

SERFF Tracking Number: WAKE-126822858 State: Arkansas  
Filing Company: The Order of United Commercial Travelers of America State Tracking Number: 46837  
Company Tracking Number: KEGUCT2010TLAR  
TOI: L04I Individual Life - Term Sub-TOI: L04I.213 Specified Age or Duration - Fixed/Indeterminate Premium - Single Life  
Product Name: Term Life  
Project Name/Number: The Order of United Commercial Travelers of America/KEGUCT2010TLAR

## Filing at a Glance

Company: The Order of United Commercial Travelers of America

Product Name: Term Life

SERFF Tr Num: WAKE-126822858 State: Arkansas

TOI: L04I Individual Life - Term

SERFF Status: Closed-Approved-Closed State Tr Num: 46837

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

Co Tr Num: KEGUCT2010TLAR State Status: Approved-Closed

Filing Type: Form

Reviewer(s): Linda Bird

Authors: Toni Hess, Katlyn Gorman, Austin Taylor, Michelle Miller, Ben Cohen

Disposition Date: 09/28/2010

Date Submitted: 09/20/2010

Disposition Status: Approved-Closed

Implementation Date Requested: On Approval

Implementation Date:

State Filing Description:

## General Information

Project Name: The Order of United Commercial Travelers of America

Status of Filing in Domicile: Pending

Project Number: KEGUCT2010TLAR

Date Approved in Domicile:

Requested Filing Mode: Review & Approval

Domicile Status Comments: This filing is currently pending approval in the home domicile state of Ohio as of now.

Explanation for Combination/Other:

Market Type: Individual

Submission Type: New Submission

Group Market Size:

Overall Rate Impact:

Group Market Type:

Filing Status Changed: 09/28/2010

Explanation for Other Group Market Type:

State Status Changed: 09/28/2010

Deemer Date:

Created By: Katlyn Gorman

Submitted By: Katlyn Gorman

Corresponding Filing Tracking Number:

Filing Description:

Please see cover letter under supporting documentation tab for description of filing.

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## Company and Contact

### Filing Contact Information

Katlyn Gorman, Administrative Assistant katlyn.gorman@wakelyactuarial.com  
 34125 US Highway 19 North 888-590-5504 [Phone] 2100 [Ext]  
 Suite 310 727-373-4559 [FAX]  
 Palm Harbor, FL 34684

### Filing Company Information

(This filing was made by a third party - WAS01)

The Order of United Commercial Travelers of America CoCode: 56383 State of Domicile: Ohio  
 1801 Watermark Drive, Suite 100 Group Code: -99 Company Type:  
 P.O. Box 159019 Group Name: State ID Number:  
 COLUMBUS, OH 43215-8619 FEIN Number: 31-4273120  
 (800) 848-0123 ext. [Phone]

## Filing Fees

Fee Required? Yes  
 Fee Amount: \$650.00  
 Retaliatory? Yes  
 Fee Explanation: \$50.00 per form X 13  
 Per Company: No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
The Order of United Commercial Travelers of America	\$650.00	09/20/2010	39664753

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## Correspondence Summary

### Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Linda Bird	09/28/2010	09/28/2010

### 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	09/23/2010	09/23/2010	Katlyn Gorman	09/27/2010	09/27/2010

### Amendments

Schedule	Schedule Item Name	Created By	Created On	Date Submitted
Form	Term Life Insurance Policy	Katlyn Gorman	09/22/2010	09/22/2010

*SERFF Tracking Number:* WAKE-126822858      *State:* Arkansas  
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## **Disposition**

Disposition Date: 09/28/2010

Implementation Date:

Status: Approved-Closed

Comment:

Rate data does NOT apply to filing.

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Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification		Yes
Supporting Document	Application		Yes
Supporting Document	Life & Annuity - Actuarial Memo		No
Supporting Document	Cover Letter		Yes
Supporting Document	AR Rule and Regulation Certification 19 & 49		Yes
Supporting Document	Consumer Notice		Yes
Supporting Document	Actuarial Response to 9/23/10 objection		Yes
Form (revised)	Term Life Insurance Policy		Yes
Form	Term Life Insurance Policy	Replaced	Yes
Form	Term Life Insurance Policy	Replaced	Yes
Form	Application for Term Life Insurance		Yes
Form	Accidental Death Benefit Rider		Yes
Form	Waiver of Premium Rider		Yes
Form	Accelerated Death Benefit Rider		Yes
Form	Accelerated Death Benefit Disclosure Statement		Yes
Form	Accelerated Death Benefit Payment Notice		Yes
Form	Coronary Artery Disease		Yes
Form	Diabetes Mellitus Questionnaire		Yes
Form	Drug Questionnaire		Yes
Form	Hypertension Questionnaire		Yes
Form	Physical History Questionnaire		Yes
Form	Life – Certificate of Health		Yes

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## Objection Letter

Objection Letter Status Pending Industry Response  
Objection Letter Date 09/23/2010  
Submitted Date 09/23/2010  
Respond By Date 10/25/2010

Dear Katlyn Gorman,

This will acknowledge receipt of the captioned filing.

### Objection 1

- Flesch Certification (Supporting Document)
- Application (Supporting Document)
- Life & Annuity - Acturial Memo (Supporting Document)
- Cover Letter (Supporting Document)
- AR Rule and Regulation Certification 19 & 49 (Supporting Document)
- Consumer Notice (Supporting Document)
- Actuarial Response to 9/23/10 objection (Supporting Document)
- Term Life Insurance Policy, TERM 0610 AR (Form)
- Application for Term Life Insurance , TERM APP 0610 (Form)
- Accidental Death Benefit Rider, TERM AD 0610 (Form)
- Waiver of Premium Rider, TERM WP 0610 (Form)
- Accelerated Death Benefit Rider, TERM ABR 0610 (Form)
- Accelerated Death Benefit Disclosure Statement, TERM ABR DS 0610 (Form)
- Accelerated Death Benefit Payment Notice, TERM ABR PN 0610 (Form)
- Coronary Artery Disease, TERM CADQ 0610 (Form)
- Diabetes Mellitus Questionnaire, TERM DMQ 0610 (Form)
- Drug Questionnaire, TERM DQ 0610 (Form)
- Hypertension Questionnaire, TERM HYPQ 0610 (Form)
- Physical History Questionnaire, TERM PHQ 0610 (Form)
- Life – Certificate of Health, TERM COH 0710 (Form)

Comment: Ark. Code Ann. 23-79-138 requires that certain information accompany every policy. Bulletin 15-2009 further address this issue. Please review your issue prcedures and assure us that you are in compliance with Ark. Code Ann. 23-79-138.

Regulation 49 requires that a Life and Health guaranty notice be given to each policy owner. Please review your issue

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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 provisos of this rule as well as all applicable requirements of this Department.

We did not find a provision in the contract that provide for refund of monthly deductions beyond the month of death and for the payment of 8% interest on delayed claim payments as described in Ark. Code Ann. 23-81-118.

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 09/27/2010  
Submitted Date 09/27/2010

Dear Linda Bird,

### Comments:

This is in response to your objection letter dated September 23, 2010.

### Response 1

Comments: The Term Policy has been revised. Also, please see the attached actuarial response and all additional attachments.

### Related Objection 1

Applies To:

- Flesch Certification (Supporting Document)
- Term Life Insurance Policy, TERM 0610 (Form)

Comment:

Ark. Code Ann. 23-79-138 requires that certain information accompany every policy. Bulletin 15-2009 further address this issue. Please review your issue procedures and assure us that you are in compliance with Ark. Code Ann. 23-79-138.

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.

We did not find a provision in the contract that provide for refund of monthly deductions beyond the month of death and for the payment of 8% interest on delayed claim payments as described in Ark. Code Ann. 23-81-118.

### Changed Items:

### Supporting Document Schedule Item Changes

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Satisfied -Name: AR Rule and Regulation Certification 19 & 49

Comment:

Satisfied -Name: Consumer Notice

Comment:

Satisfied -Name: Actuarial Response to 9/23/10 objection

Comment:

**Form Schedule Item Changes**

Form Name	Form Number	Edition Date	Form Type	Action	Action Specific Data	Readability Score	Attach Document
Term Life Insurance Policy	TERM 0610	AR	Policy/Contract/Fraternal Certificate	Initial		55.100	TERM 0610 AR.pdf
<b>Previous Version</b>							
Term Life Insurance Policy	TERM 0610		Policy/Contract/Fraternal Certificate	Initial		55.100	UCT TERM 0610 FINAL 92210.pdf
Term Life Insurance Policy	TERM 0610		Policy/Contract/Fraternal Certificate	Initial		55.100	UCT TERM 0610 FINAL.pdf

No Rate/Rule Schedule items changed.

Thank you,  
 Katlyn Gorman

Sincerely,  
 Austin Taylor, Ben Cohen, Katlyn Gorman, Michelle Miller, Toni Hess

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**Amendment Letter**

Submitted Date: 09/22/2010

**Comments:**

I have revised the third page in the Term Policy under the section labeled "Risk Class" to show "Standard or Rated" and attached it under the form schedule tab.

Thank you,  
 Katlyn Gorman

**Changed Items:**

**Form Schedule Item Changes:**

**Form Schedule Item Changes:**

Form Number	Form Type	Form Name	Action	Form Action Other	Previous Filing #	Replaced Form #	Readability Score	Attachments
TERM 0610	Policy/Contract/Fraternal Certificate	Term Life Insurance Policy	Initial				55.100	UCT TERM 0610 FINAL 92210.pdf

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## Form Schedule

### Lead Form Number: TERM 0610

Schedule Item Status	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
	TERM 0610 AR		Policy/Cont ract/Fraternal Certificate	Initial		55.100	TERM 0610 AR.pdf
	TERM 0610 APP		Application/ Enrollment Form	Initial		46.700	UCT TERM APP 0610.pdf
	TERM 0610 AD	Other	Accidental Death Benefit Rider	Initial		53.900	UCT TERM AD 0610 FINAL.pdf
	TERM 0610 WP	Other	Waiver of Premium Rider	Initial		50.600	UCT TERM WP 0610 FINAL.pdf
	TERM 0610 ABR	Other	Accelerated Death Benefit Rider	Initial		51.200	UCT TERM ABR 0610 FINAL.pdf
	TERM 0610 ABR DS	Other	Accelerated Death Benefit Disclosure Statement	Initial		52.600	UCT TERM ABR DS 0610.pdf
	TERM 0610 ABR PN	Other	Accelerated Death Benefit Payment Notice	Initial		55.000	UCT TERM ABR PN 0610.pdf
	TERM 0610 CADQ	Other	Coronary Artery Disease	Revised	Replaced Form #: CADQ 0610 Previous Filing #:		TERM CADQ 0610.pdf
	TERM 0610 DMQ	Other	Diabetes Mellitus Questionnaire	Revised	Replaced Form #: DMQ 0610 Previous Filing #:		TERM DMQ 0610.pdf
	TERM 0610 DQ	Other	Drug Questionnaire	Revised	Replaced Form #:		TERM DQ

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0610					DQ 0610	0610.pdf
					Previous Filing #:	
TERM	Other	Hypertension	Revised	Replaced Form #:		TERM HYPQ
HYPQ		Questionnaire		HYPQ 0610		0610.pdf
0610				Previous Filing #:		
TERM PHQ	Other	Physical History	Revised	Replaced Form #:		TERM PHQ
0610		Questionnaire		PHQ 0610		0610.pdf
				Previous Filing #:		
TERM	Other	Life – Certificate of	Revised	Replaced Form #:		TERM COH
COH 0710		Health		LIFE COH 0710		0710.pdf
				Previous Filing #:		



The Order of United Commercial Travelers of America • A Fraternal Benefit Society  
1801 Watermark Drive, Suite 100, P.O. Box 159019, Columbus, Ohio 43215-8619  
Tel: 614.487.9680 • Toll-free: 800.848.0123 • Fax: 614.487.9675 • www.uct.org

## Term Life Insurance Policy

**Proceeds are payable at the Insured's death during term period**

**This policy is nonparticipating**

This is a contract between you and The Order of United Commercial Travelers of America. We issue this contract based on the application signed by you and the payment of premiums as stated on the schedule sheet included in this contract.

We will pay the benefits subject to all the terms and conditions of the contract. If we receive proof satisfactory to us that the Insured died while this policy was in force, we will pay to the beneficiary the death benefits described in the DEATH BENEFITS section of this policy.

The beneficiary is named in the application unless changed as provided for in this policy.

**Right to Cancel**  
**Please Read this Contract Carefully.**

We want you to be satisfied with your policy. If, for any reason, you are not satisfied, you may cancel this policy within 30 days of receiving it. Do this by mailing or delivering it to us at our Home Office at Columbus, Ohio. Within 30 days after we receive the policy, we will refund all premiums which you have paid. The policy will be considered void from its start.

Signed for the Society at Columbus, Ohio

Joseph H. Hoffman  
Chief Executive Officer

MEMBER OF THE AMERICAN FRATERNAL ALLIANCE

**TERM LIFE INSURANCE POLICY**  
**PAYABLE UPON DEATH DURING TERM PERIOD**  
**PREMIUMS PAYABLE DURING TERM PERIOD**  
**NON-PARTICIPATING**

## Guide to Policy Provisions

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**POLICY DATA**

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**INSURED**  
[JOHN DOE]**ISSUE AGE – GENDER – TOBACCO CLASS**  
[35] [MALE or FEMALE] [N or Y]**POLICY NUMBER**  
[SPECIMEN]**RISK CLASS**  
[STANDARD or RATED]**POLICY DATE**  
[JULY 1, 2010]**FACE AMOUNT**  
[\$100,000.00]**EXPIRY DATE**  
[JULY 1, 2070]**STATE OF ISSUE**  
[OHIO]**INITIAL TERM PERIOD**  
[10 YEARS]

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**SCHEDULE OF BENEFITS AND PREMIUMS**

---

<b>BENEFIT</b>	<b>BENEFIT AMOUNT</b>	<b>INITIAL ANNUAL PREMIUM</b>
[TERM LIFE INSURANCE POLICY]	[\$100,000]	[\$ 113.00]
[ACCIDENTAL DEATH BENEFIT]	[\$100,000]	[\$ 85.00]
[WAIVER OF PREMIUM]		[\$ 13.00]
[ACCELERATED DEATH BENEFIT]	[\$ 25,000]	[\$ 0.00]
	PLUS: POLICY FEE	[\$ 50.00]
	<b>TOTAL</b>	<b>[\$ 261.00]</b>

The premium for this policy as of the policy date is

[ \$261.00] ANNUALLY or  
[ \$135.72] SEMI-ANNUALLY, or  
[ \$ 69.17] QUARTERLY, or  
[ \$ 21.75] MONTHLY EFT

These premiums are payable for [10] years.  
Thereafter, the premiums will increase each year as shown in the Table of Renewal Annual Premiums below.

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**TABLE OF RENEWAL ANNUAL PREMIUMS**

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<b>POLICY YEAR</b>	<b>INSURED'S ATTAINED AGE</b>	<b>ANNUAL PREMIUM</b>	<b>POLICY YEAR</b>	<b>INSURED'S ATTAINED AGE</b>	<b>ANNUAL PREMIUM</b>
11	45	1,038.00	41	75	14,768.00
12	46	1,119.00	42	76	16,315.00
13	47	1,186.00	43	77	18,115.00
14	48	1,239.00	44	78	20,205.00
15	49	1,306.00	45	79	22,547.00
16	50	1,395.00	46	80	25,158.00
17	51	1,507.00	47	81	27,998.00
18	52	1,644.00	48	82	31,005.00
19	53	1,803.00	49	83	34,289.00
20	54	2,003.00	50	84	37,940.00
21	55	2,229.00	51	85	42,001.00
22	56	2,461.00	52	86	46,468.00
23	57	2,686.00	53	87	51,296.00
24	58	2,912.00	54	88	56,428.00
25	59	3,175.00	55	89	61,813.00
26	60	3,496.00	56	90	67,176.00
27	61	3,885.00	57	91	72,456.00
28	62	4,339.00	58	92	77,987.00
29	63	4,835.00	59	93	83,819.00
30	64	5,352.00	60	94	89,964.00
31	65	5,891.00			
32	66	6,437.00			
33	67	7,008.00			
34	68	7,611.00			
35	69	8,290.00			
36	70	8,897.00			
37	71	9,849.00			
38	72	10,962.00			
39	73	12,135.00			
40	74	13,395.00			

## Definitions

**Age Anniversary.** An Age Anniversary is the Policy Anniversary on which the Insured becomes that attained Insurance Age.

