

SERFF Tracking Number: FRCS-126987253 State: Arkansas
Filing Company: AAA Life Insurance Company State Tracking Number: 47802
Company Tracking Number: 5441
TOI: L08 Life - Other Sub-TOI: L08.000 Life - Other
Product Name: Application
Project Name/Number: AAA/81/81

Filing at a Glance

Company: AAA Life Insurance Company

Product Name: Application

TOI: L08 Life - Other

Sub-TOI: L08.000 Life - Other

Filing Type: Form

SERFF Tr Num: FRCS-126987253 State: Arkansas

SERFF Status: Closed-Approved-
Closed State Tr Num: 47802

Co Tr Num: 5441

State Status: Approved-Closed

Reviewer(s): Linda Bird

Authors: Jana Finlay, Kevin Wiggs

Disposition Date: 01/28/2011

Date Submitted: 01/26/2011

Disposition Status: Approved-
Closed

Implementation Date:

Implementation Date Requested: On Approval

State Filing Description:

General Information

Project Name: AAA/81

Project Number: 81

Requested Filing Mode: Review & Approval

Explanation for Combination/Other:

Submission Type: New Submission

Overall Rate Impact:

Deemer Date:

Submitted By: Kevin Wiggs

Filing Description:

We are submitting the enclosed forms on behalf of AAA Life Insurance Company ("AAA Life" or "the Company") for your review and approval.

Our fee of \$150 has been sent by EFT on this same date.

These forms are being submitted in final printed format; however, AAA Life reserves the right to change fonts, layouts, or company logo/address. AAA Life certifies that the font size will never be less than the minimum 10-point as required by your state. Once approved, these forms will be marketed on a general basis through both the Company's American Automobile Association Clubs and independent agents. No part of this filing contains any unusual or possibly

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controversial items from normal Company or industry standards.

Form LF80201APP is Part I of a 2-part application. Form LF80202APP is Part 2 of the application, and includes medical questions. The FLESCH Readability Score for Parts 1 and 2 combined is 50.1.

Both Parts I and 2 of the application must be completed and signed before the Company will deem the application process complete. These forms may be used to apply for the Company's individual term life and universal life insurance forms approved by your state, or for individual life policies approved for issue at a future date.

As with AAA Life's previously approved application forms, Part I will be completed by a licensed agent. All required disclosures and notices, including replacement notices, will be given to the applicant at the time the Part I is completed. The application may be completed on a computer, and when so completed, the applicant may sign the application by means of either a signature pad or an internet signature (iSign) process. An applicant always has the option of signing a printed paper version with a wet signature as well. In no case will the applicant complete Part 1 without agent involvement.

Part 2 will be completed via a telephone interview performed by a third party vendor, representatives of whom are licensed agents and have been appointed by AAA Life. The applicant's voice signature will be obtained for Part 2.

The interview begins with an explanation to the applicant about the process. During this part of the interview, the applicant is informed that the entire interview will be recorded. The identity of the interviewee is verified, and a few general questions are asked. The second part of the interview includes the underwriting/medical questions appearing on the application.

The applicant is given the choice of providing a voice signature, or receiving a hard copy of Part 2 for them to sign. In all cases, Part 2 of the application is attached to and becomes a part of the issued Policy, along with Part 1 of the application. The applicant therefore has a final chance to review all responses to the application a final time.

The Temporary Insurance Agreement, form LF80200 will be provided when the applicant provides a payment with the application and meets the other qualifications stated within the agreement. The FLESCH Readability Score for this form is 50.8. Once approved, this form will be made available on a general basis through both the Company's Automobile Association Club and independent agents as part of the application process for Part 1, as well as for other applications previously approved in your state. The applicant will sign the Temporary Insurance Agreement at the same time and in the same manner as Part 1 of the application is signed.

In addition to the forms, we are attaching the required certifications for this filing.

To the best of our knowledge, this filing is complete and intended to comply with the insurance laws of your jurisdiction.

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If you have any questions or need additional information, please call toll-free 1-800-927-2730. Thank you for your assistance.

