

SERFF Tracking Number: AEGB-127817536 State: Arkansas
Filing Company: Stonebridge Life Insurance Company State Tracking Number: 50249
Company Tracking Number: L120 1011S
TOI: L071 Individual Life - Whole Sub-TOI: L071.101 Fixed/Indeterminate Premium - Single Life
Product Name: L120 1011S
Project Name/Number: L120 1011S/L120 1011S

Filing at a Glance

Company: Stonebridge Life Insurance Company

Product Name: L120 1011S

TOI: L071 Individual Life - Whole

Sub-TOI: L071.101 Fixed/Indeterminate
Premium - Single Life

Filing Type: Form

SERFF Tr Num: AEGB-127817536 State: Arkansas

SERFF Status: Closed-Approved-
Closed State Tr Num: 50249

Co Tr Num: L120 1011S

State Status: Approved-Closed

Author: Sherri Sturtz

Date Submitted: 11/11/2011

Reviewer(s): Linda Bird

Disposition Date: 11/16/2011

Disposition Status: Approved-
Closed

Implementation Date:

Implementation Date Requested: On Approval

State Filing Description:

General Information

Project Name: L120 1011S

Project Number: L120 1011S

Requested Filing Mode: Review & Approval

Explanation for Combination/Other:

Submission Type: New Submission

Overall Rate Impact:

Deemer Date:

Submitted By: Sherri Sturtz

Status of Filing in Domicile: Pending

Date Approved in Domicile:

Domicile Status Comments: Filed concurrently.

Market Type: Individual

Individual Market Type:

Filing Status Changed: 11/16/2011

State Status Changed: 11/16/2011

Created By: Sherri Sturtz

Corresponding Filing Tracking Number:
30822760

Filing Description:

November 3, 2011

Commissioner of Insurance

Arkansas Insurance Division

1200 West 3rd Street

Little Rock, Arkansas 72201-1904

RE; STONEBRIDGE LIFE INSURANCE COMPANY NAIC# 468-65021

Form Number: L120 1011S – Life Application FEIN# 03-0164230

SERFF Tracking Number: AEGB-127817536 State: Arkansas
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Dear Sir/Madam:

Please find attached copies of the above referenced form. This is a new form and is not intended to replace any form previously approved by your Department. This form has been submitted in final printed form in which it will be distributed to Insureds. This form is subject to only minor modifications in paper size and stock, ink, border, Company logo, Company address, adaptation to computer printing, and Officers' signatures.

Life Application – This is an individual life insurance application that will be used with our life portfolio. This application will be used via paper by licensed agents. We intend to use this form in a traditional manner whereby the Owner/applicant signs the application in ink and submits the application to the Company.

We also plan to make this application form available electronically. It is our intent to use this application form in a variety of electronic environments, including a laptop and web based application process. Regardless of the application process used, we intend to adopt measures to secure both the integrity of the document once signed, and the confidentiality of any information transmitted, including transmission of information via a secured socket layer/secured line. The information contained in the application will be transmitted to our administrative office electronically as well as the electronic signature of the Owner/Applicant. Current technology will be used to ensure that the confidential information is not compromised. All processes used will comply with the Uniform Electronic Transactions act, and to the extent applicable, the Federal ESIGN Act.

We hereby certify that any electronic signature we obtain will be linked to the date on the electronic application in such a manner that the electronic signature is invalidated if any of the data on the application is changed. We also certify that such electronic signature intended for use with this application will not be affixed to or duplicated on any other document.

A copy of the application, identical to the filed form, will be printed and made part of any policy issued. We would appreciate your review and approval of this form. Should you have any questions or need any additional information, please do not hesitate to contact me.

