termination.
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ADDITIONAL BENEFITS AND RIDERS	Any benefits or riders listed on the Schedule Page will be included following Section 9.
APPLICATION	A copy of the application for this policy is attached at Date of Issue.

Schedule Page

Benefit	Benefit Amount	Years Premium Payable	Annual Premium
Participating 10 Year Level Term	[\$100,000]	10	[\$172.00]

Dividends are not guaranteed.

Total Premiums at Date of Issue

**Monthly	Semi-Annual	Annual
[\$15.77]	[\$93.04]	[\$172.00]

Premiums Shown Above Include The Following Policy Fees:

Monthly – [\$7.00], Semi-Annual – [\$40.00], Annual – [\$70.00]

**This premium is applicable if premiums are payable by monthly pre-authorized payment. On termination, for any reason, of the agreement permitting premiums to be paid monthly, the method of premium payment will automatically change to annual. If premiums are being paid by pre-authorized payment, you must notify the company, in advance, of your intention not to continue the policy.

Method of Premium Payment on Date of Issue – [Annual]

Beneficiary As Named In the Application, Unless Changed By the Owner

Owner As Named In the Application Unless Otherwise Provided By Endorsement

Underwriting Classification [Standard Non-Tobacco]

Insured	[John Doe]	Face Amount	[\$100,000]
Policy Number	[012345678L]	Date of Issue	[July 15, 2011]
Issue Age	[40]	Expiry Date	[July 15, 2021]
Sex	[Male]	Final Conversion Date	[July 15, 2018]

SECTION 1. DEFINITIONS

- 1.1 You or Your** means the Owner of this policy.
- 1.2 Our, Us, We, or the Company** means Southern Farm Bureau Life Insurance Company.
- 1.3 Age** means age at the last birthday.
- 1.4 Amount of Insurance In Force** under this policy is the face amount shown on the Schedule Page, unless changed by endorsement.
- 1.5 Beneficiary** is the person (or persons) named by You to whom the proceeds payable on the death of the Insured will be paid.
- 1.6 Contingent Beneficiary** is (are) as named in the application, unless changed by the Owner.
- 1.7 Contingent Owner**, if any, is as named in the application, unless otherwise provided by endorsement. If the Owner dies, the Contingent Owner will become the Owner of this policy. If there is no living or named Contingent Owner, the Owner's estate will become Owner of this policy on the Owner's death.
- 1.8 Date Of Issue** is shown on the Schedule Page. Policy months and years, premium due dates, and policy anniversaries will be measured from this date.
- 1.9 Due Proof of Death** means proof of death that is satisfactory to Us. Such proof may consist of a certified copy of the death record, a certified copy of a court decree reciting a finding of death, or any other proof satisfactory to Us.
- 1.10 Expiry Date** is shown on the Schedule Page. All coverage under this policy terminates on the Expiry Date.
- 1.11 Home Office** means the principal office of the Southern Farm Bureau Life Insurance Company, [1401 Livingston Lane, Jackson, Mississippi 39213].
- 1.12 Insured** is the person whose life is insured under the policy. The Insured is as named in the application and shown on the Schedule Page.
- 1.13 Owner** is the person who owns the policy and who is entitled to exercise all rights and privileges provided in the policy while the Insured is alive. Exercise of these rights is subject to the rights of any assignee of record and any irrevocably designated Beneficiary. The original Owner is as named in the application.
- 1.14 Policy Anniversary** means the same date in each year as the Date of Issue.
- 1.15 Policy Year** means the 12-month period that begins on the Date of Issue or on a Policy Anniversary.
- 1.16 Written Notice to the Company** means, unless otherwise stated, a notice written by the Owner. Written Notice to the Company must be on forms furnished by or acceptable to Us, and must be received at the Home Office.

SECTION 2. POLICY PROCEEDS

- 2.1 Death Benefit-** The amount of proceeds payable upon the Insured's death before the Expiry Date and while this policy is in force will be the sum of:
- (a) the Amount of Insurance In Force at that time;
 - (b) any dividend accumulations and outstanding dividends; and
 - (c) any premium refunded at death;
- less:
- (d) any premium due and unpaid at the time of the Insured's death.
- 2.2 Payment of Proceeds** - Policy proceeds will be paid in a single sum unless another method of payment is elected.
- 2.3 Interest on Proceeds** – Any amount becoming payable under this policy by reason of death will be paid within a reasonable period of time. Any such amount becoming payable in a single sum which is not paid within 30 days after proof of death is received at the home office, will include interest at the rate of 8% per year from the date of death to the date of payment.

SECTION 3. PREMIUMS AND REINSTATEMENT

- 3.1 Payment of Premiums** - The premiums are shown on the Schedule Page. All premiums are due and payable in advance at Our Home Office. A receipt signed by an officer of the Company is available upon request.
- 3.2 Method of Payment** - Premiums may be paid:
- (a) annually (once a year);
 - (b) semiannually (twice a year); or
 - (c) other frequency (with Our consent).
- With Our consent, You may change the method of payment on any premium due date.

3.3 Grace Period - A grace period of 31 days will be allowed for the payment of each premium after the first. This policy will continue in force during the grace period. If any premium due remains unpaid at the end of the grace period, this policy will lapse as of that premium's due date with no value.

Any payment sent by U.S. mail and postmarked within the grace period will be considered paid during the grace period.

3.4 Refund at Death - We will refund the portion of any premium paid for a period beyond the policy month of the Insured's death, unless the premium was waived under any attached waiver of premium agreement.

3.5 Reinstatement - This policy may be reinstated within five years after the date of lapse and before the Expiry Date if each of the following conditions is satisfied:

(a) Satisfactory evidence of insurability of the Insured is furnished to Us; and

(b) all overdue premiums are paid with interest from the due date of each premium, at the rate of 6% per year, compounded annually.

SECTION 4. DIVIDENDS

4.1 Annual Dividend - This policy, while in force, will share in the divisible surplus of the Company beginning no later than the end of the second policy year. This policy's share, if any, will be determined each year by the Company and credited as a dividend.

4.2 Dividend Options - The Owner may elect by Written Notice to the Company to apply dividends under one of the following options.

Cash. Dividends are paid in cash.

Reduce Premium. Dividends are applied toward the payment of a premium due during the following Policy Year, if the balance of the premium is paid. If the balance is not paid or if there is no premium due, the dividends will be paid in cash. This option will not apply if premiums are being paid monthly.

Accumulate with Interest. Dividends are left to accumulate with interest. Interest will be credited at a rate of at least 3% per year, compounded annually. Dividend accumulations may be withdrawn at any time. Upon termination of the policy by any means other than death of the Insured, any dividend accumulations shall be paid to the Owner.

4.3 Automatic Option - If the Owner does not elect a dividend option, dividends will accumulate with interest.

SECTION 5. OPTIONAL METHODS OF PAYMENT OF POLICY PROCEEDS

5.1 Alternate Payment of Policy Proceeds - All or part of the policy proceeds may be applied under one of the payment options described in this section. If no payment option is elected, policy proceeds will be paid in a single sum.

5.2 Election of Options - While the Insured is living, You may elect or change a payment option and name or change one or more payees under that option by filing Written Notice to the Company. After the death of the Insured, any Beneficiary entitled to receive payment in a single sum may elect a payment option by filing Written Notice to the Company.

