Filing at a Glance

Company: Shelter Life Insurance Company
Product Name: Level Term to Age 100 Policy
TOI: L04I Individual Life - Term
Sub-TOI: L04I.213 Specified Age or Duration - Fixed/Indeterminate Premium - Single Life
Filing Type: Form

SERFF Tr Num: SHLI-126784147
SERFF Status: Closed-Approved-Closed
Co Tr Num: 03L10510

Authors: Dina Krofta, Berdetta Moore
Date Submitted: 08/25/2010

State: Arkansas
State Tr Num: 46604
State Status: Approved-Closed

Reviewer(s): Linda Bird
Disposition Date: 08/30/2010

Disposition Status: Approved-Closed
Implementation Date:

Implementation Date Requested: On Approval
State Filing Description:

General Information

Project Name: Level Term Policy
Project Number: L10910
Requested Filing Mode: Review & Approval
Explanation for Combination/Other:
Submission Type: New Submission
Overall Rate Impact:
Filing Status Changed: 08/30/2010

Deemer Date:
Submitted By: Berdetta Moore

Status of Filing in Domicile: Pending
Date Approved in Domicile:
Domicile Status Comments:
Market Type: Individual
Group Market Size:
Group Market Type:
Explanation for Other Group Market Type:
State Status Changed: 08/30/2010
Created By: Berdetta Moore
Corresponding Filing Tracking Number: 03L10510

Filing Description:
Term life insurance to age 100 with 3 premium options.

Company and Contact

Filing Contact Information

Berdetta Moore, Actuarial Administrative Assistant
blmoore@shelterinsurance.com
1817 W. Broadway
573-214-4832 [Phone]
Columbia, MO 65203
573-214-6942 [FAX]

Filing Company Information

Shelter Life Insurance Company	CoCode: 65757	State of Domicile: Missouri
1817 W. Broadway Street	Group Code: 123	Company Type: Life and Health
Columbia, MO 65203	Group Name:	State ID Number:
(800) 743-5837 ext. [Phone]	FEIN Number: 43-0740882	

Filing Fees

Fee Required?	Yes
Fee Amount:	$50.00
Retaliatory?	No
Fee Explanation:	
Per Company:	No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Shelter Life Insurance Company	$50.00	08/25/2010	39009039

Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Linda Bird	08/30/2010	08/30/2010

Objection Letters and Response Letters

Objection Letters				Response Letters		
Status	**Created By**	**Created On**	**Date Submitted**	**Responded By**	**Created On**	**Date Submitted**
Pending Industry Response	Linda Bird	08/26/2010	08/26/2010	Berdetta Moore	08/27/2010	08/27/2010

Disposition

Disposition Date: 08/30/2010
Implementation Date:
Status: Approved-Closed
Comment:

Rate data does NOT apply to filing.

SERFF Tracking Number:	*SHLI-126784147*	*State:*	*Arkansas*
Filing Company:	*Shelter Life Insurance Company*	*State Tracking Number:*	*46604*
Company Tracking Number:	*03L10510*		
TOI:	*L04I Individual Life - Term*	*Sub-TOI:*	*L04I.213 Specified Age or Duration - Fixed/Indeterminate Premium - Single Life*
Product Name:	*Level Term to Age 100 Policy*		
Project Name/Number:	*Level Term Policy/L10910*		

Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification		Yes
Supporting Document	Application		Yes
Supporting Document	Life & Annuity - Acturial Memo		No
Supporting Document	Illustration Certification		Yes
Supporting Document	Statement of Variability		Yes
Supporting Document	Certification		Yes
Form	Term Life Insurance To Age 100		Yes

Objection Letter

Objection Letter Status	Pending Industry Response
Objection Letter Date	08/26/2010
Submitted Date	08/26/2010
Respond By Date	09/27/2010

Dear Berdetta Moore,

This will acknowledge receipt of the captioned filing.

Objection 1
No Objections
Comment: Ark. Code Ann. 23-79-138 requires that certain information accompany every policy. Bulletin 15-2009 further address this issue.

Regulation 49 requires that a Life and Health guaranty notice be given to each policy owner. Please review your issue procedures and assure us that you are in compliance with Regulation 49.

Regulation 19s10B requires that all new or revised filings submitted must contain a certification that the submission meets the provisions of this rule as well as all applicable requirements of this Department.

Please feel free to contact me if you have questions.
Sincerely,
Linda Bird

Response Letter

Response Letter Status	Submitted to State
Response Letter Date	08/27/2010
Submitted Date	08/27/2010

Dear Linda Bird,

Comments:

Response 1

Comments: Attached is tghe certification you requested.

Related Objection 1

Comment:

Ark. Code Ann. 23-79-138 requires that certain information accompany every policy. Bulletin 15-2009 further address this issue.

Regulation 49 requires that a Life and Health guaranty notice be given to each policy owner. Please review your issue procedures and assure us that you are in compliance with Regulation 49.

Regulation 19s10B requires that all new or revised filings submitted must contain a certification that the submission meets the provisions of this rule as well as all applicable requirements of this Department.

Changed Items:

Supporting Document Schedule Item Changes

Satisfied -Name: Certification

Comment:

No Form Schedule items changed.

No Rate/Rule Schedule items changed.

Thanks so much.

Sincerely,

Berdetta Moore, Dina Krofta

Form Schedule

Lead Form Number: L-956

Schedule Item Status	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
	L-956	Policy/Contract/Fraternal Certificate: Amendment, Insert Page, Endorsement or Rider	Term Life Insurance To Age 100	Initial		51.700	L-956.pdf

SHELTER LIFE INSURANCE COMPANY

A STOCK COMPANY

1817 WEST BROADWAY
1-800-743-5837

COLUMBIA, MO 65218-0001

SHELTER LIFE INSURANCE COMPANY (referred to in this policy as we, us or our) WILL PAY the Death Benefit to the **beneficiary(ies)** upon receipt of due proof that the **insured's** death occurred during the term period. Payment will be made only if this policy is in force on the date of the **insured's** death.

This policy terminates on the **Expiry Date**.

20 Day Free Examination Period. Please examine your policy. Within 20 days after delivery, you can return it to us or any other agent of the company with a written request for cancellation. Upon such request, you will receive a full refund of premiums.

This policy is signed at **our home office** in Columbia, Missouri.

Secretary

President and CEO

TERM LIFE INSURANCE TO AGE 100
WITH PREMIUMS SUBJECT TO CHANGE
CONVERTIBLE AS SHOWN IN SCHEDULE
NONRENEWABLE
NONPARTICIPATING

READ THIS POLICY CAREFULLY.
This Policy is a legal contract between the Owner and Us.

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SHELTER LIFE INSURANCE COMPANY
1817 West Broadway
Columbia, MO 65218-0001
1-800-743-5837

Policy Schedule

INSURED: [JOHN SMITH]

AGE/GENDER: [35 MALE]

POLICY NUMBER: [L000123001]

POLICY DATE: [DECEMBER 1, 2010]

FACE AMOUNT: [$500,00.00]

MATURITY DATE: [DECEMBER 1, 2075]

PREMIUM CLASS: [NON-TOBACCO]

RISK CLASS: [STANDARD]

BENEFIT: TERM LIFE TO AGE 100 WITH PREMIUM SUBJECT TO CHANGE, CONVERSION OPTIONS SHOWN BELOW

PREMIUM OPTION: [20]

UNDER PREMIUM OPTION [20] , IT IS ANTICIPATED THAT PREMIUMS WILL REMAIN LEVEL FOR [20] YEARS AND THEN INCREASE ANNUALLY THEREAFTER AS SHOWN BY THE CURRENT BASIC PREMIUM BEGINNING ON PAGE 3A.

POLICY RIDERS: [WAIVER OF PREMIUM] (WP)
[ACCIDENTAL DEATH RIDER] (ADB)

ANNUAL	SEMI-ANNUAL	QUARTERLY	SPECIAL MONTHLY
[$880.00]	[$453.20]	[$231.00]	[$74.80]

*INITIAL PREMIUM MODE SELECTED.
(INCLUDING PREMIUM FOR RIDERS AND ANNUAL POLICY FEE OF $70.00)

CONVERSION PERIOD CONVERTIBLE THROUGH: [DECEMBER 1, 2026 OR AGE 65 IF EARLIER].

POLICY SCHEDULE CONTINUED

Premiums for each term period are shown below. The premium shown below under the column "Current Basic Premium" is the premium that we intend to charge for renewal term periods under this policy. After the [10]th policy year we reserve the right to increase or decrease the annual premium on all insureds under this plan of insurance, no more than once per year. Premium changes may be based on future anticipated or emerging experience. Experience to determine premium changes are mortality. Investment earnings, persistency, taxes and expenses.

If, after the [10]th year, we change the "Current Basic Premium", the change will be made for all insureds with the same issue age, sex, face amount, duration, and rate class as the insured. Changes in health or occupation will not affect any change in the premium rates. We will not change the premium for any riders other than the term life insurance benefit. We will send the owner:

A. a notice of any change before it takes effect; and
B. a new premium rate table when rates are changed which shows the then current premium rates for all policy years.

Annual term life insurance premium payable, assuming policy renewed each term period.

