

SERFF Tracking Number: AFLC-127664865 State: Arkansas
 Filing Company: Americo Financial Life and Annuity Insurance Company State Tracking Number: 49999
 Company Tracking Number: 1305
 TOI: L08 Life - Other Sub-TOI: L08.000 Life - Other
 Product Name: 1305: 5098 (06/11)
 Project Name/Number: 1305: 5098 (06/11)/1305

Filing at a Glance

Company: Americo Financial Life and Annuity Insurance Company

Product Name: 1305: 5098 (06/11)

TOI: L08 Life - Other

Sub-TOI: L08.000 Life - Other

Filing Type: Form

SERFF Tr Num: AFLC-127664865 State: Arkansas

SERFF Status: Closed-Approved-Closed
 State Tr Num: 49999

Co Tr Num: 1305

Author: Ronni Jones

Date Submitted: 10/10/2011

State Status: Approved-Closed

Reviewer(s): Linda Bird

Disposition Date: 10/13/2011

Disposition Status: Approved-Closed

Implementation Date:

Implementation Date Requested: On Approval

State Filing Description:

General Information

Project Name: 1305: 5098 (06/11)

Project Number: 1305

Requested Filing Mode: Review & Approval

Explanation for Combination/Other:

Submission Type: New Submission

Overall Rate Impact:

Deemer Date:

Submitted By: Ronni Jones

Filing Description:

Submission description

Enclosed, for review and approval, is revised life insurance application ABB5098 (06/11). This application replaces AAA5098, which was previously approved in your jurisdiction on 3/26/2007, under SERFF tracking number AFLC-125102278.

Status of Filing in Domicile: Pending

Date Approved in Domicile:

Domicile Status Comments: Texas is our state of domicile.

Market Type: Individual

Individual Market Type:

Filing Status Changed: 10/13/2011

State Status Changed: 10/13/2011

Created By: Ronni Jones

Corresponding Filing Tracking Number:

In addition, this application contains no unusual or controversial elements. This application will be used in the individual life insurance market by our licensed independent agents.

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Application ABB5098 (06/11) description

This application is an Application for Individual Life Insurance that will be used with the forms listed in the Associated Forms List, which is provided under the Supporting Documentation tab.

Some of the high level changes made between the aforementioned previously approved application and this application include:

- Reorganized section placement in application
- Pg.1: moved height and weight to the Medical History section on pg.4
- Moved Owner Information section and Payor Information section from pg.1 to pg.2
- Pg.1: revised Product Information section
- Pg.1: revised Riders section
- Pg.2: updated Section 6. Life Insurance In Force and Replacement Information
- Pg.3: revised title of Section 9. to more accurately reflect the content
- Pgs.3-4: former Declaration of Insurability section broken out in to two sections: Personal History and Medical History
- Pg.3: revised Personal History questions, Section 11
- Pg.4: revised Medical History questions, Section 12
- Pg.5: revised Authorization and Acknowledgment

Electronic Initiatives

In addition to traditional use as a paper application, this application will accommodate our electronic initiatives by accepting the applicant's application for life insurance in one of two electronic application processing methods.

METHOD 1

The agent meets with the client in person. The applicant's responses will be entered electronically, by the agent, through the Company's secure website and populated to applicable blanks on the captured application form.

Once the application data has been entered, the agent uses an e-mail delivery system to send the completed application to the appropriate parties for signature. Each party (Owner, Insured, Payor, Agent) responds to the received e-mail by logging into a secure website where they will review the completed application in PDF form and electronically apply their signatures while in the presence of the agent or at a later time using any internet service.

Once the Owner, Insured, and Payor have electronically signed the application, the agent completes the process by applying his/her signature.

METHOD 2

The agent will contact the applicant by telephone, and the agent completes the application interview over the telephone. The call is not recorded. The applicant's responses will be entered electronically by the agent through the Company's

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Company and Contact

Filing Contact Information

Ronni Jones, Associate Compliance Analyst ronni.jones@americo.com
 300 W. 11th Street 816-512-2831 [Phone]
 Kansas City, MO 64105 816-391-2083 [FAX]

Filing Company Information

Americo Financial Life and Annuity Insurance CoCode: 61999 State of Domicile: Texas
 Company
 300 West 11th Street Group Code: 449 Company Type:
 Kansas City, MO 64105 Group Name: State ID Number:
 (800) 231-0801 ext. [Phone] FEIN Number: 35-0810610

Filing Fees

Fee Required? Yes
 Fee Amount: \$100.00
 Retaliatory? Yes
 Fee Explanation: TX retaliatory filing fee for 1 form = \$100.00
 Per Company: No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Americo Financial Life and Annuity Insurance Company	\$100.00	10/10/2011	52660665

