

SERFF Tracking Number: AEGF-127085873 State: Arkansas
Filing Company: Monumental Life Insurance Company- State Tracking Number: 48268
Company Tracking Number: FORM A11130 ET AL
TOI: L071 Individual Life - Whole Sub-TOI: L071.101 Fixed/Indeterminate Premium - Single Life
Product Name: iGo Part 3 Application
Project Name/Number: /

Filing at a Glance

Company: Monumental Life Insurance Company-

Product Name: iGo Part 3 Application

TOI: L071 Individual Life - Whole

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

Filing Type: Form

SERFF Tr Num: AEGF-127085873 State: Arkansas

SERFF Status: Closed-Approved- State Tr Num: 48268
Closed

Co Tr Num: FORM A11130 ET AL State Status: Approved-Closed

Author: Neil Tomas

Date Submitted: 03/17/2011

Reviewer(s): Linda Bird

Disposition Date: 03/24/2011

Disposition Status: Approved-
Closed

Implementation Date Requested: On Approval

Implementation Date:

State Filing Description:

General Information

Project Name:

Project Number:

Requested Filing Mode: Review & Approval

Explanation for Combination/Other:

Submission Type: New Submission

Overall Rate Impact:

Status of Filing in Domicile: Authorized

Date Approved in Domicile: 03/15/2011

Domicile Status Comments:

Market Type: Individual

Individual Market Type:

Filing Status Changed: 03/24/2011

State Status Changed: 03/22/2011

Created By: Neil Tomas

Corresponding Filing Tracking Number:

Deemer Date:

Submitted By: Neil Tomas

Filing Description:

Re: Monumental Life Insurance Company - NAIC #468-66281 - FEIN #52-0419790

Form – Description – Replaces Forms – Approved

Form A11130 – Agreement/Authorization - Part 3 – A95110AR, A95130AR – 02/23/1998

A11131FW – Fraud Warning – N/A – N/A

Previously approved forms to be used in conjunction with Form A11130 and A11131FW:

A08100 – Life & Health Application - Part 1 – Approved 07/15/2008

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A08101 – Life & Health Application - Part 2 – Approved 07/15/2008

A08102 – Cancer Application - Part 2 – Approved 07/15/2008

A08103 – Accident Application - Part 2 – Approved 07/15/2008

A0910R – Conditional Receipt – Approved 06/24/2009

To Whom It May Concern:

We respectfully request that the above captioned forms be considered for approval. Form A11130 is a new form that will replace the previously approved forms indicated above and A11131FW is a new form that will not replace any previously approved form.

Monumental Life has developed an application process for life and health insurance that consists of three parts. Part 1 inquires about basic information such as the applicant's name, address, employer, etc. Part 2 consists of a series of health questions that will depend of the type of product being applied for. Part 3, Form A11130, consists of an Agreement and Authorization that must be signed by the applicant at the point of sale. A11131FW is a fraud warning statement page that will always be used with the aforementioned applications. And the Conditional Receipt will be used whenever an initial premium is paid.

These forms will be marketed by career and general agents on an individual basis. No part of this filing contains any unusual or controversial items from normal company or industry standards.

Your prompt attention to this filing will be greatly appreciated. Please feel free to contact me if you have any questions.

Sincerely,

Neil Tomas
Compliance Analyst
Phone: 410-685-2900, ext. 2034
Fax: 410-576-4554
Neil.Tomas@Transamerica.com

Company and Contact

Filing Contact Information

Neil Tomas, Compliance Analyst
2 E Chase Street
Baltimore, MD 21202

NTomas@monlife.com
410-685-2900 [Phone] 2034 [Ext]
410-576-4554 [FAX]

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Filing Company Information

Monumental Life Insurance Company-
 4333 Edgewood Rd NE
 Cedar Rapids, IA 52499
 (410) 685-2900 ext. [Phone]