Sincerely,

Sherri A. Sturtz

Forms Management Coordinator

(319) 355-7965 (collect)

Fax #: (319) 355-2501

Sherri.Sturtz@Transamerica.com

Company and Contact

Filing Contact Information

Paige Johnson, Forms Management

Paige.Johnson@Transamerica.com

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Coordinator
 4333 Edgewood Road NE 319-355-6869 [Phone]
 Cedar Rapids, IA 52499

Filing Company Information

Stonebridge Life Insurance Company CoCode: 65021 State of Domicile: Vermont
 4333 Edgewood Rd. NE Group Code: 468 Company Type: Life & Health
 Cedar Rapids, IA 52499 Group Name: State ID Number:
 (319) 355-8511 ext. [Phone] FEIN Number: 03-0164230

Filing Fees

Fee Required? Yes
 Fee Amount: \$0.00
 Retaliatory? Yes
 Fee Explanation:
 Per Company: No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Stonebridge Life Insurance Company	\$50.00	11/11/2011	53686289

SERFF Tracking Number: AEGB-127817536 State: Arkansas
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Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Linda Bird	11/16/2011	11/16/2011

SERFF Tracking Number: AEGB-127817536 *State:* Arkansas
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Product Name: L120 1011S
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Disposition

Disposition Date: 11/16/2011

Implementation Date:

Status: Approved-Closed

Comment:

Rate data does NOT apply to filing.

SERFF Tracking Number: AEGB-127817536 State: Arkansas
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Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification		Yes
Supporting Document	Application		Yes
Supporting Document	Life & Annuity - Actuarial Memo		No
Supporting Document	Statement of Variability		Yes
Form	Life Application		Yes

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Form Schedule

Lead Form Number: L120 1011S

Schedule Item Status	Form Number	Form Type Form Name	Action	Action Specific Data	Readability	Attachment
	L120 1011S	Application/Life Application Enrollment Form	Initial		50.600	L120 1011S.pdf

Part A1 - Proposed Insured						
Name (First, M.I., Last)			Address, City, State, Zip Code (cannot be a P.O. Box)			
SSN	Gender	D.O.B. (MM/DD/YYYY)	Age	U.S. State or Country of Birth	Phone Number ()	
<p>1) Life Insurance Face Amount \$ _____</p> <p>a) Plan: _____</p> <p>b) Total Premium \$ _____</p> <p>c) Accidental Death Benefit Rider? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>d) Automatic Premium Loan provision (if available)? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>e) If a policy cannot be issued as applied for, would you accept a rated policy if available? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>f) If 'yes,' adjust face amount to premium? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>2) Within the last 12 months has the proposed Insured used tobacco products in any form? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>3) Does the proposed Insured have any existing life insurance or annuity contracts with the company or any other company? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>4) Is this insurance intended to replace or change any life insurance or annuity contract in force with the company or any other company? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If yes, submit the state required forms and please provide company name and policy number. _____</p>						
Part A2 - Owner (If Other Than Proposed Insured)						
Name (First, MI, Last)		SSN	Gender	Relationship to Insured	D.O.B. (MM/DD/YYYY)	
Address, City, State, Zip Code (If different from Insured) (cannot be a P.O. Box)				Are you a citizen of the U.S.? <input type="checkbox"/> Yes <input type="checkbox"/> No If not, what country?		
Part A3 - Beneficiary (Please use the Supplemental Information form if additional room is needed)						
Primary Name (First, MI, Last)		SSN	Gender	Relationship to Insured	D.O.B. (MM/DD/YYYY)	
Contingent Name (First, MI, Last)		SSN	Gender	Relationship to Insured	D.O.B. (MM/DD/YYYY)	
Part B1 - If Any Question In This Section Is Answered "Yes", The Proposed Insured Is Not Eligible For Any Coverage.						
<p>1) Is the proposed Insured hospitalized, bedridden, residing in a nursing home or long term care facility, receiving hospice or home health care, confined to a wheelchair, or has the proposed Insured been advised or is the proposed Insured planning to have inpatient surgery or currently waiting for an organ transplant? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>2) Has the proposed Insured ever:</p> <p>a) Been diagnosed with, been treated for or advised to receive treatment for Alzheimer's disease, senile dementia, organic brain disease, mental incapacity, Lou Gehrig's disease (ALS), Downs Syndrome, Huntington's disease, sickle cell anemia, Spina Bifida not surgically corrected, cystic fibrosis, cerebral palsy or any terminal medical condition? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>b) Tested positive for the antibodies to the AIDS (HIV) virus or been medically diagnosed with or received treatment for HIV, Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC)? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>c) Been in a diabetic coma or had or been advised to have an amputation due to disease or disorder? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>3) Within the past 2 years has the proposed Insured:</p> <p>a) Been diagnosed with, been treated for or advised to receive treatment for cancer (other than basal cell carcinoma)? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>b) Undergone testing by a medical professional for which the results have not been received? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>						
Part B2						
<p>4) Has the proposed Insured been diagnosed with, been treated for or advised to receive treatment for diabetes (other than gestational diabetes) before the age of 18? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>5) Within the past 4 years has the proposed Insured been diagnosed with, been treated for or advised to receive treatment for cancer (other than basal cell carcinoma)? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>6) Within the past 1 year has the proposed Insured:</p> <p>a) Used illegal drugs or been diagnosed with, been treated for or advised to receive treatment for alcohol abuse, drug abuse or muscular dystrophy? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>b) Had more than 12 seizures or been diagnosed with, been treated for or advised to receive treatment for congestive heart failure, cirrhosis, hepatitis B or C or other liver disease? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>c) Been diagnosed with, been treated for or advised to receive treatment for heart attack, stroke (CVA), transient ischemic attack (TIA), aneurysm, angina, or had or been advised to have heart surgery of any kind including bypass surgery or pacemaker implant? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>d) Used oxygen to assist in breathing due to a disease or disorder, received kidney dialysis or been diagnosed with, been treated for or advised to receive treatment for kidney failure due to a disease or disorder? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>						
<ul style="list-style-type: none"> • If All Questions in Part B2 Are Answered "No", Proceed to Part B3. • If One Question in Part B2 Is Answered "Yes", The proposed Insured Is Only Eligible For The Graded Death Benefit Product. Proceed to Part C1. • If Two Or More Questions in Part B2 Are Answered "Yes", The proposed Insured Is Not Eligible For Any Coverage. 						

