

SERFF Tracking Number: ONFS-127826256 State: Arkansas  
Filing Company: The Ohio National Life Insurance Company State Tracking Number: 50302  
Company Tracking Number:  
TOI: L08 Life - Other Sub-TOI: L08.000 Life - Other  
Product Name: Life Application Form 6420  
Project Name/Number: 2012 Life Application Form 6420/

## Filing at a Glance

Company: The Ohio National Life Insurance Company

Product Name: Life Application Form 6420

SERFF Tr Num: ONFS-127826256 State: Arkansas

TOI: L08 Life - Other

SERFF Status: Closed-Approved- State Tr Num: 50302

Closed

Sub-TOI: L08.000 Life - Other

Co Tr Num:

State Status: Approved-Closed

Filing Type: Form

Reviewer(s): Linda Bird

Authors: Doris Jackson, Peggy  
Johnson, Amy Hall

Disposition Date: 11/22/2011

Date Submitted: 11/18/2011

Disposition Status: Approved-  
Closed

Implementation Date Requested:

Implementation Date:

State Filing Description:

## General Information

Project Name: 2012 Life Application Form 6420

Status of Filing in Domicile: Pending

Project Number:

Date Approved in Domicile:

Requested Filing Mode: Review & Approval

Domicile Status Comments:

Explanation for Combination/Other:

Market Type:

Submission Type: New Submission

Overall Rate Impact:

Filing Status Changed: 11/22/2011

State Status Changed: 11/22/2011

Deemer Date:

Created By: Amy Hall

Submitted By: Amy Hall

Corresponding Filing Tracking Number: ONFS-127826257

Filing Description:

Re: The Ohio National Life Insurance Company

Form 6420-AR, Life Insurance Application

Form TIA.L Rev. 1/12, Temporary Life Insurance Agreement

Enclosed for your review for approval is an individual Life Insurance Application, Form 6420-AR and a Temporary Life Insurance Agreement, Form TIA.L Rev. 1/12. The application is new and intended to replace previously approved application Form 6498-AR, approved for use in your state on 6-18-98. Form TIA.L Rev. 1/12 is new and not intended to replace any previously approved form.

SERFF Tracking Number: ONFS-127826256 State: Arkansas  
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These forms are also being submitted for approval for use with our subsidiary, Ohio National Life Assurance Corporation under SERFF Tracking Number ONFS-127826257.

The new application will be used in the sale of our term life, universal life and variable universal life insurance products issued through Ohio National Life Assurance Corporation and of our whole life insurance products issued through The Ohio National Life Insurance Company, that are approved for issue in your state.

The main difference in the new application is in the formatting. In addition to the information being placed to be more user friendly for the agents, the types of plans in the Life Plan section have been separated out by title, and four questions have been added to the Nonmedical Information section in order to help detect and prevent stranger originated life insurance.

The Life Riders section of the application has been bracketed in order to be able to remove discontinued riders and add new riders as they become approved. A Statement of Variability is enclosed.

Please feel free to contact me with any questions or concerns. I can be reached at 1-800-366-6654, Dept. 7, Option 3 (press 7 after the initial greeting, the system does not prompt this), via fax at 1-513-794-4522, or at the following e-mail address: Amy\_Hall@ohionational.com.

Thank you for your assistance with this filing. I look forward to your approval.

Sincerely,

Amy Hall  
Contract Compliance Regulatory Technician  
Contract Implementation Unit/Product Development

## Company and Contact

### Filing Contact Information

Amy Hall, Amy\_Hall@ohionational.com  
One Financial Way 513-794-6374 [Phone]  
Cincinnati, OH 45242

### Filing Company Information

The Ohio National Life Insurance Company CoCode: 67172 State of Domicile: Ohio  
1 Financial Way Group Code: 704 Company Type: Life and Annuity

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 Product Name: Life Application Form 6420  
 Project Name/Number: 2012 Life Application Form 6420/  
 Cincinnati, OH 45242 Group Name: ONFS State ID Number:  
 (513) 794-6100 ext. [Phone] FEIN Number: 31-0397080  
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## Filing Fees

Fee Required? Yes  
 Fee Amount: \$100.00  
 Retaliatory? No  
 Fee Explanation: \$50 per form \* 2 forms = \$100.00  
 Per Company: No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
The Ohio National Life Insurance Company	\$100.00	11/18/2011	53902246