CoCode: 66281
 Group Code: 468
 Group Name:
 FEIN Number: 52-0419790

State of Domicile: Iowa
 Company Type: Life & Health
 State ID Number:

Filing Fees

Fee Required? Yes
 Fee Amount: \$40.00
 Retaliatory? No
 Fee Explanation: 20 x Amount of Applications = Total
 20 x 2 = 40
 Per Company: No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Monumental Life Insurance Company-	\$40.00	03/17/2011	45700658
Monumental Life Insurance Company-	\$60.00	03/18/2011	45766945

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Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Linda Bird	03/24/2011	03/24/2011
Approved-Closed	Linda Bird	03/22/2011	03/22/2011

Objection Letters and Response Letters

Objection Letters				Response Letters		
Status	Created By	Created On	Date Submitted	Responded By	Created On	Date Submitted
Pending Industry Response	Linda Bird	03/18/2011	03/18/2011	Neil Tomas	03/18/2011	03/18/2011

Amendments

Schedule	Schedule Item Name	Created By	Created On	Date Submitted
Form	Fraud Warning	Neil Tomas	03/23/2011	03/23/2011

Filing Notes

Subject	Note Type	Created By	Created On	Date Submitted
Request to re-open	Note To Filer	Linda Bird	03/23/2011	03/23/2011

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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 - Acturial Memo		No
Form	Agreement/Authorization - Part 3		Yes
Form (revised)	Fraud Warning		Yes
Form	Fraud Warning	Replaced	Yes

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Objection Letter

Objection Letter Status Pending Industry Response
Objection Letter Date 03/18/2011
Submitted Date 03/18/2011
Respond By Date 04/18/2011

Dear Neil Tomas,

This will acknowledge receipt of the captioned filing.

Objection 1

Comment: Regulation 57 was revised effective January 2010, the filing fee is now \$50.00 per form. We will hold your filing in a pending status until the additional \$60.00 is received.

The forms were not attached to the submission.

Please feel free to contact me if you have questions.

Sincerely,

Linda Bird

SERFF Tracking Number: AEGF-127085873 State: Arkansas
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Project Name/Number: /

Response Letter

Response Letter Status Submitted to State
Response Letter Date 03/18/2011
Submitted Date 03/18/2011

Dear Linda Bird,

Comments:

We received your objection letter dated March 18, 2011 and can now respond as follows.

Response 1

Comments: Pursuant Regulation 57 revised effective January 2010, we have submitted an additional \$60.00 in filing fees to bring the total to \$100.00.

Related Objection 1

Comment:

Regulation 57 was revised effective January 2010, the filing fee is now \$50.00 per form. We will hold your filing in a pending status until the additional \$60.00 is received.

The forms were not attached to the submission.

Changed Items:

No Supporting Documents changed.

No Form Schedule items changed.

No Rate/Rule Schedule items changed.

Your continued review of this filing is greatly appreciated. If you have questions or concerns, please do not hesitate to contact me.

Sincerely,
Neil Tomas

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Amendment Letter

Submitted Date: 03/23/2011

Comments:

Dear Linda Bird,

Thank you for re-opening this filing. We have submitted a revised version of A11131FW in which we have corrected the fraud warning for Maine, Tennessee, Virginia and Washington. No other change has been made to this filing.

Sincerely,

Neil Tomas

Changed Items:

Form Schedule Item Changes:

Form Schedule Item Changes:

Form Number	Form Type	Form Name	Action	Form Action Other	Previous Filing #	Replaced Form #	Readability Score	Attachments
A11131FW	Application/EFraud nrollment Form	Warning	Initial					A11131FW.pdf

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Note To Filer

Created By:

Linda Bird on 03/23/2011 11:38 AM

Last Edited By:

Linda Bird

Submitted On:

03/23/2011 11:38 AM

Subject:

Request to re-open

Comments:

Filing has been re-opened in order for correction to be made.