**Effective Date of Coverage.** The effective date of coverage under this policy is the earlier of the following:

1. The date of your application provided a valid premium was submitted with the application; or
2. The Policy Date provided a valid premium is paid during the Insured's lifetime and within 21 days of the Policy Date.

If neither 1 nor 2 above exists, coverage will not be In Force.

**In Force.** The Insured person named under Policy Data is Insured under the terms of this policy.

**Insurance Age.** Insurance Age means the Insured's age on last birthday. The issue age shown under Policy Data is the Insured's Insurance Age as of the Policy Date. Attained Insurance Ages are determined from the Policy Date.

**Insured.** The person who is Insured by this policy. The Insured is shown under Policy Data.

**Lapse.** A premium payment is in default because it was not paid by the end of the grace period. The Insured person is no longer insured.

**Non-Participating.** This policy does not participate in the distribution of our surplus. As a result, no dividends will be paid under this policy.

**Policy Anniversary.** The same day and month as the Policy Date each year that the policy remains In Force.

**Policy Date.** The date from which policy anniversaries, policy years, policy months and premium due dates are determined. Your Policy Date is shown under Policy Data.

**Proceeds.** The amount we pay under the terms of this policy. Proceeds are payable upon the Insured's death.

**Terminate.** This policy is no longer In Force. All insurance coverage under this policy has stopped.

**We, Our, Us, Society.** The Order of United Commercial Travelers of America.

**Written Request.** A request in writing signed by you.

**You, Your.** The owner of this policy.

## General Provisions

**Conformity with State and Provincial Laws.** On the Policy Date, any provision of this policy in conflict with the laws of the state or province in which you reside on that date is amended to conform with the minimum requirement of those laws.

**Entire Contract of Insurance.** The Entire Contract between you and us consists of:

1. This policy, including any attached riders or amendments;
2. The application attached to this policy; and,
3. The Articles of Incorporation, Constitution and Bylaws of the Society and all amendments made to them after the Policy Date.

**Incontestability.** Statements in the application are considered representations, not warranties. Statements may be used to contest the validity of this Policy or in defense of a claim only if they are contained in an attached application or endorsement. We will not contest this policy, except for nonpayment of premiums, after it has been in force 2 years after the Policy Date.

**Legal Actions.** No action at law or in equity shall be brought to recover on this Policy prior to the expiration of 60 days after written proof of loss has been furnished in accordance with the requirements of this Policy. No such action shall be brought after the expiration of 3 years after the time written proof of loss is required to be furnished.

**Maintenance of Solvency.** UCT's constitution provides that in the event that its reserves as to all or any class of contracts of insurance issued by it become impaired, the Board of Governors may require that these shall be paid by each Owner of such contract of insurance to UCT an amount equal to such Owner's equitable proportion of such deficiency as ascertained by the Board of Governors.

If payment of the amount required to be paid is not made by such Owner, then either or both of the following, at the election of the Owner, shall apply:

1. the amount shall stand as Indebtedness against the contract of insurance and shall bear interest at a rate not to exceed ten percent (10%) per annum; or
2. the Owner shall accept a proportionate reduction in benefits paid pursuant to the contract of insurance.

The Owner shall make such election by notifying the Board of Governors of his or her election on a form prescribed by the Board of Governors that shall be provided to each Owner. Failure to make such election shall result in a presumption that the Owner elects to accept a proportionate reduction in benefits paid pursuant to the contract of insurance.

The Owner hereby agrees that if they affirmatively elect to have the amount stand as Indebtedness against the contract of insurance, then UCT may offset the amount of such Indebtedness together with interest thereon against any payment of benefits under this contract of insurance.

**Misstatement of Age or Sex or Tobacco Class.** If the Insured's age or sex or tobacco class has been misstated on the application form, the proceeds will be based on the amount that premiums paid would have purchased at the correct age or sex or tobacco class.

**Policy Changes.** No change in this contract is valid unless it is made in writing and signed by our Chief Executive Officer of the Society. All changes must be endorsed in or attached to this policy. None of our representatives or other persons have the authority to change or waive any of our rights or requirements under this policy.

**Suicide Exclusion.** Coverage is not provided if the Insured commits suicide within 2 years from the Policy Date. In this event, the only amount payable by us to the beneficiary will be the premiums which you have paid.

**Suspension/Expulsion.** If You are suspended/expelled from the Society, except for nonpayment of a premium or within the contestable period for material misrepresentation in the application for membership or insurance, you shall have the privilege of maintaining this contract In Force by continuing payment of the required premium.

### **Owner and Beneficiary**

**Assignment.** During the Insured's lifetime, you can assign this policy or any interest in it. Your interest and the interest of any beneficiary is subject to the interest of the assignee. A collateral assignment is not a change of ownership. Any policy proceeds payable to the assignee will be paid in a single sum.

A copy of any assignment must be submitted to us, and no assignment will be binding on the Society until it is recorded at our Home Office. We are not responsible for the validity or effect of any assignment.

**Beneficiary.** We will pay the Proceeds to the beneficiary or beneficiaries who you have named in the application unless you have since changed the beneficiary as provided in this policy or unless an assignment of the proceeds to another has been made. If the beneficiary has been changed, we will pay the Proceeds in accordance with your last change of beneficiary request. Only those beneficiaries who are living at the Insured's death may share in the Proceeds. If the beneficiary should die at the same time as the Insured or within 30 days of the Insured's death, but before payment of any Proceeds to the beneficiary, Proceeds will be paid as if the Insured had survived the beneficiary.

In the event a trustee is named as beneficiary, the Society will not be responsible for the application or disposition of the funds paid to the trustee. The payment will be made in a lump sum and receipt by the trustee will fully discharge the Society for any amount paid to the trustee.

**Change of Beneficiary.** You may change the beneficiary any time during the Insured's lifetime while this policy is In Force. The request must be made in writing, dated and signed by you. Once the change is recorded by us at our Home Office, it will take effect as of the date of your request. Payments made or other actions taken by the Society before such recording will not be subject to the new designation.

**Rights as Policyowner.** While this policy is In Force and unless otherwise provided in this policy, you may exercise all rights and privileges stated in this policy or allowed by us.

## Death Benefits

**Amount of Death Benefit.** The Benefit Amount is shown in the Schedule of Benefits on page 3 of this policy.

**Proceeds.** If the Insured dies while this policy is in force, we will pay the proceeds to the beneficiary. The proceeds are the sum of:

1. The death benefit of the policy at the time of the Insured's death; plus
2. Any insurance on the Insured's life that may be provided by riders attached to this policy; plus
3. That portion of any premium paid which applies to a period beyond the policy month in which the Insured dies; minus
4. Any unpaid past due premium if death occurs during the Grace Period.

## Premiums and Reinstatement

**Premium Adjustments at Death.** The following premium adjustments will be made if the Insured dies while this policy is In Force on a premium paying basis:

1. The part of any premium paid for the period beyond the month of the Insured's death will be added to the policy proceeds.
2. If the Insured dies during the grace period, we will deduct one month's premium to cover the elapsed part of that period from the policy proceeds.

**Premium in Default and Grace Period.** Any premium not paid on or before its due date is a premium in default. Except for the first premium, you may pay the premium in default within a grace period of 31 days after its due date. This policy will remain In Force during the 31-day grace period.

If a premium in default is not paid within the grace period, this policy will lapse and no more premium payments may be made. If this policy has a surrender value when it lapses, certain options are available as described in the Policy Values section.

**Premium Due Dates.** Your first premium is due as of the Policy Date. All premiums after the first are payable on or before their due date. Premiums must be mailed or delivered to us at our Home Office or to an authorized agent. We will give you a receipt if you request one. The premiums due each year for the policy are specified under Policy Data. The premiums for this policy are payable during the Insured's lifetime for the periods shown under Policy Data.

You can change the payment mode. A premium payment paid in a mode not shown under the premiums chart on the schedule sheet included in this contract must be approved by us.

**Reinstatement.** Within 3 years of the date of default, you may ask to reinstate this policy to a premium paying basis. To reinstate the policy to a premium paying basis, we will require all of the following:

1. Your written request to reinstate the policy;
2. Evidence of the Insured's insurability that is satisfactory to us;
3. Payment of all past due premiums with interest at eight percent (8%) per year compounded annually.

These requirements must be met during the Insured's lifetime.

## Termination Provision

**End of Policy.** This policy will end on the earliest of the following:

1. The date you request it ends; or
2. The date the Insured dies; or
3. The date the Grace Period ends if sufficient premium has not been paid; or
4. The Expiry Date shown on page 3.

### **Policy Surrender Values**

This policy has no policy surrender value or non-forfeiture benefits.

### **Policy Loans**

This policy has no loan values.

### **Policy Settlement**

**Payment of Proceeds.** The proceeds of this policy are payable at our Home Office after we receive due proof of the Insured's death. We require surrender of this policy for payment of any proceeds. The proceeds will be paid in one lump-sum. **If we do not pay the proceeds within 30 days from the date we receive due proof of the Insured's death, then we will pay interest at a rate equal to 8% per year on the proceeds from the date of the Insured's death to the settlement date.**

**TERM LIFE INSURANCE POLICY  
PAYABLE UPON DEATH DURING TERM PERIOD  
PREMIUMS PAYABLE DURING TERM PERIOD  
NON-PARTICIPATING**



<b>APPLICATION FOR TERM LIFE INSURANCE</b>	<i>Requested Effective Date of Policy</i>
--	---

**1. PROPOSED INSURED AND BENEFICIARY INFORMATION**

<b>Last Name</b>	<b>First Name</b>	<b>MI</b>	<b>RESIDENCE ADDRESS</b>			
			<i>Street:</i> _____			
<b>OCCUPATION</b>			<i>City:</i> _____			
<i>Description:</i> _____			<i>State/Zip Code:</i> _____			
<i>Employer:</i> _____			<i>Email:</i> _____			
<i>Address:</i> _____			<i>Telephone:</i> _____			
<i>Telephone:</i> _____						
<b>AGE</b>	<b>DATE OF BIRTH</b>	<b>BIRTH STATE</b>	<b>SEX</b>	<b>HEIGHT</b>	<b>WEIGHT</b>	<b>SOCIAL SECURITY NO.</b>
	<i>Month Day Year</i>		<input type="checkbox"/> Male <input type="checkbox"/> Female			
<b>Driver's License Number</b>			<b>Driver's License State</b>	<b>Marital Status</b>		
				<input type="checkbox"/> Married <input type="checkbox"/> Single <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		
<b>Has the Proposed Insured used any form of tobacco in the past two years?</b> ..... <input type="checkbox"/> Yes <input type="checkbox"/> No						

<input type="checkbox"/> <b>Primary Beneficiary</b>	<b>Percentage of Death Benefit</b>	
<b>Name (Last, First, MI) or Non-Natural Entity Name</b>	<b>Social Security No. / Tax I.D.</b>	<b>Relationship to Proposed Insured</b>
<input type="checkbox"/> <b>Primary Beneficiary</b> <input type="checkbox"/> <b>Contingent Beneficiary</b>	<b>Percentage of Death Benefit</b>	
<b>Name (Last, First, MI) or Non-Natural Entity Name</b>	<b>Social Security No. / Tax I.D.</b>	<b>Relationship to Proposed Insured</b>
<b>ADD ADDITIONAL SHEET FOR MORE BENEFICIARIES</b>		

**Are you a member of The Order of United Commercial Travelers of America?** .....  Yes     No

**Member Number:** \_\_\_\_\_ **If "No" checked above, complete membership form (M-81).**

**2. OWNER (If other than Proposed Insured)**

<b>Last Name</b>	<b>First Name</b>	<b>MI</b>	<b>Date of Birth</b>	<b>Social Security No. / Tax I.D.</b>	<b>Relationship to Proposed Insured</b>
<b>Street</b>			<b>City</b>	<b>State</b>	<b>Zip Code</b>

### 3. PROPOSED INSURANCE PLAN

Type Plan	Face Amount	Premium	Premium Mode:
Term Life	\$ _____	\$ _____	<input type="checkbox"/> Annual <input type="checkbox"/> Semi-Annual
Initial Term Period:	<input type="checkbox"/> 10 Yrs <input type="checkbox"/> 15 Yrs <input type="checkbox"/> 20 Yrs <input type="checkbox"/> 30 Yrs		<input type="checkbox"/> Quarterly <input type="checkbox"/> Monthly EFT *
Riders: <input type="checkbox"/> Accidental Death Benefit		\$ _____	* Electronic Funds Transfer
<input type="checkbox"/> Waiver of Premium		\$ _____	
<input type="checkbox"/> Accelerated Death Benefit		\$ <u>0.00</u>	
			Annual Policy Fee: <u>\$50.00</u>

**Sum Paid with Application** \$ \_\_\_\_\_      **Total Modal Premium** \$ \_\_\_\_\_

(Receipt valid only if amount paid with application is entered here)

Will the Premium be paid by the Proposed Insured or the Owner? .....  Yes     No  
 If "No" please complete the Payor's information below:

Payor's Name	Payor's Address (number and street, city, state, zip code)
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### 4. ELIGIBILITY QUESTIONS

(If any question in this section is answered "yes", the Proposed Insured is not eligible for coverage)

1. Has the Proposed Insured ever tested positive for exposure to the Human Immunodeficiency Virus (HIV) infection, or been diagnosed as having AIDS Related Complex (ARC) or Acquired Immunodeficiency Syndrome (AIDS) caused by the HIV infection or other sickness or condition derived from such infection? .....  Yes     No
2. Is the Proposed Insured currently bedridden, receiving home health care, hospitalized, confined to a nursing home or long-term care facility, or been advised in the past 6 months to be hospitalized or to go into a nursing home or long-term care facility and refused? .....  Yes     No
3. Is the Proposed Insured in the end stages of a terminal illness, or been told his/her life expectancy is 12 months or less, or receiving or on the waiting list for hospice care? .....  Yes     No
4. Is the Proposed Insured currently awaiting an organ transplant? .....  Yes     No
5. Within the past 2 years, has the Proposed Insured:
  - (a) been administered oxygen or recommended the use of oxygen? .....  Yes     No
  - (b) had a heart attack, stroke, transient ischemic attack (TIA, also known as a mini-stroke), had or been advised to have heart surgery (including angioplasty or stent placement)? .....  Yes     No
6. Within the past 2 years, has the Proposed Insured been diagnosed with or treated for:
  - (a) dementia, Alzheimer's disease, schizophrenia, or any mental disorder? .....  Yes     No
  - (b) cancer (other than basal cell carcinoma), leukemia, lymphoma, tumor, or chronic blood disorder (including sickle cell anemia)? .....  Yes     No
7. In the past 5 years, has the Proposed Insured been incarcerated? .....  Yes     No
8. Has the Proposed Insured *ever* been diagnosed with or treated for:
  - (a) chronic kidney disease or disorder, or received kidney dialysis? .....  Yes     No
  - (b) hepatitis (except Hepatitis A), or any liver or pancreas disease? .....  Yes     No
  - (c) Congestive Heart Failure (CHF)? .....  Yes     No
  - (d) Multiple sclerosis, lupus, or ALS (also known as Lou Gehrig's disease)? .....  Yes     No