BEGINNING MO-DAY-YR	CURRENT BASIC PREMIUM	MAXIMUM BASIC PREMIUM	WP	ADB	TOTAL CURRENT PREMIUMS	TOTAL MAXIMUM PREMIUMS
[12-1-2011	720.00	720.00	160.00	-	880.00	880.00
12-1-2012	720.00	720.00	160.00	-	880.00	880.00
12-1-2013	720.00	720.00	160.00	-	880.00	880.00
12-1-2014	720.00	720.00	160.00	-	880.00	880.00
12-1-2015	720.00	720.00	160.00	-	880.00	880.00
12-1-2016	720.00	720.00	160.00	-	880.00	880.00
12-1-2017	720.00	720.00	160.00	-	880.00	880.00
12-1-2018	720.00	720.00	160.00	-	880.00	880.00
12-1-2019	720.00	720.00	160.00	-	880.00	880.00
12-1-2020	720.00	3,425.00	160.00	-	880.00	3,585.00
12-1-2021	720.00	3,741.25	160.00	-	880.00	3,901.25
12-1-2022	720.00	4,002.50	160.00	-	880.00	4,162.50
12-1-2023	720.00	4,208.75	160.00	-	880.00	4,368.75
12-1-2024	720.00	4,470.00	160.00	-	880.00	4,630.00
12-1-2025	720.00	4,813.75	160.00	-	880.00	4,973.75
12-1-2026	720.00	5,253.75	160.00	-	880.00	5,413.75
12-1-2027	720.00	5,790.00	160.00	-	880.00	5,950.00
12-1-2028	720.00	6,408.75	160.00	-	880.00	6,568.75
12-1-2029	720.00	7,192.50	160.00	-	880.00	7,352.50
12-1-2030	6,595.05	8,072.50	565.00	-	7,160.05	8,637.50
12-1-2031	7,305.75	8,980.00	660.00	-	7,965.75	9,640.00
12-1-2032	8,016.45	9,860.00	775.00	-	8,791.45	10,635.00

POLICY SCHEDULE CONTINUED

BEGINNING MO-DAY-YR	CURRENT BASIC PREMIUM	MAXIMUM BASIC PREMIUM	WP	ADB	TOTAL CURRENT PREMIUMS	TOTAL MAXIMUM PREMIUMS
12-1-2033	8,685.95	10,740.00	915.00	-	9,600.95	11,655.00
12-1-2034	9,520.25	11,771.25	1,085.00	-	10,605.25	12,856.25
12-1-2035	10,478.15	13,022.50	425.00	-	10,903.15	13,447.50
12-1-2036	11,760.50	14,548.75	385.00	-	12,145.50	14,933.75
12-1-2037	13,264.30	16,322.50	335.00	-	13,599.30	16,657.50
12-1-2038	14,912.30	18,261.25	260.00	-	15,172.30	18,521.25
12-1-2039	16,642.70	20,282.50	155.00	-	16,797.70	20,437.50
12-1-2040	18,460.65	22,386.25	-	-	18,460.65	22,386.25
12-1-2041	20,417.65	24,517.50	-	-	20,417.65	24,517.50
12-1-2042	22,493.10	26,745.00	-	-	22,493.10	26,745.00
12-1-2043	24,707.60	29,096.25	-	-	24,707.60	29,096.25
12-1-2044	27,205.35	31,736.25	-	-	27,205.35	31,736.25
12-1-2045	30,135.70	34,816.25	-	-	30,135.70	34,816.25
12-1-2046	33,684.05	38,556.25	-	-	33,684.05	38,556.25
12-1-2047	37,855.55	42,928.75	-	-	37,855.55	42,928.75
12-1-2048	42,310.30	47,535.00	-	-	42,310.30	47,535.00
12-1-2049	47,146.15	52,485.00	-	-	47,146.15	52,485.00
12-1-2050	52,466.10	57,875.00	-	-	52,466.10	57,875.00
12-1-2051	58,496.75	63,952.50	-	-	58,496.75	63,952.50
12-1-2052	65,547.10	71,020.00	-	-	65,547.10	71,020.00
12-1-2053	73,776.80	79,228.75	-	-	73,776.80	79,228.75
12-1-2054	83,067.40	88,427.50	-	-	83,067.40	88,427.50
12-1-2055	93,521.90	98,685.00	-	-	93,521.90	98,685.00
12-1-2056	104,084.55	109,836.25	-	-	104,084.55	109,836.25
12-1-2057	115,280.65	121,647.50	-	-	115,280.65	121,657.50
12-1-2058	127,496.45	134,545.00	-	-	127,496.45	134,545.00
12-1-2059	141,087.30	148,886.25	-	-	141,087.30	148,886.25
12-1-2060	156,202.55	164,836.25	-	-	156,202.55	164,836.25
12-1-2061	172,831.90	182,381.25	-	-	172,831.90	182,321.25
12-1-2062	190,795.10	201,342.50	-	-	190,795.10	201,342.50
12-1-2063	209,896.45	221,500.00	-	-	209,896.45	221,500.00

POLICY SCHEDULE CONTINUED

BEGINNING MO-DAY-YR	CURRENT BASIC PREMIUM	MAXIMUM BASIC PREMIUM	WP	ADB	TOTAL CURRENT PREMIUMS	TOTAL MAXIMUM PREMIUMS
12-1-2064	229,940.25	242,647.50	-	-	229,940.50	242,647.50
12-1-2065	249,896.50	263,712.50	-	-	249,896.50	263,712.50
12-1-2066	269,548.90	284,447.50	-	-	269,548.90	284,447.50
12-1-2067	290,133.45	306,172.50	-	-	290,133.45	306,172.50
12-1-2068	311,835.55	329,080.00	-	-	311,835.55	329,080.00
12-1-2069	334,706.70	353,211.25	-	-	334,706.70	353,211.25
12-1-2070	339,481.24	377,108.75	-	-	339,481.24	377,108.75
12-1-2071	356,939.24	385,883.50	-	-	356,939.24	385,883.50
12-1-2072	374,397.25	394,376.50	-	-	374,397.25	394,376.50
12-1-2073	391,855.25	418,958.50	-	-	391,855.25	418,958.50
12-1-2074	409,313.25	445,185.25	-	-	409,313.25	445,185.25
12-1-2075]	Expiry Date					

PREMIUM CHANGE BASED ON ADDITION OR TERMINATION OF RIDERS
BASIS OF RESERVES—INTEREST RATE—3.5%
COMISSIONERS RESRVE VALUATION METHOD

[MISSOURI DEPARTMENT OF INSURANCE
P.O. BOX 690
JEFFERSON CITY, MO 65102-0690
PHONE NUMBER: 573-751-4126
Insurance.mo.gov]

POLICY RIDERS

The policy riders, if any, listed on the Policy Schedule are described in the rider agreements that follow page 9.

DEFINITIONS

Beneficiary(ies): The person(s) who is (are) named in the application or by later designation to receive the Death Benefit of this policy.

Evidence of Insurability: Information about an **insured** which is used to approve or Reinstate this policy or any rider(s).

Expiry Date: The **policy anniversary** following the **insured's** 100th birthday. The policy terminates on the Expiry Date.

Home Office: 1817 West Broadway, Columbia, Missouri 65218-0001.

Insured: The person whose life is insured under this policy as shown on the Policy Schedule.

Monthly Date: The same date in each month as the Policy Date.

Policy Anniversary: The same month and date as the Policy Date for each succeeding year this policy remains in force.

Policy Year: A one year period of time starting on successive **policy anniversaries**, with the first **policy year** starting on the Policy Date.

Rate Class: The mortality or morbidity classifications assigned to the **insured** under this policy, as specified by the Premium Class and Risk Class.

We, Our, Us, The Company: Shelter Life Insurance Company.

You, Your: The Owner of this policy.

OWNERSHIP; ASSIGNMENT

Owner - The **insured** will be the Owner unless otherwise stated. **You** may exercise all policy rights, except for proceeds which are to be paid to the **beneficiary(ies)**. **Your** rights will be subject to the rights of an assignee or irrevocable **beneficiary(ies)**. If **you** die before the **insured**, **your** estate will become the Owner unless otherwise provided. If the Owner is a partnership, the rights belong to the partnership as it exists when a right is exercised. If ownership is joint, either Owner may exercise permissible policy right. If a corporation owns the policy, representatives authorized by the corporation may exercise permissible policy rights.

Successor Owner - **You** may designate a Successor Owner. This must be made by written notice to **us**. When **you** die, the Successor Owner becomes the new Owner. If no Successor Owner survives, **your** estate becomes the new Owner.

Change of Ownership - The Ownership change must be made while the **insured** is living by filing at **our home office** written notice satisfactory to **us**. When acknowledged in writing by **us**, the change will take effect on the date notice was signed. **We** will not be liable for payment made or action taken before notice was acknowledged.

Assignment - Assignment of this policy will be binding on **us** only after a copy of the Assignment is received at **our home office**. The Assignment will be effective on the date the notice is signed by the Owner. **We** are not responsible for the validity of any Assignment. If the Assignment is absolute, all rights of the Owner and any revocable **beneficiary(ies)** are transferred to the assignee. If the Assignment is collateral, such rights are transferred only to the extent of the assignee's interest.

Death Benefit - The amount payable at the death of the **insured** will be:

1) The Face Amount in force at death; plus
2) Any premium refund due; minus
3) Any premium due and unpaid to the **monthly date** following the date of death.

When this policy has become a claim by death of the **insured**, settlements shall be made upon receipt of due proof of death and not later than two (2) months after receipt of such proof.

Proceeds payable will include interest if required by state law.