Part B3

- 7) Within the past **2 years** has the proposed Insured:
- a) Had or been treated for a heart attack, angina (chest pain), stroke (CVA), transient ischemic attack (TIA), aneurysm, circulatory or blood disorder, heart surgery including bypass or irregular heart rhythm such as atrial fibrillation? Yes No
 - b) Had more than 12 seizures, taken insulin shots or been diagnosed with, been treated for or advised to receive treatment for congestive heart failure, cirrhosis, hepatitis B or C or other liver disease? Yes No
 - c) Used illegal drugs or been diagnosed with, been treated for or advised to receive treatment for alcohol abuse or drug abuse? Yes No
- 8) Within the past **4 years** has the proposed Insured been diagnosed with, been treated for or advised to receive treatment for kidney disease? Yes No
- 9) Has the proposed Insured **ever** been diagnosed with, been treated for or advised to receive treatment for Parkinson's disease, multiple sclerosis, chronic obstructive pulmonary disease (COPD) including emphysema, chronic asthma, black lung or other chronic respiratory disease? Yes No
- 10) Is the proposed Insured currently under the age of **50 and** if so, has the proposed Insured within the past **5 years** been diagnosed with, been treated for or advised to receive treatment for any mental disorder such as manic or clinical depression, schizophrenia, bipolar disease or post traumatic stress syndrome? Yes No

- If All Questions in Part B3 Are Answered "No," The proposed Insured Is Eligible For The Preferred Product. Please Proceed to B4, and Then Check The Appropriate Box Below.
- If One Question in Part B3 Is Answered "Yes," The proposed Insured Is Eligible For The Standard Product. Please Proceed to B4, and Then Check The Appropriate Box Below.
- If Two Or More "Yes" Answers in Part B3, The proposed Insured Is Only Eligible For The Graded Death Benefit Product. Please Proceed To C1.

