

SERFF Tracking Number: BNLC-126676280 State: Arkansas
 Filing Company: Colonial Penn Life Insurance Company State Tracking Number: 46598
 Company Tracking Number:
 TOI: L04I Individual Life - Term Sub-TOI: L04I.213 Specified Age or Duration - Fixed/Indeterminate Premium - Single Life
 Product Name: Individual Term and Whole Life Applications
 Project Name/Number: SI Applications/12-82-049(F)

Filing at a Glance

Company: Colonial Penn Life Insurance Company

Product Name: Individual Term and Whole Life SERFF Tr Num: BNLC-126676280 State: Arkansas

Applications

TOI: L04I Individual Life - Term SERFF Status: Closed-Approved- State Tr Num: 46598
 Closed

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

Filing Type: Form

Reviewer(s): Linda Bird

Author: Karen Schussler

Disposition Date: 08/26/2010

Date Submitted: 08/25/2010

Disposition Status: Approved-Closed

Implementation Date Requested: On Approval

Implementation Date:

State Filing Description:

General Information

Project Name: SI Applications

Status of Filing in Domicile: Pending

Project Number: 12-82-049(F)

Date Approved in Domicile:

Requested Filing Mode: Review & Approval

Domicile Status Comments:

Explanation for Combination/Other:

Market Type: Individual

Submission Type: New Submission

Group Market Size:

Overall Rate Impact:

Group Market Type:

Filing Status Changed: 08/26/2010

Explanation for Other Group Market Type:

State Status Changed: 08/26/2010

Deemer Date:

Created By: Karen Schussler

Submitted By: Karen Schussler

Corresponding Filing Tracking Number:

Filing Description:

12-82-049(F) Application for Life Insurance

12-82-050(F) Application for Life Insurance with Accidental Death Rider

12-82-055 Application for Life Insurance

12-82-056 Application for Life Insurance

12-82-057 Application for Life Insurance with Accidental Death Rider

12-82-058 Application for Life Insurance with Accidental Death Rider

SERFF Tracking Number: BNLC-126676280 State: Arkansas
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TOI: L04I Individual Life - Term Sub-TOI: L04I.213 Specified Age or Duration -
Fixed/Indeterminate Premium - Single Life
Product Name: Individual Term and Whole Life Applications
Project Name/Number: SI Applications/12-82-049(F)

Enclosed for your review and approval are the above-captioned forms. These forms are new and will not replace any forms which are currently on file with your Department.

Applications 12-82-049(F), 12-82-055 and 12-82-056 are intended for use when applying for coverage under any previously approved individual whole or term life insurance policies. The applications are identical except that form 12-82-056 allows for an owner other than the insured. Form 12-82-049(F) is typeset for use in direct mail kits and forms 12-82-055 and 12-82-056 are system generated for telemarketing use.

Application 12-82-050(F), 12-82-057 and 12-82-058 are also intended for use when applying for coverage under any previously approved individual whole or term life coverage along with any previously approved Accidental Death Benefit Rider offered at initial sale. Again, the forms are identical except form 12-82-058(F) allows for an owner other than the insured. Form 12-82-050(F) is typeset for use in direct mail kits and forms 12-82-057 and 12-82-058 are system generated for telemarketing use.

All of the application forms are intended for use when coverage is marketed on a direct mail, simplified issue underwriting basis.

Areas bracketed or presented in "John Doe" fashion are intended to be variable. Such variability includes computer personalization of name, address, sex, phone number, age and date of birth. Also, the payment mode and benefit amounts may vary depending on the marketing offerings available.

The forms are in final printed format, subject only to minor changes in ink, color, paper stock, company logo and logo type, border design, margins and positioning.

I trust this submission is in order. However, should additional information be required please contact me.

Thank you for your courtesy.

Company and Contact

Filing Contact Information

Karen Schussler, Associate Analyst kschussler@colpenn.com
399 Market Street 215-928-6420 [Phone]
Philadelphia, PA 19181 215-928-6431 [FAX]

Filing Company Information

Colonial Penn Life Insurance Company CoCode: 62065 State of Domicile: Pennsylvania

SERFF Tracking Number: *BNLC-126676280* State: *Arkansas*
 Filing Company: *Colonial Penn Life Insurance Company* State Tracking Number: *46598*
 Company Tracking Number:
 TOI: *L04I Individual Life - Term* Sub-TOI: *L04I.213 Specified Age or Duration - Fixed/Indeterminate Premium - Single Life*
 Product Name: *Individual Term and Whole Life Applications*
 Project Name/Number: *SI Applications/12-82-049(F)*
 399 Market Street Group Code: 233 Company Type: Life/Health
 Philadelphia, PA 19181 Group Name: State ID Number:
 (215) 928-8688 ext. [Phone] FEIN Number: 23-1628836