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## Correspondence Summary

### Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Linda Bird	11/22/2011	11/22/2011

*SERFF Tracking Number:*      *ONFS-127826256*                      *State:*                      *Arkansas*  
*Filing Company:*              *The Ohio National Life Insurance Company*      *State Tracking Number:*      *50302*  
*Company Tracking Number:*  
*TOI:*                      *L08 Life - Other*                      *Sub-TOI:*                      *L08.000 Life - Other*  
*Product Name:*              *Life Application Form 6420*  
*Project Name/Number:*      *2012 Life Application Form 6420/*

## **Disposition**

Disposition Date: 11/22/2011

Implementation Date:

Status: Approved-Closed

Comment:

Rate data does NOT apply to filing.

SERFF Tracking Number: ONFS-127826256 State: Arkansas  
 Filing Company: The Ohio National Life Insurance Company State Tracking Number: 50302  
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 TOI: L08 Life - Other Sub-TOI: L08.000 Life - Other  
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Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification		Yes
Supporting Document	Application		Yes
Supporting Document	Statement of Variability		Yes
Form	Life Insurance Application		Yes
Form	Temporary Life Insurance Agreement		Yes

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## Form Schedule

### Lead Form Number: 6420

Schedule Item Status	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
	FORM 6420-AR	Application/ Enrollment Form	Life Insurance Application Form	Initial		0.000	6420-AR.pdf
	FORM TIA.L REV 1/12	Other	Temporary Life Insurance Agreement	Initial		0.000	TIA.L Rev. 1.12.pdf

**1. Proposed Insured Information**

**a.** First Name  Middle Name (no initials, please)  Last Name

**b.** Home Address  How long at this address?

City  State  Zip

**c.** Mailing Address (if different than home)  City  State  Zip

**d.** Birth Date  **e.** Issue Age (nearest birthday)  **f.** Do you elect to backdate the policy to Save Age?  Yes  No

**g.**  Male  Female

**h.** Social Security Number  **i.** Driver's License Number  **j.** Expiration Date

**k.** State Licensed  **l.** State of Birth

**m.** Country of Birth  **n.** Are you a U.S. citizen?  Yes  No  
 If "No," currently a citizen of what country?

**o.** If non-US citizen, do you have a U.S. Green Card?  Yes  No

**p.** Net Worth  Net Annual Income  All Other Income

\$  \$  \$

**2. Proposed Insured Employment Information**

**a.** Occupation/Position  **b.** Present Employer  **c.** Type of Business

**d.** Address  City  State  Zip

**3. Owner Information**

Complete this Section only if the policy will be owned by a person or entity other than the Proposed Insured. The Owner must sign page 6 of this application. If two or more persons are designated as Owner in any one category, their interests shall be joint and survivor.

**a.** Name of Owner or Trustee of Trust  Relationship to Insured  Birth Date

Full Name of Trust (if applicable) complete and attach Trustee Certification Form 6437.  
 Attach a copy of the complete Trust documentation, including any amendments.  Date of Trust

**b.** Address  City  State  Zip

**c.** Social Security Number/Tax ID  Driver's License Number  Expiration Date  State Licensed

**If the owner is a corporation, an authorized officer of the corporation must complete, sign and attach the Corporate Certification Form 3068.**

## 4. Beneficiary Information

“Children” shall mean the lawful children of the Insured by birth or adoption.

**a. Primary Beneficiary or Name of Trustee**

Relationship to Insured

Full Name of Trust (If Applicable)

Date of Trust



**b. Contingent Beneficiary(ies)**

Relationship to Insured

If there are additional Beneficiaries, please use and sign Form 6501.

## 5. Payor Information

Complete this section only if the Payor is different than the Proposed Insured or Owner.

Name	Relationship to Insured	Birth Date
<input type="text"/>	<input type="text"/>	<input type="text" value="-"/> <input type="text" value="-"/>
Address	City	State
<input type="text"/>	<input type="text"/>	<input type="text" value=""/>
Social Security Number/Tax ID	Driver's License Number	Expiration Date
<input type="text" value="-"/> <input type="text" value="-"/>	<input type="text"/>	<input type="text" value="-"/> <input type="text" value="-"/>
		State Licensed
		<input type="text"/>

## 6. Temporary Life Insurance Coverage

Yes  No **a.** Has any person proposed for coverage been diagnosed or treated for heart attack, stroke or cancer within the last five years, or been advised to have any surgery which has not been performed?