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Form Schedule

Lead Form Number: Form A11130

Schedule Item Status	Form Number	Form Type Form Name	Action	Action Specific Data	Readability	Attachment
	Form A11130	Application/ Agreement/Authorization - Part 3 Form	Revised	Replaced Form #: A95110AR; A95130AR Previous Filing #:	51.000	A11130.pdf
	A11131FW	Application/ Fraud Warning Enrollment Form	Initial			A11131FW.pdf

AUTHORIZATION TO OBTAIN INFORMATION

I authorize any licensed physician, medical practitioner, hospital, clinic, other medical or medically related facility, insurance, or reinsuring company, the Medical Information Bureau Inc. and its members or affiliates, Consumer Reporting Agency, or employer, having information as to testing, diagnosis, treatment, and/or prognosis with respect to any physical or mental condition of any proposed insured, and any other non-medical information of any proposed insured, to give to the Monumental Life Insurance Company, or its legal representative or reinsurers, any and all such information.

I understand the information obtained by use of the Authorization will be used by the Monumental Life Insurance Company to determine eligibility for insurance and eligibility for benefits under an existing policy. Any information obtained will not be released by the Monumental Life Insurance Company to any person or organization EXCEPT to reinsuring companies, the Medical Information Bureau, Inc., or other persons or organizations performing business or legal services in connection with my application, claim, or as may be otherwise lawfully required or as I may further authorize.

I know that I may request a copy of this Authorization. This Authorization will be valid for twenty-six months from the date shown below. A photocopy or facsimile of this Authorization will be as valid as the original.

Date

Proposed Insured
(if proposed insured is a minor, Signature
of Parent, Guardian, or Person liable for
child's support)

Spouse/Additional Insured

Names of Minor Children

FRAUD WARNING

The following state(s) require that insurance applicants acknowledge a fraud warning statement. Please refer to the fraud warning statement for your state as indicated below.

ARKANSAS, DISTRICT OF COLUMBIA, LOUISIANA, NEW MEXICO and RHODE ISLAND: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an insurance application is guilty of a crime and may be subject to fines and confinement in prison.

COLORADO: 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 an 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 settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

FLORIDA: Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

KENTUCKY: Any person who knowingly and with intent to defraud any insurance company or other person files a statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime.

MAINE, TENNESSEE, VIRGINIA and WASHINGTON: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

MARYLAND: 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.

NEW YORK: 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 materially 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 shall also be subject to a civil penalty not to exceed five thousand dollars and the state value of the claim for each such violation.

OHIO: Any person who, with 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 is guilty of insurance fraud.

OKLAHOMA: WARNING: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

PENNSYLVANIA: 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 materially 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.

ALL OTHER STATES: Any person who knowingly presents a false statement in an application for insurance may be guilty of a criminal offense and subject to penalties.

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Supporting Document Schedules

Item Status: **Status Date:**

Satisfied - Item: Flesch Certification

Comments:

Attachment:

Readability Certification.pdf

Item Status: **Status Date:**

Satisfied - Item: Application

Comments:

Attached are the previously approved application forms to be used in conjunction with the two applications filed for approval under the Form Schedule tab. Please see the Filing Description for further details.

Attachments:

A08100.pdf

A08101.pdf

A08102.pdf

A08103.pdf

A0910R.pdf

CERTIFICATION

THIS IS TO CERTIFY, that the forms listed below achieved the following Flesch Reading Ease Scores and are in compliance with the requirements of Arkansas Insurance Code ACA 23-80-206.

<u>Form</u>	<u>Flesch Score</u>
Form A11130	51.0

MONUMENTAL LIFE INSURANCE COMPANY

Date: 03/17/2011

By: 

Christopher L. Wilhelm
Assistant General Counsel &
Assistant Vice President

CRTARR.DOC

ISSUE DATE:

APPLICATION FOR LIFE/HEALTH INSURANCE

POLICY NO.

