

SERFF Tracking Number: FRTH-127727194 State: Arkansas  
 Filing Company: Forethought Life Insurance Company State Tracking Number: 50039  
 Company Tracking Number: LTC3001-01  
 TOI: A02I Individual Annuities- Deferred Non- Variable Sub-TOI: A02I.003 Single Premium  
 Product Name: Single Premium Deferred Annuity Application  
 Project Name/Number: Single Premium Deferred Annuity Application/LTC3001-01

## Filing at a Glance

Company: Forethought Life Insurance Company

Product Name: Single Premium Deferred Annuity Application SERFF Tr Num: FRTH-127727194 State: Arkansas

TOI: A02I Individual Annuities- Deferred Non- Variable SERFF Status: Closed-Approved- Closed State Tr Num: 50039

Sub-TOI: A02I.003 Single Premium Co Tr Num: LTC3001-01 State Status: Approved-Closed  
 Filing Type: Form Reviewer(s): Linda Bird

Author: Beth Witte

Disposition Date: 10/20/2011

Date Submitted: 10/17/2011

Disposition Status: Approved-Closed

Implementation Date Requested: On Approval

Implementation Date:

State Filing Description:

## General Information

Project Name: Single Premium Deferred Annuity Application

Status of Filing in Domicile: Pending

Project Number: LTC3001-01

Date Approved in Domicile:

Requested Filing Mode: Review & Approval

Domicile Status Comments:

Explanation for Combination/Other:

Market Type: Individual

Submission Type: New Submission

Individual Market Type:

Overall Rate Impact:

Filing Status Changed: 10/20/2011

State Status Changed: 10/20/2011

Deemer Date:

Created By: Beth Witte

Submitted By: Beth Witte

Corresponding Filing Tracking Number:

Filing Description:

Please find attached application form LTC3001-01 for your review. This application is similar to application LTC3000-02-AR which was approved by your office on February 17, 2011, Serff tracking #FRTH-126999627. This form has been re-formatted to condense to fewer pages.

Also attached is form LTC3002-01. This application is a Medical Questionnaire that may be used in conjunction with application LTC3001-01. There have been no changes to this form with the exception of the form number. This was part of LTC3000-02-AR approved with the previously mentioned filing. We would like to have it as a separate document with a different form number.

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 Variable  
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The forms are being filed on a general use basis and will be marketed in the individual annuity market exclusively by the Company's licensed agents/brokers and bank distribution channels. The forms contain no unusual or controversial features or language that deviate from normal insurance industry standards.

If you have any questions concerning this filing, you may contact me directly at 1-800-648-0075 ext. 6748 or by e-mail at kasey\_poettker@forethought.com.

Sincerely,

Kasey Poettker  
 Compliance Analyst  
 Forethought Life Insurance Company

## Company and Contact

### Filing Contact Information

Kasey Poettker, Compliance Analyst kasey\_poettker@forethought.com  
 1 Forethought Center 812-933-6748 [Phone]  
 Batesville, IN 47006 812-933-6348 [FAX]

### Filing Company Information

Forethought Life Insurance Company CoCode: 91642 State of Domicile: Indiana  
 1 Forethought Center Group Code: 1266 Company Type: Insurance  
 Batesville, IN 47006 Group Name: State ID Number:  
 (800) 648-0075 ext. [Phone] FEIN Number: 06-1016329

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## Filing Fees

Fee Required? Yes  
 Fee Amount: \$100.00  
 Retaliatory? No  
 Fee Explanation: \$50.00 PER FORM X 2 FORMS = \$100.00  
 Per Company: No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
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Forethought Life Insurance Company \$100.00 10/17/2011 52891305

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## Correspondence Summary

### Dispositions

Status	Created By	Created On	Date Submitted
Approved- Closed	Linda Bird	10/20/2011	10/20/2011

SERFF Tracking Number: *FRTH-127727194* State: *Arkansas*  
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## **Disposition**

Disposition Date: 10/20/2011

Implementation Date:

Status: Approved-Closed

Comment:

Rate data does NOT apply to filing.

