

SERFF Tracking Number: CEUL-127071604 State: Arkansas
Filing Company: Family Life Insurance Company State Tracking Number: 48198
Company Tracking Number:
TOI: L071 Individual Life - Whole Sub-TOI: L071.101 Fixed/Indeterminate Premium - Single Life
Product Name: Whole Life
Project Name/Number: /

Filing at a Glance

Company: Family Life Insurance Company

Product Name: Whole Life

TOI: L071 Individual Life - Whole

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

Filing Type: Form

SERFF Tr Num: CEUL-127071604 State: Arkansas

SERFF Status: Closed-Approved-
Closed State Tr Num: 48198

Co Tr Num:

State Status: Approved-Closed

Author: Scott Gadd

Date Submitted: 03/09/2011

Reviewer(s): Linda Bird

Disposition Date: 03/22/2011

Disposition Status: Approved-
Closed

Implementation Date:

Implementation Date Requested: On Approval

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:

Deemer Date:

Submitted By: Scott Gadd

Filing Description:

Please see cover letter in Supporting Documentation.

Status of Filing in Domicile: Authorized

Date Approved in Domicile: 02/22/2011

Domicile Status Comments: Our State of
Domicile is Texas.

Market Type: Individual

Individual Market Type:

Filing Status Changed: 03/22/2011

State Status Changed: 03/22/2011

Created By: Scott Gadd

Corresponding Filing Tracking Number:

Company and Contact

Filing Contact Information

Scott Gadd, Compliance Technician

10700 Northwest Freeway

sgadd@manhattanlife.com

800-669-9030 [Phone] 5107 [Ext]

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Houston, TX 77092 713-821-6551 [FAX]

Filing Company Information

Family Life Insurance Company CoCode: 63053 State of Domicile: Texas
 10700 Northwest Freeway Group Code: 1117 Company Type:
 Houston, TX 77092 Group Name: Manhattan Insurance State ID Number:
 Group
 (800) 877-7705 ext. [Phone] FEIN Number: 91-0550883

Filing Fees

Fee Required? Yes
 Fee Amount: \$250.00
 Retaliatory? No
 Fee Explanation: 1 x Policy \$50
 3 x Riders \$150
 1 x Application \$50
 5 x Questionnaires
 Total: \$250
 Per Company: No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Family Life Insurance Company	\$250.00	03/09/2011	45412251
Family Life Insurance Company	\$250.00	03/14/2011	45540007

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Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
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	03/15/2011	03/15/2011	Scott Gadd	03/16/2011	03/21/2011
Pending Industry Response	Linda Bird	03/11/2011	03/11/2011	Scott Gadd	03/14/2011	03/14/2011

Filing Notes

Subject	Note Type	Created By	Created On	Date Submitted
Contact info	Note To Filer	Linda Bird	03/16/2011	03/16/2011
Contact info	Note To Reviewer	Scott Gadd	03/16/2011	03/16/2011
Flesch Certification	Note To Reviewer	Scott Gadd	03/09/2011	03/09/2011

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Disposition

Disposition Date: 03/22/2011

Implementation Date:

Status: Approved-Closed

Comment:

Rate data does NOT apply to filing.

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Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document (revised)	Flesch Certification	No	No
Supporting Document	Flesch Certification	No	No
Supporting Document	Application	No	No
Supporting Document	Life & Annuity - Actuarial Memo	No	No
Supporting Document	Cover Letter	No	No
Supporting Document	Statement of Variability	No	No
Supporting Document	Regulation 19 Certification	No	No
Supporting Document	Guaranty Notice	No	No
Form (revised)	Endowment Life Insurance Policy	No	No
Form	Endowment Life Insurance Policy	No	No
Form	Insured's Level Term Insurance	No	No
Form	Additional Insured's Level Term Insurance Rider	No	No
Form	Insured's Spouse's Level Term Insurance Rider	No	No
Form	Application for Life Insurance	No	No
Form	Alcohol Usage Questionnaire	No	No
Form	Business Insurance Questionnaire	No	No
Form	Drug Usage Questionnaire	No	No
Form	Military and Sports Questionnaire	No	No
Form	Supplemental Questionnaire	No	No
Form	Required Notice	No	No

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Objection Letter

Objection Letter Status Pending Industry Response
Objection Letter Date 03/15/2011
Submitted Date 03/15/2011
Respond By Date 04/15/2011

Dear Scott Gadd,

This will acknowledge receipt of the captioned filing.