MONUMENTAL LIFE INSURANCE COMPANY

HOME OFFICE: CEDAR RAPIDS, IA

ADMINISTRATIVE OFFICE: 2 E. CHASE ST. / BALTIMORE, MARYLAND 21202

PART 1

1. Name of Proposed Insured: _____ 2. Phone No.: _____

3. Address: _____

4. Social Security No.: _____ 5. Birth Date: _____ Age: _____

6. Sex: _____ 7. Birth Place: _____ 8. Height: _____ Weight: _____

9. Employer: _____ Phone No.: _____

Employer Address: _____

Industry: _____

Occupation: _____

10. Plan of Insurance: _____ 11. Amount of Insurance: _____

12. Supplemental Riders and/or Benefits Requested: _____

13. Premiums Payable: _____ Payment Mode: _____

14. Full Names of All others Proposed for Coverage:

<u>Name</u>	<u>Birth Place</u>	<u>Birth Date</u>	<u>Age</u>	<u>Sex</u>	<u>Height</u>	<u>Weight</u>	<u>Pending & Present Insurance</u>	<u>Relationship</u>

15. Additional Insured: _____

Employer: _____ Phone No.: _____

Employer Address: _____

Industry: _____

Occupation: _____

16. Payor (if other than insured):

Name: _____ Phone No.: _____

Address: _____

17. Primary Beneficiaries:

<u>Name</u>	<u>Relationship</u>	<u>Address</u>	<u>SSN</u>	<u>%</u>

18. Contingent Beneficiaries (automatically becomes beneficiary upon death of the Primary):

<u>Name</u>	<u>Relationship</u>	<u>Address</u>	<u>SSN</u>	<u>%</u>

19. Owner(s):
Name: _____ Relationship: _____
Soc Sec No/Tax ID: _____ Phone No: _____
Address: _____

Name: _____ Relationship: _____
Soc Sec No/Tax ID: _____ Phone No: _____
Address: _____

20. Contingent owner (automatically becomes owner upon death of the Primary):
Name: _____ Relationship: _____
Soc Sec No/Tax ID: _____ Phone No: _____
Address: _____

21. Does proposed insured now have life or health insurance with this or any other company?
Life: YES [] NO [] Not Asked [] Health: Yes [] No [] Not Asked []
If yes, give details:

Company	Policy Number	Life/Health	Year Issued	Amount	Accidental Death?	Waiver?	Pending?
-----	-----	-----	-----	-----	-----	-----	-----

22. Are all owners citizens of the United States?
If no, provide details at the end of Part 1 Yes [] No [] Not Asked []

23. Are all proposed insureds citizens of the United States?
If no, provide details at the end of Part 1 Yes [] No [] Not Asked []

EXPLAIN ALL YES RESPONSES AT THE END OF PART 1

24. Has any proposed insured in the past 2 years traveled or resided, or does any proposed insured intend to travel or reside, outside of the continental United States for more than 3 consecutive weeks? Yes [] No [] Not Asked []

25. Provide all proposed insureds Drivers License Number(s):
Name: _____ License number: _____ State: _____
Name: _____ License number: _____ State: _____
Name: _____ License number: _____ State: _____

26. Within the past 5 years, has any proposed insured had his/her driver's license suspended or revoked, had two or more moving violations or accidents or been convicted of, pled guilty or no contest to, driving under the influence of alcohol or drugs?
Yes [] No [] Not Asked []

27. Within the past 3 years has any proposed insured participated in or within the next 12 months does any proposed insured intend to participate in flying as a pilot, racing a motor vehicle, underwater diving or any other similar sport, activity or avocation?
Yes [] No [] Not Asked []

28. Is any proposed insured currently on probation, parole, or awaiting trial for an illegal activity or within the past 10 years, has a proposed insured been convicted of a felony? Within the past 5 years, has any proposed insured been convicted of a misdemeanor?
Yes [] No [] Not Asked []

29. Will any existing life (including paid-up additions), health or annuity contracts be lapsed, surrendered, or borrowed against, reissued or converted (in order to reduce amount, premium, or period of coverage including surrender options) if the proposed policy is issued? Yes [] No [] Not Asked []

30. Has any person to be covered applied for life or accident & health insurance without receiving the amount and plan applied for at the standard premium?
Yes [] No [] Not Asked []

31. Special Request:

Details of YES answers (Identify question number, indicate applicable items).