## 5. HEALTH QUESTIONS

(If "yes", please provide details – attach additional sheet if necessary)

9. In the past 2 years, has the Proposed Insured had an application for life or health insurance or reinstatement declined, rated, or modified in any way? .....  Yes  No

10. Has any Proposed Insured ever been diagnosed with, been treated by a member of the medical profession, taken medication for, or been advised to have diagnostic tests for: (check applicable conditions)

- |   |   |
|---|---|
| <input type="checkbox"/> Internal cancer                              | <input type="checkbox"/> Heart Attack   |
| <input type="checkbox"/> Leukemia                                     | <input type="checkbox"/> Stroke   |
| <input type="checkbox"/> Lymphoma                                     | <input type="checkbox"/> Transient Ischemic Attack                            |
| <input type="checkbox"/> Hodgkin's disease                            | <input type="checkbox"/> Heart Surgery  |
| <input type="checkbox"/> Malignant melanoma                           | <input type="checkbox"/> Coronary Artery Surgery                              |
| <input type="checkbox"/> Dementia, Alzheimer's or Parkinson's disease | <input type="checkbox"/> Heart or circulatory system disease                  |
| <input type="checkbox"/> Malignant or benign tumors of any kind       | <input type="checkbox"/> Angioplasty  |
| <input type="checkbox"/> Emphysema or other chronic lung disease      | <input type="checkbox"/> Paralysis, epilepsy, or other nervous system disease |
| <input type="checkbox"/> Blood disorder                               | <input type="checkbox"/> Diabetes Mellitus                                    |

11. Does the Proposed Insured require the use of a wheel chair due to chronic illness? .....  Yes  No

12. In the last 2 years, has the Proposed Insured had a systolic blood pressure reading higher than 150 more than once or a diastolic blood pressure reading higher than 100 more than once? .....  Yes  No

13. In the past 3 years, has the Proposed Insured been treated for alcohol and/or drug abuse? .....  Yes  No

14. In the past 3 years, has the Proposed Insured been convicted of or put on probation for: (1) a felony; (2) driving under the influence (DUI); or (3) driving while intoxicated (DWI)? .....  Yes  No

Give details to any "Yes" answers to the Health Questions

Question No.	Explanation (including Medications)	Dates / Duration	Name of Physician and/or Hospital

**With Regard to Phone Interviews:**

Daytime Phone No: \_\_\_\_\_ Best Time to Call: \_\_\_\_\_

## 6. REPLACEMENT INFORMATION

a. Does the Proposed Insured have any existing life insurance or annuities currently in force or pending with this or any other company? .....  Yes  No

b. Will this policy, if issued, replace or modify insurance or annuities with this or any other company? .....  Yes  No

If "yes", provide the following information:

Name of Company \_\_\_\_\_ Policy No. \_\_\_\_\_

Reason for replacement? \_\_\_\_\_

## 7. AUTHORIZATIONS AND SIGNATURES

I hereby apply to The Order of United Commercial Travelers of America for a policy to be issued solely and entirely in reliance on my written answers to the questions on this application. The answers are, to the best of my knowledge and belief, true. The Order of United Commercial Travelers of America has the right to deny benefits or rescind my Policy. I also understand that the agent cannot determine eligibility for or alter the terms of the proposed policy. I agree the policy shall not be effective until it has actually been issued.

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

Signed At: \_\_\_\_\_ Applicant's Signature: \_\_\_\_\_

Dated: \_\_\_\_\_  
(Month/Day/Year)

## 8. AGENT'S CERTIFICATION

The undersigned Agent certifies that the Applicant has read, or has had read to them, the completed application and that the Applicant realizes that any false statement or misrepresentation in the application may result in loss of coverage under the policy.

### TO BE COMPLETED BY AGENT (Attach separate sheet, if necessary)

1. List any other life insurance or annuity policies you have sold to the Applicant that are still in force.

\_\_\_\_\_  
\_\_\_\_\_

2. List any other life insurance or annuity policies you have sold to the Applicant in the past five (5) years that are no longer in force.

\_\_\_\_\_

3. Do you have any knowledge or reason to believe that the Applicant is intending to replace an existing insurance? ...  Yes  No

I certify that:

I have accurately recorded the information supplied by the Applicant; and I have given an outline of coverage for the policy applied for to the applicant.

Agent's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Agent's Printed Name: \_\_\_\_\_

Agent Email Address: \_\_\_\_\_

Agent License Number: \_\_\_\_\_

**HIPAA & MIB AUTHORIZATION & ACKNOWLEDGEMENT  
THE ORDER OF UNITED COMMERCIAL TRAVELERS OF AMERICA**

I understand the information obtained by use of the Authorization will be used by The Order of United Commercial Travelers of America to determine eligibility for insurance or for benefits under an existing policy. Any information obtained will not be released by The Order of United Commercial Travelers of America to any person or organization **EXCEPT** to reinsurance companies, the Medical Information Bureau Inc. (MIB), or other persons or organizations performing business or legal services in connection with my application, claims, including legal proceedings thereon, or as may be otherwise lawfully required or as I may authorize.

I hereby authorize any licensed physician, medical practitioner, hospital, clinic, other medically-related facility, insurance or reinsuring company, the Medical Information Bureau or other organization, institution, or person, that has my records or knowledge of my health or prescription drug usage, to disclose to The Order of United Commercial Travelers of America or its reinsurer(s) any such information. A photocopy of this authorization shall be as valid as the original.

I understand that when my medical records are disclosed pursuant to this Authorization, my medical records and the information contained in those records may be subject to re-disclosure by the recipient and may no longer be protected by federal privacy laws. I understand that I may revoke this Authorization, except to the extent that any care provider or The Order of United Commercial Travelers of America has acted in reliance upon this Authorization. My revocation must be submitted in writing to: The Order of United Commercial Travelers of America, 1801 Watermark Drive, Suite 100, P.O. Box 159019, Columbus, Ohio 43215-8619.

I also understand that this authorization shall remain in force for **thirty (30) months** from the date shown below if used in connection with an application for an insurance policy, an application for reinstatement of an insurance policy, or a request for change in policy benefits; or for the duration of a claim if used for the purpose of collecting information in connection with a claim for benefits under a policy.

\_\_\_\_\_  
**Applicant Name**

\_\_\_\_\_  
**Social Security Number**

\_\_\_\_\_  
**Date of Birth**

\_\_\_\_\_  
**Signature of Applicant**

\_\_\_\_\_  
**Date**

**NOTICE TO APPLICANT**

In making this application for insurance to The Order of United Commercial Travelers of America, it is understood that an investigative consumer report may be prepared whereby information is obtained through personal interviews with your neighbors, friends or others whom you are acquainted. This inquiry includes information as to your character, general reputation, personal characteristics and mode of living. You have the right to make a written request within a reasonable period of time to receive additional, detailed information about the nature and scope of this investigation.

Information regarding your insurability will be treated as confidential. The Order of United Commercial Travelers of America, or its reinsurer, may; however, make a brief report thereon to the Medical Information Bureau (MIB), a non-profit membership organization of life insurance companies which operates an information exchange on behalf of its members. If you apply to another Bureau member company for life or health coverage, or a claim for benefits is submitted to such company, the Bureau, upon request will supply such company with the information in its file.

Upon receipt of a request from you, MIB will arrange disclosure of any information it may have 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, Braintree, Massachusetts 02184-8734.

The Order of United Commercial Travelers of America, or its reinsurer, may also release information from its file to other insurance companies to whom you 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](http://www.mib.com).

**AUTHORITY TO HONOR PREMIUM CHECKS**

<b>AUTHORIZATION</b>	<b>IN FAVOR OF:</b>	<b>The Order of United Commercial Travelers of America 1801 Watermark Drive, Suite 100, P.O. Box 159019, Columbus, Ohio 43215-8619</b>		<b>AUTHORIZATION</b>
	<b>Name of Bank Customer:</b>	_____	<b>Type of Account:</b> <input type="checkbox"/> Checking	
	<b>Insured's Name:</b>	_____	<input type="checkbox"/> Savings	
	<b>Routing Number:</b>	_____	<b>Account Number:</b> _____	
	<b>To (Name of Bank):</b>	_____		
	<b>Address of Bank:</b>	_____		
	<p>You are hereby authorized, as a convenience to me, to honor and charge my account for checks, drafts and other orders, including without limitation any order initiated by electronic means, drawn by The Order of United Commercial Travelers of America indicated above, on my account by and payable to the order of The Order of United Commercial Travelers of America for the payment of premiums provided there are sufficient collected funds in such account to pay the same upon presentation. I agree that your rights in respect to each such check or other order drawn by The Order of United Commercial Travelers of America shall be the same as if it were a check drawn on you and signed personally by me. This authority is to remain in effect until revoked by me in writing, and until you actually receive such notice I agree that you shall be fully protected in honoring any such check or other orders drawn by The Order of United Commercial Travelers of America. I further agree that if any such checks or other orders drawn by The Order of United Commercial Travelers of America be dishonored, whether with or without cause and whether intentionally or inadvertently, you shall be under no liability whatsoever even though such dishonor results in forfeiture of insurance.</p>			
	<b>Date:</b>	<b>Signature of Bank Customer:</b>		

**Signature must be the same as on the signature card at bank, and if a company account the name of the account must be shown.**

**To: Bank above:** In consideration of your compliance with the individual authorization of your depositors to pay checks, drafts or orders, drawn and signed by us to our Order, we agree:

- To indemnify you and hold you harmless from any loss you may suffer as a consequence of your actions resulting from or in connection with the execution and issuance of any check, draft or order, whether or not genuine, purporting to be executed and received by you in the regular course of business for the purpose of payment of such insurance premiums including any costs or expenses reasonably incurred in connection therewith.
- In the event that any such check, draft or order shall be dishonored, whether with or without cause, and whether intentionally or inadvertently, to indemnify you for such loss even though dishonor results in forfeiture of the insurance.
- To defend at our own cost and expense any action which might be brought by any depositor or any other persons because of your actions taken pursuant to said authorization and direction or in any manner arising by reason of your participation in this plan of premium collection.

**ATTACH VOIDED CHECK HERE – Deposit Slips NOT Accepted**

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PREMIUM RECEIPT

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**Make check payable to UCT.**

Received from \_\_\_\_\_, the sum of \$ \_\_\_\_\_.

If, for any reason, the policy is not issued, payment will be refunded in full in a timely manner. Insurance is not effective until the application is approved, the premium has been paid and the policy is issued.

Date: \_\_\_\_\_ Licensed Resident Agent: \_\_\_\_\_

*Do not make check payable to the agent or leave the payee blank.*

## Accidental Death Benefit Rider

This is an additional benefit to the contract of insurance between The Order of United Commercial Travelers of America and the owner of the policy to which this rider is attached. It has the same effective date as the policy date shown on the Policy Data page of the policy. It is issued in consideration of the statements made in the application and the payment of the premium as shown on the Schedule of Premiums in the policy. It is subject to the definitions, provisions, exceptions, and limitations of the policy which are not inconsistent with the provisions of this rider.

**BENEFIT** - We will pay the Accidental Death Benefit equal to the Benefit Amount shown on the Schedule of Benefits in the policy when we receive proof that the Insured's death:

1. Resulted directly from an injury caused by an accident, independent of disease or bodily or mental illness or infirmity or any other cause, within 180 days after such injury; and
2. Occurred prior to the policy anniversary following the Insured's 70<sup>th</sup> birthday and while this rider was in force.

This benefit will be paid to the beneficiary as part of the policy proceeds.

**EXCLUSIONS** - This benefit will not be paid if the Insured's death resulted from or was contributed to by:

1. Disease or infirmity of mind or body, or medical or surgical treatment for such disease or infirmity;
2. An infection not occurring as a direct result or consequence of the accidental bodily injury;
3. Any attempt at suicide, or intentionally self-inflicted injury, while sane or insane;
4. Riding in or descending from any kind of aircraft if the Insured acted in a capacity other than as a passenger;
5. War or act of war while the Insured is serving: (i) in the military, naval, or air forces of any country or international organization; or (ii) in any civilian non-combatant unit serving with such forces. "War" includes, but is not limited to, declared war, and armed aggression by one or more countries. "Act of War" means any act peculiar to military, naval, or air operations in time of war;
6. Active participation in a riot, insurrection or terrorist activity;
7. While the Insured is incarcerated;
8. While committing or attempting to commit a felony;
9. The voluntary intake or use by any means of: (i) any drug, unless prescribed or administered by a physician and taken in accordance with the physician's instructions; or (ii) poison, gas or fumes, unless a direct result of an occupational accident;
10. Intoxication where "intoxicated" means that which is determined and defined by the laws and jurisdiction of that geographical area in which the loss or cause of loss occurred;
11. Riding or driving an air, land, or water vehicle in a race, speed, or endurance contest;
12. Bungee jumping, rock or mountain climbing, hang-gliding, skydiving, parachuting, ultra light flying, ballooning, or parasailing.

**NOTIFICATION** - Written notice of claim and proof of death must be provided as stated in the policy.

**AUTOPSY** - If it is permitted in the state where the policy is issued, we have the right to examine the Insured's body or perform an autopsy. Such exam or autopsy will be done at our expense.

**INCONTESTABILITY** – We will not contest this rider, except for nonpayment of premiums, after it has been in force 2 years after the Policy Date.

**TERMINATION OF RIDER** - This rider will end on the earliest of the following:

1. The date you request it ends; or
2. The date when the policy terminates; or
3. The date the Insured dies; or
4. The policy anniversary following the Insured's 70<sup>th</sup> birthday.

Any accidental death benefit that becomes payable while this rider was in force will not be affected by this provision.

**NONFORFEITURE VALUES** - This rider does not have cash values or loan values.

Signed for the Society at Columbus, Ohio

A handwritten signature in black ink, appearing to read 'J. H. Hoffman', with a horizontal line extending to the right from the end of the signature.

Joseph H. Hoffman  
Chief Executive Officer

MEMBER OF THE AMERICAN FRATERNAL ALLIANCE



## Waiver of Premium Rider

This is an additional benefit to the contract of insurance between The Order of United Commercial Travelers of America and the owner of the Policy to which this Rider is attached. It has the same Effective Date as the policy date shown on the Policy Data page of the policy. It is issued in consideration of the statements made in the application and the payment of the premium as shown on the Schedule of Benefits and Premiums in the policy. It is subject to the definitions, provisions, exceptions, and limitations of the policy which are not inconsistent with the provisions of this rider.

**BENEFIT** - We will waive the payment of all premiums as they become due for the Policy and for any included rider(s) when we receive proof that the Insured has been Totally and Permanently Disabled.

Total Disability of the Insured must begin:

1. while this Rider is in force; and
2. prior to the policy anniversary following the Insured's 65<sup>th</sup> birthday.

Premiums will be waived beginning with the premium due on or after the date the Total and Permanent Disability commences and continuing during such disability to the end of the Initial Term Period shown on the Schedule of Benefits and Premiums in the policy. No premiums will be waived beyond the end of the Initial Term Period.

Premiums to be waived will not reduce any benefits payable under the policy.

**DEFINITION OF TOTAL AND PERMANENT DISABILITY** - For the purpose of this rider, Total and Permanent Disability means:

1. during the first 24 months of total disability, the Insured due to sickness or accidental bodily injury is unable to perform the substantial and material duties of his own occupation; and
2. after the first 24 months of total disability, the Insured due to sickness or accidental bodily injury is unable to perform the substantial and material duties of any employment or occupation for which the Insured is reasonably qualified by education, training or experience.

The disability must continue for a consecutive period of at least 6 months before we will approve a claim for the waiver benefit.

The disability must begin while this rider and the policy is in force.