Company and Contact

Filing Contact Information

Kevin Wiggs, Compliance Specialist kevin.wiggs@firstconsulting.com
 1020 Central 800-927-2730 [Phone] 2736 [Ext]
 Suite 201 816-391-2755 [FAX]
 Kansas City, MO 64105

Filing Company Information

(This filing was made by a third party - FC01)

AAA Life Insurance Company CoCode: 71854 State of Domicile: Michigan
 17250 Newburgh Road Group Code: Company Type:
 Livonia, MI 48152 Group Name: State ID Number:
 (734) 805-2958 ext. [Phone] FEIN Number: 52-0891929

Filing Fees

Fee Required? Yes
 Fee Amount: \$150.00
 Retaliatory? No
 Fee Explanation: AR fee of \$50 per form = \$150
 Per Company: No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
AAA Life Insurance Company	\$150.00	01/26/2011	44115172

SERFF Tracking Number: FRCS-126987253

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Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Linda Bird	01/28/2011	01/28/2011

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Disposition

Disposition Date: 01/28/2011

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		No
Supporting Document	Third Party Authorization		Yes
Form	Individual Life Insurance Application (Part 1)		Yes
Form	Individual Life Insurance Application (Part 2)		Yes
Form	Temporary Insurance Agreement		Yes

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Form Schedule

Lead Form Number: LF80201APP

Schedule Item Status	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
	LF80201AP	Application/ Individual Life Enrollment Form	Insurance Application (Part 1)	Initial		50.100	LF80201APP Non-Compact Part 1_john doe_dist.pdf
	LF80202AP	Application/ Individual Life Enrollment Form	Insurance Application (Part 2)	Initial		50.100	LF80202APP Non-Compact Part 2_john doe_dist.pdf
	LF80200	Application/ Temporary Insurance Enrollment Form	Insurance Agreement	Initial		50.800	LF80200 TIA Non-Compact_john doe_dist.pdf



Application for Life Insurance

Part 1

[App I.D.]
17900 N Laurel Park Dr.
Livonia, MI 48152
(800) 624-1662

PROPOSED INSURED INFORMATION

Full Legal Name (First, Middle, Last) John A. Doe					
Street Address 123 Any Street			City Any City	State Any	Zip 12345
Home Phone (123) 456-7890	Work Phone (123) 456-7890	Cell Phone (123) 456-7890	Email address Any Email		
Date of Birth 01/01/1970	<input type="checkbox"/> Male <input type="checkbox"/> Female	Social Security Number 123-45-6789	Driver's License or Government ID No. 123456	State Issued Any	
Occupation ABC Occupation		Membership Number 123456	Club Code 12354	Nicotine Use <input type="checkbox"/> Yes <input type="checkbox"/> No	
Annual Earned Income \$100,000			Net Worth \$100,000		

INSURANCE REQUESTED

Plan/Duration 10 years	Face Amount \$ \$100,000
Risk Class Quoted ABC class	Death Benefit Option (For Universal Life Only) <input checked="" type="checkbox"/> A -Level <input type="checkbox"/> B-Increasing <input type="checkbox"/> C-Premium Recovery

RIDERS REQUESTED (not all riders are available with all plans)

<input type="checkbox"/> Return of Premium / IPE	<input checked="" type="checkbox"/> Disability Waiver of Premium	<input type="checkbox"/> Waiver of Monthly Deductions
<input type="checkbox"/> Primary Insured _____	<input type="checkbox"/> Child Term _____	<input checked="" type="checkbox"/> Guaranteed Purchase Option _____
<input type="checkbox"/> Additional Insured _____	<input type="checkbox"/> Travel Accident _____	<input type="checkbox"/> Accidental Death Benefit _____
<input type="checkbox"/> Other _____	<input type="checkbox"/> Other _____	