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Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved- Closed	Linda Bird	10/13/2011	10/13/2011

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Disposition

Disposition Date: 10/13/2011

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	Statement of Variability		Yes
Supporting Document	Agent's Report		Yes
Supporting Document	Associated Forms List		Yes
Form	Application for Individual Life Insurance		Yes

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Form Schedule

Lead Form Number: ABB5098 (06/11)

Schedule Item Status	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
	ABB5098 (06/11)	Application/ Enrollment Form	Application for Individual Life Insurance	Initial		52.200	ABB5098 (06-11) FINAL for FILING 2011-10-09.pdf

1. PROPOSED INSURED INFORMATION

a. Proposed Insured's Name <i>(Last, First, MI)</i>		b. <input type="checkbox"/> Single <input type="checkbox"/> Married
		c. <input type="checkbox"/> Male <input type="checkbox"/> Female
d. Address <i>(Include City, State, and ZIP. If mailing address is a PO Box, a street address is also required.)</i>		
e. How long at current address? _____ <i>If less than 5 years at current address, prior address is required.</i>		
f. Primary Phone: <input type="checkbox"/> Home <input type="checkbox"/> Cell <input type="checkbox"/> Work	g. Alternate Phone: <input type="checkbox"/> Home <input type="checkbox"/> Cell <input type="checkbox"/> Work	h. Email Address
i. Social Security # or Taxpayer ID #	j. Date of Birth <i>(MM/DD/YYYY)</i>	k. Age
l. Place of Birth <i>(City, State, Country)</i>		
m. Is the Proposed Insured currently employed? <input type="checkbox"/> Yes <input type="checkbox"/> No	n. Occupation	o. Annual Salary
p. Employer and employer address <i>(Include City, State, and ZIP)</i>		
q. Provide description of job duties:		

2. PRODUCT INFORMATION *(Verify that the product is available in the state where the application is being signed.)*

a. <input type="checkbox"/> Quality 25 <input type="checkbox"/> LifeCrest <input type="checkbox"/> LifeCrest Index	<input type="checkbox"/> AdvantageWL <input type="checkbox"/> LifeTerm <i>(Specify Term Period):</i> _____ <input type="checkbox"/> Other _____	b. Face Amount \$ _____	c. Was premium collected with the application? <input type="checkbox"/> Yes <input type="checkbox"/> No <i>If Yes, indicate amount collected: \$ _____</i>
d. Planned Premium <i>(Subject to change upon underwriting review.)</i> \$ _____	e. Effective Date <i>(If not checked, Effective Date will be Issue date. Cannot be the 29th, 30th, or 31st of the month.)</i> <input type="checkbox"/> Issue Date <input type="checkbox"/> Save Age of _____ <input type="checkbox"/> Specific Date _____	f. Death Benefit Option <i>(Select for UL Products only; will be Option A, if not checked.)</i> <input type="checkbox"/> A- Level <input type="checkbox"/> B- Increasing <input type="checkbox"/> N/A	g. Initial Allocation Percentage <i>(LifeCrest Index only)</i> Index Option _____% Declared Interest Option _____% Total must equal 100% <input type="checkbox"/> N/A
h. Automatic Premium Loan <i>(AdvantageWL only)</i> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A	i. Premium Mode <i>(Subject to availability)</i> <i>(Note: Additional charges may apply for modes other than Annual.)</i> Mode: <input type="checkbox"/> Annual <input type="checkbox"/> List Bill No. _____ <input type="checkbox"/> Semi-Annual <input type="checkbox"/> FEDD <input type="checkbox"/> Quarterly <input type="checkbox"/> Military Allotment <input type="checkbox"/> Monthly Bank Draft <i>(Drawn on a U.S. bank)</i> <input type="checkbox"/> Other <i>(Provide source of funds)</i> _____	j. Premium Class applied for <i>(Standard if not checked; subject to availability)</i> <input type="checkbox"/> Ultra Preferred <input type="checkbox"/> Standard Nicotine <input type="checkbox"/> Preferred Non-nicotine <input type="checkbox"/> Nonsmoker Select <input type="checkbox"/> Preferred Nicotine <input type="checkbox"/> Select <input type="checkbox"/> Standard Non-nicotine <input type="checkbox"/> Standard	