Total Disability also means the permanent and total loss of (i) the sight of both eyes, or (ii) the use of both hands, or (iii) the use of both feet, or (iv) the use of one hand and one foot occurring while the rider is in force.

If a recurrence of a Total Disability follows within 30 days after the recovery from Total and Permanent Disability, and is due to the same or related causes, such Total Disability shall be considered a continuation of the original Total and Permanent Disability.

**PAYMENT OF DUE PREMIUMS** - Any premium that becomes due prior to the Company's approval of the waiver claim must be paid in order to avoid a lapse of insurance. Upon our approval of the claim, we will refund all premiums due and paid after the date the Insured's Total and Permanent Disability began.

If Total and Permanent Disability begins during the Grace Period, then payment of the overdue premium is required.

**PREMIUM MODE** - We will not change the mode of premium payment, during any period for which premiums are waived, from that in effect at the date of Total and Permanent Disability.

**NOTICE AND PROOF OF CLAIM** - We must receive notice and proof of Disability during the lifetime of the Insured and while the Insured is totally disabled. We must also receive such notice within 1 year after Disability begins unless we are satisfied that the proof was given as soon as reasonably possible. The notice of claim should be mailed or delivered to our Home Office and should include the Insured's name and the policy number.

We may require proof that Total and Permanent Disability is continuous by having the Insured examined by any doctor we designate at our expense. Examinations may be made at any reasonable interval during the first 2 years of Disability, but not more frequently than once every 30 days. After 2 years, we may require proof no more than once a year.

Date of commencement of Total and Permanent Disability shall be the beginning of total disability which is later presumed permanent, but in no event shall such disability be considered to have commenced more than 6 months prior to the date on which the Company receives notice of claim.

**EXCLUSIONS** - No premium will be waived if Disability resulted from:

1. Any attempt at suicide, or intentionally self-inflicted injury, whether sane or insane;
2. An injury or disease attributable to war or act of war while the Insured is serving: (i) in the military, naval, or air forces of any country or international organization; or (ii) in any civilian non-combatant unit serving with such forces. "War" includes, but is not limited to, declared war, and armed aggression by one or more countries. "Act of War" means any act peculiar to military, naval, or air operations in time of war;
3. Active participation in a riot, insurrection or terrorist activity;
4. While committing or attempting to commit a felony;
5. The voluntary intake or use by any means of: (i) any drug, unless prescribed or administered by a physician and taken in accordance with the physician's instructions; or (ii) poison, gas or fumes, unless a direct result of an occupational accident;
6. Participation in an illegal occupation or activity;
7. Intoxication where "intoxicated" means that which is determined and defined by the laws and jurisdiction of that geographical area in which the intoxication occurred.

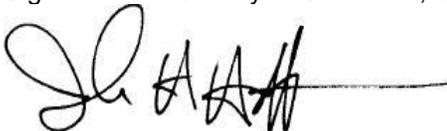
**INCONTESTABILITY** – We will not contest this rider, except for nonpayment of premiums, after it has been in force 2 years after the Policy Date.

**TERMINATION OF RIDER** - This rider will end on the earliest of the following:

1. The date you request it ends; or
2. The date when the policy terminates; or
3. The date the Insured dies; or
4. The end of the Initial Term Period shown on the Schedule of Benefits and Premiums page in the policy; or
5. The policy anniversary following the Insured's 65<sup>th</sup> birthday.

**NONFORFEITURE VALUES** - This rider does not have cash values or loan values.

Signed for the Society at Columbus, Ohio



Joseph H. Hoffman  
Chief Executive Officer

MEMBER OF THE AMERICAN FRATERNAL ALLIANCE



## Accelerated Death Benefit Rider

This is an additional benefit to the contract of insurance between The Order of United Commercial Travelers of America and the owner of the Term Life Insurance policy to which this rider is attached. It has the same Effective Date as the policy date shown on the Policy Data page of the policy. It is issued in consideration of the statements made in the application and the payment of the premium as shown on the Schedule of Benefits and Premiums in the policy. It is subject to the definitions, provisions, exceptions, and limitations of the policy which are not inconsistent with the provisions of this rider.

**TAX CONSEQUENCES** - It is possible that part, or all, of the Accelerated Death Benefit payable under this rider may be considered taxable by the Internal Revenue Service. In addition, receipt of this benefit may adversely affect your eligibility for Medicaid or other government benefits or entitlements. You should consult your attorney, accountant or other tax advisor before requesting this benefit. You are responsible for any and all tax consequences which may result from the payment of the Accelerated Death Benefit.

**DEFINITIONS – Terminal Illness** means a medical condition which is reasonably expected to result in the Insured's death within 12 months or less from the date a physician signs the statement of proof of terminal illness.

**BENEFIT** – While this rider is in force you may make a one-time election to receive the Accelerated Death Benefit if the Insured is diagnosed as having a Terminal Illness.

The Accelerated Death Benefit will be [25%] of the death benefit of the policy. The death benefit used in this calculation must be incontestable. Payment of the benefit under this rider has no impact on possible future benefits provided by other riders attached to this same policy provided the policy and riders remain in force. This option may be exercised only once during the lifetime of the Insured. The benefit will be paid to you or to any other payee you so designate in a lump sum.

The Accelerated Death Benefit amount will be reduced by:

1. An interest charge - the interest charge will equal one year's interest on the amount of the Accelerated Death Benefit using an interest rate not more than the greater of: (a) the current yield on 90-day treasury bills; or (b) the maximum statutory adjustable policy loan interest rate. For the purposes of this rider, we will determine these interest rates at the beginning of each calendar quarter; and
2. An administrative fee - the administrative fee will not be more than \$250.00 to process a claim under this rider; and
3. Any due but unpaid premiums - the amount of any due but unpaid premiums on your policy.

**CONDITIONS** – We will pay the Accelerated Death Benefit subject to the following conditions:

1. The policy must be in force when you request the Accelerated Death Benefit; and
2. You must request payment of the Accelerated Death Benefit in writing and the written request must be received by our Home Office; and
3. You must provide proof satisfactory to us that the Insured has a Terminal Illness; and
4. Any irrevocable beneficiary and any assignee must agree in writing to the payment of the Accelerated Death Benefit.

**PROOF OF TERMINAL ILLNESS** – We will require medical evidence acceptable to us from a licensed physician acting within the scope of his license, other than the Insured or a member of the Insured's immediate family, that:

1. the Insured has been diagnosed as having a terminal illness; and
2. such terminal illness was first diagnosed while the Insured was covered by the policy; and
3. such terminal illness is expected to result in death within 12 months from the date the physician signs the statement of proof of terminal illness.

We may require a second opinion and examination of the Insured at our expense by a physician designated by us. If a second opinion is requested and such opinion conflicts with the first diagnosis, then our Medical Director will reconcile the conflicting opinions and make a determination of Terminal Illness.

**RIDER PREMIUM** - There is no premium charge for this rider.

**EFFECT ON POLICY AND THIS RIDER** - Once we approve your claim, the death benefit of your policy will be reduced by the amount of the Accelerated Death Benefit (before deducting the interest charge or administrative fee). No further premiums on your policy will be due. We will send you an endorsement to your policy reflecting the reduction in the policy's death benefit and premiums.

**EXCLUSIONS** - The Accelerated Death Benefit will not be available if:

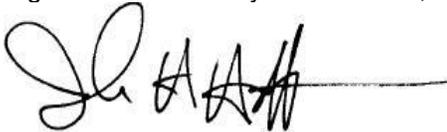
1. the Insured's terminal illness is the result of an intentionally self-inflicted injury or attempted suicide; or
2. all or part of the policy's death benefits have been awarded to a former spouse as part of a divorce decree; or
3. You are required by law to use the policy benefit to meet the claims of creditors, whether in bankruptcy or otherwise; or
4. You are required by a government agency to use the policy benefit in order to apply for, obtain, or keep a government benefit or entitlement.

**TERMINATION OF RIDER** - This rider will end on the earliest of the following:

1. the date you request it ends; or
2. the date the Accelerated Death Benefit is paid; or
3. the date the policy terminates; or
4. the date the Insured dies.

**NONFORFEITURE VALUES** - This rider does not have cash values or loan values.

Signed for the Society at Columbus, Ohio



Joseph H. Hoffman  
Chief Executive Officer

MEMBER OF THE AMERICAN FRATERNAL ALLIANCE



## Accelerated Death Benefit Rider Disclosure Statement

**CONSEQUENCES OF THIS BENEFIT – Receipt of the Accelerated Death Benefit will reduce the death benefit of your term policy.**

<p>Medical Condition allowing the Accelerated Death Benefit</p>	<p>An Accelerated Death Benefit is a benefit that allows you, the policyowner, to be advanced a portion of the death benefit of your term life insurance policy if the Insured is diagnosed with a terminal illness after the policy effective date. <i>Terminal Illness</i> means a medical condition which is reasonably expected to result in the Insured's death within 12 months or less.</p> <p>This disclosure form highlights some of the information in the Accelerated Death Benefit rider form. This form is not an insurance contract. If there are any inconsistencies between this disclosure form and the rider, then the terms and conditions of the rider will control.</p>
<p>Benefit Amount</p>	<p>The amount of the Accelerated Death Benefit will be [25%] of the policy face amount. The Accelerated Death Benefit amount payable to you is reduced:</p> <ul style="list-style-type: none"> <li>• first by any due but unpaid premiums on your policy</li> <li>• by an interest charge for a time period of one year using an interest rate no more than the greater of: (a) the current yield on 90-day treasury bills; or (b) the current maximum statutory adjustable policy loan interest rate</li> <li>• by an administrative fee not more than \$250 to process the claim under this rider.</li> </ul>
<p>To File a Claim</p>	<p>The Accelerated Death Benefit will be paid to you during the Insured's lifetime while the policy is in force, upon receipt of all of the following:</p> <ul style="list-style-type: none"> <li>• a completed Accelerated Death Benefit request form; and</li> <li>• proof that the Insured has been diagnosed with a terminal illness. Such proof will include a signed statement from a licensed physician; and</li> <li>• written consent of any irrevocable beneficiary or any assignee, if applicable, agreeing that the owner may elect the death benefit advance.</li> </ul>
<p>Benefit Payment</p>	<p>We will pay the Accelerated Death Benefit in a lump sum. Upon payment of the Accelerated Death Benefit, the face amount of the policy will be reduced by the amount of the Accelerated Death Benefit (before any deductions). Also, no further premium payments will be due on your policy.</p>

**Example to show results of exercising the Accelerated Death Benefit on a \$100,000 policy**

1. Death Benefit of policy before Accelerated Death Benefit is paid	\$100,000	
2. Accelerated Death Benefit calculation:  Accelerated Death Benefit amount ([25%])  Less adjustments: • any due but unpaid premiums on the policy • an administrative fee (assume \$250) • an interest charge (assume 6% interest rate)  Amount paid to you	\$25,000  (\$0) (\$250) (\$1,500)  \$23,250	
3. Death Benefit of policy after Accelerated Death Benefit is paid	\$75,000	

**TAX CONSEQUENCES - It is possible that part, or all, of the Accelerated Death Benefit may be considered taxable by the Internal Revenue Service. In addition, receipt of this benefit may adversely affect your eligibility for Medicaid or other government benefits or entitlements. You should consult your attorney, accountant or professional tax advisor before requesting this benefit.**

\_\_\_\_\_  
Signature of Policyowner

\_\_\_\_\_  
Signature of Agent

\_\_\_\_\_  
Date signed (MM/DD/YYYY)

\_\_\_\_\_  
Policyowner Social Security Number



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## Accelerated Benefit

Payment Notice as of \_\_\_\_\_

Name of Insured: \_\_\_\_\_

Policy Number: \_\_\_\_\_

Your request for an advance against your death benefit in the amount of \$ \_\_\_\_\_ will result in the following changes to your policy:

### Revised Schedule of Benefits and Premiums

	<u>Current</u>	<u>After Benefit Payment</u>
Policy Benefit Amount	\$ _____	\$ <u>0.00</u> _____

	<u>Current</u>	<u>After Benefit Payment</u>
Annual Premium	\$ _____	\$ <u>0.00</u> _____
Semiannual Premium	\$ _____	\$ <u>0.00</u> _____
Quarterly Premium	\$ _____	\$ <u>0.00</u> _____
Monthly EFT Premium	\$ _____	\$ <u>0.00</u> _____

**Receipt of the Accelerated Benefit Payment may be taxable. You should consult your personal tax advisor for specific advice. Neither the Company nor its agents can provide tax advice.**



## Coronary Artery Disease Questionnaire

Name of Proposed Insured: \_\_\_\_\_

1. Please describe the initial episode, including:
  - a) Nature of episode: \_\_\_\_\_
  - b) Date: \_\_\_\_\_
  - c) Duration of acute symptoms: \_\_\_\_\_
  - d) Date of return to normal activities: \_\_\_\_\_
  
2. Has myocardial infarction occurred?  Yes  No If so, please indicate the site, if known, i.e. anterior, inferior, anterolateral, posterolateral, subendocardial, etc.  
\_\_\_\_\_
  
3. If the history is one of angina pectoris, have symptoms always been non-disabling or short duration and easily controlled?  Yes  No
  
4. Please give dates and results of any investigations performed. i.e. resting/exercise ECGs, cardiac enzyme levels, isotope imaging, angiography, etc. Please mention specifically the location and severity of coronary stenosis and the state of left ventricular function, if known.  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_
  
5. Has cardiac surgery been performed?  Yes  No If so, please provide date and type of surgery:
  - a. Coronary artery bypass grafting (please state number and sites of grafts) \_\_\_\_\_
  - b. Left ventricular aneurysmectomy \_\_\_\_\_
  - c. Transluminal coronary angioplasty \_\_\_\_\_
  
6. Please describe the subsequent course, including the dates, nature and duration of further symptoms and, in particular, any disabling episodes.  
\_\_\_\_\_  
\_\_\_\_\_
  
7. How would you describe the applicant's current symptoms? \_\_\_\_\_
  - a) No symptoms whatsoever
  - b) Infrequent minor symptoms on extraordinary activity
  - c) Occasional symptoms with every day activity
  - d) More frequent symptoms with every day activity
  - e) Severe limitation of functional capacity
  
8. What is the current therapy? \_\_\_\_\_
  
9. Is there any other disorder of the cardiovascular system?  Yes  No  
If so, please give details: \_\_\_\_\_

I hereby represent, to the best of my knowledge and belief, that all of the above statements are complete and true, and I agree that they shall form a part of the application and are made to request that The Order of United Commercial Travelers of America issue the policy applied for.

Signature of Proposed Insured: \_\_\_\_\_ Date: \_\_\_\_\_



## Diabetes Mellitus Questionnaire

Name of Proposed Insured: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

1. Name/Address of physician(s) consulted for diabetes? (If Kaiser, obtain patient #)

Name: \_\_\_\_\_ Address: \_\_\_\_\_

Date & reason last consulted? \_\_\_\_\_

What treatment was given or medications prescribed or changed? \_\_\_\_\_

How often do you consult your physician? \_\_\_\_\_

2. Date diabetes was diagnosed? \_\_\_\_\_

3. Identify any parents, brothers, sisters or children that have diabetes and the age at which they were diagnosed.

\_\_\_\_\_

4. How is your diabetes controlled? (circle one)      Diet      Oral      Medications      Insulin

List all medications currently taken. \_\_\_\_\_

5. How often do you test your own blood sugar? \_\_\_\_\_

What are the results and the dates of the last 3 readings? \_\_\_\_\_

What are the dates and results of your last three HgA1c (glycohemoglobin) readings?