SERFF Tracking Number: *FRTH-127727194* State: *Arkansas*  
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<b>Schedule</b>	<b>Schedule Item</b>	<b>Schedule Item Status</b>	<b>Public Access</b>
<b>Supporting Document</b>	Flesch Certification		Yes
<b>Supporting Document</b>	Application		Yes
<b>Supporting Document</b>	Life & Annuity - Acturial Memo		No
<b>Form</b>	FOECARE ANNUITY APPLICATION		Yes
<b>Form</b>	PART 2 - MEDICAL QUESTIONNAIRE		Yes

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## Form Schedule

**Lead Form Number: LTC3001-01**

Schedule Item Status	Form Number	Form Type Form Name	Action	Action Specific Data	Readability	Attachment
	LTC3001-01	Application/ FORECARE Enrollment Form ANNUITY APPLICATION	Initial		52.000	LTC3001-01 Fore Care Application 08.18.11.pdf
	LTC3002-01	Application/ PART 2 - MEDICAL Enrollment Form QUESTIONNAIRE	Initial		53.000	LTC3002-01 Part 2 - Medical Ques ForeCare Application 09.22.11.pdf



# ForeCare<sup>sm</sup> Annuity Application

9 Year

Forethought Life Insurance Company  
One Forethought Center  
P.O. Box 246  
Batesville, IN 47006-0246  
(855) 244-4441  
Fax (855) 596-5404

### OWNER (All Policyholder correspondence will be sent to this address.)

Name: \_\_\_\_\_ Sex: \_\_\_ Age: \_\_\_ DOB: \_\_\_\_\_  
Address: \_\_\_\_\_ SSN: \_\_\_\_\_  
Daytime Phone: ( ) \_\_\_\_\_

### JOINT OWNER (Optional)

Name: \_\_\_\_\_ Sex: \_\_\_ Age: \_\_\_ DOB: \_\_\_\_\_  
Address: \_\_\_\_\_ SSN: \_\_\_\_\_  
Daytime Phone: ( ) \_\_\_\_\_

### ANNUITANT (Complete only if the Owner and Annuitant are different)

Name: \_\_\_\_\_ Sex: \_\_\_ Age: \_\_\_ SSN: \_\_\_\_\_  
Address: \_\_\_\_\_ Daytime Phone \_\_\_\_\_ DOB: \_\_\_\_\_  
Relationship to Owner: \_\_\_\_\_

### JOINT ANNUITANT

Name: \_\_\_\_\_ Sex: \_\_\_ Age: \_\_\_ SSN: \_\_\_\_\_  
Address: \_\_\_\_\_ Daytime Phone \_\_\_\_\_ DOB: \_\_\_\_\_  
Relationship to Owner: \_\_\_\_\_

### PROPOSED INSURED INFORMATION (Must be Owner or Spouse, unless Trust, then must be Annuitant or Spouse)

Name: \_\_\_\_\_ Sex: \_\_\_ Age: \_\_\_ SSN: \_\_\_\_\_  
Address: \_\_\_\_\_ Daytime Phone \_\_\_\_\_ DOB: \_\_\_\_\_  
Relationship to Owner: \_\_\_\_\_

### PROPOSED JOINT INSURED INFORMATION (Optional, must be Spouse of Insured)

Name: \_\_\_\_\_ Sex: \_\_\_ Age: \_\_\_ SSN: \_\_\_\_\_  
Address: \_\_\_\_\_ Daytime Phone \_\_\_\_\_ DOB: \_\_\_\_\_  
Relationship to Owner: \_\_\_\_\_

### BENEFICIARY INFORMATION

Primary Beneficiary Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ SSN: \_\_\_\_\_  
Contingent Beneficiary Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ SSN: \_\_\_\_\_

### COUPLES DISCOUNT

Does the Proposed Insured's spouse have long term care benefits inforce or applied for with Forethought Life Insurance Company?  
 Yes  No If "yes," enter spouse information:

Spouse's Name	Date of Birth	Policy/Contract #	Social Security Number

### ANNUITY DEPOSIT

Annuity Deposit ..... \$ \_\_\_\_\_ **Type of Annuity:**  **Non-Qualified**  
 Estimated Annuity Deposit of 1035 Exchange/Transfer \$ \_\_\_\_\_ **Guaranteed Rate Period:**  1 Year

### Free Withdrawal Option

10% Free Withdrawal  Market Value Adjustment

### RIDER BENEFIT INFORMATION

Rider Selections:  **Rider for Long-Term Care Benefits**

#### Optional Inflation Protection Benefit Rider (select one)

- I reject the 5% compounding Inflation Protection Benefit Rider
- I choose the 5% compounding Inflation Protection Benefit Rider

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**RIDER BENEFIT INFORMATION CONTINUED****Optional Nonforfeiture Rider** (select one)

- No I reject the Nonforfeiture Benefit Rider  
 Yes I accept the Nonforfeiture Benefit Rider

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**PROTECTION AGAINST UNINTENTIONAL TERMINATION OR REDUCTION OF LONG-TERM CARE BENEFITS**

**This section is to be completed by the Owner. You have the right to designate a Third Party to receive notice from us of a request from you that results in reduction or termination of the Long Term Care Benefit.**

I understand that I have the right to designate others to receive notice from the Company of a request from me that results in the reduction or termination of long-term care benefits.

- I elect **NOT** to designate another person to receive such notice.  
 I designate the following person or entity to receive such notice.

Full Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
City, State, Zip: \_\_\_\_\_  
Telephone Number: \_\_\_\_\_

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**OTHER COVERAGE AND REPLACEMENT INFORMATION**

The Producer shall comply with any additional state and/or company replacement requirements.

- Does the proposed Insured currently have a long-term care policy or certificate in force (including health care service contracts or health maintenance organization contracts)?  Yes  No  
**If "yes," provide details on Addendum.**
- Has the proposed Insured had a long-term care policy or certificate in force during the last 12 months?  Yes  No  
**If "yes," provide details on Addendum.**
- Does the proposed Insured intend to replace any long-term care, medical or health insurance coverage with this coverage? **If "yes," provide details on Addendum.**  Yes  No
- Producer must list all health insurance, including long-term care policies that he or she sold to the proposed Insured which are still in force; or were purchased in the last five years but are no longer in force. If "None," check the 'None' box.  None  
**Provide details on Addendum.**
- Is the proposed Insured currently eligible for benefits under or covered by Medicaid (not Medicare)?  Yes  No

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**SIGNATURES Checks must be made payable to: *Forethought Life Insurance Company***

Do you have any existing life insurance policies or annuity contracts?  Yes  No

Will this annuity replace, discontinue or change any existing life insurance or annuity contract issued by a company?  Yes  No

I understand this annuity is not federally insured. I have read and understand the important disclosures located in this application. I represent that all statements and answers in this application are complete and true, on my behalf and any person who may claim any interest under this policy.

X \_\_\_\_\_  
Owner's Signature

X \_\_\_\_\_  
Joint Owner's Signature (if applicable)

X \_\_\_\_\_  
Annuitant's Signature (if not the Owner)

X \_\_\_\_\_  
Joint Annuitant's Signature (if applicable)

X \_\_\_\_\_  
Insured's Signature (if not the Owner or Annuitant)

X \_\_\_\_\_  
Joint Insured's Signature (if applicable)

Signed at (city/state): \_\_\_\_\_ on (date): \_\_\_\_\_

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**AGENT INFORMATION**

To the best of my knowledge, the applicant has an existing life insurance policy or annuity contract.

Yes  No

Do you have any reason to believe this annuity will replace, discontinue or change any existing life insurance or annuity?

Yes  No

As agent, have you complied with all State Replacement Regulations and completed all required State Replacement forms?

Yes  No

Did you observe the proposed Insured having any physical or mental impairment with regard to walking or talking?

Yes  No

If **yes**, attach documentation.

By signing this form, I certify that I have truly and accurately recorded herein the information provided by the applicant.