3. RIDERS *(Verify rider availability to avoid amendments.)*

<input type="checkbox"/> Accidental Death Benefit \$ _____	<input type="checkbox"/> Guaranteed Insurability	<input type="checkbox"/> Waiver of Premium <i>(Not available on UL)</i> \$ _____
<input type="checkbox"/> Annual Renewable & Convertible Term Life Insurance \$ _____	<input type="checkbox"/> Spouse* \$ _____ [Spouse's Occupation _____]	<input type="checkbox"/> Waiver of Specified Monthly Premium <i>(UL Only)</i> \$ _____
<input type="checkbox"/> Children's Term* \$ _____	<input type="checkbox"/> Waiver of Cost of Insurance & Monthly Expense Charges <i>(UL only)</i> _____	<input type="checkbox"/> Other _____
<input type="checkbox"/> Disability Income [†] \$ _____		<input type="checkbox"/> Other _____

*Complete Additional Proposed Insured(s) section of this application. †Complete additional supplemental application.

4. BENEFICIARY INFORMATION *(Include percentage shares. If shares are not given, they will be equal.)*

<i>If not specified, all beneficiaries will be Primary.</i>	Name	Social Security # or Taxpayer ID #	Date of Birth	Relationship	% of Share <i>(Must total 100%)</i>
<input type="checkbox"/> Primary					
<input type="checkbox"/> Primary <input type="checkbox"/> Contingent					
<input type="checkbox"/> Primary <input type="checkbox"/> Contingent					

5. ADDITIONAL PROPOSED INSURED(S) *(To include [Spouse] [and Children's Term] rider.)*

Name of Additional Proposed Insured <i>(Last, First, MI)</i>	Date of Birth <i>(MM/DD/YYYY)</i>	Place of Birth <i>(City, State, Country)</i>	Sex	Height	Weight <i>(lbs.)</i>	Social Security # or Taxpayer ID #	Relationship to Proposed Insured
			<input type="checkbox"/> M <input type="checkbox"/> F	' "			
			<input type="checkbox"/> M <input type="checkbox"/> F	' "			
			<input type="checkbox"/> M <input type="checkbox"/> F	' "			
			<input type="checkbox"/> M <input type="checkbox"/> F	' "			
			<input type="checkbox"/> M <input type="checkbox"/> F	' "			
			<input type="checkbox"/> M <input type="checkbox"/> F	' "			

6. LIFE INSURANCE IN FORCE AND REPLACEMENT INFORMATION Yes No

- a. Does any Proposed Insured have life insurance or annuity applications pending with other companies? Yes No
- b. Is there any existing life insurance or annuity coverage on the life of any Proposed Insured? *(If Yes, provide information below.)* Yes No

Proposed Insured's Name <i>(Last, First, MI)</i>	Company	Owner	Amount	Accidental Death Benefit	Policy Date <i>(MM/DD/YYYY)</i>

- c. Will the life insurance applied for replace, or otherwise reduce in value, any existing life insurance or annuity now in force? Yes No
(If Yes, complete the applicable replacement form(s) and submit with application. Application and replacement form(s) must be dated on the same date.)
- d. Is this an internal replacement? *(If Yes, include a Surrender form or Absolute Assignment form for the life insurance or annuity being replaced.)* ... Yes No
- e. If a1035 exchange, indicate value to be transferred *(include Absolute Assignment form)*. \$ _____ N/A
- f. If current life insurance or annuity is being replaced, indicate the amount of surrender charges that will be assessed. \$ _____ N/A

7. OWNER INFORMATION *(If different from the Proposed Insured.)*

a. Owner's Name <i>(Last, First, MI)</i>		b. Relationship to Proposed Insured	c. Social Security # or Taxpayer ID #
d. Address <i>(Include City, State, and ZIP. If mailing address is a PO Box, a street address is also required.)</i>			
e. How long at current address? _____ <i>If less than 5 years at current address, prior address is required.</i>			
f. Primary Phone: <input type="checkbox"/> Home <input type="checkbox"/> Cell <input type="checkbox"/> Work		g. Alternate Phone: <input type="checkbox"/> Home <input type="checkbox"/> Cell <input type="checkbox"/> Work	
h. Email Address		i. Date of Birth <i>(MM/DD/YYYY)</i>	j. Place of Birth <i>(City, State, Country)</i>

8. PAYOR INFORMATION *(If different from the Proposed Insured and Owner.)*

a. Payor's Name <i>(Last, First, MI)</i>		b. Relationship to Proposed Insured	c. Social Security # or Taxpayer ID #
d. Address <i>(Include City, State, and ZIP. If mailing address is a PO Box, a street address is also required.)</i>			
e. How long at current address? _____ <i>If less than 5 years at current address, prior address is required.</i>			
f. Primary Phone: <input type="checkbox"/> Home <input type="checkbox"/> Cell <input type="checkbox"/> Work		g. Alternate Phone: <input type="checkbox"/> Home <input type="checkbox"/> Cell <input type="checkbox"/> Work	
h. Email Address		i. Date of Birth <i>(MM/DD/YYYY)</i>	j. Place of Birth <i>(City, State, Country)</i>