- 5.3 Availability** - Payment options are available only if:
- (a) the amount applied under an option is at least \$2,000; and
 - (b) each regular payment under the option is at least \$20.
- 5.4 Payment Options** - The following payment options are available for amounts payable under this policy. Guaranteed amounts and frequencies of payments under payment options are determined from the Payment Options Tables shown on the following pages. Payments are made at the beginning of the interval elected, except under the Interest Income option.
- Interest Income.** The proceeds will be left on deposit with the Company with interest on the proceeds payable annually, semiannually, quarterly, or monthly, as elected. Payments are made at the end of the interval elected.
- Income for Fixed Period.** Equal annual, semiannual, quarterly, or monthly payments for a fixed number of years, as elected. Payment amounts are at least equal to those shown in Table A. The rate of interest will be determined by Us. The payee may withdraw all or part of the proceeds at any time.
- Life Income.** Equal annual, semiannual, quarterly, or monthly payments for the life of the payee, either with no guaranteed payments or with payments guaranteed for 10, 15 or 20 years, as elected. Payment amounts depend on the payee's sex and Age on the first payment date, and are at least equal to those shown in Table C.
- Income of Fixed Amount.** Equal annual, semiannual, quarterly, or monthly payments for a specified amount until the proceeds and interest are paid in full. Periods of income will be at least equal to those shown in Table A.
- Joint and 2/3 Survivor Income.** Equal monthly payments during the joint lifetime of the two payees, with 2/3 of the original monthly payment continuing during the remaining lifetime of the survivor. Payments will stop when the surviving payee dies. The amount of monthly payments is computed using the sexes and ages of the payees on the first payment date and is at least equal to those shown in Table B. Payment amounts for other ages will be furnished by Us on request.
- The proceeds may be paid in any other manner requested by the payee and agreed to by Us, or under any other payment options made available by the Company.
- Payments under any payment option at time of commencement will not be less than those that would be provided by the application of the policy proceeds to purchase a single consideration immediate annuity contract at purchase rates offered by the Company at the time to the same class of annuitants.
- 5.5 Payee** - A person who is not a natural person (such as a corporation) or who is a fiduciary may not be designated as a payee. We may require satisfactory proof of Age or continuing survival of any payee.
- 5.6 Death of Payee** - If the payee dies and there is no designated person entitled to receive the remaining guaranteed payments, We will make a final, single payment to the estate of the last surviving payee. The amount of the final single payment will not be less than the present value of any remaining guaranteed payments, based on an interest rate of 3% per year.
- 5.7 Increased Payment Amounts** - Payment amounts under these payment options may be increased. The amounts of increased or additional payments and the manner in which they are paid will be determined by Us.
- 5.8 Interest and Mortality**- The minimum interest rate used in computing any payment option is 3% per year. The mortality table which is used for options involving payments for the life of a payee is the "Annuity 2000" individual annuity mortality table.

5.9 Supplementary Contract - Payments under a payment option will be made upon surrender of this policy to Our Home Office in exchange for a Supplementary Contract.

5.10 Payment Option Tables

Table A Income for Fixed Period or Amount Installments per \$1,000 of Proceeds		
Number of Years	Annual	Monthly
5	\$211.99	\$17.91
10	113.82	9.61
15	81.33	6.87
20	65.26	5.51
25	55.76	4.71
30	49.53	4.18

Table B Joint and Two-thirds to Survivor Monthly Life Income Monthly Installments per \$1,000 of Proceeds					
Male Age	Female Age				
	55	60	62	65	70
60	4.33	4.58	4.68	4.85	5.16
62	4.41	4.67	4.79	4.97	5.31
65	4.53	4.82	4.95	5.16	5.54
70	4.75	5.09	5.24	5.49	5.97
75	4.97	5.35	5.53	5.83	6.42

Table C Life Income with Term Certain Monthly Installments per \$1,000 Proceeds										
Age	Male					Female				
	Years Certain					Years Certain				
	0	5	10	15	20	0	5	10	15	20
55	\$4.51	\$4.50	\$4.45	\$4.38	\$4.27	\$4.19	\$4.19	\$4.16	\$4.12	\$4.06
56	4.60	4.59	4.54	4.46	4.33	4.27	4.26	4.24	4.19	4.12
57	4.70	4.68	4.63	4.54	4.39	4.36	4.35	4.32	4.27	4.19
58	4.81	4.79	4.73	4.62	4.46	4.44	4.43	4.40	4.34	4.25
59	4.92	4.90	4.83	4.71	4.52	4.54	4.53	4.49	4.42	4.32
60	5.04	5.01	4.94	4.79	4.59	4.64	4.63	4.58	4.51	4.39
61	5.17	5.14	5.05	4.89	4.66	4.75	4.73	4.68	4.59	4.46
62	5.30	5.27	5.17	4.98	4.72	4.86	4.84	4.79	4.69	4.53
63	5.45	5.41	5.29	5.08	4.79	4.98	4.96	4.90	4.78	4.60
64	5.61	5.56	5.42	5.18	4.85	5.11	5.09	5.01	4.88	4.67
65	5.77	5.72	5.55	5.28	4.91	5.25	5.22	5.14	4.98	4.75
66	5.95	5.89	5.69	5.38	4.97	5.40	5.37	5.27	5.09	4.82
67	6.14	6.07	5.84	5.48	5.03	5.56	5.52	5.40	5.19	4.89
68	6.34	6.26	5.99	5.58	5.09	5.73	5.69	5.55	5.30	4.96
69	6.56	6.46	6.15	5.68	5.14	5.91	5.86	5.70	5.42	5.02
70	6.79	6.67	6.31	5.78	5.19	6.11	6.05	5.86	5.53	5.08
71	7.03	6.89	6.48	5.88	5.23	6.33	6.26	6.03	5.64	5.14
72	7.29	7.12	6.65	5.98	5.27	6.56	6.47	6.20	5.75	5.20
73	7.57	7.37	6.82	6.07	5.31	6.81	6.71	6.38	5.87	5.25
74	7.87	7.63	6.99	6.16	5.34	7.08	6.96	6.57	5.97	5.29
75	8.18	7.91	7.17	6.24	5.37	7.37	7.22	6.77	6.08	5.33

SECTION 6. OWNERSHIP AND ASSIGNMENT

- 6.1 Change of Ownership** - You may name a new Owner and name or change a Contingent Owner during the Insured's lifetime by filing Written Notice to the Company, accompanied by this policy for endorsement. Upon recording at the Home Office, the change will be effective as of the date it was signed. We will not be responsible for any payment or other action taken by Us before receipt of Written Notice to the Company.
- 6.2 Assignment** - You may assign this policy. We will not be charged with notice of any assignment unless it is in writing and filed at the Home Office. We do not assume any responsibility for the validity of an assignment. Assignments, unless otherwise specified by the Owner, shall take effect on the date the notice of assignment is signed by the Owner, subject to any payments made or actions taken by the Company prior to receipt of this notice.

SECTION 7. BENEFICIARY

- 7.1 Successive Beneficiaries** - The policy proceeds will be paid to the Beneficiary or Beneficiaries upon the Insured's death. The policy proceeds will be paid in equal shares to the surviving Beneficiaries, unless otherwise provided. Payments will be made successively in the following order:
- (a) the Primary Beneficiary or Beneficiaries, if any; otherwise
 - (b) the Contingent Beneficiary or Beneficiaries, if any; otherwise
 - (c) the Owner or the estate of the last surviving Owner.
- 7.2 Change of Beneficiary** - You may change the Beneficiary during the Insured's lifetime by filing Written Notice to the Company. Change of an irrevocable Beneficiary will require the consent of said irrevocable Beneficiary.
- Upon recording at the Home Office, the change will be effective as of the date it was signed, subject to any payments made or actions taken by the Company prior to receipt of this notice. We will not be responsible for any payment or other action taken by Us before receipt of Written Notice to the Company.

SECTION 8. GENERAL PROVISIONS

- 8.1 Entire Contract** - The entire contract consists of:
- (a) the basic policy;
 - (b) any endorsements or additional benefit riders;
 - (c) the attached copy of Your application; and
 - (d) any amendments, supplemental applications or other attached papers.