PAYMENT OF BENEFITS

Succession in Interest of Beneficiaries - Unless otherwise stated in this policy, including any settlement agreement or in a **beneficiary** designation in effect under this policy, the following provisions apply:

1. A **beneficiary** is either a primary **beneficiary** or a contingent **beneficiary**. If no primary **beneficiary** survives the **insured**, then any proceeds are payable to the contingent **beneficiary**.
2. The interest of any surviving primary **beneficiary** in any proceeds payable is paramount to and exclusive of the interest of any contingent **beneficiary**.
3. All **beneficiaries** in the same class will share equally.
4. Proceeds will be paid to the **beneficiaries** living at the time of the **insured's** death.
5. Any proceeds payable after the death of all designated **beneficiaries** will be paid to: (a) the Owner; or (b) the successors, transferees or estate of the Owner. However, the withdrawal value of any remaining guaranteed payments due will be paid in one sum to the estate of the person or persons then receiving such payments.

We may rely on the affidavit of the **insured's** executor or estate administrator to determine the identity or nonexistence of **beneficiaries** identified by class and not by name.

Claims Against Beneficiaries - To the extent allowed by law, no payment of proceeds or interest will be subject to: (a) claims of a **beneficiary's** creditors; or (b) legal process against a **beneficiary**.

Change of Beneficiary - **You** may change the **beneficiary** by submitting a written request with **us**. The change of **beneficiary** request will not be effective until approved and recorded by **us** at **our home office**. Once approved and recorded, the change will be effective as of the date **you** signed the request, whether or not **you** or the **insured** is alive when **we** record the change. However, the change will be subject to any payments made or other actions taken by **us** before **your** request was approved and recorded at **our home office**.

THE CONTRACT

Consideration; Entire Contract - This policy is issued in consideration of: (a) the attached application; and (b) the payment of premiums. This policy and the application are the entire contract between the Owner and **us**. Statements made in the application or a Reinstatement application are considered representations and not warranties, except in the case of fraud. No statement will void this policy or be used as a defense to claim unless made in the application.

Modification of Policy - No Agent has authority to change this policy or waive any of its provisions. Only an officer of **the company** may make or modify this policy.

Policy Date - Policy months, years and anniversaries are measured from the Policy Date, as shown on the Policy Schedule.

Effective Date - This policy will be effective as soon as it has been accepted by the Owner and the first premium has been paid during the lifetime and continued insurability of the proposed **insured**. If the first premium is paid in exchange for a conditional coverage receipt on the date of the application, then this policy will be effective as stated on the receipt.

Payments by Us - Any amount payable by **us** will be made at **our home office** in Columbia, Missouri. **We** may require surrender of the policy.

Incontestability - This policy will not be contestable after it has been in force during the **insured's** lifetime for two years from the Policy Date, except for non-payment of premium.

Suicide - If the **insured** commits Suicide, while sane or insane, within two years from the Policy Date, the amount payable by **us** will be limited to the premium paid.

Misstatement of Age; Sex - The age of the **insured** is the age last birthday on the Policy Date or on a **policy anniversary**. Age is determined from the birth date shown in the application. If the age or sex shown on the Policy Schedule is not correct, **we** will adjust the Face Amount. The amount payable will be the amount the most recent premium would have purchased at the correct age and sex.

Reduction in Rate Class - **You** may request that **we** reduce the **rate class** assigned to the **insured**. **We** will allow a reduction in **rate class** if **we** receive satisfactory evidence that the **insured** qualifies. Any evidence **we** may require must be provided by a medical examiner approved by **us**. A new policy will not be issued. A new Policy Schedule will be provided to **you**.

Nonparticipating – This policy does not participate in **our** earnings or surplus.

PREMIUMS

Payment - The first premium is due on the Policy Date. Due dates of later premiums are measured from that date. All premiums after the first are payable: (a) at **our home office**; or (b) to one of **our** Agents. Upon request, **we** will give **you** a receipt signed by **our** Secretary. Premiums may be paid annually, semi-annually, quarterly or monthly at the published rates used by **us** on the Policy Date. Payment of premiums is subject to **our** current minimum premium requirements and permitted methods of payment.

This policy terminates on the due date of any premium not paid on or before that date, subject to the Grace Period provision.

Grace Period - A Grace Period of 31 days will be allowed for payment of any premium after the first. This policy will remain in force during the Grace Period. At least 30 days prior to termination of coverage, **we** will send a notice of such termination to **you** and any assignee of record.

Reinstatement –This policy may be reinstated to restore coverage within five years of lapse of policy provided the **insured** is living. **Your** policy may not be reinstated after it has been surrendered. Reinstatement is subject to:

1) **Evidence of insurability** satisfactory to **us**; and
2) Payment of all overdue premiums with compound interest of 6% per year.

If this Policy is reinstated, the time period for the Incontestability provision will begin again at the time of Reinstatement. **Our** only basis for contesting a reinstated policy beyond the policy's original contestable period is for material misstatements made in the Reinstatement application.

Premium Adjustment At Death - Any part of a premium which pays beyond the next **monthly date** following the date of death will be returned. If death occurs during a Grace Period, any part of any unpaid premium to the next **monthly date** following the date of death will be deducted from the benefits paid.

Refund of Unearned Premiums - If this policy is terminated at **your** request, **we** will refund any unearned premiums. Unearned premium is the premium you paid, if any, to cover the period after the next **monthly date** following termination.

GUARANTEED VALUES

Computation of Reserves - The 2001 Commissioners Standard Ordinary Smoker or Non-Smoker Mortality Table is used to establish reserves.

The interest basis and the reserve method used in calculating the reserves for this policy are shown in the Policy Schedule.

A detailed statement of the methods of calculations has been filed with the insurance supervisory official of the jurisdiction in which this policy was delivered.

CONVERSION OPTION

Conversion Period - The period during which this policy may be converted is shown on the Policy Schedule. Insurance may be converted to a Permanent Life policy by the Owner while this policy is in force during this period. If the conversion is requested after the Conversion Period terminates, **evidence of insurability** satisfactory to **us** will be required.

The **conversion period** does not include the **policy anniversary** at the end of the term period.

Conditions for Conversion - Insurance in force may be converted during the **conversion period** subject to these conditions:

1. Conversion amount must be no more than the Face Amount of this policy.

2. Benefits are not being paid under any Waiver of Premium due to Total Disability Benefit.

3. No premiums on this policy are in default.

4. The new policy will be issued at the attained age on the date of conversion, on the forms and at the premium rates in use by **us** on that date. The Policy Date of the new policy will be the date of conversion. The first premium is due on the Policy Date of the new policy. If this policy is issued in a substandard class, the premium rate for the new policy will be based on the same substandard rate for that class. A new Suicide or Contestable Period will not apply to benefits converted from this policy to a new policy. These periods will be measured from the Policy Date of this policy.

5. The new policy will be in the same **rate class** as this policy, if available. If the same **rate class** is not available, the new policy will be in the most similar **rate class** available. The premium for the new policy will be based on the rate in use on the date of conversion for the **insured's** sex and then-attained age. The initial premium rate for the new policy must be higher than the corresponding premium rate for this policy on the date of conversion. The initial premium for any new whole life policy is the premium rate per $1,000 of coverage. The initial premium is the minimum initial premium for any flexible premium adjustable life policy.

6. The new policy will be subject to **our** minimum policy requirements in effect at the time of conversion.

7. Accidental Death Benefits that are a part of this policy and in force on the date of conversion may be issued with the new policy only if offered by **us**. Disability benefits that are a part of this policy and in force on the date of conversion may be issued with the new policy only if offered by **us**. The premiums for these benefits will be at the **insured's** attained age on the date of conversion. The new policy will cover only bodily injury or disease which starts after the date of conversion.

8. Additional benefits will be issued with the new policy only with **our** consent, and subject to **our** requirements.

Automatic Conversion When Disabled - If disability benefits are being allowed under this policy at the end of the Conversion Period, **we** will convert this policy to an Permanent Life policy. The Permanent Life policy will be issued for the same amount as this policy. The Permanent Life policy will be issued at the Insured's attained age.

Disability benefits provided by this policy will terminate. However, the Permanent Life policy will provide disability benefits for any continuing disability existing on the date of conversion.

OPTIONAL INCOME PAYMENT OF PROCEEDS

Election of Payment Option - Proceeds are payable to the **beneficiary(ies)** in a lump sum or in any of the Payment Options below. An option election must be in writing. It must be received by **us**.

Payment options are available only to natural persons. Options 1, 2 and 3 may not exceed 30 years.

PAYMENT OPTIONS

Option 1. Held at Interest - We will hold the amount applied under this option. Interest will be paid at the rate of 3% per year. Interest payment intervals of 12, 6, 3 or 1 month(s) may be selected. If interest is applied to the proceeds, it will be applied on an annual basis.

Option 2. Payments of a Selected Amount - Each payment will be for the amount selected. The amount may not be less than $20. Payment intervals of 12, 6, 3 or 1 month(s) may be selected. Payments will be made until the amount applied plus interest at 3% per year is exhausted. The last payment will be for the balance only.

Option 3. Selected Number of Payments - Equal payments will be made for the number of payments selected. The amount of each payment depends on: the total amount applied; the number of payments selected; and the interval of payment. Payment intervals of 12, 6, 3 or 1 month(s) may be selected. The following table shows the amount of payment for each $1,000 applied.

