

SERFF Tracking Number: AEGB-126693564 State: Arkansas
Filing Company: Transamerica Advisors Life Insurance Company State Tracking Number: 46627
Company Tracking Number: RA0510AR, QUAA0510TA
TOI: L08 Life - Other Sub-TOI: L08.000 Life - Other
Product Name: RA0510AR, QUAA0510TA
Project Name/Number: RA0510AR, QUAA0510TA/RA0510AR, QUAA0510TA

Filing at a Glance

Company: Transamerica Advisors Life Insurance Company

Product Name: RA0510AR, QUAA0510TA SERFF Tr Num: AEGB-126693564 State: Arkansas
TOI: L08 Life - Other SERFF Status: Closed-Approved- State Tr Num: 46627
Closed

Sub-TOI: L08.000 Life - Other Co Tr Num: RA0510AR, State Status: Approved-Closed
QUAA0510TA

Filing Type: Form

Reviewer(s): Linda Bird
Author: Theresa Meyers Disposition Date: 09/01/2010
Date Submitted: 08/26/2010 Disposition Status: Approved-
Closed

Implementation Date Requested: On Approval

Implementation Date:

State Filing Description:

General Information

Project Name: RA0510AR, QUAA0510TA
Project Number: RA0510AR, QUAA0510TA
Requested Filing Mode: Review & Approval
Explanation for Combination/Other:
Submission Type: New Submission
Overall Rate Impact:
Filing Status Changed: 09/01/2010

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: 09/01/2010

Created By: Theresa Meyers

Corresponding Filing Tracking Number:
30823400

Deemer Date:

Submitted By: Theresa Meyers

Filing Description:

August 16, 2010

Commissioner of Insurance

Arkansas Insurance Division

1200 West 3rd Street

Little Rock, Arkansas 72201-1904

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Product Name: RA0510AR, QUAA0510TA
Project Name/Number: RA0510AR, QUAA0510TA/RA0510AR, QUAA0510TA

Re: TRANSAMERICA ADVISORS LIFE INSURANCE COMPANY
NAIC #: 468-79022
FEIN #: 91-1325756
RA0510AR – Application for Reinstatement and/or Policy Change
QUAA0510TA – Avocation & Aviation Questionnaire

Dear Sir/Madam:

Please find attached are copies of the above referenced forms. These are new forms, which are not intended to replace any forms previously approved by your Department. These forms have been submitted in final printed form in which they will be distributed to the Insureds upon a request for reinstatement of a life policy. These forms are subject to only minor modifications in paper size and stock, ink, border, Company logo, Company address, adaptation to computer printing, and Officer's signatures.

Application for Reinstatement and/or Policy Change form RA0510AR is an application for reinstatement that will be used with our life portfolio.

Avocation & Aviation Questionnaire form QUAA0510TA is a questionnaire that will be completed upon a "yes" answer to Question 8 of the Reinstatement Application.

We would appreciate your review and approval of these forms.

Sincerely,

TRANSAMERICA ADVISORS LIFE INSURANCE COMPANY

Theresa Meyers
Policy Analyst
Contract Development
(319) 355-7520 (collect)
Fax #: (319) 369-2501
thmeyers@aegonusa.com

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Company and Contact

Filing Contact Information

Theresa Meyers, Policy Analyst thmeyers@aegonusa.com
 4333 Edgewood Rd. NE 319-355-7520 [Phone]
 MS 2225 319-355-2501 [FAX]
 Cedar Rapids, IA 52499

Filing Company Information

Transamerica Advisors Life Insurance CoCode: 79022 State of Domicile: Arkansas
 Company
 4333 Edgewood Road NE Group Code: 468 Company Type: Life
 Cedar Rapids, IA 52499 Group Name: State ID Number:
 (319) 355-8511 ext. [Phone] FEIN Number: 91-1325756

Filing Fees

Fee Required? Yes
 Fee Amount: \$100.00
 Retaliatory? No
 Fee Explanation: \$50.00 per form X 2 forms = \$100.00
 Per Company: No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Transamerica Advisors Life Insurance Company	\$100.00	08/26/2010	39053359