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Licensed Agent's Signature

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Business Name and Branch Number

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Licensed Agent (Print Name)

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State License Number or Agent Number

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**STATE REQUIRED NOTICES****AR, HI, KY, MA, ND, OK, PA, SD, TN, and WA Residents**

Any person who knowingly and with intent to injure, defraud or deceive any insurance company, submits an application for insurance containing any materially false, incomplete, or misleading information, or conceals for the purpose of misleading, any material fact, is guilty of insurance fraud, which is a crime and in certain states, a felony. Penalties may include imprisonment, fine, denial of benefits, or civil damages.

**CA Residents – Reg. 789.8**

The sale or liquidation of any asset in order to buy insurance, either life insurance or an annuity contract, may have tax consequences. Terminating any life insurance policy or annuity contract may have early withdrawal penalties or other costs or penalties, as well as tax consequences. You may wish to consult independent legal or financial advice before the sale or liquidation of any asset and before the purchase of any life insurance or annuity contract.

**CO Residents**

It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance and civil damages. Any insurance company or agent of any insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Department of Regulatory Agencies.

**ME Residents**

**It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance benefits.**

**MD, NM and RI Residents**

Any person who knowingly and willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly and willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

**NJ Residents**

Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

**VA Residents**

Any person who, with the 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 may have violated the state law.

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**Forethought Annuity LTC Application – Part 2 Medical Questionnaire**

**Proposed Insured**

Name (First, Middle Initial, Last)		Date of birth (mm/dd/yyyy)	
Mailing Address		Height	Weight
City	State	Social Security Number	

**Proposed Insured Health Questions**

<p>1. Are you currently confined to a nursing facility, receiving home health care, using Adult Day Care services, receiving hospice care, residing in an Assisted Living Facility, or in the last 12 months have you used or been medically advised to seek such confinement or care, or are you currently hospitalized or confined to a bed?</p>	<input type="checkbox"/> Yes <input type="checkbox"/> No
<p>2. Do you require assistance or supervision in performing any of the following activities: bathing, dressing, transferring, eating, toileting, bowel or bladder control, mobility, or taking medications?</p>	<input type="checkbox"/> Yes <input type="checkbox"/> No
<p>3. Do you use or have you been medically advised to use a walker, multi prong cane, wheelchair, motorized scooter, hospital bed, stair lift, or any medical appliance such as oxygen, respirator, dialysis machine or have a defibrillator implanted?</p>	<input type="checkbox"/> Yes <input type="checkbox"/> No
<p>4. Have you been medically diagnosed, treated for, advised to have treatment for, been prescribed or taken medication for any of the following:</p> <p>a. Alzheimer’s disease, dementia, recurrent memory loss, Organic Brain Syndrome (OBS), mental incapacity or retardation?</p> <p>b. Stroke, Parkinson’s disease, paralysis, paraplegia, or quadriplegia?</p> <p>c. Multiple Sclerosis, Muscular Dystrophy, Lou Gehrig’s disease (ALS), Cystic Fibrosis, or Huntington’s disease?</p>	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No
<p>If “yes” to any of the above questions, please list all medications in #12 - Additional Information.</p>	
<p>5. Have you ever been medically diagnosed as having or been treated for Acquired Immune Deficiency Syndrome (AIDS), or have you ever tested positive for the Human Immunodeficiency Virus (HIV)?</p>	<input type="checkbox"/> Yes <input type="checkbox"/> No
<p>6. In the last three (3) years have you applied for any long term care policy or long term care rider that was declined or postponed?</p>	<input type="checkbox"/> Yes <input type="checkbox"/> No
<p>7. In the last 6 months, have you been medically diagnosed as having had a heart attack or aneurysm, had angioplasty, coronary bypass surgery, vascular surgery, or heart valve replacement?</p>	<input type="checkbox"/> Yes <input type="checkbox"/> No
<p>8. In the last 12 months have you:</p> <p>a. Been medically diagnosed as having or been treated for congestive heart failure or cardiomyopathy?</p> <p>b. Had a seizure or convulsion, multiple falls, or any fall resulting in a fracture?</p> <p>c. Been hospitalized overnight two (2) or more times?</p>	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No
<p>9. In the last two (2) years have you been:</p> <p>a. Medically diagnosed or received treatment for leukemia, Hodgkins’ disease or other lymphoma, cancer of the bone, breast, colon, esophagus, liver, lung, ovary, pancreas, stomach, uterus, or any metastatic cancer?</p>	<input type="checkbox"/> Yes <input type="checkbox"/> No