Objection 1

Comment: Ark. Code Ann. 23-79-138 requires that certain information accompany every policy. Bulletin 15-2009 further address this issue. Please review your procedures and assure us that you are in compliance.

Regulation 19s10B requires that all new or revised filings submitted must contain a certification that the submission meets the provisions of this rule as well as all applicable requirements of this Department.

Regulation 49 requires that a Life and Health guaranty notice be given to each policy owner. Please review your issue procedures and assure us that you are in compliance with Regulation 49.

Please refer to policy General Provisions under the Suicide provision. After the incontestable period expiration you may not restart upon reinstatement. Review Ark. Code Ann. 23-81-115(a)(2)(E).

Please feel free to contact me if you have questions.

Sincerely,

Linda Bird

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Project Name/Number: /

Response Letter

Response Letter Status Submitted to State
Response Letter Date 03/16/2011
Submitted Date 03/21/2011

Dear Linda Bird,

Comments:

Thank you for you assistance in reviewing this filing.

Response 1

- Comments: 1. The Required Notice has been attached under the Form Schedule.
2. Regulation 19 Certification has been attached under Supporting Documentation.
3. The Guaranty Notice has been attached under Supporting Documentation
4. The provision has been amended.

Related Objection 1

Comment:

Ark. Code Ann. 23-79-138 requires that certain information accompany every policy. Bulletin 15-2009 further address this issue. Please review your procedures and assure us that you are in compliance.

Regulation 19s10B requires that all new or revised filings submitted must contain a certification that the submission meets the provisions of this rule as well as all applicable requirements of this Department.

Regulation 49 requires that a Life and Health guaranty notice be given to each policy owner. Please review your issue procedures and assure us that you are in compliance with Regulation 49.

Please refer to policy General Provisions under the Suicide provision. After the incontestable period expiration you may not restart upon reinstatement. Review Ark. Code Ann. 23-81-115(a)(2)(E).

Changed Items:

Supporting Document Schedule Item Changes

Satisfied -Name: Regulation 19 Certification

Comment:

Satisfied -Name: Guaranty Notice

SERFF Tracking Number: CEUL-127071604 State: Arkansas
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Comment:

Form Schedule Item Changes

Form Name	Form Number	Edition Date	Form Type	Action	Action Specific Data	Readability Score	Attach Document
Endowment Life Insurance Policy	FWL2010-AR		Policy/Contract/Fraternal Certificate: Amendment, Insert Page, Endorsement or Rider	Initial		52.300	FWL2010-AR.pdf
Previous Version							
Endowment Life Insurance Policy	FWL2010		Policy/Contract/Fraternal Certificate: Amendment, Insert Page, Endorsement or Rider	Initial		52.300	FWL2010.pdf
Required Notice	AR-Notice		Other	Initial			AR-Notice.pdf

No Rate/Rule Schedule items changed.

I apologize for my lack of oversight. Please notify me for any additional required changes.

Sincerely,
 Scott Gadd

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Objection Letter

Objection Letter Status Pending Industry Response
Objection Letter Date 03/11/2011
Submitted Date 03/11/2011
Respond By Date 04/11/2011

Dear Scott Gadd,

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 \$250.00 is received.

Please feel free to contact me if you have questions.

Sincerely,

Linda Bird

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Product Name: Whole Life
Project Name/Number: /

Response Letter

Response Letter Status Submitted to State
Response Letter Date 03/14/2011
Submitted Date 03/14/2011

Dear Linda Bird,

Comments:

Thank you for your assistance in reviewing this filing.

Response 1

Comments: The additional \$250 has been submitted.

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 \$250.00 is received.

Changed Items:

Supporting Document Schedule Item Changes

Satisfied -Name: Flesch Certification

Comment:

No Form Schedule items changed.

No Rate/Rule Schedule items changed.