Filing Fees

Fee Required? Yes
 Fee Amount: \$300.00
 Retaliatory? No
 Fee Explanation: 6 applications at \$50 per application
 Per Company: No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Colonial Penn Life Insurance Company	\$300.00	08/25/2010	39002135

SERFF Tracking Number: BNLC-126676280 State: Arkansas
Filing Company: Colonial Penn Life Insurance Company State Tracking Number: 46598
Company Tracking Number:
TOI: L041 Individual Life - Term Sub-TOI: L041.213 Specified Age or Duration -
Fixed/Indeterminate Premium - Single Life
Product Name: Individual Term and Whole Life Applications
Project Name/Number: SI Applications/12-82-049(F)

Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved- Closed	Linda Bird	08/26/2010	08/26/2010

SERFF Tracking Number: *BNLC-126676280* *State:* *Arkansas*
Filing Company: *Colonial Penn Life Insurance Company* *State Tracking Number:* *46598*
Company Tracking Number:
TOI: *L04I Individual Life - Term* *Sub-TOI:* *L04I.213 Specified Age or Duration -*
Fixed/Indeterminate Premium - Single Life

Product Name: *Individual Term and Whole Life Applications*
Project Name/Number: *SI Applications/12-82-049(F)*

Disposition

Disposition Date: 08/26/2010

Implementation Date:

Status: Approved-Closed

Comment:

Rate data does NOT apply to filing.

SERFF Tracking Number: *BNLC-126676280* State: *Arkansas*
 Filing Company: *Colonial Penn Life Insurance Company* State Tracking Number: *46598*
 Company Tracking Number:
 TOI: *L04I Individual Life - Term* Sub-TOI: *L04I.213 Specified Age or Duration - Fixed/Indeterminate Premium - Single Life*
 Product Name: *Individual Term and Whole Life Applications*
 Project Name/Number: *SI Applications/12-82-049(F)*

Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification		Yes
Supporting Document	Application		No
Supporting Document	Life & Annuity - Acturial Memo		No
Form	Application		Yes

SERFF Tracking Number: BNLC-126676280 State: Arkansas
 Filing Company: Colonial Penn Life Insurance Company State Tracking Number: 46598
 Company Tracking Number:
 TOI: L041 Individual Life - Term Sub-TOI: L041.213 Specified Age or Duration -
 Fixed/Indeterminate Premium - Single Life
 Product Name: Individual Term and Whole Life Applications
 Project Name/Number: SI Applications/12-82-049(F)

Form Schedule

Lead Form Number: 12-82-049

Schedule Item Status	Form Number	Form Type Form Name	Action	Action Specific Data	Readability	Attachment
	12-82-049(F)	Application/ Application Enrollment Form	Initial		57.200	12-82-049(F).pdf
	12-82-050(F)	Application/ Application Enrollment Form	Initial		57.200	12-82-050(F).pdf
	12-82-055	Application/ Application Enrollment Form	Initial		57.200	12-82-055.pdf
	12-82-056	Application/ Application Enrollment Form	Initial		57.200	12-82-056.pdf
	12-82-057	Application/ Application Enrollment Form	Initial		57.200	12-82-057.pdf
	12-82-058	Application/ Application Enrollment Form	Initial		57.200	12-82-058.pdf

COLONIAL PENN LIFE INSURANCE COMPANY, Philadelphia, PA 19181
APPLICATION for [Term Life]

Proposed Insured <u>[John Doe]</u>	Area Code/Phone # - Day <u>[000-000-0000]</u>
Address <u>[123 Main St.]</u>	Area Code/Phone # - Evening <u>[000-000-0000]</u>
City <u>[Anytown]</u> ST <u>[OH]</u> ZIP <u>[00000-0000]</u>	E-Mail Address <u>[xxxxxxxxxxxxxxxxxxxxxxxxxxxx]</u>
	Age <u>[x]</u> Date of Birth <u>[00/00/0000]</u> Sex <u>[x]</u>

Please check your desired insurance protection and payment option:

Amount of Life Insurance: \$0,000 \$0,000 \$00,000 \$00,000 \$00,000 \$00,000

Initial Premium Enclosed: Monthly Annual \$ _____

Check here for Monthly Automatic Bank Deduction and sign below.