If 6a is answered “Yes,” the amount applied for exceeds \$1 million, or age exceeds 70, no premium may be submitted, and 6b must be answered “No.”

Yes  No **b.** Is premium submitted with the application? Amount remitted

\$

## 7. Other Coverage/Replacement Information

Yes  No **a.** Are you currently applying for other life insurance? If “Yes,” provide details: \_\_\_\_\_

\_\_\_\_\_

Yes  No **b.** Do you have existing individual life insurance policy(ies) or annuity contract(s)?

Yes  No **c.** Does the proposed policy replace or cause a change in any existing individual life insurance policy or annuity contract?

If either 7b or 7c is answered “Yes,” list all types of insurance below, and indicate whether the proposed policy will replace or cause change in any existing life insurance policy or annuity contract. The “Important Notice: Replacement of Life Insurance or Annuities,” Form 6486, must be completed, signed and submitted with this Application.

Company	Policy Number	Face Amount of Insurance	Purpose	Will It Be Replaced?	1035 Exchange	Replacement Date
_____	_____	_____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes	_____
_____	_____	_____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes	_____
_____	_____	_____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes	_____
_____	_____	_____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes	_____
_____	_____	_____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes	_____

# Life Plans

## 8. Term Plans

<b>a. Plan of Insurance</b> <input style="width: 95%;" type="text"/>	<b>b. Face Amount</b> <input style="width: 95%;" type="text"/> \$
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## 9. Whole Life Plans

<b>a. Plan of Insurance</b> <input style="width: 95%;" type="text"/>	<b>b. Face Amount</b> <input style="width: 95%;" type="text"/> \$
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**c.** Dividend  Paid-Up Addition  Reduced Premium  Cash  Accumulate at Interest  1-Year Term  
**d.** Non-forfeiture Option  Extended Term Insurance  Automatic Premium Loan  
 (If no Non-Forfeiture Option is elected, the default option elected will be extended term insurance.)  
**Please submit signed NAIC Illustration or Disclosure Form 6451.**

## 10. Universal/Variable/Survivor Life Plans

<b>a. Plan of Insurance</b> <input style="width: 95%;" type="text"/>	<b>b. DEFRA Test</b> <input type="checkbox"/> GPT <input type="checkbox"/> CVAT	<b>c. Face Amount</b> <input style="width: 95%;" type="text"/> \$
<b>d. Death Benefit Type</b> <input type="checkbox"/> A - Level <input type="checkbox"/> B - Increasing	<b>e. Planned Premium Payment</b> <input style="width: 80%;" type="text"/> \$	

**Please submit signed NAIC Illustration or Disclosure Form 6451.**

## 11. Premium Mode

Premium Mode  Annual  Semi-Annual  Quarterly  Monthly (Bank Draft)  List Bill Group # \_\_\_\_\_

Government Allotment Branch of Government \_\_\_\_\_

## 12. Life Riders/Benefits

<b>a.</b> <input type="checkbox"/> Additional Coverage Rider Primary Insured <input style="width: 80%;" type="text"/> \$  <b>b.</b> <input type="checkbox"/> Additional Coverage Rider Spouse or Additional Insured <input style="width: 80%;" type="text"/> \$ The Additional Insured is the owner of the Additional Coverage Life Rider unless the base policy owner is specifically designated. <b>c.</b> <input type="checkbox"/> Children's Rider <input style="width: 80%;" type="text"/> \$ <b>d.</b> <input type="checkbox"/> Annual API Rider (Submit Illustration) <input style="width: 80%;" type="text"/> \$ <b>e.</b> <input type="checkbox"/> Flex API Rider (Submit Illustration) <input style="width: 80%;" type="text"/> \$ <b>f.</b> <input type="checkbox"/> Single API Rider <input style="width: 80%;" type="text"/> \$	<b>g.</b> <input type="checkbox"/> Waiver of Premium (Whole Life and Term only) <input type="checkbox"/> Waiver of Premium (UL, VUL and Survivor only) <input style="width: 80%;" type="text"/> \$ Per Month <b>h.</b> <input type="checkbox"/> Accidental Death Benefit <input style="width: 80%;" type="text"/> \$ <b>i.</b> <input type="checkbox"/> Guaranteed Insurability Option <input style="width: 80%;" type="text"/> \$ <b>j.</b> <input type="checkbox"/> Lifetime Advantage Rider (Complete Form 2946) <b>k.</b> <input type="checkbox"/> Protector Plus Rider <input style="width: 80%;" type="text"/> \$ <b>l.</b> <input type="checkbox"/> Other Riders and Benefits: <input style="width: 80%;" type="text"/> \$ <input style="width: 95%;" type="text"/>
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## 13. Additional Insureds - Spouse & Children (by Birth or Adoption)