Sincerely,
Scott Gadd

SERFF Tracking Number: CEUL-127071604 *State:* Arkansas
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Company Tracking Number:
TOI: L071 Individual Life - Whole *Sub-TOI:* L071.101 Fixed/Indeterminate Premium - Single Life
Product Name: Whole Life
Project Name/Number: /

Note To Filer

Created By:

Linda Bird on 03/16/2011 01:02 PM

Last Edited By:

Linda Bird

Submitted On:

03/16/2011 01:02 PM

Subject:

Contact info

Comments:

You may contact me at (501) 371-2769.

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Product Name: Whole Life
Project Name/Number: /

Note To Reviewer

Created By:

Scott Gadd on 03/16/2011 11:15 AM

Last Edited By:

Scott Gadd

Submitted On:

03/16/2011 11:15 AM

Subject:

Contact info

Comments:

Ms. Bird,

Could you please provide me with your contact information? I have some questions regarding some of the AR regulations. Thank you.

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Project Name/Number: /

Note To Reviewer

Created By:

Scott Gadd on 03/09/2011 11:26 AM

Last Edited By:

Scott Gadd

Submitted On:

03/09/2011 11:26 AM

Subject:

Flesch Certification

Comments:

I forgot to insert "the State of Arkansas" into the Flesch certification. An updated version has been attached under Supporting Documentation.

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Form Schedule

Lead Form Number: FWL2010

Schedule Item Status	Form Number	Form Type Form Name	Action	Action Specific Data	Readability	Attachment
	FWL2010-AR	Policy/Cont Endowment Life ract/Fratern Insurance Policy al Certificate: Amendmen t, Insert Page, Endorseme nt or Rider	Initial		52.300	FWL2010-AR.pdf
	FLI20YTR2010	Policy/Cont Insured's Level Term ract/Fratern Insurance al Certificate: Amendmen t, Insert Page, Endorseme nt or Rider	Initial		58.000	FLI20YTR2010.pdf
	FLAI20YTR2010	Policy/Cont Additional Insured's Level Term ract/Fratern Level Term al Insurance Rider Certificate: Amendmen t, Insert Page, Endorseme nt or Rider	Initial		53.600	FLAI20YTR2010.pdf
	FLS20YTR2010	Policy/Cont Insured's Spouse's Level Term ract/Fratern Level Term al Insurance Rider	Initial		57.800	FLS20YTR2010.pdf

SERFF Tracking Number: CEUL-127071604 *State:* Arkansas
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Company Tracking Number:
TOI: L071 Individual Life - Whole *Sub-TOI:* L071.101 Fixed/Indeterminate Premium - Single Life

Product Name: Whole Life
Project Name/Number: /

Certificate:
 Amendmen
 t, Insert
 Page,
 Endorseme
 nt or Rider

FL-LFAPP 0801	Application/ Enrollment Form	Application for Life Insurance	Initial	FL-LFAPP 0810.pdf
FL-AUQ	Other	Alcohol Usage Questionnaire	Initial	FL-AUQ.pdf
FL-5030	Other	Business Insurance Questionnaire	Initial	FL-5030.pdf
FL-DUQ	Other	Drug Usage Questionnaire	Initial	FL-DUQ.pdf
FL-MSQ	Other	Military and Sports Questionnaire	Initial	FL-MSQ.pdf
C-10	Other	Supplemental Questionnaire	Initial	C-10.pdf
AR-Notice	Other	Required Notice	Initial	AR-Notice.pdf

Family Life Insurance Company

Home Office: [Houston, TX]
Administrative Office: [10700 Northwest Freeway, Houston, TX 77092]
[(800) 877-7705]

READ THIS POLICY CAREFULLY!

It is a legal contract between You and the Company.

FAMILY LIFE INSURANCE COMPANY agrees to pay the Face Amount of this Policy as shown in the Policy Schedule to the Beneficiary when We receive proper written claim and due proof of the death of the Insured while this Policy is in force or to the Insured on the Maturity Date provided the Insured is then living and this Policy is in force. Our payment will be subject to the terms and provisions of this Policy.

This policy is issued in consideration of the application for this Policy, a copy of which is attached, and in consideration of the payment of premiums as provided herein, for the full premium paying period as stated herein or until the prior death of the Insured.