Your initial premium check will give us all the information we need. I authorize Colonial Penn Life Insurance Company to charge my insurance premiums, including past due amounts, to my bank account on or after the day I have selected below. I understand that if a draft on my bank account fails due to insufficient available funds, Colonial Penn will submit the draft again within a week. This authorization is to remain in effect until I inform Colonial Penn otherwise and allow reasonable time to cancel this payment arrangement.

Payor's Signature X _____ **Premium Deduction Date** _____
(As Name Appears on Bank Account) (3rd to 28th Day of the Month)

1. Statement of Health — Answer each of the following questions "Yes" or "No." If "Yes," (circle) the condition(s) which apply.

- A. Are you currently: (1) using assistance from another person to perform your daily activities such as dressing, eating or walking; (2) using a walker, wheelchair or motorized mobility device; (3) using supplemental oxygen; (4) confined to a hospital, assisted care or nursing facility, or correctional institution? Yes No
 - B. Have you been advised to have in-patient surgery which has not yet been performed? Yes No
 - C. In the past three years, have you had, been diagnosed by a member of the medical profession with, or received treatment for (1) chronic obstructive pulmonary disease (COPD), emphysema or chronic bronchitis; (2) chronic liver disease (including chronic hepatitis), cirrhosis of the liver; (3) chronic kidney disease (not including kidney stones); (4) heart attack (myocardial infarction), cardiac arrhythmia, or congestive heart failure; (5) thrombosis or embolism (blood clots)? Yes No
 - D. In the past five years, have you had, been diagnosed by a member of the medical profession with, or received treatment for (1) stroke, transient ischemic attack (TIA), or heart or blood vessel surgery; (2) dementia, Alzheimer's disease, or ALS (amyotrophic lateral sclerosis); (3) diabetes; (4) cancer (not including basal cell skin cancer); (5) AIDS (Acquired Immunodeficiency Syndrome), infection with HIV (Human Immunodeficiency Virus), or other immune system disorder; (6) mental or nervous system disorder for which inpatient treatment or confinement in an institution was recommended or completed; (7) alcohol or drug abuse, or has treatment been recommended? Yes No
- E. Physician _____
Please Print Name Address Area Code and Phone No.

2. Beneficiary Designation (will be divided equally unless noted otherwise)

A. _____	B. _____
<small>Beneficiary Name (Please Print)</small>	<small>Beneficiary Name (Please Print)</small>
<small>Relationship to You</small>	<small>Relationship to You</small>
<small>% Share</small>	<small>% Share</small>

3. Is this insurance intended to replace or change any existing life insurance or annuity plan? Yes No

_____	_____	_____
<small>Name of Insurance Company</small>	<small>Plan of Insurance</small>	<small>Amount of Insurance</small>

I have read the questions and my answers are true to the best of my knowledge and belief. I understand that this application shall form a part of any policy issued and that, within the contestable period, a false statement or answer can be used to contest the policy as of its effective date or to deny a claim. **I understand and agree that no life insurance is in effect as a result of this application unless this application is approved by the Company, a policy is issued during my lifetime and my continued insurability, according to medical information provided in this application and the premium has been paid.** The policy will be effective on the Policy Date shown on the Policy Schedule.

I authorize any licensed physician, medical practitioner, hospital, clinic or other medical or medically related facility, insurance company, or MIB, Inc., or any other organization, institution or person, that has any records or knowledge of me or my health, to give to Colonial Penn Life Insurance Company and its underwriters or reinsurers any such information. I understand such information will be used to determine my eligibility for this insurance. A reproduction of this authorization shall be as valid as the original. The authorization will be valid for a period of 24 months from the date signed. I understand that upon request, I or an authorized representative have a right to receive a copy of this authorization. I have received and read the Notice to Applicant.

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.

Signature of Proposed Insured X _____ **Date:** _____
(Your Legal Signature/Do Not Print)

COLONIAL PENN LIFE INSURANCE COMPANY, Philadelphia, PA 19181

APPLICATION for [WHOLE Life]

Proposed Insured [John Doe] Area Code/Phone # - Day [000-000-0000]
Address [123 Main St.] Area Code/Phone # - Evening [000-000-0000]
City [Anytown] ST [OH] ZIP [00000-0000] E-Mail Address [XXXXXXXXXXXXXXXXXXXXXXX]
Age [x] Date of Birth [00/00/0000] Sex [x]

Please check your desired insurance protection and payment option:
Amount of Life Insurance: [] \$0,000 [] \$0,000 [] \$00,000 [] \$00,000 [] \$00,000 [] \$00,000
Amount of Accidental Death Protection: [] \$0,000 [] \$0,000 [] \$00,000 [] \$00,000 [] \$00,000 [] \$00,000
Initial Premium Enclosed: [] Monthly [] Annual [Term] Life \$ + Accidental Death \$ = Total \$

Check here for Monthly Automatic Bank Deduction and sign below.
Your initial premium check will give us all the information we need. I authorize Colonial Penn Life Insurance Company to charge my insurance premiums, including past due amounts, to my bank account on or after the day I have selected below.