ADDITIONAL INSURED INFORMATION

Full Legal Name (First, Middle, Last) John A. Doe					
Street Address 123 Any Street			City Any City	State Any	Zip 12345
Home Phone (123) 456-7890	Work Phone (123) 456-7890	Cell Phone (123) 456-7890	Email address Any Email		
Date of Birth 01/01/1970	<input type="checkbox"/> Male <input type="checkbox"/> Female	Social Security Number 123-45-6789	Driver's License or Government ID No. 123456	State Issued Any	
Occupation ABC Occupation		Membership Number 123456	Club Code 12354	Nicotine Use <input type="checkbox"/> Yes <input type="checkbox"/> No	
Annual Earned Income \$100,000			Net Worth \$100,000		
Plan/Duration 10 years		Face Amount \$ \$100,000	Risk Class Quoted ABC class		

PREMIUM AND BILLING INFORMATION

Initial Premium for this Application	Future Premium Billing (Select Only One Mode and One Payment Type)		Send Premium Notices To (Select Only One)
Initial Premium Amount \$ \$100,000	MODE	PAYMENT TYPE	<input checked="" type="checkbox"/> Proposed Insured <input type="checkbox"/> Owner
<input type="checkbox"/> EFT <input type="checkbox"/> Credit Card <input checked="" type="checkbox"/> Check	<input checked="" type="checkbox"/> Annually (A)	<input type="checkbox"/> Credit Card <input type="checkbox"/> EFT <input checked="" type="checkbox"/> Direct Bill <input type="checkbox"/> Credit Card <input type="checkbox"/> EFT	<input type="checkbox"/> Other (Full Name & Address) _____ _____
Process Upon:	<input type="checkbox"/> Semi Annually (S-A)		Secondary Addressee (Full Name & Address) _____ _____
<input type="checkbox"/> Receipt at Home Office <input checked="" type="checkbox"/> Issue	<input type="checkbox"/> Quarterly (Q)		_____
1035 Exchange: <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Monthly (M)		_____
Lump Sum Payment \$ \$100,000 (For Universal Life Only)			_____



Application for Life Insurance

Part 1

[App I.D.]
 17900 N Laurel Park Dr.
 Livonia, MI 48152
 (800) 624-1662

OWNER INFORMATION *(If Not Proposed Insured)*

Full Legal Name (First, Middle, Last) John A. Doe					
Street Address 123 Any Street			City Any City	State Any	Zip 12345
Relationship to Insured Brother	SSN/TIN 123456	Home Phone (123) 456-7890	Work Phone (123) 456-7890	Cell Phone (123) 456-7890	

BENEFICIARY INFORMATION—PROPOSED INSURED

PRIMARY Beneficiary(ies)	Relationship to Insured	Benefit % <i>(Total = 100%)</i>
John Doe	Brother	100%
CONTINGENT Beneficiary(ies)	Relationship to Insured	Benefit % <i>(Total = 100%)</i>
John Doe	Brother	100%

BENEFICIARY INFORMATION—ADDITIONAL INSURED

PRIMARY Beneficiary(ies)	Relationship to Insured	Benefit % <i>(Total = 100%)</i>
John Doe	Brother	100%
CONTINGENT Beneficiary(ies)	Relationship to Insured	Benefit % <i>(Total = 100%)</i>
John Doe	Brother	100%

EXISTING INSURANCE—PROPOSED INSURED *(Including Life Insurance With AAA Life)*

Are there any life insurance policies or annuity contracts inforce or any applications pending on the life of the Proposed Insured?							<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Will the coverage applied for replace or change any existing or applied for life insurance policies?							<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Insurance Company Name	Policy Number	Type of Insurance	Issue Year	Amount	Accidental Death	To Be Replaced	
						<input type="checkbox"/> Yes <input type="checkbox"/> No	
						<input type="checkbox"/> Yes <input type="checkbox"/> No	
						<input type="checkbox"/> Yes <input type="checkbox"/> No	
						<input type="checkbox"/> Yes <input type="checkbox"/> No	

EXISTING LIFE INSURANCE—ADDITIONAL INSURED *(Including Life Insurance With AAA Life)*