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Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Linda Bird	09/01/2010	09/01/2010

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	08/31/2010	08/31/2010	Theresa Meyers	08/31/2010	08/31/2010

SERFF Tracking Number: AEGB-126693564 State: Arkansas
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Product Name: RA0510AR, QUAA0510TA
Project Name/Number: RA0510AR, QUAA0510TA/RA0510AR, QUAA0510TA

Disposition

Disposition Date: 09/01/2010

Implementation Date:

Status: Approved-Closed

Comment:

Rate data does NOT apply to filing.

SERFF Tracking Number: AEGB-126693564 State: Arkansas
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 Project Name/Number: RA0510AR, QUAA0510TA/RA0510AR, QUAA0510TA

Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification		Yes
Supporting Document	Application		No
Supporting Document	Statement of Variability		Yes
Supporting Document	AR - Rule and Regulation 19		Yes
Form (revised)	Application for Reinstatement and/or Policy Change		Yes
Form	Application for Reinstatement and/or Policy Change	Replaced	Yes
Form	Avocation & Aviation Questionnaire		Yes

SERFF Tracking Number: AEGB-126693564 State: Arkansas
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Product Name: RA0510AR, QUAA0510TA
Project Name/Number: RA0510AR, QUAA0510TA/RA0510AR, QUAA0510TA

Objection Letter

Objection Letter Status Pending Industry Response
Objection Letter Date 08/31/2010
Submitted Date 08/31/2010
Respond By Date 10/01/2010

Dear Theresa Meyers,

This will acknowledge receipt of the captioned filing.

Objection 1

No Objections

Comment: Ark. Code Ann. 23-66-503(a) and Bulletin 7-97 requires a statement in an application substantially the same as that included in the statute.

Please feel free to contact me if you have questions.

Sincerely,

Linda Bird

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Response Letter

Response Letter Status Submitted to State
 Response Letter Date 08/31/2010
 Submitted Date 08/31/2010

Dear Linda Bird,

Comments:

Thank you for your review of this filing. The following change has been made in response to your letter of 8-31-10:

Response 1

Comments: We have added the following Fraud Warning language to page 3 of the application:

FRAUD WARNING: 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.

Related Objection 1

Comment:

Ark. Code Ann. 23-66-503(a) and Bulletin 7-97 requires a statement in an application substantially the same as that included in the statute.

Changed Items:

No Supporting Documents changed.

Form Schedule Item Changes

Form Name	Form Number	Edition Date	Form Type	Action	Action Specific Data	Readability Score	Attach Document
Application for Reinstatement and/or Policy Change	RA0510A R		Application/Enrollment Form	Initial		50.100	RA0510A R.pdf
Previous Version							
Application for Reinstatement and/or	RA0510A R		Application/Enrollment Form	Initial		50.100	RA0510A R.pdf

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 Project Name/Number: RA0510AR, QUAA0510TA/RA0510AR, QUAA0510TA

Form Schedule

Lead Form Number: RA0510AR, QUAA0510TA

Schedule Item Status	Form Number	Form Type Form Name	Action	Action Specific Data	Readability	Attachment
	RA0510AR	Application/ Enrollment Form	Initial		50.100	RA0510AR.pdf
	QUAA0510TA	Application/ Enrollment Form	Initial	Avocation & Aviation Questionnaire	51.000	QUAA0510TA.pdf

Application for Reinstatement and/or Policy Change

Policy Number: _____ Insured Name: _____

If reinstatement is approved, the contestable period will start anew. This application must be accompanied by all required premiums.

PART 1. PROPOSED INSURED(S) INFORMATION

	Last Name	M.I.	First name	Birth Date	Birth Place	Height Ft. in.	Weight Lbs.	Sex
Primary Insured								
Spouse or 1 st OIR								
CIR or 2 nd OIR								
CIR or 3 rd OIR								

Telephone Number () _____ Best time to call AM PM _____

If additional space is necessary for CIR's, list child's name and date of birth on a separate sheet of paper.