9. FINANCIAL AND PURPOSE STATEMENT *(To be completed if amount applied for and in force with the Company is over \$500,000.)*

a. Personal Finances				b. Business Finances			
Total Assets	Total Liabilities	Net Worth	Income from Occupation	Income from Other Sources	Annual Sales	Total Liabilities	Net Income
\$	\$	\$	\$	\$	\$	\$	\$

- c. What is the purpose of this insurance?
- Family Protection Key Man
- Buy/Sell *If checked, are partners applying for a like amount of coverage in force?.....* Yes No
- Debt Protection *If checked, state loan amount and terms of agreement.* _____
- Other _____
- d. Have you or your company ever filed for bankruptcy?..... Yes No
(If Yes, provide full details in "Additional Comments/Special Requests" section and include discharge date, if applicable.)

10. ADDITIONAL COMMENTS/SPECIAL REQUESTS

11. PERSONAL HISTORY *(Provide details of all "Yes" answers in the Personal History Details section below.)*

	Proposed Insured		Additional Proposed Insured(s)
	Yes	No	Yes No

- a. Within the past two (2) years, has any Proposed Insured:
- made any flights as a pilot, student pilot, or member of a flight crew? *(If Yes, complete Aviation questionnaire.)*
 - engaged in the following hazardous sports: bungee or base jumping, parachuting, hang gliding; competitive skiing/snowboarding (such as heli-skiing or ski jumping); diving activities (such as scuba, cave diving, or underwater photography); canyoning, kayaking, or white water rafting; organized racing (such as automobiles, drag racers, or motorcycles); rock or mountain climbing, rodeo riding, or any other hazardous sport/activity? *(If Yes, complete Sports Activities questionnaire.)*
- b. Has any Proposed Insured:
- been convicted of reckless driving or driving under the influence of alcohol or drugs in the past five (5) years?
 - had a driver's license suspended or revoked within the past five (5) years or is currently under license suspension or revocation?.....
 - been convicted of or plead guilty to more than two (2) moving violations in the past five (5) years?
 - been convicted of or plead guilty to more than three (3) moving violations in the past three (3) years?
- c. Driver's License Number(s) during the past five (5) years:

Name of Proposed Insured(s) on Driver's License	Driver's License Number	State Issued

- d. Within the past seven (7) years, has any Proposed Insured been convicted of, plead guilty to, or entered a plea of no contest to any felony?
- e. Is any Proposed Insured currently on probation or been placed on probation within the last twelve (12) months?
- f. Has any Proposed Insured ever been declined, postponed, rated, or modified for insurance?.....
- g. Within the next two (2) years, does any Proposed Insured intend to work, travel, or reside outside of the United States for more than thirty (30) days? *(If Yes, where? Provide details below.)*
- h. **Personal History Details.** Please provide details of all "Yes" answers in the area below. *(Attach a separate sheet if more space is needed. Any additional sheet MUST be signed and dated by the applicable Proposed Insured/Owner to avoid amendments.)*

PERSONAL HISTORY DETAILS

Question #	Proposed Insured's Name	Dates	Details

12. MEDICAL HISTORY

a. Proposed Insured's Height ' " b. Proposed Insured's Weight lbs.