\_\_\_\_\_

6. Describe any loss of work or disability associated with diabetes? \_\_\_\_\_

\_\_\_\_\_

7. Have you ever had:      Provide details for any "yes" answers.

a) Diabetic Coma?.....  Yes  No \_\_\_\_\_

b) Insulin Shock?.....  Yes  No \_\_\_\_\_

c) Heart Trouble?.....  Yes  No \_\_\_\_\_

d) High Blood Pressure?.....  Yes  No \_\_\_\_\_

e) Kidney Trouble?.....  Yes  No \_\_\_\_\_

f) Neuropathy or numbness/tingling?  Yes  No \_\_\_\_\_

g) Retinopathy or eye problems?.....  Yes  No \_\_\_\_\_

8. Have you ever been hospitalized (except when first diagnosed) due to your diabetes?  Yes  No

If "Yes," provide details when, where and results. \_\_\_\_\_

9. What is your current height and weight? \_\_\_\_\_

I hereby represent, to the best of my knowledge and belief, that all of the above statements are complete and true, and I agree that they shall form a part of the application and are made to request that The Order of United Commercial Travelers of America issue the policy applied for.

Signature of Proposed Insured: \_\_\_\_\_ Date: \_\_\_\_\_



## Drug Questionnaire

Name of Proposed Insured: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

In the past 10 years, has the Proposed Insured named above used:

- a. Barbiturates, sedatives or tranquilizers habitually?  Yes  No
- b. LSD, marijuana or any amphetamine?  Yes  No
- c. Heroin, morphine or other narcotic drug?  Yes  No

List below the drug, dosage, frequency, reason taken and length of time:

Drug:	Dosage/Frequency:	Why Taken:	How long:

**Additional Remarks:**


I hereby represent, to the best of my knowledge and belief, that all of the above statements are complete and true, and I agree that they shall form a part of the application and are made to request that The Order of United Commercial Travelers of America issue the policy applied for.

Signature of Proposed Insured: \_\_\_\_\_ Date: \_\_\_\_\_





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Physical History Questionnaire

Name of Proposed Insured: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Have you ever been diagnosed with or treated for:

- Asthma, Liver Disorder, Back Disorder, Heart Disorder, G.I. Tract Disorder, Urinary Disorder, Nervous Disorder, Reproductive Disorder, Respiratory Disorder, Diabetes, Tumor, Other

Describe symptoms: \_\_\_\_\_ Date of Onset: \_\_\_\_\_

What special tests were done? \_\_\_\_\_

What diagnosis was made? \_\_\_\_\_

Any malignancy? Yes No When? \_\_\_\_\_ Duration of illness? \_\_\_\_\_

What type of treatment did you receive:

- Surgery: Yes No What type?
Radiation: Yes No What type?
Medication: Yes No What type? Dosage?
Other: Yes No What type?

Are you currently under treatment? Yes No

Has additional treatment or surgery been suggested? Yes No

Have you been confined to the hospital? Yes No When? \_\_\_\_\_ How long? \_\_\_\_\_

Has your doctor suggested follow-up check-ups? Yes No

When did you last see your doctor? \_\_\_\_\_ Routine Check up? Yes No

Have there been any recurrences? Yes No How many? \_\_\_\_\_ Frequency? \_\_\_\_\_

Has the problem caused you to be disabled for more than one month? Yes No

Any associated diseases or complications? Yes No

Furnish blood pressure readings: Highest: \_\_\_/\_\_\_ When? \_\_\_
Lowest: \_\_\_/\_\_\_ When? \_\_\_ Usual: \_\_\_/\_\_\_
Latest: \_\_\_/\_\_\_ When? \_\_\_

Furnish names and addresses of all doctors and hospitals and indicate by "X" who has complete records.
\_\_\_\_\_
\_\_\_\_\_
\_\_\_\_\_

Additional Comment: \_\_\_\_\_

I hereby represent, to the best of my knowledge and belief, that all of the above statements are complete and true, and I agree that they shall form a part of the application and are made to request that The Order of United Commercial Travelers of America issue the policy applied for.

Signature of Proposed Insured: \_\_\_\_\_ Date: \_\_\_\_\_



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POLICY: \_\_\_\_\_

INSURED: \_\_\_\_\_

\_\_\_\_\_

**LIFE  
Certificate of Health**

I hereby apply to The Order of United Commercial Travelers of America for my policy to be reinstated based on my written answers on my original application.

I understand and agree that this application will become a part of the policy contract; and that any person who submits an application or claim containing a false or deceptive statement, and does so with intent to defraud or knowing that he/she is facilitating a fraud against an insurer, may be guilty of insurance fraud.

To the best of my knowledge and belief, my medical history has not changed since the original application except as stated below.

DATE	MEDICAL TREATMENT	NAME AND ADDRESS OF PHYSICIAN

I understand the information obtained by use of the Authorization will be used by The Order of United Commercial Travelers of America to determine eligibility for insurance or for benefits under an existing policy. Any information obtained will not be released by The Order of United Commercial Travelers of America to any person or organization EXCEPT to reinsurance companies, the Medical Information Bureau Inc. (MIB), or organizations performing business or legal services in connection with my application, claims, including legal proceedings thereon, or as may be otherwise lawfully required or as I may authorize. I hereby authorize any licensed physician, medical practitioner, hospital, clinic, other medically-related facility, insurance or reinsuring company, the Medical Information Bureau or other organization, institution, or person, that has my records or knowledge of my health or prescription drug usage, to disclose to The Order of United Commercial Travelers of America or its reinsurer(s) any such information. A photocopy of this authorization shall be as valid as the original. I understand that when my medical records are disclosed pursuant to this Authorization, my medical record and the Information contained in those records may be subject to re-disclosure by the recipient and my no longer be protected by federal privacy laws. I understand that I may revoke this Authorization, except to the extent that any care provider or The Order of United Commercial Travelers of America has acted in reliance upon this Authorization. My revocation must be submitted in writing to: The Order of United Commercial Travelers of America, 1801 Watermark Drive, Suite 100, P.O. Box 159019, Columbus, Ohio 43231-8619. I also understand that this authorization shall remain valid for 24 months from the date signed shown below if used in connection for the reinstatement of an insurance policy.

\_\_\_\_\_  
Signature of Insured

\_\_\_\_\_  
Date

\_\_\_\_\_  
Witness

\_\_\_\_\_  
Date

SERFF Tracking Number: WAKE-126822858 State: Arkansas  
Filing Company: The Order of United Commercial Travelers of America State Tracking Number: 46837  
Company Tracking Number: KEGUCT2010TLAR  
TOI: L04I Individual Life - Term Sub-TOI: L04I.213 Specified Age or Duration - Fixed/Indeterminate Premium - Single Life  
Product Name: Term Life  
Project Name/Number: The Order of United Commercial Travelers of America/KEGUCT2010TLAR

## Supporting Document Schedules

	Item Status:	Status Date:
<b>Satisfied - Item:</b> Flesch Certification <b>Comments:</b> <b>Attachment:</b> Readability Cert signed.pdf		

	Item Status:	Status Date:
<b>Satisfied - Item:</b> Application <b>Comments:</b> <b>Attachment:</b> UCT TERM APP 0610.pdf		

	Item Status:	Status Date:
<b>Satisfied - Item:</b> Cover Letter <b>Comments:</b> <b>Attachment:</b> AR Cover Letter.pdf		

	Item Status:	Status Date:
<b>Satisfied - Item:</b> AR Rule and Regulation Certification 19 & 49 <b>Comments:</b> <b>Attachments:</b> AR - R&R19 Certification.pdf AR - R&R49 Certification.pdf		

SERFF Tracking Number: WAKE-126822858 State: Arkansas  
Filing Company: The Order of United Commercial Travelers of America State Tracking Number: 46837  
Company Tracking Number: KEGUCT2010TLAR  
TOI: L04I Individual Life - Term Sub-TOI: L04I.213 Specified Age or Duration - Fixed/Indeterminate Premium - Single Life  
Product Name: Term Life  
Project Name/Number: The Order of United Commercial Travelers of America/KEGUCT2010TLAR

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

**Satisfied - Item:** Consumer Notice  
**Comments:**  
**Attachment:**  
CONS NOT.pdf

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

**Satisfied - Item:** Actuarial Response to 9/23/10 objection  
**Comments:**  
**Attachment:**  
AR DOI Response Letter 9-27-10.pdf

## READABILITY COMPLIANCE CERTIFICATION

**Name and Address of Insurer:**

**The Order of United Commercial Travelers of America  
1801 Watermark Drive, Suite 100  
Columbus, OH 43215**

I hereby certify that the Flesch Reading Ease Test Score of the listed forms are as follows:

Title of Form	Form Number	Flesch Score	
		Stand-Alone	Combined with Policy Form
Term Life Insurance Policy	TERM 0610	55.1	55.1
Application for Term Life Insurance	TERM APP 0610	36.0	46.7
Accidental Death Benefit Rider	TERM AD 0610	45.6	53.9
Waiver of Premium Disability Rider	TERM WP 0610	36.0	50.6
Accelerated Death Benefit Rider	TERM ABR 0610	37.0	51.2
Accelerated Death Benefit Disclosure Statement	TERM ABR DS 0610	35.3	52.6
Accelerated Death Benefit Payment Notice	TERM ABR PN 0610	42.4	55.0

In determining the Flesch Scores shown above, the following "text" was excluded:

1. The name and address of the company;
2. The name, number, and title of the form;
3. The table of contents or index;
4. Captions and sub-captions;
5. Specifications pages, schedules and tables;
6. Any provisions required by federal law or regulation;
7. Any medical terminology.

The type size of the text is at least 10-pointed leaded.

I also certify to the best of my knowledge and belief that the form is in compliance with the Insurance Code and with all other applicable requirements of the Insurance Department in this state.

  
Signature of Insurance Company Officer

**Joseph Hoffman**

**Name**

**Chief Executive Officer**

**Title**

**August 31, 2010**

**Date**



<b>APPLICATION FOR TERM LIFE INSURANCE</b>	<i>Requested Effective Date of Policy</i>
--	---

**1. PROPOSED INSURED AND BENEFICIARY INFORMATION**

<b>Last Name</b>	<b>First Name</b>	<b>MI</b>	<b>RESIDENCE ADDRESS</b>			
			<i>Street:</i> _____			
			<i>City:</i> _____			
			<i>State/Zip Code:</i> _____			
			<i>Email:</i> _____			
			<i>Telephone:</i> _____			
<b>OCCUPATION</b>						
<i>Description:</i> _____						
<i>Employer:</i> _____						
<i>Address:</i> _____						
<i>Telephone:</i> _____						
<b>AGE</b>	<b>DATE OF BIRTH</b>	<b>BIRTH STATE</b>	<b>SEX</b>	<b>HEIGHT</b>	<b>WEIGHT</b>	<b>SOCIAL SECURITY NO.</b>
	<i>Month Day Year</i>		<input type="checkbox"/> Male <input type="checkbox"/> Female			
<b>Driver's License Number</b>			<b>Driver's License State</b>	<b>Marital Status</b>		
				<input type="checkbox"/> Married <input type="checkbox"/> Single <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		
<b>Has the Proposed Insured used any form of tobacco in the past two years?</b> ..... <input type="checkbox"/> Yes <input type="checkbox"/> No						

<input type="checkbox"/> <b>Primary Beneficiary</b>	<b>Percentage of Death Benefit</b>	
<b>Name (Last, First, MI) or Non-Natural Entity Name</b>	<b>Social Security No. / Tax I.D.</b>	<b>Relationship to Proposed Insured</b>
<input type="checkbox"/> <b>Primary Beneficiary</b> <input type="checkbox"/> <b>Contingent Beneficiary</b>	<b>Percentage of Death Benefit</b>	
<b>Name (Last, First, MI) or Non-Natural Entity Name</b>	<b>Social Security No. / Tax I.D.</b>	<b>Relationship to Proposed Insured</b>
<b>ADD ADDITIONAL SHEET FOR MORE BENEFICIARIES</b>		

<b>Are you a member of The Order of United Commercial Travelers of America?</b> ..... <input type="checkbox"/> Yes <input type="checkbox"/> No
<b>Member Number:</b> _____ <b>If "No" checked above, complete membership form (M-81).</b>

**2. OWNER (If other than Proposed Insured)**

<b>Last Name</b>	<b>First Name</b>	<b>MI</b>	<b>Date of Birth</b>	<b>Social Security No. / Tax I.D.</b>	<b>Relationship to Proposed Insured</b>
<b>Street</b>			<b>City</b>		<b>State</b> <b>Zip Code</b>

### 3. PROPOSED INSURANCE PLAN

Type Plan	Face Amount	Premium	Premium Mode:
Term Life	\$ _____	\$ _____	<input type="checkbox"/> Annual <input type="checkbox"/> Semi-Annual
Initial Term Period:	<input type="checkbox"/> 10 Yrs <input type="checkbox"/> 15 Yrs <input type="checkbox"/> 20 Yrs <input type="checkbox"/> 30 Yrs		<input type="checkbox"/> Quarterly <input type="checkbox"/> Monthly EFT *
Riders: <input type="checkbox"/> Accidental Death Benefit		\$ _____	* Electronic Funds Transfer
<input type="checkbox"/> Waiver of Premium		\$ _____	
<input type="checkbox"/> Accelerated Death Benefit		\$ <u>0.00</u>	
			Annual Policy Fee: <u>\$50.00</u>

**Sum Paid with Application** \$ \_\_\_\_\_      **Total Modal Premium** \$ \_\_\_\_\_  
 (Receipt valid only if amount paid with application is entered here)

Will the Premium be paid by the Proposed Insured or the Owner? .....  Yes     No  
 If "No" please complete the Payor's information below:

Payor's Name	Payor's Address (number and street, city, state, zip code)
--------------	--

### 4. ELIGIBILITY QUESTIONS

(If any question in this section is answered "yes", the Proposed Insured is not eligible for coverage)

1. Has the Proposed Insured ever tested positive for exposure to the Human Immunodeficiency Virus (HIV) infection, or been diagnosed as having AIDS Related Complex (ARC) or Acquired Immunodeficiency Syndrome (AIDS) caused by the HIV infection or other sickness or condition derived from such infection? .....  Yes     No
2. Is the Proposed Insured currently bedridden, receiving home health care, hospitalized, confined to a nursing home or long-term care facility, or been advised in the past 6 months to be hospitalized or to go into a nursing home or long-term care facility and refused? .....  Yes     No
3. Is the Proposed Insured in the end stages of a terminal illness, or been told his/her life expectancy is 12 months or less, or receiving or on the waiting list for hospice care? .....  Yes     No
4. Is the Proposed Insured currently awaiting an organ transplant? .....  Yes     No
5. Within the past 2 years, has the Proposed Insured:
  - (a) been administered oxygen or recommended the use of oxygen? .....  Yes     No
  - (b) had a heart attack, stroke, transient ischemic attack (TIA, also known as a mini-stroke), had or been advised to have heart surgery (including angioplasty or stent placement)? .....  Yes     No
6. Within the past 2 years, has the Proposed Insured been diagnosed with or treated for:
  - (a) dementia, Alzheimer's disease, schizophrenia, or any mental disorder? .....  Yes     No
  - (b) cancer (other than basal cell carcinoma), leukemia, lymphoma, tumor, or chronic blood disorder (including sickle cell anemia)? .....  Yes     No
7. In the past 5 years, has the Proposed Insured been incarcerated? .....  Yes     No
8. Has the Proposed Insured *ever* been diagnosed with or treated for:
  - (a) chronic kidney disease or disorder, or received kidney dialysis? .....  Yes     No
  - (b) hepatitis (except Hepatitis A), or any liver or pancreas disease? .....  Yes     No
  - (c) Congestive Heart Failure (CHF)? .....  Yes     No
  - (d) Multiple sclerosis, lupus, or ALS (also known as Lou Gehrig's disease)? .....  Yes     No

## 5. HEALTH QUESTIONS

(If "yes", please provide details – attach additional sheet if necessary)

9. In the past 2 years, has the Proposed Insured had an application for life or health insurance or reinstatement declined, rated, or modified in any way? .....  Yes  No