PART 2. MEDICAL QUESTIONS

Has any proposed insured listed in Part 1

- 1) Within the last 5 years been treated for or been told by a member of the medical profession that they had heart disease or circulatory problems, stroke, cancer, diabetes, kidney or liver disorder, lung or respiratory disorder, Alzheimer's Disease, mental or psychiatric disorder, alcohol or drug abuse? (Please circle the applicable ailments) YES NO
- 2) Within the last 5 years consulted a medical practitioner? YES NO
- 3) Within the last 5 years, been told by a member of the medical profession that he or she had a diagnosis of or received treatment for AIDS (Acquired Immune Deficiency Syndrome), ARC (AIDS Related Complex), or the HIV (Human Immunodeficiency Virus) infection? YES NO
- 4) Used Tobacco or any other product containing nicotine in the past 5 years? YES NO
If Yes, please give the type and date last used:
Type: _____ Date Last Used: _____

Give details to all YES answers above. Please indicate person(s) to which details apply, dates of visit, reason for visit and findings. Give us the doctor, hospital, clinic, or health care providers full name and address.

Proposed Insured:	Proposed Insured:	Proposed Insured:
Question number:	Question number:	Question number:
Reason for visit:	Reason for visit:	Reason for visit:
Dates of visits:	Dates of visits:	Dates of visits:
Findings:	Findings:	Findings:
Dr./Clinics address:	Dr./Clinics address:	Dr./Clinics address:

PART 3. OCCUPATION AND MISCELLANEOUS QUESTIONS

5) Has any proposed insured listed in Part 1 had a change in occupation or income since the original application? If yes, indicate whom and describe current occupation and income. YES NO

6) State occupation and income for any adult applicant listed in Part 1 to be added to policy:

7) Has any proposed insured listed in Part 1 had their drivers license suspended, revoked, restricted, or been convicted of a moving violation in the last 12 months? YES NO

If yes, provide Driver's License number, State of issue and details. _____

8) Does any proposed insured listed in Part 1 participate in aviation or any organized hazardous sport or activity? If yes, complete Avocation and Aviation questionnaire and attach to application. YES NO

9) Will any proposed insured listed in Part 1 travel outside the United States within the next 12 months? YES NO

If yes, provide details of when, where, and length of time. _____

PART 4. REPRESENTATIONS

I represent that the statements and answers in this application are true and complete to the best of my knowledge and belief. It is agreed that:

- (a) The statements and answers given in this application, and any amendments or application supplements to it or statements made to the medical examiner, will be the basis of any reinstatement granted or insurance issued.
- (b) No agent or medical examiner has the authority to make or alter any contract for the Company.
- (c) No reinstatement will be effective or coverage provided until the date the application is approved by the company.
- (d) If a premium deposit is given, no insurance shall take effect until the application is approved by the company while all persons shown in Part 1 are living and their health remains as stated in the reinstatement and policy change application.
- (e) If a premium deposit is not given, no insurance shall take effect until the application is approved by the company and accepted by the owner, all premiums due have been paid and while all persons shown in Part 1 are living and their health remains as stated in the reinstatement and policy change application.
- (f) I further agree that this application will be attached and shall be made a part of the contract for insurance.

PART 5. AUTHORIZATION TO OBTAIN INFORMATION

I authorize any physician, medical professional, hospital, clinic, other medical care institution, the Medical Information Bureau, Inc., insurance company, consumer reporting agency, or employer having information available as to employment, other insurance coverage, medical care, advice or treatment with respect to any physical or mental condition regarding me or any of my minor children who are to be insured, to give such information to Transamerica Advisors Life Insurance Company, its reinsurers, or any consumer reporting agency except the Medical Information Bureau, acting on Transamerica Advisors Life Insurance Company's behalf.

I authorize Transamerica Advisors Life Insurance Company to obtain an investigative consumer report on me and upon my request I am entitled to receive a free copy of this report.

I authorize Transamerica Advisors Life Insurance Company to obtain a motor vehicle report on me.