We rely on statements made in the application for the policy. These statements in the absence of fraud are deemed representations and not warranties. No statement will void this policy or be used in defense of a claim unless:

- (a) it is contained in the application; and
- (b) such application is attached to this policy.

- 8.2 Modification of Contract** - This policy cannot be changed or modified unless the change is approved in writing by the President, a Vice-President, an Assistant Vice-President, the Secretary, or an Assistant Secretary of the Company.
- 8.3 Incontestability** - We will not contest this policy after it has been in force during the lifetime of the Insured for two years from the Date of Issue except for non-payment of premiums. We will not contest the validity of any reinstatement of this policy after it has been in force during the lifetime of the Insured for two years after the effective date of reinstatement except for non-payment of premiums.
- This provision does not apply to any benefit for waiver of premium; instead, this benefit will be governed by its own provisions.
- 8.4 Suicide** - If the Insured dies by suicide while sane or insane within two years from the Date of Issue or within two years from the effective date of reinstatement, the total liability of the Company will be limited to the refund of the premiums actually paid less dividends paid.
- 8.5 Incorrect Age or Sex** - If the Insured's Age or sex is incorrectly stated, any amount payable under this policy will be the amount the most recent premium paid would have purchased at the correct Age and sex.
- 8.6 Termination** - This policy will terminate and cease to be in force upon the earliest of the following:
- a) You request that the policy be canceled;
 - b) the insured dies;
 - c) the grace period ends without payment of the necessary premium; or
 - d) the Expiry Date.

SECTION 9. CONVERSION PRIVILEGE

- 9.1 Right to Convert** - While this policy is in force and before the final conversion date as shown on the Schedule Page, You may convert it to a new policy without evidence of insurability. Such conversion will be subject to the requirements and conditions listed below.
- 9.2 Date of Conversion** - The date of conversion will be the date that all of the following conditions are satisfied:
- (a) Written Notice to the Company requesting conversion is received at the Home Office;
 - (b) this policy is surrendered and received at the Home Office; and
 - (c) any premium due on the new policy is received at the Home Office.

The period of time described in the Incontestability and Suicide provisions of the new policy will be measured from the Date of Issue of this policy. However, that period of time for any benefit or rider requiring Our consent to be added to the new policy will be measured from the date of conversion.

9.3 Conditions - Conversion will be subject to the following conditions.

- (a) The new policy must be a fixed premium permanent life or endowment policy insuring a single life. The new policy will be issued as of the date of conversion at the Insured's Age on that date. Premiums for the new policy will be based on Our premium rates on the date of conversion and the Insured's Age on that date.
- (b) The date of conversion must be on or before the final conversion date shown on the Schedule Page.
- (c) The face amount of the new policy must be equal to or less than the Amount of Insurance In Force under this policy on the date of conversion, and must meet Our requirements for minimum policy size on that date.
- (d) The new policy will be issued on the underwriting classification of this policy.
- (e) Written Notice to the Company requesting conversion must be received at the Home Office at least 31 days prior to the final conversion date.

9.4 Additional Benefits - Except as provided below, additional benefits and riders may be included in the new policy only if agreed to by Us.

The new policy may include a waiver of premium agreement without evidence of insurability if on the date of conversion such an agreement is in force under this policy and the Insured is not totally disabled as defined in that agreement.

- (a) If premiums are being waived under this policy as of the final conversion date, this policy will automatically be converted to an ordinary life policy which includes a waiver of premium agreement. Premiums under the new policy will continue to be waived in accordance with the provisions of the new waiver of premium agreement.
- (b) If premiums are not being waived under this policy as of the date of conversion, any waiver of premium agreement included in the new policy will apply only to total disability beginning after the date of conversion.

Southern Farm Bureau Life Insurance Company

[P.O. Box 78, Jackson, MS 39205]

Application for Individual Life Insurance

Application No.

1 - Proposed Insured

Name (Last, First Middle) DOE, JOHN MICHAEL		Birthdate 10/26/62	Age 47	Birth Location Anywhere, AR	Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F
Driver's License Number XXXXX	DL State AR	Social Security No./Tax ID XXXXXX	Marital Status M	Height 6'	Weight 200
Home Address: Number & Street, City, State, and Zip 123 South St., Anywhere, AR 12345					Yrs. Lived There 15
Home Telephone Number (xxx) xxx-xxxx	Work Telephone Number (xxx) xxx-xxxx	Convenient Place and Time to Call During the Day Home-after 5pm			
Employer ABC Education	Employer Address (City, State, Zip) 100 North St., Anywhere, AR			Yrs. Employed 10	
Occupation & Specific Duties including secondary or part-time Teacher					

2 - Owner (Complete only if owner is other than the proposed insured.)

Name (Last, First Middle) N/A	Birthdate	Age	Sex <input type="checkbox"/> M <input type="checkbox"/> F	Relationship to Proposed Insured
Home Address: Number & Street, City, State, and Zip				Social Security No./Tax ID
Contingent Owner: Name (Last, First Middle)	Birthdate	Age	Sex <input type="checkbox"/> M <input type="checkbox"/> F	Relationship to Proposed Insured
Home Address: Number & Street, City, State, and Zip				Social Security No./Tax ID

3 - Premium Payor (Complete only if premium payor is other than owner.)

Name (Last, First Middle) N/A	Birthdate	Age	Sex <input type="checkbox"/> M <input type="checkbox"/> F	Relationship to Insured
Home Address: Number & Street, City, State, and Zip				Social Security No./Tax ID

4 - Beneficiary (Beneficiaries will share and share alike or survivors unless otherwise designated.)

Right to change beneficiary(ies) reserved unless specifically requested.

A. Base Insured	Name: (Last, First Middle)	Social Security #	Home Address: No. & Street, City, State, and Zip	Relationship
Primary Beneficiary(ies):	Doe, Jane Ellen	XXXXXX	123 South St., Anywhere, AR 12345	Spouse
Contingent Beneficiary(ies):				
B. Spouse Insured	Name: (Last, First Middle)	Social Security #	Home Address: No. & Street, City, State, and Zip	Relationship
Primary Beneficiary(ies):				
Contingent Beneficiary(ies):				

5 - Spouse To Be Insured (Complete for spouse term rider.)

Name (Last, First Middle) N/A		Birthdate	Age	Birth Location	Sex <input type="checkbox"/> M <input type="checkbox"/> F
Driver's License Number	DL State	Social Security No./Tax ID		Height	Weight
Home Telephone Number ()	Work Telephone Number ()	Convenient Place and Time to Call During the Day			
Employer	Employer Address (City, State, Zip)			Yrs. Employed	
Occupation & Specific Duties including secondary or part-time					

6 - Children To Be Insured (If children's term rider is requested, complete for each child starting with the oldest child.)

Name of Child (Last, First Middle)	Birthdate	Age	Sex	SSN/Tax ID	Hgt	Wgt	Amt. Life Ins. Now In Force	Relationship to Insured
N/A			<input type="checkbox"/> M <input type="checkbox"/> F					
			<input type="checkbox"/> M <input type="checkbox"/> F					
			<input type="checkbox"/> M <input type="checkbox"/> F					
			<input type="checkbox"/> M <input type="checkbox"/> F					

7 - Premium Payor To Be Insured (Complete for premium insurance.)

Name (Last, First Middle) N/A		Birthdate	Age	Birth Location	Sex <input type="checkbox"/> M <input type="checkbox"/> F	
Driver's License Number	DL State	Social Security No./Tax ID	Marital Status	Height	Weight	Relationship to Insured
Home Telephone Number ()	Work Telephone Number ()	Convenient Place and Time to Call During the Day				
Employer	Employer Address (City, State, Zip)			Yrs. Employed		
Occupation & Specific Duties including secondary or part-time						

8 - Life Insurance Now In Force (Include applied for, pending, or awaiting reinstatement on each person proposed for insurance.)