NOTICE OF 30-DAY RIGHT TO EXAMINE POLICY

If You are not satisfied with this Policy, it may be cancelled on or before the 30th day after its receipt by delivering or mailing it to Our Administrative Office, to the agent through whom it was purchased or to any of Our agents. Immediately upon such delivery or mailing, this Policy will be treated as if it never existed. Any premium paid will be refunded within ten days after We have received this Policy.

NOTICE

This Policy is valuable property. If anyone suggests replacing it, please contact Us first to be certain of Your rights and values.

When You write to Us, please give Us Your name, address and policy number. Please notify Us promptly of any changes. We will write to You at Your last known address.

In Witness Whereof, **FAMILY LIFE INSURANCE COMPANY** has caused this Policy to be executed at its Home Office in [Houston, Texas] to take effect on the Policy Date.

[
Mary Lou Rainey

[Mary Lou Rainey
Secretary]

Dan George

[Dan George
President]

ENDOWMENT LIFE INSURANCE POLICY

Proceeds payable on the Maturity Date or if the Insured dies while this Policy is in force

Premiums are payable [during the lifetime of the Insured]

[for the number of years stated on the Policy Schedule]

Non-Participating

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POLICY SCHEDULE

Form FWL2010	Benefits Provided Whole Life Insurance	Annual Premium [\$1,274.00] *	Premiums Payable [for [3; 5; 10; 20] years; [to age 65]; life]
-----------------	---	----------------------------------	--

Owner: [Doe, John E.]	Policy Date: [March 1, 2008]	Maturity Date: [March 1, 2073]
--------------------------	---------------------------------	-----------------------------------

Issue Age: [35 Male]	Policy No.: [12345678]
-------------------------	---------------------------

Premium Class: [Preferred; Standard]	Underwriting Class: [Nicotine; Non-Nicotine]
---	---

Annual [\$1,274.00] *	Semi-Annual [\$649.74] *	Quarterly [\$331.24] *	Monthly [\$114.66] *
--------------------------	-----------------------------	---------------------------	-------------------------

THIS POLICY

INSURES [John E. Doe]	PROVIDES A BENEFIT OF [\$10,000 - \$3,000,000 in increments of \$10,000 Face Amount
------------------------------	--

OPTIONAL RIDERS

RIDER BENEFIT	RIDER AMOUNT	RIDER ANNUAL PREMIUM
Accidental Death Benefit (Insured only)	[Minimum: Lesser of Policy Face Amount and \$250,000; Maximum: \$250,000]	[\$XX.XX]
Children's Insured Benefit [Mary Doe]	[1 – 10 Units]	[\$XX.XX]
20 Year Term Rider (Insured only)	[\$100,000 - \$1,000,000 in increments of \$10,000]	[\$XX.XX]
20 Year Additional Insured Term Rider [Suzie Smith]	[\$100,000 - \$1,000,000 in increments of \$10,000]	[\$XX.XX]
20 Year Spouse Rider [Jane Doe]	[\$100,000 - \$1,000,000 in increments of \$10,000]	[\$XX.XX]
Waiver of Premium Rider		[\$XX.XX]

TOTAL PREMIUM DUE FOR POLICY AND ALL ATTACHED RIDERS

Annual [\$xxx.xx] *	Semi-Annual [\$xx.xx] *	Quarterly [\$xx.xx] *	Monthly [\$xx.xx] *
------------------------	----------------------------	--------------------------	------------------------

BENEFICIARY: As specified in the application unless changed as provided in this Policy.