I understand that this information will be used by Transamerica Advisors Life Insurance Company or its reinsurers, to determine eligibility for life insurance.

I agree that this authorization is valid for two and one-half years from the date signed. I know that I or my authorized representative have a right to receive a copy of this authorization upon request. I agree that a photographic copy of this authorization is as valid as the original.

I also hereby authorize Transamerica Advisors Life Insurance Company to provide its affiliated companies any and all information provided herein and obtained hereafter on me. This authorization shall be valid from the date signed below until affirmatively withdrawn in writing by myself.

I elect not to have personal information disclosed to non-affiliates of Transamerica Advisors Life Insurance Company for marketing purposes.

I elect to be interviewed if an investigative consumer report is prepared in connection with this application.

FRAUD WARNING: 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.

Signed at _____ (city) _____ (state) _____ on _____ (date)

Signature of Primary Insured or Proposed Insured
(if over age 15 must sign)

Signature of Owner if other than proposed Insured

Signature of Spouse (if applicable)

Signature of Other Insured age 15 or over

Signature of Other Insured age 15 or over

Signature of Licensed Agent

Agent #

FAIR CREDIT REPORTING ACT

A routine investigative consumer report may possibly be made regarding your general reputation, character, mode of living and personal characteristics. This information may be obtained through personal interviews with your friends, neighbors and associates. Should you desire additional information on the nature and scope of such a report, you may write the Underwriting Department, Transamerica Advisors Life Insurance Company, [P.O. Box 19100, Greenville, SC 29602-9100]. You may also request information concerning the nature and scope of the investigation to be performed.

THE MEDICAL INFORMATION BUREAU PRE-NOTICE

The Medical Information Bureau ("MIB") is a non-profit organization of life insurance companies which operates as an information exchange for its members.

We may make reports to the MIB regarding factors affecting your insurability. Underwriting decision, however, are not reported to the MIB. If you apply to another Bureau member company for life or health insurance or submit a claim for benefits, the MIB will, upon request, provide that company with information in its file.

Upon your written request, the MIB will arrange for disclosure to you of any information it has in your file. If you feel the information in the MIB's file is incorrect, you may contact the MIB and seek a correction in accordance with procedures outlined in the Federal Fair Credit Reporting Act. The address of the MIB's office is: MIB, Inc., 50 Braintree Hill, Suite 400, Braintree, MA 02184-8734; telephone number 866-692-6901 (TTY 866-346-3642 for hearing impaired).

If you would like to know more about how we collect, evaluate and control information about you as one of our applicants for insurance, our sales representatives will be happy to assist you or you may contact us at our office.

Transamerica Advisors Life Insurance Company

[P.O. Box 19100, Greenville, SC 29602-9100]