	Proposed Insured		Additional Proposed Insured(s)	
	Yes	No	Yes	No
c. Has any Proposed Insured used cigarettes, cigars, pipes, chewing tobacco, nicotine patches, snuff, nicotine chewing gum, or other products containing nicotine:				
(i) within the last twelve (12) months?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(ii) within the last twelve (12) to thirty-five (35) months?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(iii) within the last thirty-six (36) months or more?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d. Within the past seven (7) years, has any Proposed Insured:				
1. been treated for or been advised or diagnosed by a medical professional to seek treatment for the use of alcohol or prescription drugs?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. been advised to reduce or discontinue the intake of alcohol or prescription drugs?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<i>(If Yes to d.1. or d.2. above, complete the Alcohol Usage and/or Prescription Medication and Drug Use questionnaire.)</i>				
3. used, except as prescribed by a physician: heroin, morphine, other narcotics, ecstasy, opium derivatives, marijuana, cocaine, crack, barbiturates, amphetamines, methamphetamines, hallucinogens, any other illegal, restricted or controlled substances, and/or been treated for or been advised by a medical professional to seek treatment for the intake of any drug?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<i>(If Yes, complete the Prescription Medication and Drug Use questionnaire.)</i>				
4. been diagnosed with, been advised to have, or had treatment for: hypertension; heart disease/disorder; valve disorders; angina; cardiac arrhythmia; heart surgery, including bypass, angioplasty or stent placement; blood vessel or blood disorders; stroke; Transient Ischemic Attach (TIA); or circulatory disorder?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. been diagnosed with, been advised to have, or had treatment for: chronic obstructive pulmonary disease (COPD); emphysema; lung or respiratory disorder; sleep apnea; current use of oxygen; or shortness of breath?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. been diagnosed with, been advised to have, or had treatment for: cancer, in any form; pancreatic disorders; or diabetes?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. been diagnosed with, been advised to have, or had treatment for: digestive disorder; gastrointestinal bleeding; bladder disorders; unexplained weight loss; kidney or liver disease, including hepatitis; Crohn's disease; or ulcerative colitis?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. been diagnosed with, been advised to have, or had treatment for: Alzheimer's disease; dementia; memory loss; emotional or psychiatric disorder; nervous system disorder; or taken any prescription medication for Alzheimer's disease, dementia, or memory loss?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. been diagnosed with, been advised to have, or had treatment for: paralysis; sexually transmitted diseases; lupus; birth defects; rheumatoid arthritis; or any disease or disorder of the bones or muscles?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10. been diagnosed with, been advised to have, or had treatment for any disease or disorder not mentioned above?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11. consulted a physician to have tests performed, such as electrocardiogram (EKG), echocardiogram, X-ray, and/or blood tests; been hospitalized for any reason; or had tests, surgery, treatment or hospitalization recommended, but not completed?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
12. consulted any healthcare provider(s) not already identified, for any reason?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e. Has any Proposed Insured ever been diagnosed as having, been told by a medical professional that they have, or been treated by a medical professional for Acquired Immune Deficiency Syndrome (AIDS), AIDS-Related Complex (ARC), or any immune deficiency-related disorder or tested positive for antibodies to the Human Immunodeficiency Virus (HIV)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
f. Does any Proposed Insured:				
(i) currently use prescription medicines? (If Yes, list each medication and advise reason taking below.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(ii) currently have a personal physician? (If Yes, list name, address, and telephone number and provide date, reason and results of last consultation below.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
g. Is any Proposed Insured currently disabled? (If Yes, provide reason for disability and details below)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
h. Medical History Details. Please provide details of all "Yes" answers in the area below. (Attach a separate sheet if more space is needed. Any additional sheet MUST be signed and dated by the applicable Proposed Insured/Owner to avoid amendments.)				

MEDICAL HISTORY DETAILS

Question #	Proposed Insured's Name	Date of Onset/ Treatment	Details/Results	Name, Address, and Telephone Number of Attending Physician

AUTHORIZATION AND ACKNOWLEDGMENT

I/We authorize any insurance or reinsurance company, employer, licensed medical physician, medical professional, hospital, pharmacy or pharmacy benefit manager, records custodians, other medical or medically related facility, clearing house, consumer reporting agency, and/or the Medical Information Bureau (MIB, Inc.) that has any record of information about me/us or my/our minor children who are to be insured, to give Americo Financial Life and Annuity Insurance Company (Americo), its reinsurers or its authorized representatives, information about other insurance coverage, employment, age, general character, motor vehicle records, habits, court records, foreign travel, finances, participation in hazardous activities, medical care or advice about any physical or mental condition, including information about drugs and alcoholism required by Americo to determine insurability and/or claims eligibility for the duration of the claim.

Americo may release information obtained by this Authorization to its reinsurers, to MIB, Inc., to other insurers with whom I/we have policies or to whom I/we may apply or submit a claim, to other persons or organizations performing business or legal services in connection with an insurance transaction for me/us, or as may otherwise be lawfully required. Although federal regulations require that Americo inform You of the potential that information disclosed pursuant to this Authorization may be subject to redisclosure by the recipient and no longer be protected by such regulation, all information received by Americo pursuant to this Authorization will be protected by federal and state privacy laws and regulations.

I/We have received a copy of the Notice of Insurance Information Practices. I/We, or my/our authorized representative, may obtain a copy of this Authorization on request. This Authorization will be valid for two (2) years from the date signed. It is Americo's practice to prohibit third parties who lawfully receive nonpublic health information from redisclosing or reusing the disclosed information. A photographic copy shall be as valid as the original. I/We understand that a copy of this Authorization will be provided, upon request, to me/us or a person authorized on my/our behalf.