Payor's Signature X Premium Deduction Date
(As Name Appears on Bank Account) (3rd to 28th Day of the Month)

1. Statement of Health - Answer each of the following questions "Yes" or "No." If "Yes," circle the condition(s) which apply.
A. Are you currently: (1) using assistance from another person to perform your daily activities such as dressing, eating or walking; (2) using a walker, wheelchair or motorized mobility device; (3) using supplemental oxygen; (4) confined to a hospital, assisted care or nursing facility, or correctional institution?
B. Have you been advised to have in-patient surgery which has not yet been performed?
C. In the past three years, have you had, been diagnosed by a member of the medical profession with, or received treatment for (1) chronic obstructive pulmonary disease (COPD), emphysema or chronic bronchitis; (2) chronic liver disease (including chronic hepatitis), cirrhosis of the liver; (3) chronic kidney disease (not including kidney stones); (4) heart attack (myocardial infarction), cardiac arrhythmia, or congestive heart failure; (5) thrombosis or embolism (blood clots)?
D. In the past five years, have you had, been diagnosed by a member of the medical profession with, or received treatment for (1) stroke, transient ischemic attack (TIA), or heart or blood vessel surgery; (2) dementia, Alzheimer's disease, or ALS (amyotrophic lateral sclerosis); (3) diabetes; (4) cancer (not including basal cell skin cancer); (5) AIDS (Acquired Immunodeficiency Syndrome), infection with HIV (Human Immunodeficiency Virus), or other immune system disorder; (6) mental or nervous system disorder for which inpatient treatment or confinement in an institution was recommended or completed; (7) alcohol or drug abuse, or has treatment been recommended?
E. Physician Name Address Area Code and Phone No.

2. Beneficiary Designation (will be divided equally unless noted otherwise)
A. Beneficiary Name (Please Print) Relationship to You % Share
B. Beneficiary Name (Please Print) Relationship to You % Share

3. Is this insurance intended to replace or change any existing life insurance or annuity plan?
Name of Insurance Company Plan of Insurance Amount of Insurance

I have read the questions and my answers are true to the best of my knowledge and belief. I understand that this application shall form a part of any policy issued and that, within the contestable period, a false statement or answer can be used to contest the policy as of its effective date or to deny a claim. I understand and agree that no life insurance is in effect as a result of this application unless this application is approved by the Company and a policy is issued during my lifetime and my continued insurability, according to medical information provided in this application. In addition, no life insurance or, if elected, additional accidental death protection, is in effect unless the appropriate premium has been paid. The life insurance benefit will be effective on the Policy Date shown on the Policy Schedule. If I elected additional accidental death protection, the accidental death benefit will be effective on the Rider Effective Date shown on the rider attached to the policy.
I authorize any licensed physician, medical practitioner, hospital, clinic or other medical or medically related facility, insurance company, or MIB, Inc., or any other organization, institution or person, that has any records or knowledge of me or my health, to give to Colonial Penn Life Insurance Company and its underwriters or reinsurers any such information. I understand such information will be used to determine my eligibility for this insurance. A reproduction of this authorization shall be as valid as the original. The authorization will be valid for a period of 24 months from the date signed. I understand that upon request, I or an authorized representative have a right to receive a copy of this authorization. I have received and read the Notice to Applicant.
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.

Signature of Proposed Insured X Date:
(Your Legal Signature/Do Not Print)

APPLICATION For [WHOLE Life]
 Colonial Penn Life Insurance Company, Philadelphia, PA 19181

Source Code:

Proposed Insured <u>JOHN DOE</u> <u>123 MAIN STREET</u> <u>ANYTOWN, OH 12345</u>	E-Mail Address: <u>[jdoe@com.com]</u> Date of Birth: <u>[03/30/1940]</u> Age: <u>[70]</u> Sex: <u>[MALE]</u>
Area Code/Phone: <u>[123-456-7890]</u>	Area Code/Phone: <u>[123-456-7890]</u>
Amount of Life Insurance: <u>[25,000]</u> I wish to pay: <u>[ANNUALLY]</u>	Amount of premium payment: <u>[]</u>

1. Statement of Health -- Answer each of the following questions "Yes" or "No." If "Yes" **CIRCLE** the condition(s) which apply.