Part B4 - Nursing Home Option - If The Following Question Is Answered "Yes", The Proposed Insured Is Not Eligible For The Nursing Home Option On The Accelerated Death Benefit Rider.

Does the proposed Insured need any assistance from other persons in performing any activities of daily living such as eating, bathing, toileting, dressing, taking medications, walking or moving in and out of bed or chair or does the proposed Insured have ongoing incontinence or, in the 2 years prior to the application, has a medical professional recommended that the proposed Insured be confined to a Nursing Home? Yes No

- Preferred Preferred Other: _____
- Standard Standard Other: _____

Part C1 - Face Amount & Payment Method

Face Amount: _____ Payment Method: Monthly EFT Quarterly Semi-Annual Annual

Full Modal Premium Included or Authorized With Application Is: _____

Part C2 - Payor Information

The Payor is the Proposed Insured Owner Other (If Other, please provide the following information:)

Name (First, MI, Last)	SSN	Gender	Relationship to Insured
Address, City, State, Zip Code (cannot be a P.O. Box)		Are you a citizen of the U.S.? <input type="checkbox"/> Yes <input type="checkbox"/> No If not, what country?	

Part C3 - Premium Payment Authorization For Electronic Funds Transfer (EFT): Payor's Authorization To Insurance Company

As a convenience to myself, I hereby authorize Stonebridge Life Insurance Company to draft premium payments from my financial institution account.

It is understood that credit for payment is conditioned upon the draft being honored when presented for payment. Furthermore, this authorization may be terminated (a) at the option of the Company if any draft is not honored when presented for payment; or (b) by the Company, financial institution or the undersigned upon 30 days written notice to the parties hereto.

If this authorization is terminated, the amount due on the policy involved will be billed on a quarterly basis.

Draft Date (1st-28th): _____ If no date selected, the draft date will be the policy date.

Checking Savings Financial Institution Name: _____ City/State: _____

Routing #: Account #:

Payor Signature (if other than proposed Insured or Owner) _____ Date: _____

Agent's Report

I represent that:

1) I have personally seen the proposed Insured. Yes No

2) I have truly and accurately recorded on this application the information as supplied by the Owner and the proposed Insured. Yes No

Is the person proposed for insurance related to you? Yes No Relationship _____

Is the policy applied for in this application intended to replace any insurance or annuity now in force? Yes No

Best time to call for a Personal History Interview _____ a.m. _____ p.m.

Home or work phone number _____

Agent Signature _____

AGREEMENT / AUTHORIZATION

ACKNOWLEDGMENT OF PROPOSED OWNER AND INSURED(S) –Each of the undersigned hereby certifies and represents as follows: The statements and answers given on this application are true and correct. I acknowledge and agree (A) that this application and any amendments shall be the basis for any insurance issued; (B) that the agent does not have the authority to waive any question on this application, to decide if insurance will be issued, or to modify any term or provision of any insurance which may be issued based on this application, only a writing signed by an officer of the Company can change the terms of this application or the terms of any insurance issued by the Company; (C) except as provided in the Conditional Receipt, if issued with the same proposed Insured(s) as on this application, no policy applied for shall take effect until after all of the following conditions have been met: 1) the minimum initial premium must be received by the Company; 2) the proposed Owner must have personally received and accepted the policy during the lifetime of all proposed Insured(s) and while all proposed Insured(s) are in good health; and 3) on the date of the later of either 1) or 2) above, all of the statements and answers given in this application must be true and complete, and the insurance will not take effect if the facts have changed. Unless otherwise stated the proposed insured is the premium payor and Owner of the policy applied for.

I have received the MIB Disclosure Notification, Notice to Persons Applying For Insurance, Accelerated Death Benefit Disclosure and Conditional Receipt. I hereby authorize any licensed physician, medical practitioner, or the Medical Information Bureau or other institution that has any records or knowledge of the proposed Insured to give any such information, including medical information, to the life insurance company. A photocopy or facsimile of this authorization shall be made as valid as the original.