PART 2 - Life/Health

1. Is any proposed insured currently hospitalized, residing in a nursing home, long term care facility, convalescent home, receiving hospice, home healthcare or waiting for an organ transplant (except corneal)? Yes [] No [] Not Asked []
2. Has any proposed insured been diagnosed with, been treated for, or advised to receive treatment for Alzheimer's disease or dementia? Yes [] No [] Not Asked []
3. Has any proposed insured been medically diagnosed, been treated for Acquired Immune Deficiency Syndrome (AIDS), any disease or disorder of the immune system or tested positive for antibodies to the AIDS (HIV Virus)? Yes [] No [] Not Asked []

4. a. Name(s) of primary health care provider: _____
Phone No: _____
Address: _____

b. Date(s) last consulted: _____

Yes answers explained in detail at the end of part 2 questions

5. Is any proposed insured taking any medication or been prescribed a medication that has not been filled? Yes [] No [] Not Asked []
6. Within the past 12 months, has any proposed insured used a tobacco or nicotine product? Yes [] No [] Not Asked []
7. Within the past 12 months, has any proposed insured lost 25 or more pounds? Yes [] No [] Not Asked []
8. Within the past 7 years, has any proposed insured been told that he/she has been diagnosed or treated by a licensed health care provider or taken medication for:
 - a. Allergies, asthma, bronchitis, chronic obstructive pulmonary disease (COPD), emphysema, pneumonia, shortness of breath, sinusitis, sleep apnea, tuberculosis (TB) or other disease or disorder of the lung or respiratory system? Yes [] No [] Not Asked []
 - b. Anemia, aneurysm, blood clot, phlebitis, coronary artery disease (CAD), chest pain, angina, cholesterol, congestive heart failure, edema, heart attack, heart murmur, high blood pressure, irregular heartbeat, palpitations, stroke, transient ischemic attack (TIA) or any other disease or disorder of the heart, circulatory system, or arteries? Yes [] No [] Not Asked []
 - c. Cirrhosis, crohn's, ulcerative colitis, diverticulitis, fatty liver, gastritis, gastroesophageal reflux, hepatitis, hernia, pancreatitis, stomach bypass, stomach banding, stomach stapling, ulcer or other disease or disorder of the stomach, liver, colon, rectum, intestines? Yes [] No [] Not Asked []
 - d. Attention deficit disorder (ADD/ADHD), anxiety, autism, depression, dizziness, vertigo, down's syndrome, fainting, schizophrenia, seizures, epilepsy, convulsions, or other disease or disorder of the brain or nervous system, or mental or nervous disorder, or consulted a psychiatrist or psychologist? Yes [] No [] Not Asked []
 - e. Amputation, arthritis, rheumatoid arthritis, osteoarthritis, cerebral palsy, concussion, fibromyalgia, fracture, herniated disc, multiple sclerosis, osteoporosis, paralysis, Parkinson's, or other disease or disorder of the muscles, bones, joints, or connective tissue? Yes [] No [] Not Asked []
 - f. Dialysis, infection, kidney stones, menstrual irregularity, nephritis, or other disease or disorder of the kidney, bladder, prostate, breast, or reproductive organs, urine abnormality or sexually transmitted disease? Yes [] No [] Not Asked []
 - g. Diabetes or other disease or disorder of the thyroid, pituitary, adrenal glands? Yes [] No [] Not Asked []