- b. Medically advised to have treatment or been treated for alcohol or drug use or dependency?  Yes  No
- c. Hospitalized for depression, bi-polar disorder or any other psychiatric disorder?  Yes  No

10. Have you ever been medically diagnosed, treated for, advised to have treatment for, been prescribed or taken medication for:

- a. Cirrhosis of the liver?  Yes  No
- b. Transient Ischemic Attach (TIA) within the last year, multiple TIA's, or a TIA with a history of heart disease?  Yes  No
- c. Bi-polar disorder, schizophrenia or other psychosis?  Yes  No
- d. Chronic kidney failure?  Yes  No
- e. Diabetes with a history of TIA, heart disease, or carotid artery disease?  Yes  No
- f. Diabetes currently treated with insulin?  Yes  No
- g. Rheumatoid arthritis with joint deformity, joint replacement or requiring daily use of narcotic medication?  Yes  No
- h. Organ transplant other than cornea?  Yes  No
- i. Multiple myeloma, scleroderma, myasthenia gravis, or systemic lupus?  Yes  No
- j. Amputation due to disease?  Yes  No

If "yes" to any of the above questions, please list all medications in #12 - Additional Information.  Yes  No

11. Have you been medically advised to have any surgery, organ transplant, diagnostic test, or medical evaluation that has not yet been completed?

12. **ADDITIONAL INFORMATION**

**Proposed Insured Statement and Representations**

**I agree that no insurance shall be in effect until: (a) a contract has been issued and (b) the premium is paid while my insurability as stated in this application remains unchanged.**

**I agree that the answers set forth on this Application are true and complete to the best of my knowledge and belief, and my answers are the basis of any insurance issued. All statements made by me shall be deemed to be representations and not warranties.**

**I agree that this Application will be part of the policy for which I apply and that I will notify the Insurer if any statements or answers given in the Application change prior to delivery of the policy.**

**I agree that a verbal confirmation may be requested for this Application during a telephone interview, and that my verbal confirmation is as valid as my written signature.**

**CAUTION: If your answers on this Application are incorrect or untrue, Forethought Life Insurance Company has the right to deny benefits or rescind the contract.**

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

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed Name of Proposed Insured

\_\_\_\_\_  
Signature of Examiner

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## Supporting Document Schedules

	<b>Item Status:</b>	<b>Status Date:</b>
<p><b>Satisfied - Item:</b> Flesch Certification</p> <p><b>Comments:</b></p> <p><b>Attachment:</b> Readability Certification - LTC3001-01.pdf</p>		

	<b>Item Status:</b>	<b>Status Date:</b>
<p><b>Satisfied - Item:</b> Application</p> <p><b>Comments:</b> The application being filed for approval is in the form schedule tab.</p>		

	<b>Item Status:</b>	<b>Status Date:</b>
<p><b>Bypassed - Item:</b> Life &amp; Annuity - Acturial Memo</p> <p><b>Bypass Reason:</b> n/a</p> <p><b>Comments:</b></p>		

## CERTIFICATION OF READABILITY

<b>FORM #</b>	<b>FORM NAME</b>	<b>FLESCH SCORE</b>
LTC3001-01	FORECARE ANNUITY APPLICATION	52.0
LTC3002-01	PART 2 – MEDICAL QUESTIONNAIRE	53.0

Forethought Life Insurance Company hereby certifies that this form achieves the Flesch reading ease score listed.



David K. Mullen, Sr. Vice President

September 12, 2011