This Authorization may be revoked; however, it may not be revoked during the contestability period of the policy or to the extent Americo has taken action in reliance on this Authorization. Notice of revocation may be sent, in writing, to Americo at its Administrative Office address.

IN ACCORDANCE WITH STATE LAW, WE MUST PROVIDE YOU WITH THE FOLLOWING FRAUD NOTICE: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

KY Residents only: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

NM Residents only: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to civil fines and criminal penalties.

The **USA PATRIOT ACT** requires all financial institutions, including insurance companies, to verify the identity of their customers. Providing your name, address, date of birth and taxpayer identification number allows us to verify your identity. Our verification process may include the use of third-party sources to verify the information provided.

REQUEST FOR OWNER'S TAXPAYER IDENTIFICATION NUMBER AND CERTIFICATION: Under penalties of perjury, I as the Owner, certify that the number shown on this form is my correct taxpayer identification number (or I am waiting for a number to be issued to me).

Any policy issued on this application will be deemed to be delivered in and governed by the laws of the jurisdiction in which this application was signed. Notwithstanding the foregoing, if this application is not solicited face to face and/or is effected through any electronic means, any policy issued on this application will be deemed to be delivered in and governed by the laws of the jurisdiction of the Owner, and said jurisdiction will also be the "Signed at (City and State)" inserted below.

No agent or medical examiner can waive the answer to any question in this application nor decide on insurability nor waive any of the company's underwriting requirements nor make or change any contract. The company shall have no knowledge of statements made by or to the Agent or medical examiner unless such statements are shown on the application.

I/We have read this application and represent to Americo that the statements made on this application are true, complete and correctly recorded to the best of my/our knowledge and belief. I/We agree that Americo can rely on these statements. I/We agree that this application and/or any medical exam form and any supplemental application or amendment to the application will be the basis for any policy issued on this application or any amendment to the application. **I/WE AGREE THAT ALL ANSWERS TO THE PERSONAL HISTORY QUESTIONS AND TO MEDICAL HISTORY QUESTIONS OF THIS APPLICATION, SIGNED AND DATED BELOW, ARE COMPLETE AND ACCURATE.**

Signed at (City and State) _____ on (Month/Day/Year) _____

X _____
Signature of Proposed Insured (required)

X _____
Signature of Owner (if different than the Proposed Insured)

X _____
Signature of Additional Proposed Insured

X _____
Signature of Witnessing Agent (required)

SERFF Tracking Number: AFLC-127664865 State: Arkansas
 Filing Company: Americo Financial Life and Annuity Insurance State Tracking Number: 49999
 Company
 Company Tracking Number: 1305
 TOI: L08 Life - Other Sub-TOI: L08.000 Life - Other
 Product Name: 1305: 5098 (06/11)
 Project Name/Number: 1305: 5098 (06/11)/1305

Supporting Document Schedules

	Item Status:	Status Date:
Satisfied - Item: Flesch Certification		
Comments:		
Attachment: Readability Certification.pdf		

	Item Status:	Status Date:
Bypassed - Item: Application		
Bypass Reason: This filing requirement is not applicable to this filing.		
Comments:		

	Item Status:	Status Date:
Satisfied - Item: Statement of Variability		
Comments:		
Attachment: 5098 (06-11) Statement of Variability.pdf		

	Item Status:	Status Date:
Satisfied - Item: Agent's Report		
Comments:		
Attachment: ABB5098-AS (06-11) FINAL for FILING 2011-10-09.pdf		

	Item Status:	Status Date:
Satisfied - Item: Associated Forms List		
Comments:		

SERFF Tracking Number: AFLC-127664865 *State:* Arkansas
Filing Company: Americo Financial Life and Annuity Insurance *State Tracking Number:* 49999
Company
Company Tracking Number: 1305
TOI: L08 Life - Other *Sub-TOI:* L08.000 Life - Other
Product Name: 1305: 5098 (06/11)
Project Name/Number: 1305: 5098 (06/11)/1305

Attachment:

Associated Forms List - AR.pdf

AMERICO FINANCIAL LIFE AND ANNUITY INSURANCE COMPANY

NAIC number: 0449-61999

FEIN number: 35-0810610

Readability Certification

I, Eric H. Petersen – FSA, MAAA hereby certify that the form listed below has the following readability score as calculated by the Flesch Reading Ease Test.