Supplement to Application dated _____

Avocation & Aviation Questionnaire

Name of Proposed Insured	Date of Birth
Part A. Avocation Questionnaire	
1. Automobile or motorcycle racing	
a. Are you a member of any racing organization? <i>(check one)</i>	<input type="checkbox"/> Yes <input type="checkbox"/> No
If "Yes" name of organization: _____	
b. Describe the car or cycle you drive	
Make: _____	Model or Class: _____
Equipped for competition? <i>(check one)</i>	<input type="checkbox"/> Yes <input type="checkbox"/> No
If "Yes" give details/describe: _____	
c. Describe racing	
Type of course: _____	Length of course: _____
Location: _____	Duration of races: _____
Maximum speed attained: _____	
d. Describe your status and experience <i>(check one)</i>	
<input type="checkbox"/> Professional <input type="checkbox"/> Amateur	
Number of races: _____	Last 12 months: _____
Anticipated next 12 months: _____	
2. Motorboat racing	
a. Are you a member of any racing organization? <i>(check one)</i>	
<input type="checkbox"/> Yes <input type="checkbox"/> No	
If "Yes" name of organization: _____	
b. Describe the boat you race	
Type: _____	Size: _____
Class: _____	Horsepower: _____
c. Describe racing	
Type of course: _____	Length of course: _____
Location: _____	Duration of races: _____
Maximum speed attained: _____	
d. Describe your status and experience <i>(check one)</i>	
<input type="checkbox"/> Professional <input type="checkbox"/> Amateur	
Number of races: _____	Last 12 months: _____
Anticipated next 12 months: _____	
3. Parachuting and Skydiving	
a. Are you a member of the United States Parachute Association? <i>(check one)</i>	
<input type="checkbox"/> Yes <input type="checkbox"/> No	
b. Do you hold a parachutist license? <i>(check one)</i>	
<input type="checkbox"/> Yes <input type="checkbox"/> No	
If "Yes" Class: _____	
c. Describe your experience in parachuting or skydiving	
Total jumps to date: _____	Total jumps last 12 months: _____
Total anticipated next 12 months: _____	
Do you perform skydiving or delay jumps? <i>(check one)</i> Give details in Remarks.	
<input type="checkbox"/> Yes <input type="checkbox"/> No	
Number of delay jumps: _____	Maximum seconds delay: _____
Do you participate in baton passing or other stunts? <i>(check one)</i> Give details in Remarks.	
<input type="checkbox"/> Yes <input type="checkbox"/> No	
Do you participate in local or national competition? <i>(check one)</i> Give details in Remarks.	
<input type="checkbox"/> Yes <input type="checkbox"/> No	
d. Location of jump areas	

4. Underwater Diving

a. Are you a member of a skin or scuba diving organization? (check one) Yes No
 If "Yes" name of organization: _____

b. Describe diving activity
 Location: _____
 Purpose: *Recreation, research, rescue team - describe.* _____

Equipment used: _____

Maximum time submerged: _____ Maximum depth attained: _____

Average depth current diving: _____

c. Describe your status and experience (check one) Professional Amateur
 Number of years diving experience: _____ Number of dives last 12 months: _____

5. Other Hazardous Sports or Avocations
Provide full details in Remarks describing participation in any other avocation commonly considered hazardous, not described elsewhere on this form. Include past experience as well as anticipated future plans.

Part B. Aviation Questionnaire For pilots and crew members.

1. What type of Pilot Certificate or License do you hold?
 Student Private Commercial Airline Transport Rating (ATR) Instrument Flight Rating (IFR)

2. Are you a member of a Military Reserve or National Guard unit on flying status? (check one) Yes No
 If "Yes" check one Active Inactive

3. What type of aircraft do you fly? _____ Crew position? _____

4. Was your certificate granted subject to physical waiver? (check one) Yes No

5. Have you ever been grounded or restricted for violation of Civil Air Regulations? (check one) Yes No
 If "Yes" give details in Remarks.

6. Has your Federal Pilot Certificate ever been cancelled? (check one) Yes No
 If "Yes" give details in Remarks.

7. Date of last flight as a Pilot: _____ Crew Member: _____

8. Is it your intention to fly in the future as a
 Pilot Yes No
 Crew Member Yes No

9. Total flying hours? Give details in Remarks.
 Student Pilot in Command Other capacity
 Describe your annual flying activity in the chart below

Type of Flying	Next 12 mos. hours	Past 12 mos. hours	1 to 2 years ago hours
Employer-owned			
Charter flying or instructing			
Non-commercial pilot or student			
Military			
Other Give details in Remarks			

10. Do you fly within the United States? (check one) Yes No
If "No" give details in Remarks.

11. If full coverage at standard rates is not available, do you desire: (check one) Yes No
 Full coverage with extra premium, if available?
 Restricted aviation coverage without extra premium, if available?

Remarks

I hereby represent, to the best of my knowledge and belief, that all the above statements are complete and true, and I agree that they shall form a part of the application and become a part of any contract of insurance issued on such application.

Dated at _____ this _____ day of _____, 2_____.