Amounts of Installments

Years Payable	Annual	Semi-Annual	Quarterly	Monthly
1	1,000.00	503.69	252.78	84.47
2	507.39	255.57	128.26	42.86
3	343.23	172.88	86.76	28.99
4	261.19	131.56	66.02	22.06
5	211.99	106.78	53.59	17.91
6	179.22	90.27	45.30	15.14
7	155.83	78.49	39.39	13.16
8	138.31	69.66	34.96	11.68
9	124.69	62.81	31.52	10.53
10	113.82	57.33	28.77	9.61
11	104.93	52.85	26.52	8.86
12	97.54	49.13	24.65	8.24
13	91.29	45.98	23.08	7.71
14	85.95	43.29	21.73	7.26
15	81.33	40.96	20.56	6.87
16	77.29	38.93	19.54	6.53
17	73.74	37.14	18.64	6.23
18	70.59	35.56	17.84	5.96
19	67.78	34.14	17.13	5.73
20	65.26	32.87	16.50	5.51
21	62.98	31.72	15.92	5.32
22	60.92	30.68	15.40	5.15
23	59.04	29.74	14.92	4.99
24	57.33	28.88	14.49	4.84
25	55.76	28.08	14.09	4.71
26	54.31	27.36	13.73	4.59
27	52.97	26.68	13.39	4.47
28	51.74	26.06	13.08	4.37
29	50.60	25.49	12.79	4.27
30	49.53	24.95	12.52	4.18

Option 4. Life Income - Payments will be made for a selected guaranteed period of 10, 15 or 20 years. Payments will stop at the end of the selected period or when the payee dies, whichever is later. The amount of each monthly payment depends on the total amount applied. The amount of each monthly payment depends on the sex and age of the payee when payments begin. Age is determined on an age last birthday basis. **We** may require proof of age and sex of the payee before payments begin. **We** may also require proof that the payee is living at the time any payment is made. The following table shows the amount of monthly payment for each $1,000 applied.

MONTHLY INSTALLMENTS

	Age	Guaranteed Period		
MALE		**10 Years**	**15 Years**	**20 Years**
	50	4.05	4.01	3.95
	55	4.41	4.34	4.24
	60	4.88	4.75	4.56
	65	5.48	5.22	4.88
	70	6.23	5.73	5.16
	75	7.08	6.20	5.36
FEMALE		**10 Years**	**15 Years**	**20 Years**
	50	3.81	3.79	3.76
	55	4.13	4.09	4.03
	60	4.54	4.46	4.35
	65	5.07	4.93	4.71
	70	5.78	5.47	5.05
	75	6.67	6.03	5.31

Monthly payments for ages not shown will be furnished on request.

TERM LIFE INSURANCE TO AGE 100
WITH PREMIUMS SUBJECT TO CHANGE
CONVERTIBLE
NONRENEWABLE
NONPARTICIPATING

SHELTER LIFE INSURANCE COMPANY • 1817 WEST BROADWAY • COLUMBIA, MO 65218-0001

Supporting Document Schedules

Item Status: **Status Date:**

Satisfied - Item: Flesch Certification

Comments:

Attachment:

CERTIFICATION-FLESCH-ARK.pdf

Item Status: **Status Date:**

Satisfied - Item: Application

Comments:

The L-953 was approved 8-9-2010 and the L-309.41 was approved on 8-11-2010.

Attachments:

L-953.pdf

L-309.41.pdf

Item Status: **Status Date:**

Satisfied - Item: Illustration Certification

Comments:

Attachment:

Illus Cert -Dina.pdf

Item Status: **Status Date:**

Satisfied - Item: Statement of Variability

Comments:

Attachment:

Statement of Variability For Level Term1.pdf

Item Status: **Status**

Date:

Satisfied - Item: Certification

Comments:

Attachment:

AR CERTIFICATION .pdf

SHELTER INSURANCE COMPANIES

SHELTER MUTUAL
SHELTER GENERAL
SHELTER LIFE

CERTIFICATION

This is to certify that the following forms have achieved the indicated Flesch Reading Ease Scores. They do not comply with the requirements of Ark. Stat. Ann. 66-3251 through 66-3258, cited as the Life and Disability Insurance Policy Language Simplification Act, due to required wording.

Form No.	Name	Score
L-956	Level Term Insurance to Age 100	51.7

Signed Robert W Omdal

Digitally signed by Robert W Omdal
DN: cn=Robert W Omdal, o, ou, email=romdal@shelterinsurance.com, c=US
Date: 2010.08.24 13:04:49 -05'00'

Robert W. Omdal, FSA, MAAA
Chief Actuary – Life and Health
Shelter Life Insurance Company

1817 WEST BROADWAY ● COLUMBIA, MISSOURI ● 65218-0001

SHELTER LIFE INSURANCE COMPANY

1817 West Broadway
Columbia, Missouri 65218-0001

INDIVIDUAL LIFE INSURANCE APPLICATION

Agent Name:

Agent #:

Agent Phone #:

Family #:

Personal Information

1. Name: Gender: SSN: Marital Status:
2. Birth Date: Age: Height: Weight: Place of Birth:
3. Physical Address: County:
3a. Mailing Address: County:
4. Home Phone: Cell Phone: Best Time to Contact:
5. Driver's License Number: State:
6. Country of Citizenship: Length of Residency in US:
   Visa Type: Category: Expiration Date:
7. Occupation: Name of Employer: Date Employed:
8. Annual Earned Income: Income All Sources:

Coverage Information

9. Plan: Face Amount: $ Rate Class:
10. Waiver of Premium: Accidental Death: Amount: $
11. Mode Premium: $ Mode of Premium: Premium included with application: $
11a. Remarks:

Information for Other Involved Parties

12. Primary Beneficiary:

    Contingent Beneficiary:

    Payor:

    Owner:

    Successor Owner:

Existing Insurance Information

13. Total individual life insurance and accidental death coverage in force or pending (excluding this application):

	(Life)	(Accidental Death)
With Shelter Life:	$	$
With Other Companies:	$	$

13a. Amount of life insurance on: Father: Mother: Sibling #1: Sibling #2:
Sibling #3: Sibling #4: Sibling #5: Sibling #6: Sibling #7:

14a. Do you have existing life insurance policies or contracts? ☐ Yes ☐ No
If yes, please send Replacement Form L-243.29 with this application.

14b. Will this application replace an existing policy or contract? ☐ Yes ☐ No
If yes, please send Replacement Form L-243.33 with this application.

Proposed Insured Name: Application Number:

Underwriting Information

15. Have you ever seen a doctor? Yes ☐ No ☐

Please provide the following information for your most recent doctor consultation(s):

Hospital or clinic:
Physician's name:
Street address:
City, State, Zip:
Phone Number:
Fax Number:

Date of last consultation:
Reason for last consultation:
Diagnosis:
Treatment:
Medication(s) prescribed:

16. Do you have a parent or sibling who has a history of diabetes, heart or kidney disease, or hypertension? Yes ☐ No ☐
Relationship to Insured: Explanation:

17. Do you have a parent or sibling who died before age 60? Yes ☐ No ☐
Relationship to Insured: Age at death:
Explanation:

18. Have you engaged in or do you anticipate engaging in:
a) Aviation activities, including ultralight flying, hang gliding or parachute jumping? Yes ☐ No ☐

b) Rodeo riding, underwater diving, racing of any motor powered vehicle or any other hazardous sport or hobby? Yes ☐ No ☐

19. In the past 5 years have you been charged with any motor vehicle violations or violations for driving while intoxicated from alcohol or drugs? Yes ☐ No ☐
Violation Date: Description:

20. Are you planning travel, residence, or employment outside the United States? Yes ☐ No ☐
Travel Dates: Description:

21. Do you now use or have you ever used any form of tobacco or nicotine substitutes? Yes ☐ No ☐
Date last used: Details:

22. Are you in the National Guard or Reserves? Yes ☐ No ☐
Details:

23. Have you been charged with any misdemeanor or felony? Yes ☐ No ☐
Date of crime: Type of offense:
Were you convicted? Description:

Medical Information

Questions in the Medical Information section (questions 24-41) may be left unanswered if a medical exam is required.

24. To the best of your knowledge and belief, have you ever been diagnosed or treated by a medical professional for hypertension, coronary artery disease, stroke, heart attack, chest pain, irregular heartbeat, or any other disease or disorder of the heart or blood vessels? Yes ☐ No ☐
Date of onset: Duration:
Description of illness or injury, medical attention received, remaining effects, and any other details:

Treating hospital(s) and/or physician(s):

25. To the best of your knowledge and belief, have you ever been diagnosed or treated by a medical professional for cancer, tumor or other growth or malignancy of any kind? Yes ☐ No ☐
Date of onset: Duration:
Description of illness or injury, medical attention received, remaining effects, and any other details:

Treating hospital(s) and/or physician(s):

Medical Information Continued

26. To the best of your knowledge and belief, have you ever been diagnosed or treated by a medical professional for bronchitis, emphysema, shortness of breath or any other disease or disorder of the lungs or respiratory system? Yes ☐ No ☐
    Date of onset: Duration:
    Description of illness or injury, medical attention received, remaining effects, and any other details:

    Treating hospital(s) and/or physician(s):

27. To the best of your knowledge and belief, have you ever been diagnosed or treated by a medical professional for depression, anxiety or any other behavioral, mental or nervous disorder? Yes ☐ No ☐
    Date of onset: Duration:
    Description of illness or injury, medical attention received, remaining effects, and any other details:

    Treating hospital(s) and/or physician(s):

28. To the best of your knowledge and belief, have you ever been diagnosed or treated by a medical professional for epilepsy, seizures, sleep apnea or any other disease or disorder of the brain or nervous system? Yes ☐ No ☐
    Date of onset: Duration:
    Description of illness or injury, medical attention received, remaining effects, and any other details:

    Treating hospital(s) and/or physician(s):