Minimum Guaranteed Interest Rate used to determine Guaranteed Policy Values: 5.00%

*Includes \$[60-100] Annual Policy Fee

TABLE OF POLICY VALUES

POLICY YEAR	CASH VALUE	REDUCE D PAID-UP AMOUNT	EXTENDE D TERM YEARS	EXTENDE D TERM DAYS
1	-	-	0	0
2	-	-	0	0
3	[341.00	2,100.00	2	242
4	1,190.00	7,000.00	7	281
5	2,075.00	11,600.00	11	269
6	2,995.00	16,100.00	14	266
7	3,950.00	20,300.00	16	323
8	4,938.00	24,400.00	18	206
9	5,961.00	28,200.00	19	297
10	7,017.00	31,900.00	20	274
11	8,107.00	35,400.00	21	182
12	9,233.00	38,700.00	22	39
13	10,402.00	41,900.00	22	216
14	11,619.00	44,900.00	22	349
15	12,885.00	47,800.00	23	73
16	14,196.00	50,600.00	23	129
17	15,551.00	53,300.00	23	157
18	16,946.00	55,900.00	23	162
19	18,381.00	58,300.00	23	145
20	19,848.00	60,600.00	23	107
Age 60	27,709.00	70,400.00	22	43
Age 65	36,319.00	78,000.00	20	100
Age 70	45,465.00	83,800.00	18	17]

Non-Forfeiture Factor: [9.17498]

DEFINITIONS

You, Your

The Owner of this Policy.

We, Us, Our, the Company

Family Life Insurance Company.

The Insured

The person whose life is insured under this Policy, as shown in the Policy Schedule.

Face Amount

The amount of insurance shown in the Policy Schedule or on any endorsement to the Policy Schedule.

Age

The Insured's age on his last birthday.

Beneficiary

The designated recipient of the Proceeds under a Settlement Option.

Cash Surrender Value

The Cash Value less any Indebtedness.

Cash Value

The amount shown in the Table of Policy Values for the age, underwriting class and sex at issue.

Indebtedness

Unpaid policy loans and loan interest.

Loan Value

The amount which, with accrued interest, equals the Cash Value on the next premium due date or the next Policy Anniversary, if earlier, less Indebtedness.

Maturity Date

The date shown in the Policy Schedule. It is the date on which the Owner will be paid the Face Amount, less any Indebtedness, if the Insured is then living, provided the Policy is still in force.

Policy Anniversary

The same day and month as Your Policy Date for each succeeding year Your policy stays in force.

Policy Date

The date this Policy takes effect, as shown in the Policy Schedule.

Policy Month

A period beginning each month on the day of the Policy Date and ending the next month on the day preceding the day of the Policy Date.

Policy Year

A period of twelve months beginning each year on the month and day of the Policy Date.

Proceeds

The amount We are obligated to pay under the terms of this Policy when the Insured dies or on the Maturity Date if the Insured is then living.

Written Request

A request in writing signed by You. All correspondence should be sent to Our Administrative Office. We may also require that Your policy be sent in with Your request.

DEATH BENEFIT

Payment of Proceeds

If the Insured dies while this Policy is in force, We will pay the Proceeds to the Beneficiary. If the Insured is living on the Maturity Date, and the Policy is still in force, We will pay the Proceeds to the Owner.

The Proceeds are the sum of:

1. the Face Amount;
2. PLUS insurance on the Insured's life that may be provided by riders to this Policy;
3. PLUS that portion of premium paid which applies to a period beyond the Policy Month in which the Insured dies;
4. LESS unpaid premium if death occurs during the Grace Period; and
5. LESS Indebtedness.

We agree to pay the Proceeds to the Beneficiary upon receiving due proof of death of the Insured and proper written claim. We will pay interest on the Proceeds at the current rate, unless a higher rate is required by Your state of residence, if payment is not made within the statutorily allowed time period.

PREMIUMS AND REINSTATEMENT

Premiums must be paid to Us at Our Administrative Office. You may pay the first premium to Us at Our Administrative Office or to Our agent. We will issue a receipt signed by one of Our officers upon request.

Premium Payments

The first premium must be paid no later than when this Policy is issued. There is no insurance unless this premium is paid while all statements and answers in all parts of the application remain correct.

Each premium after the first must be paid on or before its due date. The due dates of premiums after the first are measured from the Policy Date.

Re-Classification Based on Nicotine Use Change – If the Insured is nicotine-free for at least 12 consecutive months, You may request a re-classification from a nicotine use class to a non-nicotine use class by completing a request form required by Us and by meeting Our underwriting criteria for re-classification in use at the time of this request.