Signature of Proposed Insured

Signature of Agent

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Product Name: RA0510AR, QUAA0510TA
Project Name/Number: RA0510AR, QUAA0510TA/RA0510AR, QUAA0510TA

Supporting Document Schedules

Item Status: **Status**
Date:

Satisfied - Item: Flesch Certification

Comments:

Attachments:

AR - Rule and Regulation 19.pdf

RA0510 Flesch Score.pdf

Item Status: **Status**
Date:

Satisfied - Item: Statement of Variability

Comments:

Attachment:

Statement of Variability.pdf

Item Status: **Status**
Date:

Satisfied - Item: AR - Rule and Regulation 19

Comments:

Attachment:

AR - Rule and Regulation 19.pdf

**Transamerica Advisors Life Insurance Company
Home Office: Cedar Rapids, Iowa**

**COMPLIANCE CERTIFICATION
RULE AND REGULATION 19
STATE OF ARKANSAS**

Form Number: RA0510AR, QUAA0510TA

Date: August 16, 2010

We certify that, to the best of our knowledge and belief, this submission meets the provisions of Rule and Regulation 19 as well as all applicable requirements of the Insurance Division of the State of Arkansas.

Cheryl Bock, Assistant Vice President, Contract Development

**TRANSAMERICA ADVISORS LIFE INSURANCE COMPANY
FLESCH READABILITY CERTIFICATION**

Form Number (may vary by state)

Flesch Score

RA0510

50.1

QUAA0510TA

51.0

I certify that the machine scored Flesch Readability score(s) for the above mentioned form(s) is/are accurate.

Cheryl Bock, Assistant Vice President, Contract Development

**TRANSAMERICA ADVISORS LIFE INSURANCE COMPANY
STATEMENT OF VARIABILITY**

**APPLICATION: RAO510
QUESTIONNAIRE: QUAA0510TA**

We have bracketed the variable items in these forms. No change in the variability will be made which in any way expands the scope of the wording. Transamerica Advisors Life Insurance Company reserves the right to correct, at any time, any and all typographical errors that do not impact the benefits or intent of language.

RAO510 – Application for Reinstatement and/or Policy Change

1. **Mailing Address** (page 1): This may change to another location in the future.
2. **Underwriting Department Address** (page 3): This may change to another location in the future.

QUAA0510TA – Avocation & Aviation Questionnaire

Mailing Address (page 1): This may change to another location in the future.

**Transamerica Advisors Life Insurance Company
Home Office: Cedar Rapids, Iowa**

**COMPLIANCE CERTIFICATION
RULE AND REGULATION 19
STATE OF ARKANSAS**

Form Number: RA0510AR, QUAA0510TA

Date: August 16, 2010

We certify that, to the best of our knowledge and belief, this submission meets the provisions of Rule and Regulation 19 as well as all applicable requirements of the Insurance Division of the State of Arkansas.

Cheryl Bock, Assistant Vice President, Contract Development

SERFF Tracking Number: AEGB-126693564 State: Arkansas
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Superseded Schedule Items

Please note that all items on the following pages are items, which have been replaced by a newer version. The newest version is located with the appropriate schedule on previous pages. These items are in date order with most recent first.

Creation Date:	Schedule	Schedule Item Name	Replacement Creation Date	Attached Document(s)
06/25/2010	Form	Application for Reinstatement and/or Policy Change	08/31/2010	RA0510AR.pdf (Superceded)

Application for Reinstatement and/or Policy Change

Policy Number: _____ Insured Name: _____

If reinstatement is approved, the contestable period will start anew. This application must be accompanied by all required premiums.

PART 1. PROPOSED INSURED(S) INFORMATION

	Last Name	M.I.	First name	Birth Date	Birth Place	Height Ft. in.	Weight Lbs.	Sex
Primary Insured								
Spouse or 1 st OIR								
CIR or 2 nd OIR								
CIR or 3 rd OIR								

Telephone Number () _____ Best time to call AM PM _____

If additional space is necessary for CIR's, list child's name and date of birth on a separate sheet of paper.