29. To the best of your knowledge and belief, have you ever been diagnosed or treated by a medical professional for diabetes, hepatitis, anemia or any other disease or disorder of the blood or glands? Yes ☐ No ☐
    Date of onset: Duration:
    Description of illness or injury, medical attention received, remaining effects, and any other details:

    Treating hospital(s) and/or physician(s):

30. To the best of your knowledge and belief, have you ever been diagnosed or treated by a medical professional for arthritis, gout, or any other disease or disorder of the bones, muscles, joints, eyes or skin? Yes ☐ No ☐
    Date of onset: Duration:
    Description of illness or injury, medical attention received, remaining effects, and any other details:

    Treating hospital(s) and/or physician(s):

31. To the best of your knowledge and belief, have you ever been diagnosed or treated by a medical professional for any disease or disorder of the stomach, intestines, colon, rectum, liver, pancreas or digestive system? Yes ☐ No ☐
    Date of onset: Duration:
    Description of illness or injury, medical attention received, remaining effects, and any other details:

    Treating hospital(s) and/or physician(s):

32. To the best of your knowledge and belief, have you ever been diagnosed or treated by a medical professional for any disease or disorder of the kidney, bladder, prostate, urinary system or genital organs including complication of pregnancy? Yes ☐ No ☐
    Date of onset: Duration:
    Description of illness or injury, medical attention received, remaining effects, and any other details:

    Treating hospital(s) and/or physician(s):

33. To the best of your knowledge and belief, have you ever been diagnosed or treated by a medical professional for Acquired Immune Deficiency Syndrome (AIDS), positive HIV test, or other immunological disorder? Yes ☐ No ☐
    Date of onset: Duration:
    Description of illness or injury, medical attention received, remaining effects, and any other details:

    Treating hospital(s) and/or physician(s):

Medical Information Continued

34. Are you now pregnant? Yes ☐ No ☐
    Approximate Delivery Date:
    Description of pregnancy and any medical attention received:

    Treating hospital(s) and/or physician(s):

35. Are you currently receiving treatment, taking medication, or scheduled to have surgery? Yes ☐ No ☐
    Date of onset: Duration:
    Description of illness or injury, medical attention received, remaining effects, and any other details:

    Treating hospital(s) and/or physician(s):

36. Have you had weight loss of more than 10 lbs. in the past year? Yes ☐ No ☐
    Date: Number of pounds lost:
    Reason for and details of weight loss:

    Treating hospital(s) and/or physician(s):

37. Have you used or do you now use cocaine, methamphetamines, marijuana or any other drugs? Yes ☐ No ☐
    Date last used: Length of drug use:
    Amount: Frequency:
    Drug type(s):
    Details including any remaining effects:

    Treating hospital(s) and/or physician(s):

38. Have you used or do you now use alcoholic beverages? Yes ☐ No ☐
    Date of last drink: Frequency:
    Amount: Alcohol type(s):
    Details including any remaining effects:

    Treating hospital(s) and/or physician(s):

39. Have you sought or received treatment or counseling for alcohol or drug use? Yes ☐ No ☐
    Date of treatment: Duration:
    Description of illness or injury, medical attention received, remaining effects, and any other details:

    Treating hospital(s) and/or physician(s):

40. Have you received or do you now receive disability benefits or do you currently have a disability of any kind? Yes ☐ No ☐
    Date of onset: Duration:
    Description of illness or injury, medical attention received, remaining effects, and any other details:

    Treating hospital(s) and/or physician(s):

41. In the past 5 years, have you consulted any physician or health care facility, been hospitalized, had any abnormal diagnostic tests or been advised to have treatment for any reason not explained above? Yes ☐ No ☐
    Date of onset: Duration:
    Description of illness or injury, medical attention received, remaining effects, and any other details:

    Treating hospital(s) and/or physician(s):

Special Requests

42.

Signatures/Declaration

The Owner and Proposed Insured, if other than the Owner, each declares that he or she has read the answers recorded in this application and that they are complete and true to the best of his or her knowledge and belief, and agrees that:

a. this application and any amendments to it and any statements made and recorded on the medical examination form shall become the basis for and be a part of any contract of insurance;

b. any policy or rider issued on the basis of this application will belong to and be solely under the control of the Owner;

c. only the Shelter Life Insurance Company, at its Home Office, may make or modify contracts or waive any of its rights or requirements, and then only in writing;

d. no Agent of Shelter Life Insurance Company and no Medical Examiner is authorized to accept or pass upon insurability; and

e. except as provided in the Conditional Coverage Receipt, if issued, insurance will not be effective unless:
(1) a policy is delivered to the Owner during the lifetime of all persons proposed for insurance; and
(2) to the best of the Owner's and Proposed Insured's knowledge there has been no material change in the answers herein since the date of this application or the completion of all medical examination requirements.

THE OWNER DECLARES THAT THE CONDITIONAL COVERAGE RECEIPT HAS BEEN DETACHED FROM THIS APPLICATION AND GIVEN TO HIM OR HER Yes ☐ No ☐

IF "YES" THE OWNER FURTHER DECLARES THAT THE TERMS AND CONDITIONS OF THE CONDITIONAL COVERAGE RECEIPT HAVE BEEN BROUGHT SPECIFICALLY TO HIS OR HER ATTENTION AND THAT HE OR SHE UNDERSTANDS AND ACCEPTS THEM.

THE PROPOSED INSURED ACKNOWLEDGES RECEIPT OF THE NOTICE OF CONSUMER REPORT AND MIB PRE-NOTICE AS REQUIRED BY THE CONSUMER PROTECTION AGENCY.

THIS APPLICATION IS A LEGAL DOCUMENT. THE POLICY MAY BE ALTERED OR RESCINDED IF THE QUESTIONS ARE NOT ANSWERED CORRECTLY AND TRUTHFULLY.

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.

Dated this _____ day of _____ (Month) _____ (Year) at _____ (Time) ☐ A.M. ☐ P.M. in the city of_____ State of _____

Signature of Proposed Insured or of Parent or Legal Guardian if Under Age 18

Signature of Owner, if other than Proposed Insured, or of Parent or Grandparent Owner if Proposed Insured is Under Age 18

Owner's Social Security Number

I HEREBY CERTIFY THAT I PERSONALLY ASKED EVERY QUESTION OF THE OWNER, AND PROPOSED INSURED IF OTHER THAN OWNER, AND ACCURATELY RECORDED THE ANSWERS GIVEN AND THAT I WITNESSED THE SIGNATURE(S) ABOVE.

Print Name of Writing Agent

Signature of Writing Agent

Agent's Number

Medical Test Authorization

I hereby authorize Shelter Life Insurance Company to obtain medical tests on blood, oral fluid, or urine samples in connection with the underwriting of my application for insurance with Shelter Life Insurance Company.

I understand that such tests will be performed by laboratories selected by Shelter Life Insurance Company and may include, but are not limited to, tests for cholesterol and related blood lipids, diabetes, hepatitis or other liver disorders, kidney disorders, infection by the Acquired Immune Deficiency Syndrome virus, immune disorders, or the presence of medications, drugs, nicotine, or their metabolites.

The results of these tests will be made known only to Shelter Insurance Companies, and/or their reinsurers, and possibly the Medical Information Bureau as described in the Pre-Notice which was given to me as part of the application process. Positive HIV and hepatitis test results will be reported to your State Department of Health if we or the testing laboratory are required to do so by law. Test results will not be released to anyone else or any institution except as required by law, by court order or by written authorization from me to release it to a physician designated by me.

Date	Signature of Proposed Insured or Parent if Proposed Insured is a Juvenile

Authorization for Use or Disclosure
Of Protected Health Information

1. I hereby authorize any licensed physician, medical practitioner, hospital, clinic or other medical or medically related facility, insurance company, MIB Group, Inc. or other organization, institution, or person, that has any records or knowledge of me or my health, to give to the Shelter Life Insurance Company, its Medical Director, its reinsurers, and Shelter Mutual Insurance Company, any and all such health information. I further authorize Shelter Life Insurance Company, and its reinsurers, to disclose such protected health information to MIB Group, Inc., a non-profit membership organization of life insurance companies, which operates an information exchange on behalf of its members.

2. I understand that this protected health information will be used to locate or underwrite insurance for me, or to determine whether a valid claim for benefits has been made. The information may also be disclosed by Shelter Life Insurance Company to MIB, who, upon request, may disclose such information about me in its file to another member company with whom I apply for life or health insurance or to whom a claim for benefits may be submitted.

3. I understand that if the person or entity that receives the information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be redisclosed and no longer protected by these regulations.

4. I understand that the information in my health record may include information that may be considered a communicable or venereal disease that may include, but is not limited to diseases such as hepatitis, syphilis, gonorrhea, and acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.

5. This authorization is valid for 12 months from the date of signing. I understand that I may revoke this authorization at any time by sending written notification to Shelter Life Insurance Company, 1817 West Broadway, Columbia, MO 65218-0001, except to the extent that action has been taken in reliance on this authorization. A photographic copy of this authorization will be treated in the same manner as the original.

_____
Print Name and Date of Birth of Proposed Insured

_____ _____
Signature of Proposed Insured or Parent if Proposed Insured is a Juvenile Date

_____
Print Name and Date of Birth of Spouse, If Applying

_____ _____
Signature of Spouse, If Applying Date

A copy of this signed form will be provided to the individual upon request.

THIS AUTHORIZATION MEETS THE REQUIREMENTS SET FORTH IN THE HIPAA PRIVACY RULE (45 CFR 164.508).