Are there any life insurance policies or annuity contracts inforce or any applications pending on the life of the Additional Insured?							<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Will the coverage applied for replace or change any existing or applied for life insurance policies?							<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Insurance Company Name	Policy Number	Type of Insurance	Issue Year	Amount	Accidental Death	To Be Replaced	
						<input type="checkbox"/> Yes <input type="checkbox"/> No	
						<input type="checkbox"/> Yes <input type="checkbox"/> No	
						<input type="checkbox"/> Yes <input type="checkbox"/> No	
						<input type="checkbox"/> Yes <input type="checkbox"/> No	



Application for Life Insurance

Part 1

[App I.D.]
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RELATED APPLICATIONS

The following Proposed Insured applications should be kept together.

Name John Doe	Date of Birth 01/01/2010	Name John Doe	Date of Birth 01/01/2010
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UNDERWRITING INFORMATION

Has the **Proposed Insured** ever been diagnosed or treated by a member of the medical profession for Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC), Alzheimer's, Amyotrophic Lateral Sclerosis (ALS), Schizophrenia, Cirrhosis, or Dementia? Yes No

Has the **Additional Insured** ever been diagnosed or treated by a member of the medical profession for Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC), Alzheimer's, Amyotrophic Lateral Sclerosis (ALS), Schizophrenia, Cirrhosis, or Dementia? Yes No N/A

Will the premiums for this policy be loaned or otherwise financed by any individual(s) or entity(ies) other than the **Proposed Insured**, employer(s) of the **Proposed Insured**, or family members of the **Proposed Insured**, or will the **Proposed Insured** be compensated in any way in exchange for any portion of the policy's death benefit? Yes No

Does the **Proposed Insured** or **Owner** plan to sell or permanently assign the policy to another person or entity, life settlement provider or an investor, or will it replace any policy that has already been sold to another life settlement company or investor? Yes No

FRAUD WARNING

Any person who knowingly presents a false statement in an application for insurance may be guilty of a criminal offense and subject to penalties under state law.

REPRESENTATION, ACKNOWLEDGEMENT, AND AUTHORIZATION

I declare that all answers in this application and any attached questionnaires are, to the best of my knowledge and belief true, and complete. The answers given are the basis for any policy issued by the Company, and will be made part of the Policy.

Except for coverage provided under a Temporary Insurance Agreement, the coverage will take effect when:

- (i) A policy is issued on this application and delivered to and accepted by the Owner, and
- (ii) The first premium due is paid in full while each Proposed Insured is alive, and
- (iii) Provided there has been no change in the Proposed Insured's health, habits or occupation since the date the application was signed.

In order to determine insurability, **I authorize** any licensed medical practitioner, hospital, clinic, or other medical facility, insurance company, pharmacy benefit manager, MIB, Inc., other organization, institution, or person having any records of the Proposed Insured's medical or prescription history, to give such information to the Company, it's reinsurers, or any agency employed by the Company to collect and transmit such information. I understand that medical records are protected by certain federal regulations. The Company will not use or disclose medical information for any purpose other than stated above, except as may be required by law. This authorization is valid for 24 months from the date signed. A copy of this authorization will be as valid as the original. I have the right to revoke this authorization in writing to the Company; however if I do, the Company may decline my application.

I acknowledge receipt of the Company's Investigative Consumer Report Notice, MIB, Inc. Disclosure Notice, and Notice of Insurance Information Practices. **Temporary Insurance Agreement Received:** Yes No

Signed at (City and State) Any City, Any State	Date 1/1/10
Signature of Proposed Insured John Doe	Signature of Additional Insured John Doe
Signature of Parent or Legal Guardian (If Proposed or Additional Insured is a Minor)	Signature of Owner (If Other Than Proposed Insured)



Application for Life Insurance

Part 1

[App I.D.]
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AGENT NOTES

Agent's Statement: I represent that I have have not personally seen the person(s) proposed for insurance. To the best of my knowledge and belief there is nothing adversely affecting the insurability of the person(s) proposed for insurance other than as indicated on this application; and where required, the Company's Investigative Consumer Report Notice, MIB, Inc. Disclosure Notice, and Notice of Insurance Information Practices was given to the applicant on or before the date the application was signed. To the best of my knowledge, the Proposed Insured does does not have any insurance inforce or applications pending and the Proposed Insured does does not intend to replace or change existing insurance or annuities.