PART 2 - Life/Health Con't

h. Cancer, cysts, growths, Hodgkin's, leukemia, lupus, lymphoma, melanoma, polyps, tumors or other disease or disorder of the skin or malignant disorders? Yes [] No [] Not Asked []

9. Within the past 10 years, has any proposed insured received advice or sought advice or counseling by a licensed health care provider for the use of drugs or alcohol or has any proposed insured used amphetamines, barbiturates, cocaine, heroin, opium, LSD, PCP, hallucinogens, marijuana, narcotics or any other controlled substance except that taken in doses as prescribed by a physician? Yes [] No [] Not Asked []
10. Within the past 5 years, has any proposed insured consulted, been treated or examined by a licensed health care provider for reasons not stated in the application?
Yes [] No [] Not Asked []

(Ask only if Premium Waiver or Multiple Coverage is applied for)

11. Within the past 7 years, has any proposed insured ever requested or received a benefit, discharge or rejection, payment or pension because of a disability, impaired condition, injury, or sickness? Yes [] No [] Not Asked []
12. Within the past 12 months, excluding pregnancy, has any proposed insured had an illness or condition that prevented them from working at their job for more than 5 consecutive business days? Yes [] No [] Not Asked []

(Ask only if combined amount applied for is \$100,000 or greater and adult base or rider is less than age 60.)

13. Family History:

Father:
Age if living:
Age at death:
Cause:

Mother:
Age if living:
Age at death:
Cause:

Had a brother, or sister who was diagnosed and/or died from cancer, diabetes, stroke, heart or kidney disease or suicide? Yes [] No [] Not Asked []

(Ask only if a proposed insured is less than 1 year old)

14. Birth weight: _____

Details of YES answers (Identify question number, indicate applicable items).

PART 2 - CANCER

1. Does any proposed insured now have health insurance with this or any other company? Yes [] No [] Not Asked []

If yes, give details:

Company	Policy Number	Year Issued	Amount	Accidental Death?	Waiver?	Pending?
-----	-----	-----	-----	-----	-----	-----

2. Is any person proposed for coverage also covered by:

- a. Medicaid? Yes [] No [] Not Asked []
- b. Medicare? Yes [] No [] Not Asked []

(If yes to Medicare, I received the "Important Notice to Persons on Medicare Form.")
 Yes [] No [] Not Asked []

3. a. Name(s) of primary health care provider: _____ Phone No: _____
 Address: _____

b. Date(s) last consulted: _____
 Reason(s) for consultation: _____
 (if more than one, enter in "Details". For additional insureds primary health care provider information enter in "Details").

4. Within the past 10 years, has any proposed insured been medically diagnosed as having or been treated for Acquired Immune Deficiency Syndrome (AIDS), any disease or disorder of the immune system, or tested positive for antibodies to the AIDS (HIV) virus? Yes [] No [] Not Asked []

5. Within the past 10 years, has any proposed insured been diagnosed as having, been treated for, or had any indications of:

- a. Any benign or malignant tumor, polyp, cyst, growth, tissue enlargement or lesion? Yes [] No [] Not Asked []
- b. Cancer, leukemia, Hodgkin's disease or any cancerous or pre-cancerous disorder of the skin or blood? Yes [] No [] Not Asked []
- c. Fibrocystic breast disease, ovarian cyst, or an abnormal PAP smear that was not subsequently followed by a normal PAP smear? Yes [] No [] Not Asked []

6. Within the past 12 months, has any proposed insured had treatment for, any indications of, been advised of, or seen a physician for:

- a. Any sores that have not healed? Yes [] No [] Not Asked []
- b. Any changes in the size, shape, or appearance of a wart, mole or birthmark? Yes [] No [] Not Asked []
- c. Any unexplained weight loss? Yes [] No [] Not Asked []
- d. Any abnormal PAP smear that was not subsequently followed by a normal PAP smear, mammogram, X-ray, Prostate Specific Antigen (PSA), CAT scan, or MRI? Yes [] No [] Not Asked []
- e. Crohn's disease, regional enteritis, ileitis, or ulcerative colitis? Yes [] No [] Not Asked []
- f. Unexplained weakness, fatigue, anemia, diarrhea, enlargement of a lymph node, lump or growth? Yes [] No [] Not Asked []
- g. Any abnormal or excessive bleeding, gastric ulcer, Barrett's Esophagus, or chronic hepatitis? Yes [] No [] Not Asked []
- h. Any persistent hoarseness, cough, blood in urine or stool, breast lump or discharge? Yes [] No [] Not Asked []
- i. Any recommended test or treatment not yet completed? Yes [] No [] Not Asked []

Details of "YES" answers. (IDENTIFY QUESTION NUMBER, INDICATE APPLICABLE ITEMS:
Include diagnoses, dates, duration and name and address of all attending physicians and
medical facilities. INDICATE TO WHICH APPLICANT EACH EXPLANATION PERTAINS.)

PART 2 - ACCIDENT

1. Does any proposed insured now have accident insurance with this or any other company? YES [] NO [] Not Asked []

If yes, give details:

Company	Policy Number	Year Issued	Amount	Accidental Death?	Waiver?	Pending?
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2. Within the past 7 years, has any proposed insured been told that he/she has been diagnosed or treated by a licensed health care provider or taken medication for:

- a. Diabetes or other disease or disorder of the thyroid, pituitary, adrenal glands? Yes [] No [] Not Asked []
- b. Anemia, aneurysm, blood clot, phlebitis, coronary artery disease (CAD), chest pain, angina, cholesterol, congestive heart failure, edema, heart attack, heart murmur, high blood pressure, irregular heartbeat, palpitations, stroke, transient ischemic attack (TIA) or any other disease or disorder of the heart, circulatory system, or arteries? Yes [] No [] Not Asked []
- c. Attention deficit disorder (ADD/ADHD), anxiety, autism, depression, dizziness, vertigo, down's syndrome, fainting, schizophrenia, seizures, epilepsy, convulsions, or other disease or disorder of the brain or nervous system, or mental or nervous disorder or consulted a psychiatrist or psychologist? Yes [] No [] Not Asked []
- d. Amputation, arthritis, rheumatoid arthritis, osteoarthritis, cerebral palsy, concussion, fibromyalgia, fracture, herniated disc, multiple sclerosis, osteoporosis, paralysis, Parkinson's, or other disease or disorder of the muscles, bones, joints, or connective tissue? Yes [] No [] Not Asked []

3. Within the past 10 years, has any proposed insured received advice or sought advice or counseling by a licensed health care provider for the use of drugs or alcohol or has any proposed insured used amphetamines, barbiturates, cocaine, heroin, opium, LSD, PCP, hallucinogens, marijuana, narcotics or any other controlled substance except that taken in doses as prescribed by a physician? Yes [] No [] Not Asked []

Details of "YES" answers. (IDENTIFY QUESTION NUMBER, INDICATE APPLICABLE ITEMS: Include diagnoses, dates, duration and name and address of all attending physicians and medical facilities. INDICATE TO WHICH APPLICANT EACH EXPLANATION PERTAINS.)

CONDITIONAL RECEIPT

MONUMENTAL LIFE INSURANCE COMPANY

Home Office: Cedar Rapids, Iowa
Administrative Office: 2 East Chase Street, Baltimore, MD 21202

IMPORTANT NOTICE TO PROPOSED INSURED AND OWNER

Please Read This Receipt Carefully. No insurance will become effective prior to delivery of the policy and/or rider applied for unless and until all the conditions of this receipt are met. No agent, producer and/or broker is authorized to alter or waive any conditions of this receipt. Under no circumstances can a claim be made both under this receipt and under the policy and/or rider applied for should the policy and/or rider applied for be issued.