Detach and leave with Proposed Insured
or owner **ONLY IF** premium is collected with application.

Conditional Coverage Receipt

CONDITIONAL COVERAGE RECEIPT - void if altered or modified or if check given in payment is not honored.

NO INSURANCE WILL BE EFFECTIVE BEFORE POLICY DELIVERY TO PROPOSED INSURED OR OTHER OWNER UNLESS ALL THE CONDITIONS ON THIS RECEIPT ARE FULFILLED EXACTLY.

Premium received from _____ Amount $_____
in connection with the application for insurance made on this date to Shelter Life Insurance Company, 1817 West Broadway, Columbia, Missouri 65218-0001.

Policy Applied For _____ Face Amount $_____

by _____ _____ _____
Signature of Writing Agent Agent's Number Date

ALL PREMIUM CHECKS MUST BE PAYABLE TO SHELTER LIFE INSURANCE COMPANY. DO NOT POSTDATE OR MAKE CHECKS PAYABLE TO THE AGENT OR LEAVE THE PAYEE BLANK.

If Shelter Life Insurance Company declines to issue the policy applied for, or issues it other than as applied for, which you do not accept, the payment will be returned.

PAYMENT BY CREDIT OR DEBIT CARD - Payment will be charged to your card on the date and time of the application. If Shelter Life Insurance Company declines to issue the policy applied for, or issues it other than as applied for, which you do not accept, the payment will be returned by company check.

CONDITIONS PRECEDENT - EFFECTIVE DATE OF INSURANCE

The insurance for which you (Proposed Insured) have applied, will be effective on the date of the application or the date a required medical examination and/or test(s) of any kind is completed, whichever is later, but only if the following conditions are met:

1. You have paid the full premium with the application;
2. You have completed all medical examination requirements;
3. We (Shelter Life Insurance Company), at our Home Office, have determined by our guidelines, that all persons for whom coverage is requested are qualified for the types and amounts of insurance requested at the premium paid.

If the above conditions are not met, no one for whom insurance is requested will be insured unless we offer and you accept the policy under modified terms. That modified policy will be effective on the date approved by us at our Home Office only if (1) we deliver your policy while all persons in the application are alive; (2) to the best of your knowledge there has been no material change in your answers on the application since the application date; and (3) you have paid any additional premium and/or signed any endorsements required.

CONDITIONAL COVERAGE AMOUNT AND LIMIT - The amount of insurance which may become effective on any person to be insured under the policy applied for prior to delivery will not exceed the lesser of: (a) $250,000, including accidental death benefits, on all pending applications or (b) the amount applied for.

NO AGENT OF SHELTER LIFE INSURANCE COMPANY IS AUTHORIZED TO CHANGE ANY PROVISION OR CONDITION OF THIS RECEIPT.

Detach and leave with Proposed Insured
when application is written.

MIB PRE-NOTICE

Information regarding your insurability will be treated as confidential. Shelter Life Insurance Company or its reinsurer(s) may, however, make a brief report thereon to **the MIB, Inc., formerly known as Medical Information Bureau**, a not-for-profit membership organization of insurance companies, which operates an information exchange on behalf of its members. If you apply to another MIB member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, MIB, upon request, will supply such company with the information about you in its file.

Upon receipt of a request from you, MIB will arrange disclosure of any information in your file. Please contact MIB at 866-692-6901 (TTY 866-346-3642). If you question the accuracy of the information in MIB's file, you may contact MIB and seek a correction in accordance with the procedures set forth in the federal Fair Credit Reporting Act. The address of MIB's information office is **50 Braintree Hill Park, Suite 400, Braintree, Massachusetts 02184-8734**.

Shelter Life Insurance Company, or its reinsurers, may also release information from its file to other insurance companies to whom you may apply for life or health insurance, or to whom a claim for benefits may be submitted. **Information for consumers about MIB may be obtained on its website at www.mib.com.**

NOTICE OF CONSUMER REPORT

As a part of our normal underwriting procedure, an investigative consumer report may be made to give us applicable information concerning character, general reputation and personal characteristics except as may be related directly or indirectly to the Insured's mode of living of persons to be insured. This information will be obtained through personal interviews primarily with you or your family, friends, neighbors, business associates and financial sources. Upon written request to the Life Underwriting Department at Shelter Life Insurance Company's home office in Columbia, Missouri, additional information as to the nature and scope of the Investigative Consumer Report, if one is made, will be furnished to you.

CONTRACT

Agent Name_____
Agent # _____
Agent Telephone #_____
Applicant's Family #_____

SHELTER LIFE INSURANCE COMPANY

1817 WEST BROADWAY, COLUMBIA, MISSOURI 65218-0001

LIFE INSURANCE APPLICATION

PROPOSED INSURED

1. Name (Last) (First) (MI) (Suffix) | Soc. Sec. No. | ☐ Male ☐ Female
2. Marital Status | Hgt. ' " | Wgt. lbs. | Birth Date | Age | State of Birth
3. Physical Address (Street) (City) (County) (State) (Zip)
3a. Mailing Address If Different
4. Home Phone | Cell Phone | Best Time to Contact
5. Driver's License No. State
6. Country of Citizenship: ☐ US ☐ Other
   If Other, provide the following: Country of Citizenship _____ Length of Residency in US _____
   Visa Type: ☐ Permanent ☐ Temporary If Temporary, Category Expiration Date
7. Occupation Name of Employer Date Employed
   Annual Earned Income $ Income All Sources $

BENEFICIARY

8. Primary (List name, address, age, relationship, payment option) (If a trust, list name of trustee, name & date of trust)
   Contingent

TERM / TRADITIONAL

9. ☐ 10 Yr. Level Term to 100 ☐ Whole Life ☐ YRT to 85 | Face Amount $
   ☐ 20 Yr. Level Term to 100 ☐ 20 Pay Whole Life ☐ | Mode Premium $
   ☐ 30 Yr. Level Term to 100 ☐ Secure Whole Life ☐
10. Rate Class: **(LT)** ☐ T ☐ PRF/T ☐ NT ☐ PRF/NT ☐ ULT PRF/NT **(YRT)** ☐ STD ☐ STD/NT ☐ PRF/NT **(All other)** ☐ STD ☐ NT
11. WP ☐ Yes ☐ No | AD ☐ Yes Amount $_____ ☐ No | Auto Prem Loan ☐ Yes ☐ No (Not available on term insurance)
12. Dividend Options: (WL & WL 20 Pay Only) ☐ Pd. Up. Adds ☐ Accum. at Interest ☐ Cash ☐ Reduce Premium (N/A on Special Monthly)

UNIVERSAL

13. ☐ Specified Amount - New Policy $ | Target Prem $ | Planned Prem (If more than Target) $
14. ☐ Specified Amount - Increase $ to UL Policy # | Planned Prem after Increase $
15. Rate Class: ☐ STD ☐ NT | ☐ Option A (Level) ☐ Option B (Increasing) | WMD ☐ Yes ☐ No | AD ☐ Yes ☐ No

RIDERS

16. ☐ Paid Up Additional Insurance Rider Premium Amount (WL and 20 Pay WL) $_____ 1035 Exchange ☐ Yes ☐ No
17. ☐ Guaranteed Insurability Rider - Amount $ | 18. ☐ Payor Death or Disability Benefit (WL, 20 Pay WL, Secure WL)
19. Payor To Be Insured | Relationship | Sex | Hgt | Wgt | Birth Date | Age | US Cit? | Birth St. | SS No.
    Payor's Occupation | Payor's Address

PREMIUM

20. ☐ Annual ☐ Semi-Annual ☐ Quarterly ☐ Payroll Deduction
    ☐ PAC - Withdrawal Day of Month _____ Send Form & Void Check ☐ Government Allotment (Except YRT)
    ☐ Special Billing - Name & Address of Company _____
    Remarks _____
    ☐ Prem included with application $ ☐ COD | ☐ Paid Up Additional Insurance Rider Prem Collected $
21. Name and address of person paying premium **only if** other than proposed insured or owner

IN FORCE

	(Life)	(Accidental Death)
22. a. Total individual life insurance and accidental death coverage in force or pending (excluding this application) in all companies including Shelter Life:	$	$

	(Father)	(Mother)	(Sibling[s])
b. If Proposed Insured is under 16, show amount of life insurance on:	$	$	$

REPLACEMENT

23. Do you have existing life insurance policies or contracts? ☐ Yes ☐ No
(If yes, send Replacement Form L-243.29 with application.)

Will this application replace an existing policy or contract? ☐ Yes ☐ No
(If yes, send Replacement Memorandum L-243.33 with application.)

QUESTIONS 24 THROUGH 40 MUST BE ANSWERED FOR EACH PERSON TO BE INSURED INCLUDING APPLICANTS FOR SPOUSE'S TERM RIDER, CHILDREN'S TERM RIDER & PAYOR BENEFIT.