10. Has any Proposed Insured *ever* been diagnosed with, been treated by a member of the medical profession, taken medication for, or been advised to have diagnostic tests for: (check applicable conditions)

- |   |   |
|---|---|
| <input type="checkbox"/> Internal cancer                              | <input type="checkbox"/> Heart Attack   |
| <input type="checkbox"/> Leukemia                                     | <input type="checkbox"/> Stroke   |
| <input type="checkbox"/> Lymphoma                                     | <input type="checkbox"/> Transient Ischemic Attack                            |
| <input type="checkbox"/> Hodgkin's disease                            | <input type="checkbox"/> Heart Surgery  |
| <input type="checkbox"/> Malignant melanoma                           | <input type="checkbox"/> Coronary Artery Surgery                              |
| <input type="checkbox"/> Dementia, Alzheimer's or Parkinson's disease | <input type="checkbox"/> Heart or circulatory system disease                  |
| <input type="checkbox"/> Malignant or benign tumors of any kind       | <input type="checkbox"/> Angioplasty  |
| <input type="checkbox"/> Emphysema or other chronic lung disease      | <input type="checkbox"/> Paralysis, epilepsy, or other nervous system disease |
| <input type="checkbox"/> Blood disorder                               | <input type="checkbox"/> Diabetes Mellitus                                    |

11. Does the Proposed Insured require the use of a wheel chair due to chronic illness? .....  Yes  No

12. In the last 2 years, has the Proposed Insured had a systolic blood pressure reading higher than 150 more than once or a diastolic blood pressure reading higher than 100 more than once? .....  Yes  No

13. In the past 3 years, has the Proposed Insured been treated for alcohol and/or drug abuse? .....  Yes  No

14. In the past 3 years, has the Proposed Insured been convicted of or put on probation for: (1) a felony; (2) driving under the influence (DUI); or (3) driving while intoxicated (DWI)? .....  Yes  No

Give details to any "Yes" answers to the Health Questions

Question No.	Explanation (including Medications)	Dates / Duration	Name of Physician and/or Hospital

**With Regard to Phone Interviews:**

Daytime Phone No: \_\_\_\_\_ Best Time to Call: \_\_\_\_\_

## 6. REPLACEMENT INFORMATION

a. Does the Proposed Insured have any existing life insurance or annuities currently in force or pending with this or any other company? .....  Yes  No

b. Will this policy, if issued, replace or modify insurance or annuities with this or any other company? .....  Yes  No

If "yes", provide the following information:

Name of Company \_\_\_\_\_ Policy No. \_\_\_\_\_

Reason for replacement? \_\_\_\_\_

## 7. AUTHORIZATIONS AND SIGNATURES

I hereby apply to The Order of United Commercial Travelers of America for a policy to be issued solely and entirely in reliance on my written answers to the questions on this application. The answers are, to the best of my knowledge and belief, true. The Order of United Commercial Travelers of America has the right to deny benefits or rescind my Policy. I also understand that the agent cannot determine eligibility for or alter the terms of the proposed policy. I agree the policy shall not be effective until it has actually been issued.

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

Signed At: \_\_\_\_\_ Applicant's Signature: \_\_\_\_\_

Dated: \_\_\_\_\_  
(Month/Day/Year)

## 8. AGENT'S CERTIFICATION

The undersigned Agent certifies that the Applicant has read, or has had read to them, the completed application and that the Applicant realizes that any false statement or misrepresentation in the application may result in loss of coverage under the policy.

### TO BE COMPLETED BY AGENT (Attach separate sheet, if necessary)

1. List any other life insurance or annuity policies you have sold to the Applicant that are still in force.

\_\_\_\_\_  
\_\_\_\_\_

2. List any other life insurance or annuity policies you have sold to the Applicant in the past five (5) years that are no longer in force.

\_\_\_\_\_

3. Do you have any knowledge or reason to believe that the Applicant is intending to replace an existing insurance? ...  Yes  No

I certify that:

I have accurately recorded the information supplied by the Applicant; and I have given an outline of coverage for the policy applied for to the applicant.

Agent's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Agent's Printed Name: \_\_\_\_\_

Agent Email Address: \_\_\_\_\_

Agent License Number: \_\_\_\_\_

**HIPAA & MIB AUTHORIZATION & ACKNOWLEDGEMENT  
THE ORDER OF UNITED COMMERCIAL TRAVELERS OF AMERICA**

I understand the information obtained by use of the Authorization will be used by The Order of United Commercial Travelers of America to determine eligibility for insurance or for benefits under an existing policy. Any information obtained will not be released by The Order of United Commercial Travelers of America to any person or organization **EXCEPT** to reinsurance companies, the Medical Information Bureau Inc. (MIB), or other persons or organizations performing business or legal services in connection with my application, claims, including legal proceedings thereon, or as may be otherwise lawfully required or as I may authorize.

I hereby authorize any licensed physician, medical practitioner, hospital, clinic, other medically-related facility, insurance or reinsuring company, the Medical Information Bureau or other organization, institution, or person, that has my records or knowledge of my health or prescription drug usage, to disclose to The Order of United Commercial Travelers of America or its reinsurer(s) any such information. A photocopy of this authorization shall be as valid as the original.

I understand that when my medical records are disclosed pursuant to this Authorization, my medical records and the information contained in those records may be subject to re-disclosure by the recipient and may no longer be protected by federal privacy laws. I understand that I may revoke this Authorization, except to the extent that any care provider or The Order of United Commercial Travelers of America has acted in reliance upon this Authorization. My revocation must be submitted in writing to: The Order of United Commercial Travelers of America, 1801 Watermark Drive, Suite 100, P.O. Box 159019, Columbus, Ohio 43215-8619.

I also understand that this authorization shall remain in force for **thirty (30) months** from the date shown below if used in connection with an application for an insurance policy, an application for reinstatement of an insurance policy, or a request for change in policy benefits; or for the duration of a claim if used for the purpose of collecting information in connection with a claim for benefits under a policy.

\_\_\_\_\_  
**Applicant Name**

\_\_\_\_\_  
**Social Security Number**

\_\_\_\_\_  
**Date of Birth**

\_\_\_\_\_  
**Signature of Applicant**

\_\_\_\_\_  
**Date**

**NOTICE TO APPLICANT**

In making this application for insurance to The Order of United Commercial Travelers of America, it is understood that an investigative consumer report may be prepared whereby information is obtained through personal interviews with your neighbors, friends or others whom you are acquainted. This inquiry includes information as to your character, general reputation, personal characteristics and mode of living. You have the right to make a written request within a reasonable period of time to receive additional, detailed information about the nature and scope of this investigation.

Information regarding your insurability will be treated as confidential. The Order of United Commercial Travelers of America, or its reinsurer, may; however, make a brief report thereon to the Medical Information Bureau (MIB), a non-profit membership organization of life insurance companies which operates an information exchange on behalf of its members. If you apply to another Bureau member company for life or health coverage, or a claim for benefits is submitted to such company, the Bureau, upon request will supply such company with the information in its file.

Upon receipt of a request from you, MIB will arrange disclosure of any information it may have 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, Braintree, Massachusetts 02184-8734.

The Order of United Commercial Travelers of America, or its reinsurer, may also release information from its file to other insurance companies to whom you 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](http://www.mib.com).

**AUTHORITY TO HONOR PREMIUM CHECKS**

<b>AUTHORIZATION</b>	<b>IN FAVOR OF:</b>	<b>The Order of United Commercial Travelers of America 1801 Watermark Drive, Suite 100, P.O. Box 159019, Columbus, Ohio 43215-8619</b>		<b>AUTHORIZATION</b>
	<b>Name of Bank Customer:</b>	_____	<b>Type of Account:</b> <input type="checkbox"/> Checking	
	<b>Insured's Name:</b>	_____	<input type="checkbox"/> Savings	
	<b>Routing Number:</b>	_____	<b>Account Number:</b> _____	
	<b>To (Name of Bank):</b>	_____		
	<b>Address of Bank:</b>	_____		
	<p>You are hereby authorized, as a convenience to me, to honor and charge my account for checks, drafts and other orders, including without limitation any order initiated by electronic means, drawn by The Order of United Commercial Travelers of America indicated above, on my account by and payable to the order of The Order of United Commercial Travelers of America for the payment of premiums provided there are sufficient collected funds in such account to pay the same upon presentation. I agree that your rights in respect to each such check or other order drawn by The Order of United Commercial Travelers of America shall be the same as if it were a check drawn on you and signed personally by me. This authority is to remain in effect until revoked by me in writing, and until you actually receive such notice I agree that you shall be fully protected in honoring any such check or other orders drawn by The Order of United Commercial Travelers of America. I further agree that if any such checks or other orders drawn by The Order of United Commercial Travelers of America be dishonored, whether with or without cause and whether intentionally or inadvertently, you shall be under no liability whatsoever even though such dishonor results in forfeiture of insurance.</p>			
	<b>Date:</b>	<b>Signature of Bank Customer:</b>		

**Signature must be the same as on the signature card at bank, and if a company account the name of the account must be shown.**

**To: Bank above:** In consideration of your compliance with the individual authorization of your depositors to pay checks, drafts or orders, drawn and signed by us to our Order, we agree:

- To indemnify you and hold you harmless from any loss you may suffer as a consequence of your actions resulting from or in connection with the execution and issuance of any check, draft or order, whether or not genuine, purporting to be executed and received by you in the regular course of business for the purpose of payment of such insurance premiums including any costs or expenses reasonably incurred in connection therewith.
- In the event that any such check, draft or order shall be dishonored, whether with or without cause, and whether intentionally or inadvertently, to indemnify you for such loss even though dishonor results in forfeiture of the insurance.
- To defend at our own cost and expense any action which might be brought by any depositor or any other persons because of your actions taken pursuant to said authorization and direction or in any manner arising by reason of your participation in this plan of premium collection.

**ATTACH VOIDED CHECK HERE – Deposit Slips NOT Accepted**

---

PREMIUM RECEIPT

---

**Make check payable to UCT.**

Received from \_\_\_\_\_, the sum of \$ \_\_\_\_\_.

If, for any reason, the policy is not issued, payment will be refunded in full in a timely manner. Insurance is not effective until the application is approved, the premium has been paid and the policy is issued.

Date: \_\_\_\_\_ Licensed Resident Agent: \_\_\_\_\_

***Do not make check payable to the agent or leave the payee blank.***

September 20, 2010

State of Ohio Department of Insurance

RE:      Company:                The Order of United Commercial Travelers of America  
          NAIC Number:           56383  
          FEIN Number:           31-4273120  
          Type of Insurance:      L071 Individual Life – Term  
          Sub-Type:               L071.101 Fixed/Indeterminate Premium – Single Life

**Forms Submitted For Approval**

A. New Forms

Form Number	Description
TERM 0610	Term Life Insurance Policy
TERM APP 0610	Application for Term Life Insurance
TERM AD 0610	Accidental Death Benefit Rider
TERM WP 0610	Waiver of Premium Rider
TERM ABR 0610	Accelerated Death Benefit Rider
TERM ABR DS 0610	Accelerated Death Benefit Disclosure Statement
TERM ABR PN 0610	Accelerated Death Benefit Payment Notice

B. New Forms Similar to Previously Approved Forms

Form Number	Description	Replaces Form	Approved
TERM CADQ 0610	Coronary Artery Disease Questionnaire	CADQ 0610	9-13-2010
TERM DMQ 0610	Diabetes Mellitus Questionnaire	DMQ 0610	9-13-2010
TERM DQ 0610	Drug Questionnaire	DQ 0610	9-13-2010
TERM HYPQ 0610	Hypertension Questionnaire	HYPQ 0610	9-13-2010
TERM PHQ 0610	Physical History Questionnaire	PHQ 0610	9-13-2010
TERM COH 0710	Life – Certificate of Health	LIFE COH 0710	9-13-2010

Dear Sir or Madam:

Wakely Actuarial Services Inc. (“Wakely”) is submitting the above-referenced forms for review and approval on behalf of The Order of United Commercial Travelers of America (“the Company”). A letter from the Company authorizing Wakely to conduct this filing is included with this submission.

The forms shown above in A. are new forms and do not replace any previously approved forms.

The forms shown above in B. are new forms which will only be used in conjunction with the application form TERM APP 0610. However, these forms are very similar to some previously

approved forms; and, differ only in the following respects: (1) change in Company logo; (2) new form number; and (3) re-wording of "authorization" paragraph (on TERM COH 0710 form only). The previously approved forms will continue to be used with the Company's whole life and single premium whole life products.

With respect to the forms shown above in A., also enclosed are actuarial memoranda, Flesch score certifications, and any other required certifications and/or transmittals. Filing fees if applicable are submitted under separate cover.

We are filing these forms in 35 states including the Company's domicile state of Ohio. Upon approval, the product will be marketed to individuals by career agents and independent brokers licensed with the Company. The product is non-participating. This product will not be marketed using sales illustrations.

These forms may be subject to minor modifications in paper size, stock, layout, format, and printing specifications of the document upon issue. We certify that the text content of the forms will not change. Variable data or text is bracketed and a variability statement is enclosed. Variable data will never exclude provisions required by applicable law.

Form TERM 0610 is a level death benefit term life insurance policy providing coverage to the policy anniversary following the insured's age 95. Premiums for an initial term period are level. Following the initial term period, premiums will increase annually to the final expiry date. Four initial term period options are available: 10 Years, 15 Years, 20 Years, or 30 Years. Premiums are both sex-distinct and smoker-distinct; and are fully guaranteed in all years. Available issue ages vary depending upon the length of the initial term period so that the policy does not generate cash values.

Wakely Actuarial Services Inc. greatly appreciates the Department's time and consideration in the review of this filing. If you have any questions or need any further information, please call me on our toll free line at 1-888-590-5504.

Sincerely,

Katlyn Gorman  
Administrative Assistant

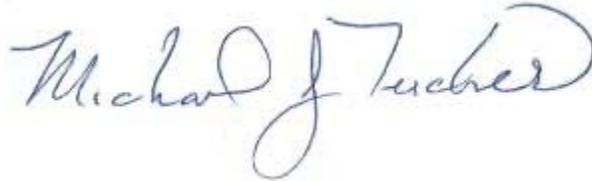
EMAIL Address: [Katlyn.Gorman@wakelyactuarial.com](mailto:Katlyn.Gorman@wakelyactuarial.com)

Enclosures

**ARKANSAS  
Rule and Regulation 19 Certification**

Form Number	Description
TERM 0610	Term Life Insurance Policy
TERM APP 0610	Application for Term Life Insurance
TERM AD 0610	Accidental Death Benefit Rider
TERM WP 0610	Waiver of Premium Rider
TERM ABR 0610	Accelerated Death Benefit Rider
TERM ABR DS 0610	Accelerated Death Benefit Disclosure Statement
TERM ABR PN 0610	Accelerated Death Benefit Payment Notice
TERM CADQ 0610	Coronary Artery Disease Questionnaire
TERM DMQ 0610	Diabetes Mellitus Questionnaire
TERM DQ 0610	Drug Questionnaire
TERM HYPQ 0610	Hypertension Questionnaire
TERM PHQ 0610	Physical History Questionnaire
TERM COH 0710	Life – Certificate of Health

I hereby certify that the above noted forms meet the provisions of Rule and Regulation 19, the Unfair Sex Discrimination in the Sale of Insurance.