Full Name(s)	Relationship*	Gender	Age	Birth Date	Height	Weight	Amount Ins. In Force

\*If Spouse/Additional Insured, please provide State of Birth:  SSN:



**15. Proposed Insured**

a. Height                      Weight  
                     

b. Name and address of your personal physician.

c. Date and reason last consulted.

**16. Additional Insured**

a. Height                      Weight  
                     

b. Name and address of your personal physician.

c. Date and reason last consulted.

**17.-21. Additional Medical Information (All Insureds, Including Additional Insureds)**

- Yes  No 17. Is anyone proposed for coverage currently taking any prescription medication, or under treatment or observation by a medical practitioner?
- Yes  No 18. Has anyone proposed for coverage had a weight change of over 10 pounds in the last year?
- Yes  No 19. Has anyone proposed for coverage ever had any of the following:
  - Yes  No a) chest pain, high blood pressure, heart murmur, heart attack, stroke or other disorder of the heart or circulatory system?
  - Yes  No b) any disease or disorder of the nervous system, paralysis, seizure disorder, dizziness or severe headaches?
  - Yes  No c) shortness of breath, asthma, sleep apnea, bronchitis, emphysema, or any other respiratory disorder?
  - Yes  No d) hernia, ulcers, hepatitis, or any disorder of the stomach, liver, gallbladder, spleen, pancreas, intestines or rectum?
  - Yes  No e) diabetes, sugar, protein or blood in the urine, stone or other disorder of the kidney, bladder, prostate, or reproductive organs?
  - Yes  No f) cancer, tumor, or cyst?
  - Yes  No g) gout, arthritis, or disorder of the muscles or bones, including the spine, back or joints?
  - Yes  No h) allergy or any disorder of the skin, eyes, ears, nose, throat, sinuses, larynx, thyroid or lymph glands?

- Yes  No 20. Has anyone proposed for coverage ever:
  - Yes  No a) been diagnosed or treated for AIDS (Acquired Immune Deficiency Syndrome) or tested positive for HIV (Human Immunodeficiency Virus)?
  - Yes  No b) received disability benefits or compensation, or a disability pension?
  - Yes  No c) used barbiturates, tranquilizers, narcotics, cocaine, marijuana, amphetamines, inhalants, anabolic steroids or hallucinogens; except as legally prescribed by a physician (if physician, other than yourself)?
  - Yes  No d) been treated or advised to seek treatment for drug abuse or alcoholism?
  - Yes  No e) had any disease or disorder of the breasts, disorder of menstruation, miscarriage or complications of pregnancy?
- Yes  No 21. To the best of your knowledge and belief, are you now pregnant?
- Yes  No 22. Has anyone proposed for coverage had, within the last five years, other than as noted above:
  - Yes  No a) a check-up, consultation, illness, injury, surgery, or been a patient in a hospital, clinic or sanitarium?
  - Yes  No b) an EKG, X-Ray or other diagnostic test?
  - Yes  No c) been advised to have a diagnostic test, hospitalization or surgery?
  - Yes  No d) been treated or received counseling for anxiety, depression, stress, mental or nervous disorder, or other emotional disorder?

Details of "Yes" answers. Please identify the question the name of the Proposed Insured to whom the answer relates. Include all diagnoses as well as names and addresses of all medical practitioners.

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## Authorization and Mutual Agreements

**AUTHORIZATION** to any physician; practitioner; hospital, clinic or other medical or medically related facility; health care provider; insurance company or reinsurance company; insurance support organization; the Veterans Administration; the Medical Information Bureau, Inc. (MIB); a consumer reporting agency; motor vehicle records facility and/or employer:

In order to enable Ohio National Life to act upon my application for insurance or to decide if I qualify for benefits or coverage, I authorize you to give to Ohio National Life any and all information, records or knowledge which you have about the physical or mental condition of myself and any of my minor children who are to be insured. This authorization covers medical history, evaluation, tests, diagnosis, treatment or prognosis, including information about drugs, alcoholism or mental illness, and includes any financial, employment or personal information requested for insurance purposes.