I understand that any omissions or misstatements in this application could cause an otherwise valid claim to be denied under any insurance issued from this application.

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.

Signed at City _____ State _____ Proposed Insured Signature _____

Date _____ Owner Signature _____
(If Owner other than Insured)

Witness _____
(Agent Signature) (Print Agent's Name and I.D. Number)

If the EFT premium payment method is chosen, please tape a voided check in this box.

NOTICE TO PERSONS APPLYING FOR INSURANCE

As part of the Company's procedure for processing your insurance application, an investigative consumer report may be prepared whereby information is obtained through physicians, hospitals, clinics, and other medically-related facilities, who may be contacted using your signed authorization, to obtain details of your past medical treatment.

You have the right to be interviewed as part of any investigative consumer report that may be prepared. If you desire to be interviewed, you must indicate this to the Company. You also have the right to request access to, and correction and amendment of, any personal information collected. Additionally, you are entitled to receive a description of procedures which allow access to and correction of personal information which may be obtained, the nature and scope of the investigation requested, and a description of the circumstances under which personal information may be disclosed without prior authorization. Your written request should be addressed to the Company.

STONEBRIDGE LIFE INSURANCE COMPANY

Home Office: [4333 Edgewood Road NE, Cedar Rapids, IA 52499]

MIB DISCLOSURE NOTIFICATION

Information regarding your insurability will be treated as confidential. Stonebridge Life Insurance Company or its reinsurers may, however, make a brief report thereon to the MIB, Inc., formerly known as Medical Information Bureau, a not-for-profit membership organization of insurance companies, which operates an information exchange on behalf of its members. If you apply to another MIB member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, MIB, upon request, will supply such company with the information about you in its file.

Upon receipt of a request from you, MIB will arrange disclosure of any information in your file. Please contact MIB at 866-692-6901 or (TTY 866-346-3642). If you question the accuracy of information in the MIB's file, you may contact MIB and seek a correction in accordance with the procedures set forth in the Federal Fair Credit Reporting Act. The address of MIB's information office is: 50 Braintree Hill, Suite 400, Braintree, Massachusetts 02184-8734.

Stonebridge Life Insurance Company, or its reinsurers may also release information from its file to other life insurance companies to whom you may apply for life or health insurance, or to whom a claim for benefits may be submitted. Information for consumers about MIB may be obtained on its website at www.mib.com.

7/08

CONDITIONAL RECEIPT

No coverage will be effective prior to delivery of the policy applied for unless and until all the following conditions are met:

Conditions of Coverage

1. On the Effective Date indicated below, the state of health and all factors affecting insurability of each person proposed for coverage must be stated in the application required by the Company and the application must not contain a material misrepresentation;
2. An amount equal to the first full premium required is paid on the plan and any check, money order, or Authorization for Electronic Funds Transfer (EFT) given in payment is honored when first presented; and,
3. Each person proposed for coverage is on the Effective Date insurable and acceptable to the Company under its rules, limits and underwriting standards for the plan and for the amount applied for, without modification of plan, premium of rates or amount of coverage.

Effective Date

If all of the above conditions are met, insurance in the amount applied for or \$25,000, whichever is lower, will become effective on the date the application is completed. If any of the above conditions are not met, or if the proposed Insured dies by suicide, this receipt provides no coverage, and the liability of the Company is the return of the amount remitted with this receipt. Coverage which takes effect through this receipt will terminate at the EARLIEST of the following: (a) the effective date of the policy; (b) thirty (30) days after the date of the application; (c) three (3) days after the date the Company sends written notice that the receipt is terminated.