Temporary Insurance Agreement Provided: <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Illustration Provided: <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Proposed Insured Understands English: <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
Signature of Writing Agent Any Agent	Date 1/1/10	Agent Phone Number 123-456-7890	Agent Email Address Any Email
Printed Agent Name Any Agent	Agent Number 123456	License Number 123456	Split % 50
Printed Agent Name Any Agent	Agent Number 123456	License Number 123456	Split % 50



Application for Life Insurance

Part 2

[App ID:]

17900 N. Laurel Park Dr.
Livonia, MI 48152
(800) 624-1662

PROPOSED INSURED INFORMATION

Full Legal Name <p style="text-align: center;">John A. Doe</p>		Social Security Number <p style="text-align: center;">123-45-6789</p>
State/Country of Birth <p style="text-align: center;">Any State</p>	U.S. Citizen <input type="checkbox"/> Yes <input type="checkbox"/> No	Permanent Resident <input type="checkbox"/> Yes <input type="checkbox"/> No
Visa Type	Visa Number	OR
		Alien Registration (Green Card) Number <p style="text-align: center;">123456</p>
Employer Name <p style="text-align: center;">ABC Employer</p>		Employer Address <p style="text-align: center;">123 Any Street, Any City 12354</p>
Is this business coverage? <input type="checkbox"/> Yes <input type="checkbox"/> No	If applicable, list Partners' Total Insurance Coverage	

IF PROPOSED INSURED HAS NO EARNED INCOME (OR IS A MINOR):

Spouse's/Parent's Annual Income <p style="text-align: center;">\$ 100,000</p>	Total Life Insurance Coverage on Spouse/Parent <p style="text-align: center;">\$ 100,000</p>
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IF PROPOSED INSURED IS A MINOR OR CHILD:

Does Father Have Life Insurance?	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A	Total Coverage 100,000
Does Mother Have Life Insurance?	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A	Total Coverage 100,000
Do All Siblings Have Life Insurance?	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> N/A	Total Coverage for Each Sibling

MEDICAL AND UNDERWRITING INFORMATION FOR PROPOSED INSURED

Primary Care Physician Name, Address and Phone Number <p style="text-align: center;">ABC Physician</p>			
Height <p style="text-align: center;">6 ft 2 in</p>	Weight <p style="text-align: center;">200 lbs</p>	In the last 12 months, have you lost more than 20 pounds?	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No [<input type="checkbox"/> N/A]
Have you ever been diagnosed, treated or advised to seek treatment by a member of the medical profession for:			
1. Heart disorder, circulatory disorder, chest pain, high blood pressure, or elevated lipids (cholesterol or triglycerides)?			<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No [<input type="checkbox"/> N/A]
2. Stroke, Transient Ischemic Attack (TIA or mini-stroke) or seizure?			<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No [<input type="checkbox"/> N/A]
3. Diabetes, thyroid disorder, pancreatic disorder, liver disorder including, but not limited to, hepatitis, or kidney disorder?			<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No [<input type="checkbox"/> N/A]
4. Lung or chronic respiratory disorder including, but not limited to, sleep apnea or asthma?			<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No [<input type="checkbox"/> N/A]
5. Cancer or tumor, cyst, or growth?			<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No [<input type="checkbox"/> N/A]
6. Rheumatoid Arthritis, Lupus, Multiple Sclerosis, or other autoimmune or connective tissue disorder?			<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No [<input type="checkbox"/> N/A]
7. Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC), or HIV (Human Immunodeficiency Virus) infection?			<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No [<input type="checkbox"/> N/A]
Have you ever:			
8. Had a parent or sibling diagnosed or treated by a member of the medical profession for heart disease, cancer, or diabetes?			<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No [<input type="checkbox"/> N/A]
9. Had a parent or sibling diagnosed or treated by a member of the medical profession for Polycystic Kidney disease or Huntington's disease?			<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No [<input type="checkbox"/> N/A]
10. Been denied coverage or rated an extra premium for life insurance?			<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No [<input type="checkbox"/> N/A]
11. Been arrested, charged, or convicted of a felony or misdemeanor other than a traffic violation?			<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No [<input type="checkbox"/> N/A]