<u>Form Number</u>	<u>Form Description</u>	<u>Readability Score</u>
ABB5098 (06/11)	Application for Individual Life Insurance	52.2

 Digitally signed by Eric Petersen
Date: 2011.10.10 14:41:36 -05'00'

Eric H. Petersen – FSA, MAAA

Assistant Vice President – Product Development
Title

October 10, 2011

Date

AMERICO FINANCIAL LIFE AND ANNUITY INSURANCE COMPANY

STATEMENT OF VARIABILITY for FORM SERIES 5098 (06/11)

PRODUCT INFORMATION - Product Names (Section 2a.)

The product names are bracketed to facilitate the removal of products that are discontinued, add products as they become approved for use in your jurisdiction, or modify marketing names without re-filing. We will never add a product for which we have not received authorization from your jurisdiction to use (if required).

PRODUCT INFORMATION - Premium Mode (Section 2i.)

The premium mode is bracketed to facilitate any change to availability. If a premium mode is eliminated, then it will be eliminated for all new applicants. Americo Financial Life and Annuity Insurance Company will never administer in a discriminatory manner.

PRODUCT INFORMATION - Premium Class applied for (Section 2j.)

The premium class is bracketed to facilitate any change to availability. If a premium class is eliminated, then it will be eliminated for all new applicants. Americo Financial Life and Annuity Insurance Company will never administer in a discriminatory manner.

RIDERS - Rider Names (Section 3.)

The rider names are bracketed to facilitate the removal of riders that are discontinued or to add riders as they become approved for use in your jurisdiction without re-filing. We will never add a rider for which we have not received authorization from your jurisdiction to use (if required).

AGENT'S REPORT

Important Note: Agent's Report must be completed and submitted with all applications

Proposed Insured's Name: _____

- | | | |
|--|--------------------------|--------------------------|
| | Yes | No |
| 1. Are you related to the Proposed Insured(s)? | <input type="checkbox"/> | <input type="checkbox"/> |
| If Yes, provide relationship: | | |
| 2. How long have you known the Proposed Insured(s)?..... | | |
| 3. Did the applicant approach you to purchase insurance? (If Yes, list their stated need for the insurance in the Agent Comments/Remarks section below.) | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. At the time this application was taken, were all of the Proposed Insureds present and did you witness their signatures? | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Did the Proposed Insured(s) directly respond to you regarding each application question? | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Was a government-issued picture ID requested, reviewed, and confirmed (by reviewing a second document such as a utility bill, tax return, etc.) for the Proposed Insured, Owner, and Payor (if different than the Proposed Insured)?..... | <input type="checkbox"/> | <input type="checkbox"/> |

Provide details of all NO answers to questions 4-6 in the Agent Comments/Remarks section below.

Replacement Information

- | | | |
|--|--------------------------|--------------------------|
| | Yes | No |
| 7. Does the applicant have any existing life insurance or annuity coverage on the life of any Proposed Insured? | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. Will the life insurance applied for replace, or otherwise reduce in value, any existing life insurance or annuity now in force? | <input type="checkbox"/> | <input type="checkbox"/> |
| <i>(If Yes, complete the applicable replacement form(s). Provide copies of replacement form(s) to the Owner and the Company. Leave copies of sales materials with Owner. If you used an electronic sales presentation, you must mail a copy to the Owner.)</i> | | |

Agent Comments/Remarks:

I hereby certify that I have personally asked each question on this application to the Proposed Insured(s), that I have truly and accurately recorded on the application the information supplied by him/her, and that I have no reason to believe that any of the information provided is inaccurate or incomplete. If not, I have set forth my reservations in the "Agent Comments/Remarks" section above.

Print Agent's Name	Agent's Signature	Americo Agent Number	% Split
	X		
	X		
	X		
Writing Agent's Phone Number	Writing Agent's Fax Number	Writing Agent's Email Address	

Does Americo have your current contact information? If not, email: licensing@americo.com.