Ohio National Life may release information to reinsurance companies, to MIB, Inc., or to others who perform business or legal services related to my application or the policy or claim thereunder. Information will not be released to anyone else unless required or permitted by law or unless further authorized by me.

- This authorization is good, as needed, for 24 months from the date signed or while I have a claim, if longer.
- I agree that a photocopy of this authorization may be used the same as the original.
- I have received the Notice to the Proposed Insured and Owner.
- I understand that I have the right to receive a copy of this authorization.

**Insurance 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.

**I certify, under penalty of perjury that my Social Security/Tax Identification Number(s) is(are) shown and is(are) correct, that I am not subject to back-up withholding, and that I am a U.S. person.**

Month                      Day                      Year

City    State

I hereby certify that I have truly and accurately recorded on this application the information supplied by the Applicant and/or Proposed Insured(s) and that the responses stated herein are, to the best of my knowledge, true and accurate.

Signature of Agent

Print Agent Name

### IT IS MUTUALLY AGREED THAT:

- a. The statements and answers on this application and Part 2, Paramed Application, are true and complete to the best of my knowledge and belief. A copy of this application will be the basis of any policy issued.
- b. By signing below, I acknowledge receipt of the Temporary Life Insurance Agreement given in exchange for my payment shown in Question 6 of this application; and I accept the terms and conditions of that Agreement.
- c. Except as otherwise provided in the Temporary Life Insurance Agreement, or the Electronic Debit Authorization Agreement, if completed, no policy shall be in force unless and until: (1) it is delivered to me; (2) the full first premium is paid during the lifetime of all persons to be insured under the policy; and (3) the health of the Proposed Insured and the statements and answers in this application remain the same, without material change, as of the date of the policy delivery.
- d. By accepting an insurance policy issued on this application, I ratify any corrections, additions or changes made by Ohio National. In those states where required, there can be no change in amount, age at issue, risk class, plan of insurance, or benefits, unless I agree to the change in writing.
- e. No agent is authorized to make or change a contract of insurance for Ohio National, nor extend the due date for a premium payment, nor waive any of Ohio National's rights or requirements.

Signature of Proposed Insured

Signature of Spouse or Additional Insured

Signature of Parent if Insured is Child

Signature of Owner (if other than above)

Detach and  
deliver to the  
proposed insured  
and owner.

**Temporary Life Insurance Agreement**

**TEMPORARY LIFE INSURANCE IS NOT AVAILABLE UNDER ANY CIRCUMSTANCES IF THE APPLICATION IS FOR MORE THAN \$1,000,000 OF LIFE INSURANCE WITH OHIO NATIONAL LIFE. YOU MUST BE INSURABLE.**

**When Insurance Begins:** Subject to all terms and conditions of this Agreement, you will have life insurance for not more than **60** days beginning when, and if, all of the following conditions are met:

1. you are not over age 70; and
2. you have not been diagnosed or treated for heart attack, stroke or cancer within the last five years; and
3. you have not been advised to have any surgery which has not been performed; and

4. you have truthfully completed and signed the Application for life insurance with Ohio National Life; and
5. you have taken all medical or paramedical exams and tests we require under our underwriting guidelines and practices, which may include an x-ray and an electrocardiogram (EKG); and
6. the first monthly premium for the policy as applied for has been paid to Ohio National Life by a means acceptable to us.

**Terms**

**NO AGENT OR BROKER HAS THE AUTHORITY TO APPROVE OR EXTEND TEMPORARY LIFE INSURANCE OR WAIVE OR CHANGE ANY TERM OR CONDITION OF THIS AGREEMENT. ALL PREMIUM CHECKS MUST BE MADE PAYABLE TO "OHIO NATIONAL LIFE." DO NOT MAKE YOUR CHECK PAYABLE TO THE AGENT OR LEAVE "THE PAYEE" BLANK.**

**Exclusions:** No life insurance under this Agreement is available:

1. under any rider for which the Applicant has applied; or
2. if death results from suicide or self-destruction; or
3. if death is proximately caused by a sickness, injury or condition for which a medical professional provided or prescribed treatment within one year prior to the date of the Application; or
4. if we find that you were not insurable as of the effective date of this Agreement under our underwriting guidelines and practices.