PART 2. MEDICAL QUESTIONS

Has any proposed insured listed in Part 1

- 1) Within the last 5 years been treated for or been told by a member of the medical profession that they had heart disease or circulatory problems, stroke, cancer, diabetes, kidney or liver disorder, lung or respiratory disorder, Alzheimer's Disease, mental or psychiatric disorder, alcohol or drug abuse? (Please circle the applicable ailments) YES NO
- 2) Within the last 5 years consulted a medical practitioner? YES NO
- 3) Within the last 5 years, been told by a member of the medical profession that he or she had a diagnosis of or received treatment for AIDS (Acquired Immune Deficiency Syndrome), ARC (AIDS Related Complex), or the HIV (Human Immunodeficiency Virus) infection? YES NO
- 4) Used Tobacco or any other product containing nicotine in the past 5 years? YES NO
If Yes, please give the type and date last used:
Type: _____ Date Last Used: _____

Give details to all YES answers above. Please indicate person(s) to which details apply, dates of visit, reason for visit and findings. Give us the doctor, hospital, clinic, or health care providers full name and address.

Proposed Insured:	Proposed Insured:	Proposed Insured:
Question number:	Question number:	Question number:
Reason for visit:	Reason for visit:	Reason for visit:
Dates of visits:	Dates of visits:	Dates of visits:
Findings:	Findings:	Findings:
Dr./Clinics address:	Dr./Clinics address:	Dr./Clinics address:

PART 3. OCCUPATION AND MISCELLANEOUS QUESTIONS

5) Has any proposed insured listed in Part 1 had a change in occupation or income since the original application? If yes, indicate whom and describe current occupation and income. YES NO

6) State occupation and income for any adult applicant listed in Part 1 to be added to policy:

7) Has any proposed insured listed in Part 1 had their drivers license suspended, revoked, restricted, or been convicted of a moving violation in the last 12 months? YES NO

If yes, provide Driver's License number, State of issue and details. _____

8) Does any proposed insured listed in Part 1 participate in aviation or any organized hazardous sport or activity? If yes, complete Avocation and Aviation questionnaire and attach to application. YES NO

9) Will any proposed insured listed in Part 1 travel outside the United States within the next 12 months? YES NO

If yes, provide details of when, where, and length of time. _____

PART 4. REPRESENTATIONS

I represent that the statements and answers in this application are true and complete to the best of my knowledge and belief. It is agreed that:

- (a) The statements and answers given in this application, and any amendments or application supplements to it or statements made to the medical examiner, will be the basis of any reinstatement granted or insurance issued.
- (b) No agent or medical examiner has the authority to make or alter any contract for the Company.
- (c) No reinstatement will be effective or coverage provided until the date the application is approved by the company.
- (d) If a premium deposit is given, no insurance shall take effect until the application is approved by the company while all persons shown in Part 1 are living and their health remains as stated in the reinstatement and policy change application.
- (e) If a premium deposit is not given, no insurance shall take effect until the application is approved by the company and accepted by the owner, all premiums due have been paid and while all persons shown in Part 1 are living and their health remains as stated in the reinstatement and policy change application.
- (f) I further agree that this application will be attached and shall be made a part of the contract for insurance.

PART 5. AUTHORIZATION TO OBTAIN INFORMATION

I authorize any physician, medical professional, hospital, clinic, other medical care institution, the Medical Information Bureau, Inc., insurance company, consumer reporting agency, or employer having information available as to employment, other insurance coverage, medical care, advice or treatment with respect to any physical or mental condition regarding me or any of my minor children who are to be insured, to give such information to Transamerica Advisors Life Insurance Company, its reinsurers, or any consumer reporting agency except the Medical Information Bureau, acting on Transamerica Advisors Life Insurance Company's behalf.

I authorize Transamerica Advisors Life Insurance Company to obtain an investigative consumer report on me and upon my request I am entitled to receive a free copy of this report.

I authorize Transamerica Advisors Life Insurance Company to obtain a motor vehicle report on me.

I understand that this information will be used by Transamerica Advisors Life Insurance Company or its reinsurers, to determine eligibility for life insurance.

I agree that this authorization is valid for two and one-half years from the date signed. I know that I or my authorized representative have a right to receive a copy of this authorization upon request. I agree that a photographic copy of this authorization is as valid as the original.