Agent Instructions: Please leave this page with the Proposed Insured/Owner

<i>SERFF Tracking Number:</i>	<i>AEGB-127817536</i>	<i>State:</i>	<i>Arkansas</i>
<i>Filing Company:</i>	<i>Stonebridge Life Insurance Company</i>	<i>State Tracking Number:</i>	<i>50249</i>
<i>Company Tracking Number:</i>	<i>L120 1011S</i>		
<i>TOI:</i>	<i>L071 Individual Life - Whole</i>	<i>Sub-TOI:</i>	<i>L071.101 Fixed/Indeterminate Premium - Single Life</i>
<i>Product Name:</i>	<i>L120 1011S</i>		
<i>Project Name/Number:</i>	<i>L120 1011S/L120 1011S</i>		

Supporting Document Schedules

	Item Status:	Status Date:
Satisfied - Item: Flesch Certification		
Comments:		
Attachments:		
Flesch Score.pdf		
AR - Rule and Regulation 19.pdf		

	Item Status:	Status Date:
Satisfied - Item: Application		
Comments:		
Attachment:		
L120 1011S.pdf		

	Item Status:	Status Date:
Bypassed - Item: Life & Annuity - Acturial Memo		
Bypass Reason: Acturial Memo is not required with this filing. This is an application only filing.		
Comments:		

	Item Status:	Status Date:
Satisfied - Item: Statement of Variability		
Comments:		
Attachment:		
L120 1011S Statement of Variability.pdf		

**STONEBRIDGE LIFE INSURANCE COMPANY
FLESCH READABILITY CERTIFICATION**

Form Number (may vary by state)

Flesch Score

L120 1011S

50.6

I certify that the machine scored Flesch Readability score for the above mentioned form is accurate.

Cheryl Bock

Cheryl Bock, Assistant Vice President, Contract Development

**Stonebridge Life Insurance Company
Home Office: Cedar Rapids, Iowa**

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

Form Number: L120 1011S

Date: November 3, 2011

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

Cheryl Bock

Cheryl Bock, Assistant Vice President, Contract Development

Part A1 - Proposed Insured						
Name (First, M.I., Last)			Address, City, State, Zip Code (cannot be a P.O. Box)			
SSN	Gender	D.O.B. (MM/DD/YYYY)	Age	U.S. State or Country of Birth	Phone Number ()	
<p>1) Life Insurance Face Amount \$ _____</p> <p>a) Plan: _____</p> <p>b) Total Premium \$ _____</p> <p>c) Accidental Death Benefit Rider? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>d) Automatic Premium Loan provision (if available)? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>e) If a policy cannot be issued as applied for, would you accept a rated policy if available? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>f) If 'yes,' adjust face amount to premium? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>2) Within the last 12 months has the proposed Insured used tobacco products in any form? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>3) Does the proposed Insured have any existing life insurance or annuity contracts with the company or any other company? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>4) Is this insurance intended to replace or change any life insurance or annuity contract in force with the company or any other company? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If yes, submit the state required forms and please provide company name and policy number. _____</p>						
Part A2 - Owner (If Other Than Proposed Insured)						
Name (First, MI, Last)		SSN	Gender	Relationship to Insured	D.O.B. (MM/DD/YYYY)	
Address, City, State, Zip Code (If different from Insured) (cannot be a P.O. Box)				Are you a citizen of the U.S.? <input type="checkbox"/> Yes <input type="checkbox"/> No If not, what country?		
Part A3 - Beneficiary (Please use the Supplemental Information form if additional room is needed)						
Primary Name (First, MI, Last)		SSN	Gender	Relationship to Insured	D.O.B. (MM/DD/YYYY)	
Contingent Name (First, MI, Last)		SSN	Gender	Relationship to Insured	D.O.B. (MM/DD/YYYY)	
Part B1 - If Any Question In This Section Is Answered "Yes", The Proposed Insured Is Not Eligible For Any Coverage.						
<p>1) Is the proposed Insured hospitalized, bedridden, residing in a nursing home or long term care facility, receiving hospice or home health care, confined to a wheelchair, or has the proposed Insured been advised or is the proposed Insured planning to have inpatient surgery or currently waiting for an organ transplant? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>2) Has the proposed Insured ever:</p> <p>a) Been diagnosed with, been treated for or advised to receive treatment for Alzheimer's disease, senile dementia, organic brain disease, mental incapacity, Lou Gehrig's disease (ALS), Downs Syndrome, Huntington's disease, sickle cell anemia, Spina Bifida not surgically corrected, cystic fibrosis, cerebral palsy or any terminal medical condition? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>b) Tested positive for the antibodies to the AIDS (HIV) virus or been medically diagnosed with or received treatment for HIV, Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC)? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>c) Been in a diabetic coma or had or been advised to have an amputation due to disease or disorder? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>3) Within the past 2 years has the proposed Insured:</p> <p>a) Been diagnosed with, been treated for or advised to receive treatment for cancer (other than basal cell carcinoma)? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>b) Undergone testing by a medical professional for which the results have not been received? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>						
Part B2						
<p>4) Has the proposed Insured been diagnosed with, been treated for or advised to receive treatment for diabetes (other than gestational diabetes) before the age of 18? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>5) Within the past 4 years has the proposed Insured been diagnosed with, been treated for or advised to receive treatment for cancer (other than basal cell carcinoma)? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>6) Within the past 1 year has the proposed Insured:</p> <p>a) Used illegal drugs or been diagnosed with, been treated for or advised to receive treatment for alcohol abuse, drug abuse or muscular dystrophy? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>b) Had more than 12 seizures or been diagnosed with, been treated for or advised to receive treatment for congestive heart failure, cirrhosis, hepatitis B or C or other liver disease? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>c) Been diagnosed with, been treated for or advised to receive treatment for heart attack, stroke (CVA), transient ischemic attack (TIA), aneurysm, angina, or had or been advised to have heart surgery of any kind including bypass surgery or pacemaker implant? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>d) Used oxygen to assist in breathing due to a disease or disorder, received kidney dialysis or been diagnosed with, been treated for or advised to receive treatment for kidney failure due to a disease or disorder? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>						
<ul style="list-style-type: none"> • If All Questions in Part B2 Are Answered "No", Proceed to Part B3. • If One Question in Part B2 Is Answered "Yes", The proposed Insured Is Only Eligible For The Graded Death Benefit Product. Proceed to Part C1. • If Two Or More Questions in Part B2 Are Answered "Yes", The proposed Insured Is Not Eligible For Any Coverage. 						