Application for Life Insurance

Part 2

[App ID:]

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12. Used any illicit drugs not prescribed by a physician, or have been advised to, or received treatment or counseling for drug or alcohol use?	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No [<input type="checkbox"/> N/A]
13. Used any tobacco or nicotine product in any form including hookahs or bidis?	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No [<input type="checkbox"/> N/A]
Have you in the <u>past 10 years</u> been diagnosed, treated, or advised to seek treatment by a member of the medical profession for:	
14. Mental or emotional disorders, including, but not limited to, anxiety, depression, bipolar, schizophrenia, dementia, eating disorders, or attempted suicide?	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No [<input type="checkbox"/> N/A]
15. Any central nervous system disorder including, but not limited to, Amyotrophic Lateral Sclerosis (ALS), Parkinson's, Alzheimer's, Huntington's disease, or Cerebral Palsy?	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No [<input type="checkbox"/> N/A]
16. Digestive system, intestinal or stomach disorder, ulcer, or colitis?	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No [<input type="checkbox"/> N/A]
17. Chronic pain or fibromyalgia?	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No [<input type="checkbox"/> N/A]
Have you in the <u>past 10 years</u>:	
18. Participated in sky diving or hang gliding, scuba or skin diving, automobile, motorcycle, boat or hydroplane racing, mountain or rock climbing, or do you plan to participate in these activities within the next two years?	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No [<input type="checkbox"/> N/A]
19. Consumed more than 3 alcoholic beverages in one day?	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No [<input type="checkbox"/> N/A]
Have you in the <u>past 7 years</u>:	
20. Filed for bankruptcy?	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No [<input type="checkbox"/> N/A]
21. Been convicted of driving under the influence of alcohol or drugs, reckless driving, had your license denied, suspended or revoked, or been ticketed for a moving violation?	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No [<input type="checkbox"/> N/A]
22. Piloted an aircraft, planned to pilot an aircraft, or studied to pilot an aircraft as a Student Pilot?	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No [<input type="checkbox"/> N/A]
Have you in the <u>past 5 years</u> been treated by a member of the medical profession and:	
23. Applied for or received income benefits for injury, sickness, or disability, or are you currently disabled?	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No [<input type="checkbox"/> N/A]
24. Been advised to have surgery, testing, hospital care, or medical investigations not already mentioned?	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No [<input type="checkbox"/> N/A]
25. Taken prescribed medications or are you currently taking any medications?	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No [<input type="checkbox"/> N/A]
Additional Information:	
26. Have you seen a doctor or consulted a member of the medical profession or been advised to seek treatment in the last 2 years for any condition or reason not already mentioned?	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No [<input type="checkbox"/> N/A]
27. Have you in the <u>past 12 months</u> or do you in the <u>next 2 years</u> intend to reside outside of the U.S. or Canada?	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No [<input type="checkbox"/> N/A]
28. Are you <u>currently</u> employed and actively working?	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No [<input type="checkbox"/> N/A]

REMARKS

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Application for Life Insurance

Part 2

[App ID:]

17900 N. Laurel Park Dr.
Livonia, MI 48152
(800) 624-1662

REMARKS CONTINUED

(This area is intentionally left blank for handwritten remarks.)

Any person who knowingly presents a false statement in an application for insurance may be guilty of a criminal offense and subject to penalties under state law.

I declare that all statements and answers in this application and any questionnaire or declaration of insurability completed in connection with this application are, to the best of my knowledge and belief, true, complete, and correctly recorded. A copy of this application will be used to determine if coverage will be issued and will be attached to and made a part of the insurance policy issued.