UNDERWRITING INFORMATION

24. List attending physician(s) for proposed insured(s) and provide name, address, phone number, date and reason for most recent consultation(s), treatment received and medications prescribed:

Physicians name, address and telephone number	Date/Reason/Diagnosis/Treatment/Medications Prescribed

	Yes	No
25. Do you have a parent, brother or sister who:		
a. has a history of diabetes, heart or kidney disease, or hypertension?	☐	☐
b. died before age 60? If yes, list relationship, age & cause of death in question 32	☐	☐
26. Have you engaged in or do you anticipate engaging in:		
a. Aviation activities, including ultralight flying, hang gliding or parachute jumping?	☐	☐
b. Rodeo riding, underwater diving, racing of any motor powered vehicle or any other hazardous sport or hobby?	☐	☐
27. In the past 5 years have you been charged with any Motor Vehicle violations or violations for driving while intoxicated from alcohol or drugs?	☐	☐
28. Are you planning travel, residence or employment outside the United States?	☐	☐
29. Do you now use or have you ever used any form of tobacco or nicotine substitutes? If yes, give date last used in question 32.	☐	☐
30. Are you in the National Guard or Reserves?	☐	☐
31. Have you been charged with any Misdemeanor or Felony? If yes, give details such as type of offense, date, and whether or not convicted in question 32.	☐	☐

32. FOR ALL YES ANSWERS TO QUESTIONS 25 THRU 31. GIVE FULL DETAILS BELOW.

Question No.	Name of Person	Date	Details

QUESTIONS 33 THROUGH 40 MAY BE OMITTED IF A MEDICAL EXAM IS REQUIRED.

UNDERWRITING INFORMATION

	Yes	No
33. To the best of your knowledge and belief, have you ever been diagnosed or treated by a medical professional for:		
a. hypertension, coronary artery disease, stroke, heart attack, chest pain, irregular heartbeat, or any other disease of the heart or blood vessels?	☐	☐
b. cancer, tumor or other growth or malignancy of any kind?	☐	☐
c. bronchitis, emphysema, shortness of breath or any other disease or disorder of the lungs or respiratory system?	☐	☐
d. depression, anxiety or any other behavioral, mental or nervous disorder?	☐	☐
e. epilepsy, seizures, sleep apnea or any other disease or disorder of the brain or nervous system?	☐	☐
f. diabetes, hepatitis, anemia or any other disease or disorder of the blood or glands?	☐	☐
g. arthritis, gout, or any other disease or disorder of the bones, muscles, joints, eyes or skin?	☐	☐
h. any disease or disorder of the stomach, intestines, colon, rectum, liver, pancreas or digestive system?	☐	☐
i. any disease or disorder of the kidney, bladder, prostate, urinary system or genital organs including complication of pregnancy?	☐	☐
j. Acquired Immune Deficiency Syndrome (AIDS), positive HIV test, or other immunological disorder?	☐	☐
34. If female, are you now pregnant? If yes, give approximate delivery date in question 40.	☐	☐
35. Are you currently receiving treatment, taking medication, or scheduled to have surgery?	☐	☐
36. Weight loss of more than 10 lbs. in past year? If yes, list # of lbs. and reason in question 40.	☐	☐
37. Have you:		
a. used or do you now use cocaine, methamphetamines, marijuana or any other drugs? If Yes, list type, amount, frequency and date last used in question 40.	☐	☐
b. used or do you now use alcoholic beverages? If Yes, provide type, frequency and amount in question 40.	☐	☐
c. sought or received treatment or counseling for alcohol or drug use?	☐	☐
38. Have you received or do you now receive disability benefits or do you currently have a disability of any kind?	☐	☐
39. In the past five years, have you consulted any physician or health care facility, been hospitalized, had any abnormal diagnostic tests or been advised to have treatment for any reason not explained above?	☐	☐

40. FOR ALL YES ANSWERS IN QUESTIONS 33 THRU 39 GIVE FULL DETAILS BELOW.

Question No.	Name of Person	Describe Illness or Injury and Medical Attention	Date Mo Day Yr	Duration	Details Including Any Remaining Effects	Names, Addresses, and Phone Numbers of Physicians & Hospitals

41. List name, address, date of birth and relationship of OWNER if other than Proposed Insured.

42. List name, address and relationship of SUCCESSOR OWNER. (A successor owner is not required.)

43. Special Requests.

44. The Owner and Proposed Insured, if other than the Owner, each declares that he or she has read the answers recorded in this application and that they are complete and true to the best of his or her knowledge and belief, and agrees that:

a. this application and any amendments to it and any statements made and recorded on the medical examination form shall become the basis for and be a part of any contract of insurance;

b. any policy or rider issued on the basis of this application will belong to and be solely under the control of the Owner;

c. only the Shelter Life Insurance Company, at its Home Office, may make or modify contracts or waive any of its rights or requirements, and then only in writing;

d. no Agent of Shelter Life Insurance Company and no Medical Examiner is authorized to accept or pass upon insurability; and

e. except as provided in the Conditional Coverage Receipt, if issued, insurance will not be effective unless:

(1) a policy is delivered to the Owner during the lifetime of all persons proposed for insurance; and

(2) to the best of the Owner's and proposed insured's knowledge there has been no material change in the answers herein since the date of this application or the completion of all medical examination requirements.

SIGNATURES/DECLARATION

45. THE OWNER DECLARES THAT THE CONDITIONAL COVERAGE RECEIPT HAS BEEN DETACHED FROM THIS APPLICATION AND GIVEN TO HIM OR HER ..... ☐ Yes ☐ No

IF "YES" THE OWNER FURTHER DECLARES THAT THE TERMS AND CONDITIONS OF THE CONDITIONAL COVERAGE RECEIPT HAVE BEEN BROUGHT SPECIFICALLY TO HIS OR HER ATTENTION AND THAT HE OR SHE UNDERSTANDS AND ACCEPTS THEM.

THE PROPOSED INSURED ACKNOWLEDGES RECEIPT OF THE NOTICE OF CONSUMER REPORT AND MIB PRE-NOTICE AS REQUIRED BY THE CONSUMER PROTECTION AGENCY.

THIS APPLICATION IS A LEGAL DOCUMENT. THE POLICY MAY BE ALTERED OR RESCINDED IF THE QUESTIONS ARE NOT ANSWERED CORRECTLY AND TRUTHFULLY.

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.

Dated this _____ day of _____, _____ at _____ ☐ A.M. ☐ P.M. in the city of_____ State of_____
Month Year Time

_____
Signature of Proposed Insured or of Parent or Legal Guardian if Under Age 18

_____
Signature of Owner, if other than Proposed Insured, or of Parent or Grandparent Owner if Proposed Insured is Under Age 18

_____
Owner's Social Security Number

I HEREBY CERTIFY THAT I PERSONALLY ASKED EVERY QUESTION OF THE OWNER, AND PROPOSED INSURED IF OTHER THAN OWNER, AND ACCURATELY RECORDED THE ANSWERS GIVEN AND THAT I WITNESSED THE SIGNATURE(S) ABOVE.

_____ (Signature of Writing Agent)

_____ (Print Name of Writing Agent)

_____ (Agent's Number)

AGENT'S STATEMENT

1. Does proposed insured have other life insurance in force with Shelter Life?
   ☐ Yes ☐ No If yes, give policy numbers
2. Has a Medical Examination and/or other testing been arranged? ☐ Yes ☐ No. SEE MANUAL FOR REQUIREMENTS.
3. If blood profile is required, have you attached the special blood test authorization form if one is required in your state? ☐ Yes ☐ No
4. Do you know or have any reason to believe that replacement of existing Life insurance is involved? ☐ Yes ☐ No
   If yes, give policy numbers, names and addresses of companies that issued such policies and expected date of lapse.
5. Does this application involve a 1035 exchange? ☐ Yes ☐ No (UL, PUA Only) If Yes, send appropriate form. ☐ External ☐ Internal
6. AS REQUIRED BY FEDERAL LAW, did you detach and give the NOTICE OF CONSUMER REPORT to the Proposed Insured (or Owner if the Proposed Insured is a juvenile)? ☐ YES.
7. Did you solicit this business? ☐ Yes ☐ No. If No, explain
8. Is any person applying for coverage related to you? ☐ Yes ☐ No. If Yes, give relationship

Signature of Writing Agent _____ Agent's Number _____

MEDICAL TEST AUTHORIZATION

I hereby authorize Shelter Life Insurance Company to obtain medical tests on blood, oral fluid or urine samples in connection with the underwriting of my application for insurance with Shelter Life Insurance Company.

I understand that such tests will be performed by laboratories selected by Shelter Life Insurance Company and may include, but are not limited to, test for cholesterol and related blood lipids, diabetes, hepatitis or other liver disorders, kidney disorders, infection by the Acquired Immune Deficiency Syndrome virus, immune disorders, or the presence of medications, drugs, nicotine, or their metabolites.

The results of these tests will be made known only to Shelter Insurance Companies and/or their reinsurers, and possibly the Medical Information Bureau as described in the Pre-Notice which was given to me as part of the application process. Positive HIV and hepatitis test results will be reported to your State Department of Health if we or the testing laboratory are required to do so by law. Test results will not be released to anyone else or any institution except as required by law, by court order or by written authorization from me to release it to a physician designated by me.

Date _____ Signature of Proposed Insured or Parent if Proposed Insured is a Juvenile _____

Date _____ Signature of Spouse, if applying _____

Authorization for Use or Disclosure
Of Protected Health Information

1. I hereby authorize any licensed physician, medical practitioner, hospital, clinic or other medical or medically related facility, insurance company, MIB Group, Inc. or other organization, institution, or person, that has any records or knowledge of me or my health, to give to the Shelter Life Insurance Company, its Medical Director, its reinsurers, and Shelter Mutual Insurance Company, any and all such health information. I further authorize Shelter Life Insurance Company, and its reinsurers, to disclose such protected health information to MIB Group, Inc., a non-profit membership organization of life insurance companies, which operates an information exchange on behalf of its members.

2. I understand that this protected health information will be used to locate or underwrite insurance for me, or to determine whether a valid claim for benefits has been made. The information may also be disclosed by Shelter Life Insurance Company to MIB, who, upon request, may disclose such information about me in its file to another member company with whom I apply for life or health insurance or to whom a claim for benefits may be submitted.