AMERICO FINANCIAL LIFE AND ANNUITY INSURANCE COMPANY

NAIC: 0449-61999

FEIN: 35-0810610

**STATE of ARKANSAS
Associated Forms List**

Form Description	Form Series Number	Disposition	Disposition Date	SERFF # State I.D. #
Flexible Premium Adjustable Life Insurance Plan	AAR119 (12/07)	Approved	3/3/2008	AFLC-125487640
Accidental Death Benefit Rider	CA2019	Approved	03/30/1993	Paper Filing
Annual Renewable and Convertible Term Life Insurance Rider	CA2020	Approved	03/30/1993	Paper Filing
Children's Level Term Insurance Rider	CA2022	Approved	03/30/1993	Paper Filing
Guaranteed Insurability Benefit Rider	CA2025	Approved	03/30/1993	Paper Filing
Spouse's Level Term Insurance Rider	CA2027	Approved	03/30/1993	Paper Filing
Waiver of Cost of Insurance and Monthly Expense Charge Rider	CA2029	Approved	03/30/1993	Paper Filing
Waiver of Monthly Specified Premium Rider	CA2030	Approved	03/30/1993	Paper Filing
Accelerated Benefit Payment Rider	AAR2127	Approved	05/10/2001	Paper Filing
Flexible Premium Adjustable Life Insurance Plan	CAR179(Rev 10/00)	Approved	12/05/2000	Paper Filing
Accidental Death Benefit Rider	CA2019	Approved	03/30/1993	Paper Filing
Children's Level Term Insurance Rider	CA2022	Approved	03/30/1993	Paper Filing
Waiver of Cost of Insurance and Monthly Expense Charge Rider	CA2029	Approved	03/30/1993	Paper Filing
Spouse's Level Term Insurance Rider	CAA2107	Approved	02/08/1999	Paper Filing
Disability Income Rider	CAA2115	Approved	06/21/1999	Paper Filing
Supplemental Application for Disability Income Rider	CBB5059	Approved	06/21/1999	Paper Filing
Accelerated Benefit Payment Rider	AAR2127	Approved	05/10/2001	Paper Filing
Flexible Premium Adjustable Life Insurance	AAR277	Approved	3/26/2007	AFLC-125102278
Accelerated Benefit Payment Rider	AAR2127	Approved	05/10/2001	Paper Filing
Whole Life Insurance Policy	AAR281	Approved	12/26/2007	AFLC-125385961
Accidental Death Benefit Rider	CA2019	Approved	03/30/1993	Paper Filing
Waiver of Premium Rider	AAA2158	Approved	1/22/2009	AFLC-125988249/41359
Children's Term Insurance Rider	CAA2113	Approved	10/03/2000	Paper Filing
Accelerated Benefit Payment Rider	AAR2146	Approved	03/07/2003	SERT-5JLLVF299
Convertible Term Life Insurance (15, 20, 30 yrs. fully guaranteed)	AAR262	Approved	5/16/2007	AFLC-125133435
Convertible Term Life Insurance (30 yr. 5-year guarantee)	AAR278	Approved	4/13/2007	AFLC-125125839
Accidental Death Benefit Rider	CAA2111	Approved	10/03/2000	Paper Filing
Children's Term Rider	CAA2018	Approved	10/24/1994	Paper Filing

Disability Income Rider	ABB2145	Approved	1/7/2003	USPH-5HETMM694
Supplemental Application for Disability Income Rider	ABB5083	Approved	1/7/2003	USPH-5HETMM694
Involuntary Unemployment Waiver of Premium Rider	AAA2140	Approved	1/21/2003	USPH-5HUS59864
Waiver of Premium Rider	CAA2100	Approved	11/04/1997	Paper Filing
Medical Exam Form	AAA5100	Approved	3/4/2009	AFLC-126007301/41692
Alcohol Usage Questionnaire	AAA5101	Approved	3/4/2009	AFLC-126007301/41692
Arthritis Questionnaire	AAA5102	Approved	3/4/2009	AFLC-126007301/41692
Aviation Questionnaire	AAA5103	Approved	3/4/2009	AFLC-126007301/41692
Back Disorders Questionnaire	AAA5104	Approved	3/4/2009	AFLC-126007301/41692
Chest Pain Questionnaire	AAA5105	Approved	3/4/2009	AFLC-126007301/41692
Diabetic Questionnaire	AAA5106	Approved	3/4/2009	AFLC-126007301/41692
Epilepsy/Seizure Questionnaire	AAA5107	Approved	3/4/2009	AFLC-126007301/41692
High Blood Pressure Questionnaire	AAA5108	Approved	3/4/2009	AFLC-126007301/41692
Military Questionnaire & Disclosure	AAA5109	Approved	3/4/2009	AFLC-126007301/41692
Nervous Disorders Questionnaire	AAA5110	Approved	3/4/2009	AFLC-126007301/41692
Prescription Medication & Drug Use Questionnaire	AAA5111	Approved	3/4/2009	AFLC-126007301/41692
Respiratory Disorders Questionnaire	AAA5112	Approved	3/4/2009	AFLC-126007301/41692
Sports Activities Questionnaire	AAA5113	Approved	3/4/2009	AFLC-126007301/41692
Tumor Questionnaire	AAA5114	Approved	3/4/2009	AFLC-126007301/41692