Signed at (City and State) Any City, Any State	Date 1/1/11
Signature of Proposed Insured John Doe	Signature of Owner <i>(If Other Than Proposed Insured)</i>
Signature of Parent or Legal Guardian <i>(If Proposed Insured is a Minor)</i>	



Temporary Insurance Agreement (TIA)

[App I.D.]

17900 N. Laurel Park Dr.
Livonia MI 48152
(800) 624-1662

IMPORTANT: THIS TEMPORARY INSURANCE AGREEMENT PROVIDES A LIMITED COVERAGE AMOUNT FOR A LIMITED PERIOD OF TIME. IT IS PROVIDED IN CONJUNCTION WITH THE SIGNED AND DATED APPLICATION FOR THE SAME PROPOSED INSUREDS, AND IS SUBJECT TO THE TERMS SET FORTH BELOW.

**DO NOT MAKE ANY CHECKS PAYABLE TO THE AGENT OR LEAVE THE PAYEE BLANK.
ALL PREMIUM CHECKS MUST BE MADE PAYABLE TO "AAA LIFE INSURANCE COMPANY".**

TEMPORARY INSURANCE AGREEMENT – QUALIFICATION QUESTIONS

1. Does the total amount of insurance on the Proposed Insured's life in force with the AAA Life Insurance Company under any policies, conditional receipts, or temporary insurance agreements exceed \$1,000,000? Yes No

Has any Proposed Insured:

2. Within the past 90 days, been admitted to or advised by a member of the medical profession to be admitted to a hospital or other licensed health care facility, or had surgery recommended or performed, or been medically advised to have any diagnostic test? Yes No

3. Within the past 5 years been diagnosed, treated, or advised by a member of the medical profession to seek treatment for: heart disease, chest pain, stroke, diabetes, cancer, lung disorder other than asthma, hepatitis C, cirrhosis or kidney disorder? Yes No

4. Within the past 5 years been diagnosed, treated, or advised by a member of the medical profession to seek treatment for: lupus, schizophrenia, bipolar disorder, dementia, Amyotrophic Lateral Sclerosis (ALS) or Alzheimer's? Yes No

5. Been diagnosed with or treated by a member of the medical profession for Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC) or HIV (Human Immunodeficiency Virus)? Yes No

6. Within the past 2 years, been declined for life insurance or offered a rated policy? Yes No

TEMPORARY INSURANCE AGREEMENT

Agreement: This agreement is between the Applicant (Proposed Owner) and AAA Life Insurance Company ("We", "Us" or "Our"). Subject to the terms of the policy applied for and this TIA, We agree to pay the Limited Coverage Amount to the beneficiaries named in the Application upon receipt of due proof that a Proposed Insured died while this TIA is in effect. Coverage under this TIA takes effect when: (1) both the Temporary Insurance Agreement and Application are signed and dated with the same date, and (2) We receive payment equal to the first monthly modal premium for the coverage applied for.

Limited Coverage Amount: The lesser of: (1) the Amount of Insurance applied for in the Application, or (2) up to \$1,000,000 minus any amount of insurance on the Proposed Insured's life under concurrent Temporary Insurance Agreements in force with Us.

Effective Date: The date all of the following requirements have been met: (1) the Application and TIA are signed by the Proposed Insured(s) and Applicant, and (2) the TIA Health Questions, numbered 2 through 6 above, are answered "No" for all Proposed Insured lives, and (3) the premium has been collected for the amount at least equal to the first monthly modal premium for the coverage applied for.

Termination Date: The earliest of the following: (1) the date the Applicant withdraws the Application; (2) the date the policy is issued; (3) the date a policy offer other than applied for has been made to the Applicant; (4) the date We send notice to the Applicant at the address on the Application that We have declined to issue insurance; (5) the date the check, bank draft or credit card transaction submitted as payment is not honored by the financial institution, or (6) 60 days after the Effective Date.