Person	Name of Insurance Company	Policy Number	Year Issued	Type Plan	Face Amount	Accidental Death Amount
N/A						

9 - Life Insurance Applied For and Additional Benefits and Riders

[Participating Whole Life Insurance

Insurance on Proposed Insured

Base Plan & Amount: Whole Life 100,000 20 Pay Life _____ Single Premium Whole Life _____
 Modified Premium Whole Life _____ 30 Pay Whole Life _____ Other _____

Participating Term Rider: 10 Year Level Term _____ 20 Year Level Term _____
 Other _____

Underwriting Classification:

Standard Tobacco Preferred Tobacco Standard Non-tobacco Preferred Non-tobacco Super Preferred Non-tobacco

Insurance on Spouse - Non-participating Term Rider

Plan and Amount: 10 Year Level Term _____ 20 Year Level Term _____
 Other _____

Underwriting Classification:

Standard Tobacco Preferred Tobacco Standard Non-tobacco Preferred Non-tobacco Super Preferred Non-tobacco

Additional Benefits

Waiver of Premium Payor Death or Disability Payor Death
 Children Term Rider Guaranteed Insurability Option \$ _____ Accelerated Death Benefit Rider

Dividend Option (If no choice is made, option 4 will be used.)

Pay by Check (1) Reduce Premiums (2) Accumulate (3) Additional Paid-Up Insurance (4) Other _____

Automatic Premium Loan Yes No

Term Insurance

Plan and Amount:

Non-Participating 10 Year Level _____ 20 Year Level _____ 30 Year Level _____
 Other _____

Participating: 10 Year Level _____ 20 Year Level _____ 30 Year Level _____
 Other _____

Underwriting Classification

Standard Tobacco Preferred Tobacco Standard Non-tobacco Preferred Non-tobacco Super Preferred Non-tobacco

Additional Benefits

Waiver of Premium Children Term Rider Accelerated Death Benefit Rider

Adjustable Premium Life Insurance

Specified Amount \$ _____ Scheduled Premium \$ _____ Additional First Year Premium \$ _____

Underwriting Classification

Standard Tobacco Preferred Tobacco Standard Non-tobacco Preferred Non-tobacco Super Preferred Non-tobacco

Additional Benefits

Waiver of Monthly Deductions Children Term Rider Accelerated Death Benefit Rider]

10 - Special Requests

11 - Replacement

Does the proposed insured have any existing life insurance policies or annuity contracts?

Yes No

If "yes", complete Notice of Replacement Form.

Is this intended to be a 1035 Exchange?

Yes No

12 - Premium

Send Premium Notice to: Proposed Insured Owner Other _____

Premium With Application \$ 1,800.00

Premium Method: Annual Semiannual Monthly EFT Monthly Salary Savings Monthly PRD Single
 If method is monthly EFT, attach a voided check.

Authorization Agreement for Preauthorized Payments: I have authorized _____ Bank to honor electronic debit entries or drafts on my account by you to cover premium insuring _____. Such debit entries or drafts are to be charged to my account with said bank in the same manner as if they were personally drawn by me.

It is understood that such debit entry or draft shall constitute notice of premium due. Should any debit entry or draft not be paid by said bank for any reason, then it is understood that this method of premium payment shall terminate and that premiums shall be payable annually directly to the Company. It is also understood that the Company assumes no responsibility for bank charges on these draws.

Bank Name Bank of America
 City Anywhere State AR
 Transit Number 1222
 Account Number 33345

John M. Doe
 Signature of Depositor/Premium Payor
 (If Corporate Payor, Signature of Appropriate Corporate Officer)

Is this bank account being used for existing policies? Yes No
 If yes, should drafts be combined with existing policies? Yes No

Account Type: Checking Savings
 Preferred Withdrawal Date: 15 of mo.

List policy numbers: _____

Do you want us to change your address as shown on voided check: Yes No

13 - Personal Doctor or Health Care Provider (List information for each person proposed for insurance.)

Person	Physician's Full Name, Address, Telephone Number, Date Last Consulted, Reason Last Consulted and Specialty
<u>John M. Doe</u>	<u>Joe Smith, 345 North St, Anywhere, AR 12345, (xxx)xxx-xxxx</u>
	<u>5/2009, sinus infection/antibiotics.</u>

14 - Family Record (Complete history including age & health status or age & cause of death of the mother, father, brothers and sisters for each person proposed for insurance. Please use separate sheet if additional space is needed.)

Relative	If Living		If Dead			Relative	If Living		If Dead		
	Age	Health	Age	Year	Cause of Death		Age	Health	Age	Year	Cause of Death
Proposed Insured: <u>John M. Doe</u>											
Mother	<u>70</u>	<u>Good</u>				Brothers					
Father	<u>71</u>	<u>Good</u>				Sisters	<u>40</u>	<u>Good</u>			
Other Insured:											
Mother						Brothers					
Father						Sisters					
Other Insured:											
Mother						Brothers					
Father						Sisters					

15 - Military

Are you a member of the service (Armed Forces, Reserves, or National Guard) or have entered into a written agreement to become a member at a future date? If "yes", complete the Military questionnaire for each person proposed for insurance. Yes No

16 - Aviation

Has any person proposed for insurance ever flown or intends within the next two years to fly, other than as a fare paying passenger on a scheduled airline? If "yes", complete the Aviation questionnaire for each person proposed for insurance. Yes No

17 - Foreign Travel

Has any person proposed for insurance traveled outside the U.S. during the past 24 months or intends to travel outside the U.S. during the next 24 months? If "yes", complete the Non US Citizen/Foreign Travel questionnaire for each person proposed for insurance. Yes No

18 - Tobacco Use (Please list details for each "Yes" answer in the space provided below for each person proposed for insurance.)

- Have you smoked one or more cigarettes in the last 12 months? Yes No
- Have you used any form of tobacco in the past 12 months? Yes No
- Have you used any form of tobacco in the past 24 months? Yes No
- Have you ever used any form of tobacco? Yes No
- Do you use nicotine gum, nicotine patch or other form of nicotine? Yes No

Give complete details for every "Yes" answer noted on the above questions.

Person	Type	Average Daily Usage	Date Last Used

19 - Avocation (Please complete appropriate avocation questionnaire for each "Yes" answer for each person proposed for insurance.)

Has any person proposed for insurance ever engaged or intends to participate (within the next 24 months) in any of the following or similar activities: Yes No

Check all that apply and complete the necessary supplemental questionnaire(s).

- Vehicle Racing
- Parasailing
- Hang Gliding
- Rodeo
- Skydiving
- Scuba Diving
- Ballooning
- Other _____

20 - Other/Driving History (Please list details for each "Yes" answer in the space provided below for each person proposed for insurance.)

Do you own or ride a motorcycle? If yes, please complete the motorcycle questionnaire. Yes No

Within the last five years, has any person proposed for insurance been convicted of two or more moving violations? If "yes", please provide details as indicated below. Yes No

Has any person proposed for insurance ever been convicted of Driving While Intoxicated, Driving Under the Influence, or reckless driving, or had a Driver's License suspended or revoked? If "yes", please provide details as indicated below. Yes No

Person	Date	Violation Type	Details (Speed, Length of suspension / revocation, etc.)