CONDITIONS WHICH MUST BE MET BEFORE INSURANCE MAY BECOME EFFECTIVE PRIOR TO DELIVERY OF THE POLICY AND/OR RIDER:

1. On the Effective Date indicated below, the state of health and all factors affecting insurability of each person proposed for coverage must be as stated in applications required by the Company; and
2. On the Effective Date indicated below, an amount equal to the initial premium indicated by the mode of payment selected on the application must be submitted; the amount must be annual, semi-annual, quarterly or monthly; and
3. Any check or money order given in payment must be honored when first presented; and
4. All medical examinations, tests, x-rays and electrocardiograms initially required by the Company's written rules with regard to age and amount requested must be completed within sixty (60) days from the date of this receipt; and
5. On the Effective Date indicated below, any person proposed for coverage must be a risk acceptable for insurance exactly as applied for on a premium basis according to the Company's underwriting rules and standards.

EFFECTIVE DATE

If all the conditions above are met, insurance in the amount set forth below or the amount applied for, whichever is lower, subject to all the terms and conditions of the policy and/or rider applied for and as if the policy and/or rider applied for had been issued and delivered, will become effective on the LATER of: a) the date of the application or, b) the date of completion of all underwriting requirements stated in (4) above.

MAXIMUM AMOUNT

The liability of the Company prior to delivery of the policy and/or rider and under the receipt and application for insurance and/or accidental death benefits will not exceed one hundred and fifty thousand dollars (\$150,000.00).

LIABILITY NOT ASSUMED

Each person proposed for insurance must meet the qualifications set forth in this receipt individually. If the Company determines, after completion of all underwriting requirements stated in (4) above, that any person proposed for coverage is not at least a standard risk according to the Company's underwriting rules and standards for the plan and amount of insurance applied for in the application or if any person proposed for coverage dies before completion of all the underwriting requirements stated in (4) above, then the Company assumes NO liability under the receipt and application for insurance with respect to that person.

RETURN OF MONEY

If any of the above stated conditions are not met, the liability of the Company shall be limited to the return of the amount remitted with this receipt. All returns shall be made without interest to or for the benefit of the owner. Any delay in returning the amount paid shall not be construed as approval of the application.

AGREEMENT

I understand and agree that: (1) any coverage provided under this receipt will be void if the application or this receipt contains any material misrepresentation or if the Proposed Insured dies by suicide; (2) any coverage of insurance available under this receipt will not begin unless all the CONDITIONS listed above are first met exactly; and (3) any coverage which takes effect through this receipt will terminate on the **EARLIEST** of the following: a) sixty (60) days after the date of this receipt; b) the date the policy and/or rider is delivered to the owner; c) the Effective Date of the policy and/or rider; d) the date the entire amount remitted with this receipt is returned; or e) the date the Company determines that the person proposed for coverage is not entitled to insurance as a standard risk on the plan and amount of insurance applied for under the Company's underwriting rules and standards.

If, after termination of coverage under this receipt pursuant to section (e) above, the Company is willing to issue a policy and/or rider on terms other than those applied for (rated policy and/or rider), no such rated policy and/or rider shall become effective until during the lifetime of the person proposed for insurance, the policy and/or rider is delivered to the Owner, the first full monthly premium on the rated policy and/or rider is delivered to the agent, and an acknowledgement referring to the rated policy and/or rider is signed by the Owner, and then only if there has been no change in the health of the person proposed for insurance since the date of this receipt. The decision to issue a rated policy and/or rider shall not create any liability on the part of the Company on a conditional receipt basis for any reason.

Signature of Proposed Insured

Date of this Receipt

Signature of Owner if Other than Proposed Insured

Payment of \$ _____ has been received toward the premium for insurance with Monumental Life Insurance Company in the application having the same name and date of this receipt. I know of no reason why any person to be covered may not be eligible for insurance. I accurately represented the terms and conditions of this receipt to the Proposed Insured(s) and Owner(s).

Signature of Agent