**Amount of Insurance:** The amount of life insurance provided by this Agreement is the **Smallest** of: (a) the amount applied for in the Application; or (b) the amount we will issue based on your income and assets according to our guidelines and practices; or (c) \$1,000,000 minus the amount of all other life insurance coverage on you with Ohio National Life.

**When Insurance Ends:** Life insurance under this Agreement ends on the **Earliest** of (a) 60 days after it begins, (b) the date the insurance policy applied for takes effect; (c) the date we offer a policy other than as applied for; (d) the date we decline, postpone or make incomplete the Application and mail notice of that decision to the Applicant and refund the premium payment; or (e) the date we mail the Applicant notice that coverage ends and refund the premium payment. We may end your coverage under this Agreement and refund the premium payment at any time.

**Death of Proposed Insured:** If you die while this Agreement is in effect we will pay the death proceeds in accordance with the beneficiary designation in the Application unless one of the Exclusions listed

Signature of Proposed Insured

Signature of Owner (if other than the above)

above applies. If we pay a claim under this Agreement, we will retain from the proceeds one month's premium for the amount of the claim at the rate for your sex and age at a standard smoker or standard non-smoker risk class based on our findings about your use of tobacco.

**Changes in the Proposed Insured's Health:** This Agreement does not commit us to issue the policy applied for or any other policy. However, if we can find, based on our underwriting guidelines and practices, that you were a standard risk or better for life insurance as of the date your coverage began under this Agreement, then: (a) we will deliver the policy as approved without regard to any change in your health which occurs while this Agreement is in effect; and (b) we will offer you policy coverage in place of this Agreement to take effect the same date as insurance began under this Agreement. Any policy we offer may be different from the one for which you applied. It may be reduced in amount according to our guidelines and practices. If your health has changed, no life insurance policy will be issued for more than the amount of your temporary coverage under this Agreement.

**Premiums; Refunds:** The payment made to us with this Temporary Life Insurance Agreement will be applied to pay premiums due under any policy we issue to you. If no policy takes effect, and no claim is incurred, our only obligation is to refund your money. All refunds are without interest.

**Definitions:** The Application to which this Agreement relates includes the health questions you answered as part of any required medical or paramedical exam. "You" or "your" means the Proposed Insured, as identified on the Application and below. "We," "our," "us" or "Ohio National Life" means The Ohio National Life Insurance Company and Ohio National Life Assurance Corporation, One Financial Way, Cincinnati, Ohio 45242.

Date of Application (Part-1)

**Receipt**

We acknowledge receipt of your payment as shown below.

Amount Received

Date

Signature of Agent

\$

SERFF Tracking Number: ONFS-127826256 State: Arkansas  
Filing Company: The Ohio National Life Insurance Company State Tracking Number: 50302  
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TOI: L08 Life - Other Sub-TOI: L08.000 Life - Other  
Product Name: Life Application Form 6420  
Project Name/Number: 2012 Life Application Form 6420/

## Supporting Document Schedules

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

**Satisfied - Item:** Flesch Certification

**Comments:**

**Attachment:**

ONLIC Flesch Certification.pdf

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

**Satisfied - Item:** Application

**Comments:**

This filing is for a new application. This attached on the forms schedule. The previously approved application is 6498-AR and was approved on 6/18/98.

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

**Satisfied - Item:** Statement of Variability

**Comments:**

**Attachment:**

Statement of Variability.pdf

**FLESCH CERTIFICATION**

STATE OF OHIO                    )  
  )  SS  
COUNTY OF HAMILTON        )

The undersigned officer of THE OHIO NATIONAL LIFE INSURANCE COMPANY certifies:

Form 6420 and a base policy form were scored together because the application becomes a part of the policy. The combined Flesch Reading Ease Test Score for these forms exceeds 50.

IN WITNESS WHEREOF, I have signed my name this 17<sup>th</sup> day of November, 2011.

THE OHIO NATIONAL LIFE INSURANCE COMPANY

BY:   
\_\_\_\_\_  
Elizabeth F. Martini  
Vice President and Counsel

## **STATEMENT OF VARIABILITY**

Re: Form 6420, Life Insurance Application

This Statement is applicable to the Life Riders section of the Life Insurance application.

This Life Riders section lists all the riders that are currently available.

Riders will be removed when they are no longer offered.

New riders will be added in the future but only after they have been filed and approved for use in your state.