The following questions must be completed in all cases with respect to all persons proposed for insurance: Yes No

- A. In the last 7 years, have you filed or are you currently contemplating filing bankruptcy? Yes No
- B. Have you ever plead guilty to or been convicted of a felony or misdemeanor, or have such a charge currently pending? Yes No

Give details for "yes" answers:

21 - Financial Information

Net Worth (assets minus liabilities) 160,000 Annual Earned Income 40,000

Spouse: Net Worth (assets minus liabilities) 100,000 Annual Earned Income 40,000

A FINANCIAL STATEMENT (FORM 1310) MUST ALSO BE COMPLETED IF THE FACE AMOUNT OF THE APPLICATION EXCEEDS \$1,000,000, OR WHERE THE TOTAL AMOUNT OF INSURANCE WITH ALL COMPANIES, INCLUDING THIS APPLICATION, IS \$5,000,000 OR MORE.

22 - Statement of Health

Complete the following questions with respect to all persons proposed for insurance:

	Yes	No
A. Have you ever been declined, postponed, or charged an extra premium for life insurance or received disability benefits?	<input type="checkbox"/>	<input checked="" type="checkbox"/>
B. Have you ever been diagnosed by a member of the medical profession or tested positive for Human Immunodeficiency Virus (AIDS virus) or Acquired Immune Deficiency Syndrome (AIDS)?	<input type="checkbox"/>	<input checked="" type="checkbox"/>
C. 1) Have you ever sought or received advice or treatment for use of alcohol from a health care professional or counselor or been advised by any health care professional or counselor to discontinue the use of alcohol?	<input type="checkbox"/>	<input checked="" type="checkbox"/>
2) Have you ever used barbiturates, sedatives, tranquilizers, amphetamines, or any narcotic or addictive drugs, whether prescribed or not?	<input type="checkbox"/>	<input checked="" type="checkbox"/>
3) Have you ever used heroin, morphine, cocaine, LSD, marijuana, or any other such drug, whether prescribed or not?	<input type="checkbox"/>	<input checked="" type="checkbox"/>
D. Have you ever had or been treated by a physician or consulted with a health advisor for any of the following:		
1) mental or nervous disorder (including but not limited to depression), convulsive disorder or any disease of the brain or nervous system?	<input type="checkbox"/>	<input checked="" type="checkbox"/>
2) asthma, emphysema, tuberculosis, sleep apnea or any disease or disorder of the lungs or respiratory system?	<input type="checkbox"/>	<input checked="" type="checkbox"/>
3) high blood pressure, chest pain, shortness of breath, heart murmur, or any disease or disorder of the heart or blood vessels?	<input type="checkbox"/>	<input checked="" type="checkbox"/>
4) any disease or disorder of the stomach, intestines, rectum, liver, pancreas, or gall bladder?	<input type="checkbox"/>	<input checked="" type="checkbox"/>
5) any disease or disorder of the kidneys or bladder, or any disease of the prostate, reproductive organs or complications of pregnancy?	<input type="checkbox"/>	<input checked="" type="checkbox"/>
6) gout, arthritis, or any disorder of the back, spine, bones, joints, or muscles?	<input type="checkbox"/>	<input checked="" type="checkbox"/>
7) diabetes, cancer, or tumor or ulcer of any kind, or venereal disease?	<input type="checkbox"/>	<input checked="" type="checkbox"/>
8) any disorder of the eyes, ears, nose or throat?	<input type="checkbox"/>	<input checked="" type="checkbox"/>
9) leukemia, anemia, or any disease or disorder of the blood or lymph glands?	<input type="checkbox"/>	<input checked="" type="checkbox"/>
E. In the past 5 years, have you, for any reason not previously explained, had treatment or a test at any medical facility?	<input type="checkbox"/>	<input checked="" type="checkbox"/>
F. In the past 2 years, have you gained or lost more than 10 pounds of weight?	<input type="checkbox"/>	<input checked="" type="checkbox"/>
G. Are you currently afflicted with any abnormality, deformity, disease, or disorder of any kind?	<input type="checkbox"/>	<input checked="" type="checkbox"/>
H. Are you currently receiving treatment, taking medication or contemplating surgery?	<input type="checkbox"/>	<input checked="" type="checkbox"/>
I. Have your parents, brothers, or sisters ever had: heart disease; cancer; diabetes; mental illness; or committed suicide?	<input type="checkbox"/>	<input checked="" type="checkbox"/>

Give complete details for every "Yes" answer noted on the above questions. (Please use separate sheet if additional space is needed.)

Question	Person	Details (including name, address, phone number, reason for treatment and dates of each physician consulted)

23 - Agreement

We, the undersigned, state that all statements and answers in this application are complete and true, to the best of our knowledge and belief. We also agree as follows:

1. This application will include: (a) Application Questions; (b) Statement to Medical Examiner, if required by the Company's rules; and (c) any supplements. This application, with any policy issued as a result of this application, will form the entire contract of insurance.
2. Any insurance issued by the Company as a result of this application will not be effective until: (a) a policy is delivered while the persons proposed for insurance are alive and a risk insurable; and (b) the full first premium for that policy is paid. An earlier Effective Date will apply only as specified in the conditional receipt with the same number as this application.
3. No statement made to or by, and no knowledge on the part of: (a) any agent; (b) any medical examiner; or (c) any other person; as to facts about any persons proposed for insurance shall be construed as having been made to or brought to the attention of the Company, unless stated in this application.
4. Only an Officer of the Company may make, modify, or discharge any insurance contract on its behalf. NO AGENT OR MEDICAL EXAMINER HAS THE AUTHORITY TO: (A) ACCEPT RISKS; (B) DETERMINE INSURABILITY; (C) MAKE OR MODIFY ANY CONTRACTUAL PROVISION; OR (D) WAIVE ANY OF THE COMPANY'S RIGHTS OR REQUIREMENTS.
5. The Company may amend this application by endorsement. Such an endorsement will be used to: (a) correct apparent errors or omissions; and (b) conform the application to any policy that may be issued. Any amendments will be deemed to be approved by the undersigned if and when such a policy is accepted. Any change in the plan of insurance, amount, age at issue, gender, class or benefits shall require the written consent of the owner and the proposed insured.

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.

We attest all applicants have read, or had read to them, the completed application. We realize that any false statements or misrepresentations which would affect the acceptance of the risk or hazard assumed may result in loss of coverage, subject to the Incontestability Provision of the policy.

We state that all Proposed Insureds (parent or guardian if Proposed Insured is a minor) have received and read a copy of the Conditional Receipt and "Notice to Proposed Insured" regarding: (a) investigative consumer reports; and (b) information which may be obtained from and released to the Medical Information Bureau.

The Owner of this policy hereby certifies the following: Under Federal law, I am required to supply, and Southern Farm Bureau Life Insurance Company is required to obtain, my social security or taxpayer identification number. Penalties for failure to supply such a number include withholding a portion of interest otherwise payable to me. I hereby certify or affirm (under penalty of perjury as provided under federal law) that the social security number or taxpayer identification number I am providing is correct and I am not currently subject to backup withholding.

The signatures below indicate acceptance of the "Agreement" section above. Please read this section carefully.

Dated at Anywhere, AR

John M. Doe
Signature of Proposed Insured (not required if a minor)

this 20th day of August, Year 2010

Signature of Other Person Proposed for Insurance (not required if a minor)

Witnessed:

JOE AGENT
Printed Name of Agent

Signature of Parent or Guardian (if Proposed Insured is a minor)

Joe Agent
Agent

Signature of Owner (if other than Proposed Insured)

Home Office Endorsements (Home Office Use Only)

Home Office Endorsement Form ICC10-1080 is attached. Yes No

Participating Non-Renewable Convertible Term Life Insurance

If You have any questions concerning this policy or if anyone suggests that You change or replace this policy, please contact Your Southern Farm Bureau Life agent.

*Southern Farm Bureau Life Insurance Company
[1401 Livingston Lane
Jackson, MS 39213]*

Schedule Page

Benefit	Benefit Amount	Years Premium Payable	Annual Premium
Participating 20 Year Level Term	[\$100,000]	20	[\$312.00]

Dividends are not guaranteed.