Grace Period

We will allow You 31 days from the premium due date to pay each premium after the first. This period is called the Grace Period. This policy will stay in force during the Grace Period. If You do not pay the premium due by the end of the Grace Period, this Policy will terminate on the day after the Grace Period ends.

A written notice will be sent to You at Your last known address as shown on Our records. If this Policy has been assigned, written notice will be sent to the assignee of record. The written notice will be sent at least 30 days prior to the date the Grace Period ends.

If the Insured dies during the Grace Period, We will pay the Death Benefit, but We will deduct from it the premium needed to cover the period from the beginning of the Grace Period to the end of the Policy Month in which the Insured died.

Automatic Premium Loan

If You so choose, any premium not paid before the end of its Grace Period will be automatically paid by Automatic Premium Loan (APL), charging the premium as a policy loan against this Policy if the policy loan and the loan interest do not exceed the Loan Value. Interest at the policy loan Interest rate will be charged on an APL from the premium due date. If the premium cannot be paid by APL, nonforfeiture options will apply. The option to have premiums paid by APL may be revoked by You at any time.

Reinstatement

If a Grace Period has ended without payment of the needed premium and this Policy has terminated, You may apply to reinstate it. To reinstate this Policy You must:

1. apply in writing within three years after the end of the Grace Period;
2. provide due proof at Your expense, at Our underwriter's discretion that the Insured's health, occupation, and other risk factors have not materially changed since the Policy Date; and, if approved for reinstatement,
3. pay all overdue premiums plus 6% interest per year, compounded annually, from their due dates to the date of reinstatement; and
4. pay or reinstate any Indebtedness, plus 6% interest per year compounded annually, thereon.

The date of reinstatement will be the first day of the Policy Month on or next following the date We approve Your application for reinstatement.

If a person other than the Insured is covered by an attached rider, such person's coverage will be reinstated if they provide sufficient evidence of insurability, unless not permitted in that rider.

OWNERSHIP AND BENEFICIARY

Owner

The Owner of this Policy is the Insured named in the Policy Schedule, unless stated otherwise in the application, or later changed. As Owner, You can exercise all rights under this Policy while the Insured is alive. You can change ownership if You send Us a Written Request to do so. If a new owner is named, any earlier designations will be void, unless specified otherwise.

Beneficiary

The Beneficiary is the person or persons named by You in the attached application (unless later changed by You) to receive the Proceeds when the Insured dies. If two or more beneficiaries are alive when the Insured dies, We will pay them in equal shares unless You have chosen otherwise.

If We cannot determine whether a Beneficiary or the Insured died first in a common disaster, We will assume that the Beneficiary dies first. Proceeds will be paid on this basis unless otherwise provided.

If no Beneficiary is alive when the Insured dies, You will be the Beneficiary if living, otherwise Your estate.

Change

You may change the Beneficiary at any time unless the Beneficiary has been designated as irrevocable. To change the Owner or Beneficiary, send Us a Written Request while the Insured is alive. A change to an irrevocable Beneficiary is permitted only with such Beneficiary's written approval.

Changes will take effect on the date the notice is signed (subject to Our receipt of the notice). The change will not apply to any payment made by Us before We recorded Your request.

Assignment

You may assign this Policy. We will not be bound by any assignment unless it is in writing, signed by You, and is recorded at Our Administrative Office. We are not responsible for the validity of any assignment. Any amount to be paid to an assignee will be paid in a single sum. Any claim made by an assignee will be subject to proof of the assignee's interest and the extent of the assignment. The rights of any named Beneficiary are subordinate to those of any assignee, unless the Beneficiary was effectively named as an irrevocable Beneficiary prior to the assignment.

SURRENDER BENEFITS

Surrenders

While this Policy is in force, You may surrender it for its Cash Surrender Value by sending Us a Written Request and this Policy. The date of surrender will be the date We receive such request and policy or a later date if specified. All coverage under this Policy will end on such date. The Cash Surrender Value will be determined from the date of surrender. However, if this Policy is surrendered within 30 days after the due date of an unpaid premium, the Cash Surrender Value will not be

less

than the value on that premium due date. If this Policy is surrendered within 30 days after a Policy Anniversary, the Cash Surrender Value will not be less than the value on that Policy Anniversary.