Agent's Report

I represent that:

1) I have personally seen the proposed Insured. Yes No

2) I have truly and accurately recorded on this application the information as supplied by the Owner and the proposed Insured. Yes No

Is the person proposed for insurance related to you? Yes No Relationship _____

Is the policy applied for in this application intended to replace any insurance or annuity now in force? Yes No

Best time to call for a Personal History Interview _____ a.m. _____ p.m.

Home or work phone number _____

Agent Signature _____

AGREEMENT / AUTHORIZATION

ACKNOWLEDGMENT OF PROPOSED OWNER AND INSURED(S) –Each of the undersigned hereby certifies and represents as follows: The statements and answers given on this application are true and correct. I acknowledge and agree (A) that this application and any amendments shall be the basis for any insurance issued; (B) that the agent does not have the authority to waive any question on this application, to decide if insurance will be issued, or to modify any term or provision of any insurance which may be issued based on this application, only a writing signed by an officer of the Company can change the terms of this application or the terms of any insurance issued by the Company; (C) except as provided in the Conditional Receipt, if issued with the same proposed Insured(s) as on this application, no policy applied for shall take effect until after all of the following conditions have been met: 1) the minimum initial premium must be received by the Company; 2) the proposed Owner must have personally received and accepted the policy during the lifetime of all proposed Insured(s) and while all proposed Insured(s) are in good health; and 3) on the date of the later of either 1) or 2) above, all of the statements and answers given in this application must be true and complete, and the insurance will not take effect if the facts have changed. Unless otherwise stated the proposed insured is the premium payor and Owner of the policy applied for.

I have received the MIB Disclosure Notification, Notice to Persons Applying For Insurance, Accelerated Death Benefit Disclosure and Conditional Receipt. I hereby authorize any licensed physician, medical practitioner, or the Medical Information Bureau or other institution that has any records or knowledge of the proposed Insured to give any such information, including medical information, to the life insurance company. A photocopy or facsimile of this authorization shall be made as valid as the original.