Total Premiums at Date of Issue

**Monthly	Semi-Annual	Annual
[\$27.81]	[\$165.84]	[\$312.00]

Premiums Shown Above Include The Following Policy Fees:

Monthly – [\$7.00], Semi-Annual – [\$40.00], Annual – [\$70.00]

**This premium is applicable if premiums are payable by monthly pre-authorized payment. On termination, for any reason, of the agreement permitting premiums to be paid monthly, the method of premium payment will automatically change to annual. If premiums are being paid by pre-authorized payment, you must notify the company, in advance, of your intention not to continue the policy.

Method of Premium Payment on Date of Issue – [Annual]

Beneficiary As Named In the Application, Unless Changed By the Owner

Owner As Named In the Application Unless Otherwise Provided By Endorsement

Underwriting Classification [Standard Non-Tobacco]

Insured	[John Doe]	Face Amount	[\$100,000]
Policy Number	[012345678L]	Date of Issue	[July 15, 2011]
Issue Age	[40]	Expiry Date	[July 15, 2031]
Sex	[Male]	Final Conversion Date	[July 15, 2026]

SERFF Tracking Number: SFBL-126713978 State: Arkansas
 Filing Company: Southern Farm Bureau Life Insurance company State Tracking Number: 46260
 Company Tracking Number:
 TOI: L041 Individual Life - Term Sub-TOI: L041.213 Specified Age or Duration - Fixed/Indeterminate Premium - Single Life
 Product Name: 10 & 20 YLT Par Term Policy
 Project Name/Number: 10 & 20 YLT Par Term Policy & Application/Form LT205

Supporting Document Schedules

	Item Status:	Status Date:
Satisfied - Item: Flesch Certification		
Comments:		
We certify that Form 850 (9/09), Notice of Agent, AND Form X800-AR, Life & Health Guaranty Association Notice, is included with each policy.		

Also, attached is the Certification stating that this submission meets the provisions of Regulation 19 of the Arkansas Department of Insurance as well as the Flesch Certification for the forms included in this submission.

Attachments:

AR CERTIFICATION_Reg 19.pdf
 AR Flesch Certification.pdf

	Item Status:	Status Date:
Satisfied - Item: Application		
Comments:		
Attached is the application (L401-AR (5/10)) to be used with Form LT205. Please note the application is also attached to the policy in the Form Schedule tab.		
Attachment:		
L401_AR.doc.pdf		

SOUTHERN FARM BUREAU LIFE INSURANCE COMPANY

CERTIFICATION

I hereby certify that this filing meets the provisions of Regulation 19 as well as all applicable requirements of the Arkansas Insurance Department.

7/20/10
Date

Stan Dickens
Stan Dickens, F.S.A., M.A.A.A

Manager, Product Development
Title

READABILITY COMPLIANCE CERTIFICATION

SOUTHERN FARM BUREAU LIFE INSURANCE COMPANY
P.O. Box 78
Jackson, MS 39205

I have reviewed or supervised the review of the policy forms contained in this filing and hereby certify that they are in compliance with the applicable statutes, regulations, and bulletins of the state of Arkansas.

I also certify that to the best of my knowledge and belief that the policy forms are in compliance with the requirements of § 23-80-201 through 23-80-208, cited as the Life & Disability Insurance Policy Language Simplification Act.

I hereby certify the Flesch reading ease score(s) shown below. I also certify that the terms listed below are entitled to be excepted from the policy "test" in computing the Flesch reading ease score for the reasons stated.

<u>Form Number and Title:</u>	<u>Flesch Score:</u>
Form LT205 – Participating Non-Renewable Term Life Insurance Policy	52.3
Form L401-AR (5/10) – Life Insurance Application	50.5

Excepted Terms:

Name and Address of Company
Number and Title of Contract
Table of Contents/Index
Schedule Page/Tables
Captions and Subcaptions

Reason Entitled to Exception:

Excepted as provided in your laws and regulations

Medical Terminology
Defined Terms
Required Language


Kenneth P. Johnston, FSA, MAAA
Vice President, Product Development

July 20, 2010

Southern Farm Bureau Life Insurance Company

[P.O. Box 78, Jackson, MS 39205]

Application for Individual Life Insurance

Application No.

1 - Proposed Insured

Name (Last, First Middle) DOE, JOHN MICHAEL		Birthdate 10/26/62	Age 47	Birth Location Anywhere, AR	Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F
Driver's License Number XXXXX	DL State AR	Social Security No./Tax ID XXXXXX	Marital Status M	Height 6'	Weight 200
Home Address: Number & Street, City, State, and Zip 123 South St., Anywhere, AR 12345					Yrs. Lived There 15
Home Telephone Number (xxx) xxx-xxxx	Work Telephone Number (xxx) xxx-xxxx	Convenient Place and Time to Call During the Day Home-after 5pm			
Employer ABC Education		Employer Address (City, State, Zip) 100 North St., Anywhere, AR			Yrs. Employed 10
Occupation & Specific Duties including secondary or part-time Teacher					

2 - Owner (Complete only if owner is other than the proposed insured.)

Name (Last, First Middle) N/A	Birthdate	Age	Sex <input type="checkbox"/> M <input type="checkbox"/> F	Relationship to Proposed Insured
Home Address: Number & Street, City, State, and Zip				Social Security No./Tax ID
Contingent Owner: Name (Last, First Middle)	Birthdate	Age	Sex <input type="checkbox"/> M <input type="checkbox"/> F	Relationship to Proposed Insured
Home Address: Number & Street, City, State, and Zip				Social Security No./Tax ID

3 - Premium Payor (Complete only if premium payor is other than owner.)

Name (Last, First Middle) N/A	Birthdate	Age	Sex <input type="checkbox"/> M <input type="checkbox"/> F	Relationship to Insured
Home Address: Number & Street, City, State, and Zip				Social Security No./Tax ID

4 - Beneficiary (Beneficiaries will share and share alike or survivors unless otherwise designated.)

Right to change beneficiary(ies) reserved unless specifically requested.

A. Base Insured	Name: (Last, First Middle)	Social Security #	Home Address: No. & Street, City, State, and Zip	Relationship
Primary Beneficiary(ies):	Doe, Jane Ellen	XXXXXX	123 South St., Anywhere, AR 12345	Spouse
Contingent Beneficiary(ies):				
B. Spouse Insured	Name: (Last, First Middle)	Social Security #	Home Address: No. & Street, City, State, and Zip	Relationship
Primary Beneficiary(ies):				
Contingent Beneficiary(ies):				

5 - Spouse To Be Insured (Complete for spouse term rider.)

Name (Last, First Middle) N/A		Birthdate	Age	Birth Location	Sex <input type="checkbox"/> M <input type="checkbox"/> F
Driver's License Number	DL State	Social Security No./Tax ID		Height	Weight
Home Telephone Number ()	Work Telephone Number ()	Convenient Place and Time to Call During the Day			
Employer	Employer Address (City, State, Zip)			Yrs. Employed	
Occupation & Specific Duties including secondary or part-time					

6 - Children To Be Insured (If children's term rider is requested, complete for each child starting with the oldest child.)

Name of Child (Last, First Middle)	Birthdate	Age	Sex <input type="checkbox"/> M <input type="checkbox"/> F	SSN/Tax ID	Hgt	Wgt	Amt. Life Ins. Now In Force	Relationship to Insured
N/A			<input type="checkbox"/> M <input type="checkbox"/> F					
			<input type="checkbox"/> M <input type="checkbox"/> F					
			<input type="checkbox"/> M <input type="checkbox"/> F					
			<input type="checkbox"/> M <input type="checkbox"/> F					

7 - Premium Payor To Be Insured (Complete for premium insurance.)