- A. Are you currently: (1) using assistance from another person to perform your daily activities such as dressing, eating or walking; (2) using a walker, wheelchair or motorized mobility device; (3) using supplemental oxygen; (4) confined to a hospital, assisted care or nursing facility, or correctional institution? () Yes (X) No
- B. Have you been advised to have in-patient surgery which has not yet been performed? () Yes (X) No
- C. In the past three years, have you had, been diagnosed by a member of the medical profession with, or received treatment for (1) chronic obstructive pulmonary disease (COPD), emphysema or chronic bronchitis; (2) chronic liver disease (including chronic hepatitis), cirrhosis of the liver; (3) chronic kidney disease (not including kidney stones); (4) heart attack (myocardial infarction), cardiac arrhythmia, or congestive heart failure; (5) thrombosis or embolism (blood clots)? () Yes (X) No
- D. In the past five years, have you had, been diagnosed by a member of the medical profession with, or received treatment for (1) stroke, transient ischemic attack (TIA), or heart or blood vessel surgery; (2) dementia, Alzheimer's disease, or ALS (amyotrophic lateral sclerosis); (3) diabetes; (4) cancer (not including basal cell skin cancer); (5) AIDS (Acquired Immunodeficiency Syndrome), infection with HIV (Human Immunodeficiency Virus), or other immune system disorder; (6) mental or nervous system disorder for which inpatient treatment or confinement in an institution was recommended or completed; (7) alcohol or drug abuse, or has treatment been recommended? () Yes (X) No
- E. Physician's Name (Please Print) _____ Phone Number _____
 Physician's Address _____

2. Beneficiary Designation (will be divided equally unless noted otherwise)

Beneficiary Name (Please Print)	Relationship to You	% Share	Beneficiary Name (Please Print)	Relationship to You	% Share

3. Is this insurance intended to replace or change any existing life insurance or annuity plan? () Yes (X) No

Name of Insurance Company	Plan of Insurance	Amount of Insurance

I have read the questions and my answers are true to the best of my knowledge and belief. I understand that this application shall form a part of any policy issued and that, within the contestable period, a false statement or answer can be used to contest the policy as of its effective date or to deny a claim. **I understand and agree that no life insurance is in effect as a result of this application unless this application is approved by the Company, a policy is issued during my lifetime and my continued insurability, according to medical information provided in this application, and the premium has been paid.** The policy will be effective on the Policy Date shown on the Policy Schedule.

I authorize any licensed physician, medical practitioner, hospital, clinic or other medical or medically related facility, insurance company, or MIB, Inc., or any other organization, institution or person, that has any records or knowledge of me or my health, to give to Colonial Penn Life Insurance Company and its underwriters or reinsurers any such information. I understand such information will be used to determine my eligibility for this insurance. A reproduction of this authorization shall be as valid as the original. The authorization will be valid for a period of 24 months from the date signed. I understand that upon request, I or an authorized representative have a right to receive a copy of this authorization. I have received and read the Notice to Applicant. I have read the fraud notice applicable to my state, if any, on the reverse side of this form.

Signature of Proposed Insured _____ Date _____
 (your legal signature - do not print)

GENERAL

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.

MAINE & WASHINGTON

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

MARYLAND

Any person who knowingly and willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly and willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

OHIO

Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

APPLICATION For <u>Whole Life</u> Colonial Penn Life Insurance Company, Philadelphia, PA 19181	Source Code: _____
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Proposed Insured: <u>JOHN DOE</u>	
Date of Birth: <u>03-30-1950</u> Age: <u>60</u> Sex: <u>MALE</u>	
Area Code/Phone: <u>123-456-7890</u>	Area Code/Phone: <u>123-456-7890</u>
Proposed Owner: <u>JANE DOE</u>	Relationship: <u>WIFE</u>
Owner Address: <u>123 MAIN STREET</u>	
City, State, Zip: <u>ANYTOWN OH 00000</u>	E-Mail Address: <u>jdoe@com.com</u>
Area Code/Phone: <u>123-456-7890</u>	Area Code/Phone: <u>123-456-7890</u>
Amount of Life Insurance: <u>25,000</u>	Premium payment enclosed: <input type="checkbox"/>
I wish to pay: <u>ANNUALLY</u>	

1. Statement of Health -- Answer each of the following questions "Yes" or "No." If "Yes" CIRCLE the condition(s) which apply.