I understand that any omissions or misstatements in this application could cause an otherwise valid claim to be denied under any insurance issued from this application.

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.

Signed at City _____ State _____ Proposed Insured Signature _____

Date _____ Owner Signature _____
(If Owner other than Insured)

Witness _____
(Agent Signature) (Print Agent's Name and I.D. Number)

If the EFT premium payment method is chosen, please tape a voided check in this box.

NOTICE TO PERSONS APPLYING FOR INSURANCE

As part of the Company's procedure for processing your insurance application, an investigative consumer report may be prepared whereby information is obtained through physicians, hospitals, clinics, and other medically-related facilities, who may be contacted using your signed authorization, to obtain details of your past medical treatment.

You have the right to be interviewed as part of any investigative consumer report that may be prepared. If you desire to be interviewed, you must indicate this to the Company. You also have the right to request access to, and correction and amendment of, any personal information collected. Additionally, you are entitled to receive a description of procedures which allow access to and correction of personal information which may be obtained, the nature and scope of the investigation requested, and a description of the circumstances under which personal information may be disclosed without prior authorization. Your written request should be addressed to the Company.

STONEBRIDGE LIFE INSURANCE COMPANY

Home Office: [4333 Edgewood Road NE, Cedar Rapids, IA 52499]

MIB DISCLOSURE NOTIFICATION

Information regarding your insurability will be treated as confidential. Stonebridge Life Insurance Company or its reinsurers may, however, make a brief report thereon to the MIB, Inc., formerly known as Medical Information Bureau, a not-for-profit membership organization of insurance companies, which operates an information exchange on behalf of its members. If you apply to another MIB member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, MIB, upon request, will supply such company with the information about you in its file.

Upon receipt of a request from you, MIB will arrange disclosure of any information in your file. Please contact MIB at 866-692-6901 or (TTY 866-346-3642). If you question the accuracy of information in the MIB's file, you may contact MIB and seek a correction in accordance with the procedures set forth in the Federal Fair Credit Reporting Act. The address of MIB's information office is: 50 Braintree Hill, Suite 400, Braintree, Massachusetts 02184-8734.

Stonebridge Life Insurance Company, or its reinsurers may also release information from its file to other life insurance companies to whom you may apply for life or health insurance, or to whom a claim for benefits may be submitted. Information for consumers about MIB may be obtained on its website at www.mib.com.

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CONDITIONAL RECEIPT

No coverage will be effective prior to delivery of the policy applied for unless and until all the following conditions are met:

Conditions of Coverage

1. On the Effective Date indicated below, the state of health and all factors affecting insurability of each person proposed for coverage must be stated in the application required by the Company and the application must not contain a material misrepresentation;
2. An amount equal to the first full premium required is paid on the plan and any check, money order, or Authorization for Electronic Funds Transfer (EFT) given in payment is honored when first presented; and,
3. Each person proposed for coverage is on the Effective Date insurable and acceptable to the Company under its rules, limits and underwriting standards for the plan and for the amount applied for, without modification of plan, premium of rates or amount of coverage.

Effective Date

If all of the above conditions are met, insurance in the amount applied for or \$25,000, whichever is lower, will become effective on the date the application is completed. If any of the above conditions are not met, or if the proposed Insured dies by suicide, this receipt provides no coverage, and the liability of the Company is the return of the amount remitted with this receipt. Coverage which takes effect through this receipt will terminate at the EARLIEST of the following: (a) the effective date of the policy; (b) thirty (30) days after the date of the application; (c) three (3) days after the date the Company sends written notice that the receipt is terminated.

Agent Instructions: Please leave this page with the Proposed Insured/Owner

**STONEBRIDGE LIFE INSURANCE COMPANY
STATEMENT OF VARIABILITY**

APPLICATION: L120 1011S

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

L120 1011S – Application for Individual Life Insurance

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