Name (Last, First Middle) N/A		Birthdate	Age	Birth Location	Sex <input type="checkbox"/> M <input type="checkbox"/> F
Driver's License Number	DL State	Social Security No./Tax ID	Marital Status	Height	Weight
Home Telephone Number ()	Work Telephone Number ()	Convenient Place and Time to Call During the Day			
Employer	Employer Address (City, State, Zip)			Yrs. Employed	
Occupation & Specific Duties including secondary or part-time					

8 - Life Insurance Now In Force (Include applied for, pending, or awaiting reinstatement on each person proposed for insurance.)

Person	Name of Insurance Company	Policy Number	Year Issued	Type Plan	Face Amount	Accidental Death Amount
N/A						

9 - Life Insurance Applied For and Additional Benefits and Riders

[Participating Whole Life Insurance

Insurance on Proposed Insured

Base Plan & Amount: Whole Life 100,000 20 Pay Life _____ Single Premium Whole Life _____
 Modified Premium Whole Life _____ 30 Pay Whole Life _____ Other _____

Participating Term Rider: 10 Year Level Term _____ 20 Year Level Term _____
 Other _____

Underwriting Classification:

Standard Tobacco Preferred Tobacco Standard Non-tobacco Preferred Non-tobacco Super Preferred Non-tobacco

Insurance on Spouse - Non-participating Term Rider

Plan and Amount: 10 Year Level Term _____ 20 Year Level Term _____
 Other _____

Underwriting Classification:

Standard Tobacco Preferred Tobacco Standard Non-tobacco Preferred Non-tobacco Super Preferred Non-tobacco

Additional Benefits

Waiver of Premium Payor Death or Disability Payor Death
 Children Term Rider Guaranteed Insurability Option \$ _____ Accelerated Death Benefit Rider

Dividend Option (If no choice is made, option 4 will be used.)

Pay by Check (1) Reduce Premiums (2) Accumulate (3) Additional Paid-Up Insurance (4) Other _____

Automatic Premium Loan Yes No

Term Insurance

Plan and Amount:

Non-Participating 10 Year Level _____ 20 Year Level _____ 30 Year Level _____
 Other _____

Participating: 10 Year Level _____ 20 Year Level _____ 30 Year Level _____
 Other _____

Underwriting Classification

Standard Tobacco Preferred Tobacco Standard Non-tobacco Preferred Non-tobacco Super Preferred Non-tobacco

Additional Benefits

Waiver of Premium Children Term Rider Accelerated Death Benefit Rider

Adjustable Premium Life Insurance

Specified Amount \$ _____ **Scheduled Premium** \$ _____ **Additional First Year Premium** \$ _____

Underwriting Classification

Standard Tobacco Preferred Tobacco Standard Non-tobacco Preferred Non-tobacco Super Preferred Non-tobacco

Additional Benefits

Waiver of Monthly Deductions Children Term Rider Accelerated Death Benefit Rider]

10 - Special Requests

11 - Replacement

Does the proposed insured have any existing life insurance policies or annuity contracts?

Yes No

If "yes", complete Notice of Replacement Form.

Is this intended to be a 1035 Exchange?

Yes No

12 - Premium

Send Premium Notice to: Proposed Insured Owner Other _____

Premium With Application \$ 1,800.00

Premium Method: Annual Semiannual Monthly EFT Monthly Salary Savings Monthly PRD Single

If method is monthly EFT, attach a voided check.

Authorization Agreement for Preauthorized Payments: I have authorized _____ Bank to honor electronic debit entries or drafts on my account by you to cover premium insuring _____. Such debit entries or drafts are to be charged to my account with said bank in the same manner as if they were personally drawn by me.

It is understood that such debit entry or draft shall constitute notice of premium due. Should any debit entry or draft not be paid by said bank for any reason, then it is understood that this method of premium payment shall terminate and that premiums shall be payable annually directly to the Company. It is also understood that the Company assumes no responsibility for bank charges on these draws.

Bank Name Bank of America

City Anywhere State AR

Transit Number 1222

Account Number 33345

Account Type: Checking Savings

Preferred Withdrawal Date: 15 of mo.

John M. Doe

Signature of Depositor/Premium Payor
(If Corporate Payor, Signature of Appropriate Corporate Officer)

Is this bank account being used for existing policies? Yes No

If yes, should drafts be combined with existing policies? Yes No

List policy numbers: _____

Do you want us to change your address as shown on voided check: Yes No

13 - Personal Doctor or Health Care Provider (List information for each person proposed for insurance.)

Person	Physician's Full Name, Address, Telephone Number, Date Last Consulted, Reason Last Consulted and Specialty
<u>John M. Doe</u>	<u>Joe Smith, 345 North St, Anywhere, AR 12345, (xxx)xxx-xxxx</u>
	<u>5/2009, sinus infection / antibiotics.</u>

14 - Family Record (Complete history including age & health status or age & cause of death of the mother, father, brothers and sisters for each person proposed for insurance. Please use separate sheet if additional space is needed.)

Relative	If Living		Age	Year	If Dead	Cause of Death	Relative	If Living		Age	Year	If Dead	Cause of Death
	Age	Health						Age	Health				

Proposed Insured: John M. Doe

Mother	<u>70</u>	<u>Good</u>					Brothers						
Father	<u>71</u>	<u>Good</u>					Sisters	<u>40</u>	<u>Good</u>				

Other Insured:

Mother							Brothers						
Father							Sisters						

Other Insured:

Mother							Brothers						
Father							Sisters						

15 - Military

Are you a member of the service (Armed Forces, Reserves, or National Guard) or have entered into a written agreement to become a member at a future date? If "yes", complete the Military questionnaire for each person proposed for insurance.

Yes No

16 - Aviation

Has any person proposed for insurance ever flown or intends within the next two years to fly, other than as a fare paying passenger on a scheduled airline? If "yes", complete the Aviation questionnaire for each person proposed for insurance.

Yes No

17 - Foreign Travel

Has any person proposed for insurance traveled outside the U.S. during the past 24 months or intends to travel outside the U.S. during the next 24 months? If "yes", complete the Non US Citizen/Foreign Travel questionnaire for each person proposed for insurance.

Yes No

18 - Tobacco Use (Please list details for each "Yes" answer in the space provided below for each person proposed for insurance.)

Have you smoked one or more cigarettes in the last 12 months?

Yes No

Have you used any form of tobacco in the past 12 months?

Yes No

Have you used any form of tobacco in the past 24 months?

Yes No

Have you ever used any form of tobacco?

Yes No

Do you use nicotine gum, nicotine patch or other form of nicotine?

Yes No

Give complete details for every "Yes" answer noted on the above questions.

Person	Type	Average Daily Usage	Date Last Used

19 - Avocation (Please complete appropriate avocation questionnaire for each "Yes" answer for each person proposed for insurance.)

Has any person proposed for insurance ever engaged or intends to participate (within the next 24 months) in any of the following or similar activities:

Yes No

Check all that apply and complete the necessary supplemental questionnaire(s).

- Vehicle Racing
 Parasailing
 Hang Gliding
 Rodeo
 Skydiving
 Scuba Diving
 Ballooning
 Other _____

20 - Other/Driving History (Please list details for each "Yes" answer in the space provided below for each person proposed for insurance.)

Do you own or ride a motorcycle? If yes, please complete the motorcycle questionnaire.

Yes No

Within the last five years, has any person proposed for insurance been convicted of two or more moving violations? If "yes", please provide details as indicated below.

Yes No

Has any person proposed for insurance ever been convicted of Driving While Intoxicated, Driving Under the Influence, or reckless driving, or had a Driver's License suspended or revoked? If "yes", please provide details as indicated below.