- A. Are you currently: (1) using assistance from another person to perform your daily activities such as dressing, eating or walking; (2) using a walker, wheelchair or motorized mobility device; (3) using supplemental oxygen; (4) confined to a hospital, assisted care or nursing facility, or correctional institution? () Yes (X) No
- B. Have you been advised to have in-patient surgery which has not yet been performed? () Yes (X) No
- C. In the past three years, have you had, been diagnosed by a member of the medical profession with, or received treatment for (1) chronic obstructive pulmonary disease (COPD), emphysema or chronic bronchitis; (2) chronic liver disease (including chronic hepatitis), cirrhosis of the liver; (3) chronic kidney disease (not including kidney stones); (4) heart attack (myocardial infarction), cardiac arrhythmia, or congestive heart failure; (5) thrombosis or embolism (blood clots)? () Yes (X) No
- D. In the past five years, have you had, been diagnosed by a member of the medical profession with, or received treatment for (1) stroke, transient ischemic attack (TIA), or heart or blood vessel surgery; (2) dementia, Alzheimer's disease, or ALS (amyotrophic lateral sclerosis); (3) diabetes; (4) cancer (not including basal cell skin cancer); (5) AIDS (Acquired Immunodeficiency Syndrome), infection with HIV (Human Immunodeficiency Virus), or other immune system disorder; (6) mental or nervous system disorder for which inpatient treatment or confinement in an institution was recommended or completed; (7) alcohol or drug abuse, or has treatment been recommended? () Yes (X) No
- E. Physician's Name (Please Print) _____ Phone Number _____
 Physician's Address _____

2. Beneficiary Designation (will be divided equally unless noted otherwise)

Beneficiary Name (Please Print) _____	Relationship to You _____	% Share _____	Beneficiary Name (Please Print) _____	Relationship to You _____	% Share _____
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3. Is this insurance intended to replace or change any existing life insurance or annuity plan? () Yes (X) No

Name of Insurance Company _____	Plan of Insurance _____	Amount of Insurance _____
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I have read the questions and my answers are true to the best of my knowledge and belief. I understand that this application shall form a part of any policy issued and that, within the contestable period, a false statement or answer can be used to contest the policy as of its effective date or to deny a claim. I understand and agree that no life insurance is in effect as a result of this application unless this application is approved by the Company, a policy is issued during my lifetime and my continued insurability, according to medical information provided in this application, and the premium has been paid. The policy will be effective on the Policy Date shown on the Policy Schedule.

I authorize any licensed physician, medical practitioner, hospital, clinic or other medical or medically related facility, insurance company, or MIB, Inc., or any other organization, institution or person, that has any records or knowledge of me or my health, to give to Colonial Penn Life Insurance Company and its underwriters or reinsurers any such information. I understand such information will be used to determine my eligibility for this insurance. A reproduction of this authorization shall be as valid as the original. The authorization will be valid for a period of 24 months from the date signed. I understand that upon request, I or an authorized representative have a right to receive a copy of this authorization. I have received and read the Notice to Applicant. I have read the fraud notice applicable to my state, if any, on the reverse side of this form.

Signature of Proposed Insured _____	Date _____
(your legal signature - do not print)	
Signature of Proposed Owner _____	Date _____
(if other than Insured)	
(your legal signature - do not print)	

GENERAL

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.

MAINE & WASHINGTON

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

MARYLAND

Any person who knowingly and willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly and willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

OHIO

Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

APPLICATION For Term Life
Colonial Penn Life Insurance Company, Philadelphia, PA 19181

Source Code: _____

Proposed Insured JOHN DOE 123. MAIN STREET ANYTOWN, PA 12345	E-Mail Address: [jdoe@com.com] Date of Birth: [03/30/1950] Age: [60] Sex: [male]
Area Code/Phone: [123-456-7890]	Area Code/Phone: [123-456-7890]
Amount of Life Insurance: [85,000] I wish to pay: [MONTHLY]	Amount of Accidental Death Protection: [] Amount of premium payment enclosed: []

1. Statement of Health -- Answer each of the following questions "Yes" or "No." If "Yes" CIRCLE the condition(s) which apply.