3. I understand that if the person or entity that receives the information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be redisclosed and no longer protected by these regulations.

4. I understand that the information in my health record may include information that may be considered a communicable or venereal disease that may include, but is not limited to diseases such as hepatitis, syphilis, gonorrhea, and acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.

5. This authorization is valid for 12 months from the date of signing. I understand that I may revoke this authorization at any time by sending written notification to Shelter Life Insurance Company, 1817 West Broadway, Columbia, MO 65218-0001, except to the extent that action has been taken in reliance on this authorization. A photographic copy of this authorization will be treated in the same manner as the original.

_____
Print Name and Date of Birth of Proposed Insured

_____ _____
Signature of Proposed Insured or Parent if Proposed Insured is a Juvenile Date

_____
Print Name and Date of Birth of Spouse, If Applying

_____ _____
Signature of Spouse, If Applying Date

A copy of this signed form will be provided to the individual upon request.

THIS AUTHORIZATION MEETS THE REQUIREMENTS SET FORTH IN THE HIPAA PRIVACY RULE (45 CFR 164.508).

Detach and leave with Proposed Insured
or owner **ONLY IF** premium is collected with application.

CONDITIONAL COVERAGE RECEIPT

CONDITIONAL COVERAGE RECEIPT - void if altered or modified or if check given in payment is not honored.

NO INSURANCE WILL BE EFFECTIVE BEFORE POLICY DELIVERY TO PROPOSED INSURED OR OTHER OWNER UNLESS ALL THE CONDITIONS ON THIS RECEIPT ARE FULFILLED EXACTLY.

Premium received from _____ Amount $ _____
in connection with the application for insurance made on this date to Shelter Life Insurance Company, 1817 West Broadway, Columbia, Missouri 65218-0001.

Policy Applied For_____ Face Amount $ _____

by _____ _____ _____
Signature of Writing Agent Agent's Number Date

ALL PREMIUM CHECKS MUST BE MADE PAYABLE TO SHELTER LIFE INSURANCE COMPANY. DO NOT POSTDATE OR MAKE CHECKS PAYABLE TO THE AGENT OR LEAVE THE PAYEE BLANK.

If Shelter Life Insurance Company declines to issue the policy applied for, or issues it other than as applied for, which you do not accept, the payment will be returned.

CONDITIONS PRECEDENT - EFFECTIVE DATE OF INSURANCE

The insurance for which you (Proposed Insured) have applied, will be effective on the date of the application or the date a required medical examination and/or test(s) of any kind is completed, whichever is later, but only if the following conditions are met:

1. You have paid the full premium with the application;
2. You have completed all medical examination requirements;
3. We (Shelter Life Insurance Company), at our Home Office, have determined by our guidelines, that all persons for whom coverage is requested are qualified for the types and amounts of insurance requested at the premium paid.

If the above conditions are not met, no one for whom insurance is requested will be insured unless we offer and you accept the policy under modified terms. That modified policy will be effective on the date approved by us at our Home Office only if (1) we deliver your policy while all persons in the application are alive; (2) to your best knowledge there has been no material change in your answers on the application since the application date; and (3) you have paid any additional premium and/or signed any endorsements required.

CONDITIONAL COVERAGE AMOUNT AND LIMIT - The amount of insurance which may become effective on any person to be insured under the policy applied for prior to delivery will not exceed the lesser of: (a) $250,000, including accidental death benefits, on all pending applications or (b) the amount applied for.

NO AGENT OF SHELTER LIFE INSURANCE COMPANY IS AUTHORIZED TO CHANGE ANY PROVISION OR CONDITION OF THIS RECEIPT.

Detach and leave with Proposed Insured
when application is written.

MIB PRE-NOTICE

Information regarding your insurability will be treated as confidential. Shelter Life Insurance Company or its reinsurer(s) may, however, make a brief report thereon to **the MIB, Inc., formerly known as Medical Information Bureau**, a not-for-profit membership organization of insurance companies, which operates an information exchange on behalf of its members. If you apply to another MIB member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, MIB, upon request, will supply such company with the information about you in its file.

Upon receipt of a request from you, MIB will arrange disclosure of any information in your file. Please contact MIB at 866-692-6901 (TTY 866-346-3642). If you question the accuracy of the information in MIB's file, you may contact MIB and seek a correction in accordance with the procedures set forth in the federal Fair Credit Reporting Act. The address of MIB's information office is **50 Braintree Hill Park, Suite 400, Braintree, Massachusetts 02184-8734**.

Shelter Life Insurance Company, or its reinsurers, may also release information from its file to other insurance companies to whom you may apply for life or health insurance, or to whom a claim for benefits may be submitted. **Information for consumers about MIB may be obtained on its website at www.mib.com.**

NOTICE OF CONSUMER REPORT

As a part of our normal underwriting procedure, an investigative consumer report may be made to give us applicable information concerning character, general reputation and personal characteristics except as may be related directly or indirectly to the Insured's mode of living of persons to be insured. This information will be obtained through personal interviews primarily with you or your family, friends, neighbors, business associates and financial sources. Upon written request to the Life Underwriting Department at Shelter Life Insurance Company's home office in Columbia, Missouri, additional information as to the nature and scope of the Investigative Consumer Report, if one is made, will be furnished to you.

ILLUSTRATION CERTIFICATION

TO: Insurance Commissioner of the State of Arkansas

RE: Policy Forms: L-956

I, Dina C. Krofta, am the Life Actuary of Shelter Life Insurance Company, and a member of the American Academy of Actuaries in good standing. I was appointed by the Board of Directors of said insurer to be the Illustration Actuary for all plans of insurance subject to the Life Insurance Illustration Regulation for this state. The appointment was documented in the Board minutes dated June 22, 2010. I meet the Academy requirements for making this certification and the requirements of applicable state regulations.

Scales of nonguaranteed elements used in illustrating the plans of insurance described above meet the requirements of the Regulation. The disciplined current scales for these plans are in conformity with the Actuarial Standard of Practice for Compliance with the NAIC Life Insurance Illustration Model Regulation (ASOP 24) promulgated by the Actuarial Standards Board. Moreover:

- No currently payable scale for business issued within the last five years and within the scope of this certification has been reduced for reasons other than changes in the experience factors underlying the disciplined current scale.

- Nonguaranteed elements illustrated for new policies are consistent with those illustrated for similar in-force policies.

- Illustrated nonguaranteed elements for new and in-force policies subject to this regulation are consistent with the nonguaranteed element amounts actually credited or charged to the same or similar forms.

- The minimum expenses used in the calculation of the disciplined current scale for all policy forms subject to this regulation are based on Fully Allocated Expenses of Shelter Life Insurance Company.

DATED: 8-24-2010

Dina C Krofta

Digitally signed by Dina C Krofta
DN: cn=Dina C Krofta, o, ou, email=dkrofta@shelterinsurance.com, c=US
Date: 2010.08.24 13:26:24 -05'00'

Dina C. Krofta, FSA, MAAA
Illustration Actuary

SHELTER LIFE INSURANCE COMPANY
Explanation of Bracketed Items

FORMS:

Bracketed Field Name on Contract Information page	Description
INSURED	Insured name
AGE/GENDER	Ages 20-70, Male or Female
POLICY NUMBER	Lxxxxxxxxx; as assigned by Shelter Life Insurance Company
POLICY DATE	Date
FACE AMOUNT	>=$100,000
EXPIRY DATE	Policy Anniversary following the Insured's 100th Birthday
PREMIUM CLASS	Std. Non-Tobacco, Pref. Non-Tobacco, Ultra Non-Tobacco, Std. Tobacco or Pref. Tobacco
RISK CLASS	Standard or Special
PREMIUM OPTION	10, 20 or 30
Guaranteed Premium Years (page 3A text)	10 for the 10 and 20 year plans, 15 years for the 30 year plan
POLICY RIDERS	Waiver of Premium, Accidental Death Rider or blank
ANNUAL, SEMI-ANNUAL, QUARTERLY and SPECIAL MONTHLY	Dollar amount of policy premium with modal factors applied
CONVERSION PERIOD	The date the conversion period ends or age 65 if earlier.
POLICY NUMBER	As assigned by Shelter Life Insurance Company
AGENT NUMBER	Varies by writing agent - all in "B354" format
AGENT STATE	Varies by writing agent - all in "24" format
Premium schedule	Date, Current Basic Premium, Maximum Basic Premium, WP Premium, ADB Premium, Total Current Premiums and Total Maximum Premium specific to this policy and insured.

SHELTER INSURANCE COMPANIES

SHELTER MUTUAL
SHELTER GENERAL
SHELTER LIFE

CERTIFICATION

I, Robert W. Omdal, an officer of the Shelter Life Insurance Company herby certify that we have reviewed our processes regarding Ark. Code Ann. 23-79-138, Bulletin 6-87 and Bulletin 11-88 and found them to be in compliance. We have also reviewed our procedures and are in compliance with Regulation 49 and Regulation 19§10B.

Robert W Omdal

Digitally signed by Robert W Omdal
DN: cn=Robert W Omdal, o, ou, email=romdal@shelterinsurance.com, c=US
Date: 2010.08.27 12:17:13 -05'00'

Signed_____

Robert W. Omdal, FSA, MAAA
Chief Actuary – Life and Health
Shelter Life Insurance Company

1817 WEST BROADWAY ● COLUMBIA, MISSOURI ● 65218-0001