Other Limitations: Our liability is limited to a return of the Amount Received if: (1) any part of the life insurance Application or this TIA contains a material misrepresentation, or (2) the Proposed Insured dies by suicide.



Temporary Insurance Agreement (TIA)

[App I.D.]

17900 N. Laurel Park Dr.
Livonia MI 48152
(800) 624-1662

SIGNATURES

I represent that I have read and received a copy of this TIA. I agree to all of its terms and conditions. I declare all statements and answers in this Agreement are, to the best of my knowledge and belief, true, complete, and correctly recorded. I understand that any fraudulent or material misrepresentations in the Application or this TIA will invalidate this Agreement. I understand that completing this TIA does not guarantee that AAA Life Insurance Company will issue a policy on the Proposed Insured's life. I understand that no one is authorized to modify or waive any of the terms of this TIA.

Signed at: _____ Any City, Any State _____
(City and State) (Date)

John Doe

Signature of Proposed Insured

John Doe

Signature of Applicant, if other than Proposed Insured

John Doe

Name of Proposed Insured (printed)

John Doe

Signature of Additional Proposed Insured

LICENSED INSURANCE AGENT'S STATEMENT

Amount Received: \$ 10,000 On the date of this TIA, I received the Amount Received listed. This TIA bears the same date as the Application. I agree that I am not authorized to change or waive the terms of this TIA and represent that I have not attempted to do so. I have read and explained the terms of this TIA to the Proposed Insured and Applicant. I have left a copy of this TIA with the Applicant.

Any Agent

Signature(s) of Licensed Insurance Agent(s)

1/1/11

Date

123456

Licensed Insurance Agent Number(s)

SERFF Tracking Number: FRCS-126987253

State: Arkansas

Filing Company: AAA Life Insurance Company

State Tracking Number: 47802

Company Tracking Number: 5441

TOI: L08 Life - Other

Sub-TOI: L08.000 Life - Other

Product Name: Application

Project Name/Number: AAA/81/81

Supporting Document Schedules

Item Status:

Status

Date:

Satisfied - Item: Flesch Certification

Comments:

Attachments:

AR RDB_app.pdf

AR CoC_app.pdf

Item Status:

Status

Date:

Satisfied - Item: Third Party Authorization

Comments:

Attachment:

Auth_AAA_2011_dist.pdf

**STATE OF ARKANSAS
READABILITY CERTIFICATION**

COMPANY NAME: AAA Life Insurance Company

This is to certify that the form(s) referenced below has achieved a Flesch Reading Ease Score as indicated below and complies with the requirements of Ark. Stat. Ann. Section 66-3251 through 66-3258, cited as the Life and Disability Insurance Policy Language Simplification Act.

Form Number	Score
LF80201APP	50.1
LF80202APP	50.1
LF80200	50.8



Robert J. Dotson
Vice President, General Counsel and Secretary

January 12, 2011

Date

**STATE OF ARKANSAS
CERTIFICATION OF COMPLIANCE**

Company Name: AAA Life Insurance Company
Form Title(s): Individual Life Insurance Application (Part 1)
Individual Life Insurance Application (Part 2)
Temporary Insurance Agreement
Form Number(s): LF80201APP
LF80202APP
LF80200

I hereby certify that to the best of my knowledge and belief, the above form(s) and submission complies with Reg. 19, as well as the other laws and regulations of the State of Arkansas.



Robert J. Dotson
Vice President, General Counsel and Secretary

January 12, 2011
Date



Robert J. Dotson
Vice President
General Counsel & Secretary
Chief Compliance Officer

17900 N. Laurel Park Drive
Livonia, Michigan 48152
Phone: 734-779-2606
Fax: 734-805-6254
rdotson@aaalife.com

January 12, 2011

To: The Insurance Commissioner

Authorization

This letter, or a copy thereof, will authorize the consulting firm of First Consulting & Administration, Inc., Kansas City, Missouri, to represent this Company in matters before the Insurance Department.

This Authorization shall be valid until revoked by us.

AAA Life Insurance Company

By: _____

Title: Vice President, General Counsel
and Secretary