- A. Are you currently: (1) using assistance from another person to perform your daily activities such as dressing, eating or walking; (2) using a walker, wheelchair or motorized mobility device; (3) using supplemental oxygen; (4) confined to a hospital, assisted care or nursing facility, or correctional institution? () Yes (X) No
- B. Have you been advised to have in-patient surgery which has not yet been performed? () Yes (X) No
- C. In the past three years, have you had, been diagnosed by a member of the medical profession with, or received treatment for (1) chronic obstructive pulmonary disease (COPD), emphysema or chronic bronchitis; (2) chronic liver disease (including chronic hepatitis), cirrhosis of the liver; (3) chronic kidney disease (not including kidney stones); (4) heart attack (myocardial infarction), cardiac arrhythmia, or congestive heart failure; (5) thrombosis or embolism (blood clots)? () Yes (X) No
- D. In the past five years, have you had, been diagnosed by a member of the medical profession with, or received treatment for (1) stroke, transient ischemic attack (TIA), or heart or blood vessel surgery; (2) dementia, Alzheimer's disease, or ALS (amyotrophic lateral sclerosis); (3) diabetes; (4) cancer (not including basal cell skin cancer); (5) AIDS (Acquired Immunodeficiency Syndrome), infection with HIV (Human Immunodeficiency Virus), or other immune system disorder; (6) mental or nervous system disorder for which inpatient treatment or confinement in an institution was recommended or completed; (7) alcohol or drug abuse, or has treatment been recommended? () Yes (X) No
- E. Physician's Name (Please Print) _____ Phone Number _____
 Physician's Address _____

2. Beneficiary Designation (will be divided equally unless noted otherwise)

Beneficiary Name (Please Print)	Relationship to You	% Share	Beneficiary Name (Please Print)	Relationship to You	% Share
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3. Is this insurance intended to replace or change any existing life insurance or annuity plan? () Yes (X) No

Name of Insurance Company	Plan of Insurance	Amount of Insurance
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I have read the questions and my answers are true to the best of my knowledge and belief. I understand that this application shall form a part of any policy issued and that, within the contestable period, a false statement or answer can be used to contest the policy as of its effective date or to deny a claim. **I understand and agree that no life insurance is in effect as a result of this application unless this application is approved by the Company and a policy is issued during my lifetime and my continued insurability, according to medical information provided in this application. In addition, no life insurance or, if elected, additional accidental death protection, is in effect unless the appropriate premium has been paid.** The life insurance benefit will be effective on the Policy Date shown on the Policy Schedule. If I elected additional accidental death protection, the accidental death benefit will be effective on the Rider Effective Date shown on the rider attached to the policy.

I authorize any licensed physician, medical practitioner, hospital, clinic or other medical or medically related facility, insurance company, or MIB, Inc., or any other organization, institution or person, that has any records or knowledge of me or my health, to give to Colonial Penn Life Insurance Company and its underwriters or reinsurers any such information. I understand such information will be used to determine my eligibility for this insurance. A reproduction of this authorization shall be as valid as the original. The authorization will be valid for a period of 24 months from the date signed. I understand that upon request, I or an authorized representative have a right to receive a copy of this authorization. I have received and read the Notice to Applicant. I have read the fraud notice applicable to my state, if any, on the reverse side of this form.

Signature of Proposed Insured _____ **Date** _____
 (your legal signature - do not print)

GENERAL

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.

MAINE & WASHINGTON

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

MARYLAND

Any person who knowingly and willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly and willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

OHIO

Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

APPLICATION For Term Life Source Code:
Colonial Penn Life Insurance Company, Philadelphia, PA 19181

Proposed Insured: JOHN DOE **Age:** 60 **Sex:** MALE
Date of Birth: 03-30-1950 **Area Code/Phone:** 123-456-7890 **Area Code/Phone:** 123-456-7890
Proposed Owner: JANE DOE **Relationship:** Wife
Owner Address: 123 MAIN STREET
City, State, Zip: ANY TOWN, PA, 12345 **E-Mail Address:** Jdoe@com.com
Area Code/Phone: 123-456-7890 **Area Code/Phone:** 123-456-7890
Amount of Life Insurance: \$5,000 **Amount of Accidental Death Protection:**
I wish to pay: ANNUALLY **Premium payment enclosed:**