Yes No

Person	Date	Violation Type	Details (Speed, Length of suspension / revocation, etc.)

The following questions must be completed in all cases with respect to all persons proposed for insurance:

A. In the last 7 years, have you filed or are you currently contemplating filing bankruptcy?

Yes No

B. Have you ever plead guilty to or been convicted of a felony or misdemeanor, or have such a charge currently pending?

Give details for "yes" answers:

21 - Financial Information

Net Worth (assets minus liabilities) 160,000 Annual Earned Income 40,000

Spouse: Net Worth (assets minus liabilities) 100,000 Annual Earned Income 40,000

A FINANCIAL STATEMENT (FORM 1310) MUST ALSO BE COMPLETED IF THE FACE AMOUNT OF THE APPLICATION EXCEEDS \$1,000,000, OR WHERE THE TOTAL AMOUNT OF INSURANCE WITH ALL COMPANIES, INCLUDING THIS APPLICATION, IS \$5,000,000 OR MORE.

22 - Statement of Health

Complete the following questions with respect to all persons proposed for insurance:

	Yes	No
A. Have you ever been declined, postponed, or charged an extra premium for life insurance or received disability benefits?	<input type="checkbox"/>	<input checked="" type="checkbox"/>
B. Have you ever been diagnosed by a member of the medical profession or tested positive for Human Immunodeficiency Virus (AIDS virus) or Acquired Immune Deficiency Syndrome (AIDS)?	<input type="checkbox"/>	<input checked="" type="checkbox"/>
C. 1) Have you ever sought or received advice or treatment for use of alcohol from a health care professional or counselor or been advised by any health care professional or counselor to discontinue the use of alcohol?	<input type="checkbox"/>	<input checked="" type="checkbox"/>
2) Have you ever used barbiturates, sedatives, tranquilizers, amphetamines, or any narcotic or addictive drugs, whether prescribed or not?	<input type="checkbox"/>	<input checked="" type="checkbox"/>
3) Have you ever used heroin, morphine, cocaine, LSD, marijuana, or any other such drug, whether prescribed or not?	<input type="checkbox"/>	<input checked="" type="checkbox"/>
D. Have you ever had or been treated by a physician or consulted with a health advisor for any of the following:		
1) mental or nervous disorder (including but not limited to depression), convulsive disorder or any disease of the brain or nervous system?	<input type="checkbox"/>	<input checked="" type="checkbox"/>
2) asthma, emphysema, tuberculosis, sleep apnea or any disease or disorder of the lungs or respiratory system?	<input type="checkbox"/>	<input checked="" type="checkbox"/>
3) high blood pressure, chest pain, shortness of breath, heart murmur, or any disease or disorder of the heart or blood vessels?	<input type="checkbox"/>	<input checked="" type="checkbox"/>
4) any disease or disorder of the stomach, intestines, rectum, liver, pancreas, or gall bladder?	<input type="checkbox"/>	<input checked="" type="checkbox"/>
5) any disease or disorder of the kidneys or bladder, or any disease of the prostate, reproductive organs or complications of pregnancy?	<input type="checkbox"/>	<input checked="" type="checkbox"/>
6) gout, arthritis, or any disorder of the back, spine, bones, joints, or muscles?	<input type="checkbox"/>	<input checked="" type="checkbox"/>
7) diabetes, cancer, or tumor or ulcer of any kind, or venereal disease?	<input type="checkbox"/>	<input checked="" type="checkbox"/>
8) any disorder of the eyes, ears, nose or throat?	<input type="checkbox"/>	<input checked="" type="checkbox"/>
9) leukemia, anemia, or any disease or disorder of the blood or lymph glands?	<input type="checkbox"/>	<input checked="" type="checkbox"/>
E. In the past 5 years, have you, for any reason not previously explained, had treatment or a test at any medical facility?	<input type="checkbox"/>	<input checked="" type="checkbox"/>
F. In the past 2 years, have you gained or lost more than 10 pounds of weight?	<input type="checkbox"/>	<input checked="" type="checkbox"/>
G. Are you currently afflicted with any abnormality, deformity, disease, or disorder of any kind?	<input type="checkbox"/>	<input checked="" type="checkbox"/>
H. Are you currently receiving treatment, taking medication or contemplating surgery?	<input type="checkbox"/>	<input checked="" type="checkbox"/>
I. Have your parents, brothers, or sisters ever had: heart disease; cancer; diabetes; mental illness; or committed suicide?	<input type="checkbox"/>	<input checked="" type="checkbox"/>

Give complete details for every "Yes" answer noted on the above questions. (Please use separate sheet if additional space is needed.)

Question	Person	Details (including name, address, phone number, reason for treatment and dates of each physician consulted)

23 - Agreement

We, the undersigned, state that all statements and answers in this application are complete and true, to the best of our knowledge and belief. We also agree as follows:

1. This application will include: (a) Application Questions; (b) Statement to Medical Examiner, if required by the Company's rules; and (c) any supplements. This application, with any policy issued as a result of this application, will form the entire contract of insurance.
2. Any insurance issued by the Company as a result of this application will not be effective until: (a) a policy is delivered while the persons proposed for insurance are alive and a risk insurable; and (b) the full first premium for that policy is paid. An earlier Effective Date will apply only as specified in the conditional receipt with the same number as this application.
3. No statement made to or by, and no knowledge on the part of: (a) any agent; (b) any medical examiner; or (c) any other person; as to facts about any persons proposed for insurance shall be construed as having been made to or brought to the attention of the Company, unless stated in this application.
4. Only an Officer of the Company may make, modify, or discharge any insurance contract on its behalf. NO AGENT OR MEDICAL EXAMINER HAS THE AUTHORITY TO: (A) ACCEPT RISKS; (B) DETERMINE INSURABILITY; (C) MAKE OR MODIFY ANY CONTRACTUAL PROVISION; OR (D) WAIVE ANY OF THE COMPANY'S RIGHTS OR REQUIREMENTS.
5. The Company may amend this application by endorsement. Such an endorsement will be used to: (a) correct apparent errors or omissions; and (b) conform the application to any policy that may be issued. Any amendments will be deemed to be approved by the undersigned if and when such a policy is accepted. Any change in the plan of insurance, amount, age at issue, gender, class or benefits shall require the written consent of the owner and the proposed insured.

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.

We attest all applicants have read, or had read to them, the completed application. We realize that any false statements or misrepresentations which would affect the acceptance of the risk or hazard assumed may result in loss of coverage, subject to the Incontestability Provision of the policy.

We state that all Proposed Insureds (parent or guardian if Proposed Insured is a minor) have received and read a copy of the Conditional Receipt and "Notice to Proposed Insured" regarding: (a) investigative consumer reports; and (b) information which may be obtained from and released to the Medical Information Bureau.

The Owner of this policy hereby certifies the following: Under Federal law, I am required to supply, and Southern Farm Bureau Life Insurance Company is required to obtain, my social security or taxpayer identification number. Penalties for failure to supply such a number include withholding a portion of interest otherwise payable to me. I hereby certify or affirm (under penalty of perjury as provided under federal law) that the social security number or taxpayer identification number I am providing is correct and I am not currently subject to backup withholding.

The signatures below indicate acceptance of the "Agreement" section above. Please read this section carefully.

Dated at Anywhere, AR

John M. Doe
Signature of Proposed Insured (not required if a minor)

this 20th day of August, Year 2010

Signature of Other Person Proposed for Insurance (not required if a minor)

Witnessed:

JOE AGENT
Printed Name of Agent

Signature of Parent or Guardian (if Proposed Insured is a minor)

Joe Agent
Agent

Signature of Owner (if other than Proposed Insured)

Home Office Endorsements (Home Office Use Only)

Home Office Endorsement Form ICC10-1080 is attached. Yes No