\_\_\_\_\_  
Signature

Michael J Tucker  
\_\_\_\_\_  
Name

Consulting Actuary,  
\_\_\_\_\_  
Title

September 27, 2010  
\_\_\_\_\_  
Date

**ARKANSAS  
Rule and Regulation 49 Certification**

Form Number	Description
TERM 0610	Term Life Insurance Policy
TERM APP 0610	Application for Term Life Insurance
TERM AD 0610	Accidental Death Benefit Rider
TERM WP 0610	Waiver of Premium Rider
TERM ABR 0610	Accelerated Death Benefit Rider
TERM ABR DS 0610	Accelerated Death Benefit Disclosure Statement
TERM ABR PN 0610	Accelerated Death Benefit Payment Notice
TERM CADQ 0610	Coronary Artery Disease Questionnaire
TERM DMQ 0610	Diabetes Mellitus Questionnaire
TERM DQ 0610	Drug Questionnaire
TERM HYPQ 0610	Hypertension Questionnaire
TERM PHQ 0610	Physical History Questionnaire
TERM COH 0710	Life – Certificate of Health

I hereby certify that the above noted forms meet the provisions of Rule and Regulation 49, the Life & Health Guaranty Association Notice.



\_\_\_\_\_  
Signature

\_\_\_\_\_  
Michael J. Tucker  
Name

\_\_\_\_\_  
Consulting Actuary  
Title

\_\_\_\_\_  
September 27, 2010  
Date

**Consumer Notice**  
**The Order of United Commercial Travelers of America**

**Policyholder Service Office:** 1801 Watermark Drive, Suite 100  
Columbus, Ohio 43215-8619

**Telephone Number:** 800-848-0123

**Name of Agent:** [Fred Smith]  
**Agent Address:** [123 First Street, Any Town, Arkansas]  
**Agent Telephone Number:** [555-555-1234]

**If we at The Order of United Commercial Travelers of America fail to provide you with reasonable and adequate service, you should feel free to contact:**

**Arkansas Insurance Department**  
**Consumer Services Division**  
**1200 West Third Street**  
**Little Rock, Arkansas 72201-1904**  
**1-800-852-5494 or 1-501-371-2460**

## **Response Letter**

Response Letter Status	Submitted to AR DOI
Response Letter Date	09/27/2010
Submitted Date	09/27/2010

Dear Ms. Linda Bird,

We are responding to your letter dated 09/23/2010.

### **Related to Comment 1**

Attached is the copy of the "Consumer Notice" form used by the Company in order to comply with Bulletin 15-20009. The number of this form is CONS NOT.

### **Related to Comment 2**

Attached is a certification of compliance with Regulation 49.

### **Related to Comment 3**

Attached is a certification of compliance with Regulation 19.

### **Related to "Refund of Monthly Deductions" in Policy**

The policy does not make "monthly deductions". However, on page 7 of the policy, item 3 in the Proceeds provision states that the Company will return the portion of any premiums paid which apply to a period beyond the policy month of death.

### **Related to "Interest on Death Proceeds" in Policy**

On page 8 of the policy, the wording of Payment of Proceeds provision has been changed to comply with Ark. Code Ann. 23-81-118. Also, the form number has been changed to TERM 0610 AR.

If you have any additional questions, please let me know.

Sincerely,

Michael J, Tucker, FSA, MAAA  
Wakely Actuarial Consulting Inc.

Phone: (727) 489-7104

SERFF Tracking Number: WAKE-126822858 State: Arkansas  
 Filing Company: The Order of United Commercial Travelers of America State Tracking Number: 46837  
 Company Tracking Number: KEGUCT2010TLAR  
 TOI: L04I Individual Life - Term Sub-TOI: L04I.213 Specified Age or Duration - Fixed/Indeterminate Premium - Single Life  
 Product Name: Term Life  
 Project Name/Number: The Order of United Commercial Travelers of America/KEGUCT2010TLAR

## 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)
09/22/2010	Form	Term Life Insurance Policy	09/27/2010	UCT TERM 0610 FINAL 92210.pdf (Superseded)
09/20/2010	Form	Term Life Insurance Policy	09/22/2010	UCT TERM 0610 FINAL.pdf (Superseded)



The Order of United Commercial Travelers of America • A Fraternal Benefit Society  
1801 Watermark Drive, Suite 100, P.O. Box 159019, Columbus, Ohio 43215-8619  
Tel: 614.487.9680 • Toll-free: 800.848.0123 • Fax: 614.487.9675 • www.uct.org

## Term Life Insurance Policy

**Proceeds are payable at the Insured's death during term period**

**This policy is nonparticipating**

This is a contract between you and The Order of United Commercial Travelers of America. We issue this contract based on the application signed by you and the payment of premiums as stated on the schedule sheet included in this contract.

We will pay the benefits subject to all the terms and conditions of the contract. If we receive proof satisfactory to us that the Insured died while this policy was in force, we will pay to the beneficiary the death benefits described in the DEATH BENEFITS section of this policy.

The beneficiary is named in the application unless changed as provided for in this policy.

**Right to Cancel**  
**Please Read this Contract Carefully.**

We want you to be satisfied with your policy. If, for any reason, you are not satisfied, you may cancel this policy within 30 days of receiving it. Do this by mailing or delivering it to us at our Home Office at Columbus, Ohio. Within 30 days after we receive the policy, we will refund all premiums which you have paid. The policy will be considered void from its start.

Signed for the Society at Columbus, Ohio

Joseph H. Hoffman  
Chief Executive Officer

MEMBER OF THE AMERICAN FRATERNAL ALLIANCE

**TERM LIFE INSURANCE POLICY**  
**PAYABLE UPON DEATH DURING TERM PERIOD**  
**PREMIUMS PAYABLE DURING TERM PERIOD**  
**NON-PARTICIPATING**

## Guide to Policy Provisions

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**POLICY DATA**

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**INSURED**  
[JOHN DOE]

**ISSUE AGE – GENDER – TOBACCO CLASS**  
[35] [MALE or FEMALE] [N or Y]

**POLICY NUMBER**  
[SPECIMEN]

**RISK CLASS**  
[STANDARD or RATED]

**POLICY DATE**  
[JULY 1, 2010]

**FACE AMOUNT**  
[\$100,000.00]

**EXPIRY DATE**  
[JULY 1, 2070]

**STATE OF ISSUE**  
[OHIO]

**INITIAL TERM PERIOD**  
[10 YEARS]

---

**SCHEDULE OF BENEFITS AND PREMIUMS**

---

BENEFIT	BENEFIT AMOUNT	INITIAL ANNUAL PREMIUM
[TERM LIFE INSURANCE POLICY]	[\$100,000]	[\$ 113.00]
[ACCIDENTAL DEATH BENEFIT]	[\$100,000]	[\$ 85.00]
[WAIVER OF PREMIUM]		[\$ 13.00]
[ACCELERATED DEATH BENEFIT]	[\$ 25,000]	[\$ 0.00]
	PLUS: POLICY FEE	[\$ 50.00]
	TOTAL	[\$ 261.00]

The premium for this policy as of the policy date is

[\$261.00] ANNUALLY            or  
 [\$135.72] SEMI-ANNUALLY,    or  
 [\$ 69.17] QUARTERLY,        or  
 [\$ 21.75] MONTHLY EFT

These premiums are payable for [10] years.  
 Thereafter, the premiums will increase each year as shown in the Table of Renewal Annual Premiums below.

---

**TABLE OF RENEWAL ANNUAL PREMIUMS**

---

<b>POLICY YEAR</b>	<b>INSURED'S ATTAINED AGE</b>	<b>ANNUAL PREMIUM</b>	<b>POLICY YEAR</b>	<b>INSURED'S ATTAINED AGE</b>	<b>ANNUAL PREMIUM</b>
11	45	1,038.00	41	75	14,768.00
12	46	1,119.00	42	76	16,315.00
13	47	1,186.00	43	77	18,115.00
14	48	1,239.00	44	78	20,205.00
15	49	1,306.00	45	79	22,547.00
16	50	1,395.00	46	80	25,158.00
17	51	1,507.00	47	81	27,998.00
18	52	1,644.00	48	82	31,005.00
19	53	1,803.00	49	83	34,289.00
20	54	2,003.00	50	84	37,940.00
21	55	2,229.00	51	85	42,001.00
22	56	2,461.00	52	86	46,468.00
23	57	2,686.00	53	87	51,296.00
24	58	2,912.00	54	88	56,428.00
25	59	3,175.00	55	89	61,813.00
26	60	3,496.00	56	90	67,176.00
27	61	3,885.00	57	91	72,456.00
28	62	4,339.00	58	92	77,987.00
29	63	4,835.00	59	93	83,819.00
30	64	5,352.00	60	94	89,964.00
31	65	5,891.00			
32	66	6,437.00			
33	67	7,008.00			
34	68	7,611.00			
35	69	8,290.00			
36	70	8,897.00			
37	71	9,849.00			
38	72	10,962.00			
39	73	12,135.00			
40	74	13,395.00			

## Definitions

**Age Anniversary.** An Age Anniversary is the Policy Anniversary on which the Insured becomes that attained Insurance Age.

**Effective Date of Coverage.** The effective date of coverage under this policy is the earlier of the following:

1. The date of your application provided a valid premium was submitted with the application; or
2. The Policy Date provided a valid premium is paid during the Insured's lifetime and within 21 days of the Policy Date.

If neither 1 nor 2 above exists, coverage will not be In Force.

**In Force.** The Insured person named under Policy Data is Insured under the terms of this policy.

**Insurance Age.** Insurance Age means the Insured's age on last birthday. The issue age shown under Policy Data is the Insured's Insurance Age as of the Policy Date. Attained Insurance Ages are determined from the Policy Date.

**Insured.** The person who is Insured by this policy. The Insured is shown under Policy Data.

**Lapse.** A premium payment is in default because it was not paid by the end of the grace period. The Insured person is no longer insured.

**Non-Participating.** This policy does not participate in the distribution of our surplus. As a result, no dividends will be paid under this policy.

**Policy Anniversary.** The same day and month as the Policy Date each year that the policy remains In Force.

**Policy Date.** The date from which policy anniversaries, policy years, policy months and premium due dates are determined. Your Policy Date is shown under Policy Data.

**Proceeds.** The amount we pay under the terms of this policy. Proceeds are payable upon the Insured's death.

**Terminate.** This policy is no longer In Force. All insurance coverage under this policy has stopped.

**We, Our, Us, Society.** The Order of United Commercial Travelers of America.

**Written Request.** A request in writing signed by you.

**You, Your.** The owner of this policy.

## General Provisions

**Conformity with State and Provincial Laws.** On the Policy Date, any provision of this policy in conflict with the laws of the state or province in which you reside on that date is amended to conform with the minimum requirement of those laws.

**Entire Contract of Insurance.** The Entire Contract between you and us consists of:

1. This policy, including any attached riders or amendments;
2. The application attached to this policy; and,
3. The Articles of Incorporation, Constitution and Bylaws of the Society and all amendments made to them after the Policy Date.

**Incontestability.** Statements in the application are considered representations, not warranties. Statements may be used to contest the validity of this Policy or in defense of a claim only if they are contained in an attached application or endorsement. We will not contest this policy, except for nonpayment of premiums, after it has been in force 2 years after the Policy Date.

**Legal Actions.** No action at law or in equity shall be brought to recover on this Policy prior to the expiration of 60 days after written proof of loss has been furnished in accordance with the requirements of this Policy. No such action shall be brought after the expiration of 3 years after the time written proof of loss is required to be furnished.

**Maintenance of Solvency.** UCT's constitution provides that in the event that its reserves as to all or any class of contracts of insurance issued by it become impaired, the Board of Governors may require that these shall be paid by each Owner of such contract of insurance to UCT an amount equal to such Owner's equitable proportion of such deficiency as ascertained by the Board of Governors.

If payment of the amount required to be paid is not made by such Owner, then either or both of the following, at the election of the Owner, shall apply:

1. the amount shall stand as Indebtedness against the contract of insurance and shall bear interest at a rate not to exceed ten percent (10%) per annum; or
2. the Owner shall accept a proportionate reduction in benefits paid pursuant to the contract of insurance.

The Owner shall make such election by notifying the Board of Governors of his or her election on a form prescribed by the Board of Governors that shall be provided to each Owner. Failure to make such election shall result in a presumption that the Owner elects to accept a proportionate reduction in benefits paid pursuant to the contract of insurance.

The Owner hereby agrees that if they affirmatively elect to have the amount stand as Indebtedness against the contract of insurance, then UCT may offset the amount of such Indebtedness together with interest thereon against any payment of benefits under this contract of insurance.

**Misstatement of Age or Sex or Tobacco Class.** If the Insured's age or sex or tobacco class has been misstated on the application form, the proceeds will be based on the amount that premiums paid would have purchased at the correct age or sex or tobacco class.

**Policy Changes.** No change in this contract is valid unless it is made in writing and signed by our Chief Executive Officer of the Society. All changes must be endorsed in or attached to this policy. None of our representatives or other persons have the authority to change or waive any of our rights or requirements under this policy.

**Suicide Exclusion.** Coverage is not provided if the Insured commits suicide within 2 years from the Policy Date. In this event, the only amount payable by us to the beneficiary will be the premiums which you have paid.

**Suspension/Expulsion.** If You are suspended/expelled from the Society, except for nonpayment of a premium or within the contestable period for material misrepresentation in the application for membership or insurance, you shall have the privilege of maintaining this contract In Force by continuing payment of the required premium.

### **Owner and Beneficiary**

**Assignment.** During the Insured's lifetime, you can assign this policy or any interest in it. Your interest and the interest of any beneficiary is subject to the interest of the assignee. A collateral assignment is not a change of ownership. Any policy proceeds payable to the assignee will be paid in a single sum.

A copy of any assignment must be submitted to us, and no assignment will be binding on the Society until it is recorded at our Home Office. We are not responsible for the validity or effect of any assignment.

**Beneficiary.** We will pay the Proceeds to the beneficiary or beneficiaries who you have named in the application unless you have since changed the beneficiary as provided in this policy or unless an assignment of the proceeds to another has been made. If the beneficiary has been changed, we will pay the Proceeds in accordance with your last change of beneficiary request. Only those beneficiaries who are living at the Insured's death may share in the Proceeds. If the beneficiary should die at the same time as the Insured or within 30 days of the Insured's death, but before payment of any Proceeds to the beneficiary, Proceeds will be paid as if the Insured had survived the beneficiary.

In the event a trustee is named as beneficiary, the Society will not be responsible for the application or disposition of the funds paid to the trustee. The payment will be made in a lump sum and receipt by the trustee will fully discharge the Society for any amount paid to the trustee.

**Change of Beneficiary.** You may change the beneficiary any time during the Insured's lifetime while this policy is In Force. The request must be made in writing, dated and signed by you. Once the change is recorded by us at our Home Office, it will take effect as of the date of your request. Payments made or other actions taken by the Society before such recording will not be subject to the new designation.

**Rights as Policyowner.** While this policy is In Force and unless otherwise provided in this policy, you may exercise all rights and privileges stated in this policy or allowed by us.

## Death Benefits

**Amount of Death Benefit.** The Benefit Amount is shown in the Schedule of Benefits on page 3 of this policy.

**Proceeds.** If the Insured dies while this policy is in force, we will pay the proceeds to the beneficiary. The proceeds are the sum of:

1. The death benefit of the policy at the time of the Insured's death; plus
2. Any insurance on the Insured's life that may be provided by riders attached to this policy; plus
3. That portion of any premium paid which applies to a period beyond the policy month in which the Insured dies; minus
4. Any unpaid past due premium if death occurs during the Grace Period.

## Premiums and Reinstatement

**Premium Adjustments at Death.** The following premium adjustments will be made if the Insured dies while this policy is In Force on a premium paying basis:

1. The part of any premium paid for the period beyond the month of the Insured's death will be added to the policy proceeds.
2. If the Insured dies during the grace period, we will deduct one month's premium to cover the elapsed part of that period from the policy proceeds.

**Premium in Default and Grace Period.** Any premium not paid on or before its due date is a premium in default. Except for the first premium, you may pay the premium in default within a grace period of 31 days after its due date. This policy will remain In Force during the 31-day grace period.