- 1. Statement of Health -- Answer each of the following questions "Yes" or "No." If "Yes" CIRCLE the condition(s) which apply.**
- A. Are you currently: (1) using assistance from another person to perform your daily activities such as dressing, eating or walking; (2) using a walker, wheelchair or motorized mobility device; (3) using supplemental oxygen; (4) confined to a hospital, assisted care or nursing facility, or correctional institution? () Yes (X) No
 - B. Have you been advised to have in-patient surgery which has not yet been performed? () Yes (X) No
 - C. In the past three years, have you had, been diagnosed by a member of the medical profession with, or received treatment for (1) chronic obstructive pulmonary disease (COPD), emphysema or chronic bronchitis; (2) chronic liver disease (including chronic hepatitis, cirrhosis of the liver); (3) chronic kidney disease (not including kidney stones); (4) heart attack (myocardial infarction), cardiac arrhythmia, or congestive heart failure; (5) thrombosis or embolism (blood clots)? () Yes (X) No
 - D. In the past five years, have you had, been diagnosed by a member of the medical profession with, or received treatment for (1) stroke, transient ischemic attack (TIA), or heart or blood vessel surgery; (2) dementia, Alzheimer's disease, or ALS (amyotrophic lateral sclerosis); (3) diabetes; (4) cancer (not including basal cell skin cancer); (5) AIDS (Acquired Immunodeficiency Syndrome), infection with HIV (Human Immunodeficiency Virus), or other immune system disorder; (6) mental or nervous system disorder for which inpatient treatment or confinement in an institution was recommended or completed; (7) alcohol or drug abuse, or has treatment been recommended? () Yes (X) No
 - E. Physician's Name (Please Print) _____ Phone Number _____
 Physician's Address _____

2. Beneficiary Designation (will be divided equally unless noted otherwise)

Beneficiary Name (Please Print)	Relationship to You	% Share	Beneficiary Name (Please Print)	Relationship to You	% Share
---------------------------------	---------------------	---------	---------------------------------	---------------------	---------

3. Is this insurance intended to replace or change any existing life insurance or annuity plan? () Yes (X) No

Name of Insurance Company	Plan of Insurance	Amount of Insurance
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I have read the questions and my answers are true to the best of my knowledge and belief. I understand that this application shall form a part of any policy issued and that, within the contestable period, a false statement or answer can be used to contest the policy as of its effective date or to deny a claim. I understand and agree that no life insurance is in effect as a result of this application unless this application is approved by the Company and a policy is issued during my lifetime and my continued insurability, according to medical information provided in this application. In addition, no life insurance or, if elected, additional accidental death protection, is in effect unless the appropriate premium has been paid. The life insurance benefit will be effective on the Policy Date shown on the Policy Schedule. If I elected additional accidental death protection, the accidental death benefit will be effective on the Rider Effective Date shown on the rider attached to the policy.

I authorize any licensed physician, medical practitioner, hospital, clinic or other medical or medically related facility, insurance company, or MIB, Inc., or any other organization, institution or person, that has any records or knowledge of me or my health, to give to Colonial Penn Life Insurance Company and its underwriters or reinsurers any such information. I understand such information will be used to determine my eligibility for this insurance. A reproduction of this authorization shall be as valid as the original. The authorization will be valid for a period of 24 months from the date signed. I understand that upon request, I or an authorized representative have a right to receive a copy of this authorization. I have received and read the Notice to Applicant. I have read the fraud notice applicable to my state, if any, on the reverse side of this form.

Signature of Proposed Insured _____ **Date** _____
(your legal signature - do not print)

Signature of Proposed Owner _____ **Date** _____
(if other than Insured)
(your legal signature - do not print)

GENERAL

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SERFF Tracking Number: BNLC-126676280

State: Arkansas

Filing Company: Colonial Penn Life Insurance Company

State Tracking Number: 46598

Company Tracking Number:

TOI: L04I Individual Life - Term

Sub-TOI: L04I.213 Specified Age or Duration -
Fixed/Indeterminate Premium - Single Life

Product Name: Individual Term and Whole Life Applications

Project Name/Number: SI Applications/12-82-049(F)

Supporting Document Schedules

Item Status:

Status

Date:

Satisfied - Item: Flesch Certification

Comments:

Attachment:

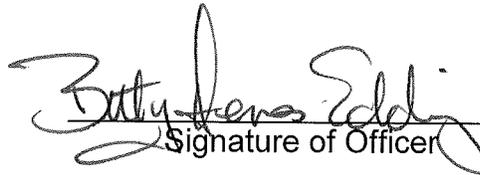
Arkansas Readability.pdf



Colonial Penn Life Insurance Company • 399 Market Street • Philadelphia, Pennsylvania 19181

**ARKANSAS
READABILITY CERTIFICATION**

This is to certify that the attached applications, Form Nos. 12-82-049, 12-82-050, 12-82-055, 12-82-056, 12-82-057 and 12-82-058 have achieved a Flesch Reading Ease Score of 57.2 and comply with the requirements of ACA 23-80-206.


Signature of Officer

Betty Hewes-Eddinger
Name of Officer

Assistant Secretary
Title

August 23, 2010
Date