If a premium in default is not paid within the grace period, this policy will lapse and no more premium payments may be made. If this policy has a surrender value when it lapses, certain options are available as described in the Policy Values section.

**Premium Due Dates.** Your first premium is due as of the Policy Date. All premiums after the first are payable on or before their due date. Premiums must be mailed or delivered to us at our Home Office or to an authorized agent. We will give you a receipt if you request one. The premiums due each year for the policy are specified under Policy Data. The premiums for this policy are payable during the Insured's lifetime for the periods shown under Policy Data.

You can change the payment mode. A premium payment paid in a mode not shown under the premiums chart on the schedule sheet included in this contract must be approved by us.

**Reinstatement.** Within 3 years of the date of default, you may ask to reinstate this policy to a premium paying basis. To reinstate the policy to a premium paying basis, we will require all of the following:

1. Your written request to reinstate the policy;
2. Evidence of the Insured's insurability that is satisfactory to us;
3. Payment of all past due premiums with interest at eight percent (8%) per year compounded annually.

These requirements must be met during the Insured's lifetime.

## Termination Provision

**End of Policy.** This policy will end on the earliest of the following:

1. The date you request it ends; or
2. The date the Insured dies; or
3. The date the Grace Period ends if sufficient premium has not been paid; or
4. The Expiry Date shown on page 3.

### **Policy Surrender Values**

This policy has no policy surrender value or non-forfeiture benefits.

### **Policy Loans**

This policy has no loan values.

### **Policy Settlement**

**Payment of Proceeds.** The proceeds of this policy are payable at our Home Office after we receive due proof of the Insured's death. We require surrender of this policy for payment of any proceeds. The proceeds will be paid in one lump-sum. We will pay interest at a rate not less than 3% per year on the proceeds from the date we receive satisfactory proof of the Insured's death to the settlement date. This interest is payable for no longer than one year from the date of death.

**TERM LIFE INSURANCE POLICY  
PAYABLE UPON DEATH DURING TERM PERIOD  
PREMIUMS PAYABLE DURING TERM PERIOD  
NON-PARTICIPATING**



The Order of United Commercial Travelers of America • A Fraternal Benefit Society  
1801 Watermark Drive, Suite 100, P.O. Box 159019, Columbus, Ohio 43215-8619  
Tel: 614.487.9680 • Toll-free: 800.848.0123 • Fax: 614.487.9675 • www.uct.org

## Term Life Insurance Policy

**Proceeds are payable at the Insured's death during term period**

**This policy is nonparticipating**

This is a contract between you and The Order of United Commercial Travelers of America. We issue this contract based on the application signed by you and the payment of premiums as stated on the schedule sheet included in this contract.

We will pay the benefits subject to all the terms and conditions of the contract. If we receive proof satisfactory to us that the Insured died while this policy was in force, we will pay to the beneficiary the death benefits described in the DEATH BENEFITS section of this policy.

The beneficiary is named in the application unless changed as provided for in this policy.

**Right to Cancel**  
**Please Read this Contract Carefully.**

We want you to be satisfied with your policy. If, for any reason, you are not satisfied, you may cancel this policy within 30 days of receiving it. Do this by mailing or delivering it to us at our Home Office at Columbus, Ohio. Within 30 days after we receive the policy, we will refund all premiums which you have paid. The policy will be considered void from its start.

Signed for the Society at Columbus, Ohio

Joseph H. Hoffman  
Chief Executive Officer

MEMBER OF THE AMERICAN FRATERNAL ALLIANCE

**TERM LIFE INSURANCE POLICY**  
**PAYABLE UPON DEATH DURING TERM PERIOD**  
**PREMIUMS PAYABLE DURING TERM PERIOD**  
**NON-PARTICIPATING**

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**POLICY DATA**

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**INSURED**  
[JOHN DOE]**ISSUE AGE – GENDER – TOBACCO CLASS**  
[35] [MALE or FEMALE] [N or Y]**POLICY NUMBER**  
[SPECIMEN]**RISK CLASS**  
[STANDARD]**POLICY DATE**  
[JULY 1, 2010]**FACE AMOUNT**  
[\$100,000.00]**EXPIRY DATE**  
[JULY 1, 2070]**STATE OF ISSUE**  
[OHIO]**INITIAL TERM PERIOD**  
[10 YEARS]

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**SCHEDULE OF BENEFITS AND PREMIUMS**

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<b>BENEFIT</b>	<b>BENEFIT AMOUNT</b>	<b>INITIAL ANNUAL PREMIUM</b>
[TERM LIFE INSURANCE POLICY]	[\$100,000]	[\$ 113.00]
[ACCIDENTAL DEATH BENEFIT]	[\$100,000]	[\$ 85.00]
[WAIVER OF PREMIUM]		[\$ 13.00]
[ACCELERATED DEATH BENEFIT]	[\$ 25,000]	[\$ 0.00]
	PLUS: POLICY FEE	[\$ 50.00]
	<b>TOTAL</b>	<b>[\$ 261.00]</b>

The premium for this policy as of the policy date is

[ \$261.00] ANNUALLY or  
[ \$135.72] SEMI-ANNUALLY, or  
[ \$ 69.17] QUARTERLY, or  
[ \$ 21.75] MONTHLY EFT

These premiums are payable for [10] years.  
Thereafter, the premiums will increase each year as shown in the Table of Renewal Annual Premiums below.

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**TABLE OF RENEWAL ANNUAL PREMIUMS**

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<b>POLICY YEAR</b>	<b>INSURED'S ATTAINED AGE</b>	<b>ANNUAL PREMIUM</b>	<b>POLICY YEAR</b>	<b>INSURED'S ATTAINED AGE</b>	<b>ANNUAL PREMIUM</b>
11	45	1,038.00	41	75	14,768.00
12	46	1,119.00	42	76	16,315.00
13	47	1,186.00	43	77	18,115.00
14	48	1,239.00	44	78	20,205.00
15	49	1,306.00	45	79	22,547.00
16	50	1,395.00	46	80	25,158.00
17	51	1,507.00	47	81	27,998.00
18	52	1,644.00	48	82	31,005.00
19	53	1,803.00	49	83	34,289.00
20	54	2,003.00	50	84	37,940.00
21	55	2,229.00	51	85	42,001.00
22	56	2,461.00	52	86	46,468.00
23	57	2,686.00	53	87	51,296.00
24	58	2,912.00	54	88	56,428.00
25	59	3,175.00	55	89	61,813.00
26	60	3,496.00	56	90	67,176.00
27	61	3,885.00	57	91	72,456.00
28	62	4,339.00	58	92	77,987.00
29	63	4,835.00	59	93	83,819.00
30	64	5,352.00	60	94	89,964.00
31	65	5,891.00			
32	66	6,437.00			
33	67	7,008.00			
34	68	7,611.00			
35	69	8,290.00			
36	70	8,897.00			
37	71	9,849.00			
38	72	10,962.00			
39	73	12,135.00			
40	74	13,395.00			

## Definitions

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1. The date of your application provided a valid premium was submitted with the application; or
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If neither 1 nor 2 above exists, coverage will not be In Force.

**In Force.** The Insured person named under Policy Data is Insured under the terms of this policy.

**Insurance Age.** Insurance Age means the Insured's age on last birthday. The issue age shown under Policy Data is the Insured's Insurance Age as of the Policy Date. Attained Insurance Ages are determined from the Policy Date.

**Insured.** The person who is Insured by this policy. The Insured is shown under Policy Data.

**Lapse.** A premium payment is in default because it was not paid by the end of the grace period. The Insured person is no longer insured.

**Non-Participating.** This policy does not participate in the distribution of our surplus. As a result, no dividends will be paid under this policy.

**Policy Anniversary.** The same day and month as the Policy Date each year that the policy remains In Force.

**Policy Date.** The date from which policy anniversaries, policy years, policy months and premium due dates are determined. Your Policy Date is shown under Policy Data.

**Proceeds.** The amount we pay under the terms of this policy. Proceeds are payable upon the Insured's death.

**Terminate.** This policy is no longer In Force. All insurance coverage under this policy has stopped.

**We, Our, Us, Society.** The Order of United Commercial Travelers of America.

**Written Request.** A request in writing signed by you.

**You, Your.** The owner of this policy.

## General Provisions

**Conformity with State and Provincial Laws.** On the Policy Date, any provision of this policy in conflict with the laws of the state or province in which you reside on that date is amended to conform with the minimum requirement of those laws.

**Entire Contract of Insurance.** The Entire Contract between you and us consists of:

1. This policy, including any attached riders or amendments;
2. The application attached to this policy; and,
3. The Articles of Incorporation, Constitution and Bylaws of the Society and all amendments made to them after the Policy Date.

**Incontestability.** Statements in the application are considered representations, not warranties. Statements may be used to contest the validity of this Policy or in defense of a claim only if they are contained in an attached application or endorsement. We will not contest this policy, except for nonpayment of premiums, after it has been in force 2 years after the Policy Date.

**Legal Actions.** No action at law or in equity shall be brought to recover on this Policy prior to the expiration of 60 days after written proof of loss has been furnished in accordance with the requirements of this Policy. No such action shall be brought after the expiration of 3 years after the time written proof of loss is required to be furnished.

**Maintenance of Solvency.** UCT's constitution provides that in the event that its reserves as to all or any class of contracts of insurance issued by it become impaired, the Board of Governors may require that these shall be paid by each Owner of such contract of insurance to UCT an amount equal to such Owner's equitable proportion of such deficiency as ascertained by the Board of Governors.

If payment of the amount required to be paid is not made by such Owner, then either or both of the following, at the election of the Owner, shall apply:

1. the amount shall stand as Indebtedness against the contract of insurance and shall bear interest at a rate not to exceed ten percent (10%) per annum; or
2. the Owner shall accept a proportionate reduction in benefits paid pursuant to the contract of insurance.

The Owner shall make such election by notifying the Board of Governors of his or her election on a form prescribed by the Board of Governors that shall be provided to each Owner. Failure to make such election shall result in a presumption that the Owner elects to accept a proportionate reduction in benefits paid pursuant to the contract of insurance.

The Owner hereby agrees that if they affirmatively elect to have the amount stand as Indebtedness against the contract of insurance, then UCT may offset the amount of such Indebtedness together with interest thereon against any payment of benefits under this contract of insurance.

**Misstatement of Age or Sex or Tobacco Class.** If the Insured's age or sex or tobacco class has been misstated on the application form, the proceeds will be based on the amount that premiums paid would have purchased at the correct age or sex or tobacco class.

**Policy Changes.** No change in this contract is valid unless it is made in writing and signed by our Chief Executive Officer of the Society. All changes must be endorsed in or attached to this policy. None of our representatives or other persons have the authority to change or waive any of our rights or requirements under this policy.

**Suicide Exclusion.** Coverage is not provided if the Insured commits suicide within 2 years from the Policy Date. In this event, the only amount payable by us to the beneficiary will be the premiums which you have paid.

**Suspension/Expulsion.** If You are suspended/expelled from the Society, except for nonpayment of a premium or within the contestable period for material misrepresentation in the application for membership or insurance, you shall have the privilege of maintaining this contract In Force by continuing payment of the required premium.

### **Owner and Beneficiary**

**Assignment.** During the Insured's lifetime, you can assign this policy or any interest in it. Your interest and the interest of any beneficiary is subject to the interest of the assignee. A collateral assignment is not a change of ownership. Any policy proceeds payable to the assignee will be paid in a single sum.

A copy of any assignment must be submitted to us, and no assignment will be binding on the Society until it is recorded at our Home Office. We are not responsible for the validity or effect of any assignment.

**Beneficiary.** We will pay the Proceeds to the beneficiary or beneficiaries who you have named in the application unless you have since changed the beneficiary as provided in this policy or unless an assignment of the proceeds to another has been made. If the beneficiary has been changed, we will pay the Proceeds in accordance with your last change of beneficiary request. Only those beneficiaries who are living at the Insured's death may share in the Proceeds. If the beneficiary should die at the same time as the Insured or within 30 days of the Insured's death, but before payment of any Proceeds to the beneficiary, Proceeds will be paid as if the Insured had survived the beneficiary.

In the event a trustee is named as beneficiary, the Society will not be responsible for the application or disposition of the funds paid to the trustee. The payment will be made in a lump sum and receipt by the trustee will fully discharge the Society for any amount paid to the trustee.

**Change of Beneficiary.** You may change the beneficiary any time during the Insured's lifetime while this policy is In Force. The request must be made in writing, dated and signed by you. Once the change is recorded by us at our Home Office, it will take effect as of the date of your request. Payments made or other actions taken by the Society before such recording will not be subject to the new designation.

**Rights as Policyowner.** While this policy is In Force and unless otherwise provided in this policy, you may exercise all rights and privileges stated in this policy or allowed by us.

## Death Benefits

**Amount of Death Benefit.** The Benefit Amount is shown in the Schedule of Benefits on page 3 of this policy.

**Proceeds.** If the Insured dies while this policy is in force, we will pay the proceeds to the beneficiary. The proceeds are the sum of:

1. The death benefit of the policy at the time of the Insured's death; plus
2. Any insurance on the Insured's life that may be provided by riders attached to this policy; plus
3. That portion of any premium paid which applies to a period beyond the policy month in which the Insured dies; minus
4. Any unpaid past due premium if death occurs during the Grace Period.

## Premiums and Reinstatement

**Premium Adjustments at Death.** The following premium adjustments will be made if the Insured dies while this policy is In Force on a premium paying basis:

1. The part of any premium paid for the period beyond the month of the Insured's death will be added to the policy proceeds.
2. If the Insured dies during the grace period, we will deduct one month's premium to cover the elapsed part of that period from the policy proceeds.

**Premium in Default and Grace Period.** Any premium not paid on or before its due date is a premium in default. Except for the first premium, you may pay the premium in default within a grace period of 31 days after its due date. This policy will remain In Force during the 31-day grace period.

If a premium in default is not paid within the grace period, this policy will lapse and no more premium payments may be made. If this policy has a surrender value when it lapses, certain options are available as described in the Policy Values section.

**Premium Due Dates.** Your first premium is due as of the Policy Date. All premiums after the first are payable on or before their due date. Premiums must be mailed or delivered to us at our Home Office or to an authorized agent. We will give you a receipt if you request one. The premiums due each year for the policy are specified under Policy Data. The premiums for this policy are payable during the Insured's lifetime for the periods shown under Policy Data.

You can change the payment mode. A premium payment paid in a mode not shown under the premiums chart on the schedule sheet included in this contract must be approved by us.

**Reinstatement.** Within 3 years of the date of default, you may ask to reinstate this policy to a premium paying basis. To reinstate the policy to a premium paying basis, we will require all of the following:

1. Your written request to reinstate the policy;
2. Evidence of the Insured's insurability that is satisfactory to us;
3. Payment of all past due premiums with interest at eight percent (8%) per year compounded annually.

These requirements must be met during the Insured's lifetime.

## Termination Provision

**End of Policy.** This policy will end on the earliest of the following:

1. The date you request it ends; or
2. The date the Insured dies; or
3. The date the Grace Period ends if sufficient premium has not been paid; or
4. The Expiry Date shown on page 3.

### **Policy Surrender Values**

This policy has no policy surrender value or non-forfeiture benefits.

### **Policy Loans**

This policy has no loan values.

### **Policy Settlement**

**Payment of Proceeds.** The proceeds of this policy are payable at our Home Office after we receive due proof of the Insured's death. We require surrender of this policy for payment of any proceeds. The proceeds will be paid in one lump-sum. We will pay interest at a rate not less than 3% per year on the proceeds from the date we receive satisfactory proof of the Insured's death to the settlement date. This interest is payable for no longer than one year from the date of death.

**TERM LIFE INSURANCE POLICY  
PAYABLE UPON DEATH DURING TERM PERIOD  
PREMIUMS PAYABLE DURING TERM PERIOD  
NON-PARTICIPATING**