Nonforfeiture Options

If this Policy has a Cash Surrender Value, one of the following options may be chosen by Written Request. Such request must be made within 60 days after the due date of an unpaid premium and before the Insured's death. The options available are:

1. **Paid-Up Insurance** -- This policy is continued from the due date of the unpaid premium at a reduced amount of paid-up life insurance. The amount of coverage will be that which the Cash Surrender Value will provide when applied as a net single premium at the Insured's attained age, sex and underwriting class (shown on page 3) on the due date of the unpaid premium.
2. **Extended Insurance** -- This option provides non-participating term insurance on the life of the Insured with no further premiums due. The amount of paid-up term insurance will be the Face Amount (Shown on Page 3). The insurance will begin on the due date of the first unpaid premium. The term will be that which the Cash Surrender Value will purchase when applied as a net single premium at the Insured's attained age, sex and underwriting class.

Before the end of the term there will be cash values but no loan value. The Cash Surrender Value on any date will be the net value of the remaining extended term insurance. Within thirty-one days after a contract anniversary, the Cash Surrender Value will not be less than it was on that anniversary.

3. **Cash Surrenders** -- This Policy ends and is surrendered in accordance with the Surrenders provision stated above.

Automatic Option

If no option is chosen within 60 days of the due date of the unpaid premium, the automatic option will be: 1. if available; otherwise 3.

Surrender of Paid-Up Insurance

Paid-up insurance may be surrendered for a Cash Surrender Value. The Cash Surrender Value of Paid-Up Insurance will be the net single premium at the attained Age of the Insured on the surrender date. If the insurance is surrendered within 30 days after a Policy Anniversary, the Cash Surrender Value will not be less than that on that anniversary. The date of surrender will be the date We receive the Written Request for surrender at Our Administrative Office. We may request the policy be sent with Your Written Request.

Deferment

We may delay paying any values for up to six months from the date of surrender.

Riders

Additional benefit riders attached to this Policy are disregarded in computing values for Nonforfeiture Options. Insurance provided under options 1. and 2. will not include such benefits.

Basis of Values

The guaranteed Policy Values applicable to this Policy are shown in the Table of Policy Values. Values shown apply only if this Policy is free from a policy loan. Values for policy years not shown will be furnished upon request. Values are shown for the end of a policy year when premiums were paid for the full policy year. If premiums were paid for a part of a policy year, values will be calculated on a consistent basis with allowance for the length of time premiums were paid.

All guaranteed minimum cash values, present values and net single premiums are calculated on the following basis:

1. Interest at 5.00% per year.
2. Mortality as provided in the Commissioners 2001 Standard Ordinary Mortality Tables, curtate; male or female, smoker or non-smoker, whichever applicable, age last birthday.
3. On the assumption that death benefits are payable at the end of the policy year in which the Insured dies and that premiums are paid annually in advance.

The non-forfeiture values are at least equal to those required by law of the state in which this Policy is delivered. All policy values equal or exceed those required by the state in which this Policy is issued. A detailed statement of the method of computing these values has been filed with the insurance supervisory official of the state in which this Policy is issued.

Reserves

The Actuarial reserves are computed in accordance with the Commissioner's Reserve Valuation Method (CRVM), with interest at 4.00%, mortality tables based on the 2001 Commissioner's Standard Ordinary tables, for male or female, smoker or non-smoker, age last birthday, assuming deaths occur throughout the Policy Year and premiums are payable annually. The actuarial reserves are equal to or greater than those required by law of the state in which this Policy is delivered.

LOANS

Policy Loans

By sending Us a Written Request, You may obtain a Policy Loan. This Policy must be assigned to Us; this is the only security needed. The most You can borrow at any time is the Loan Value.

Policy Loan Interest

The interest rate on a loan will never be greater than 7.4% per year in advance. Loan interest is payable each year on the Policy Anniversary. Interest not paid when due will be added to the loan and bear interest at the same rate. Interest accrues on a daily basis. It constitutes an additional loan against this Policy.

Repayment

1. Any outstanding loans and loan interest may be repaid at any time before the Insured's death or within 60 days after the Insured's death if this Policy is in force and the Proceeds of this Policy have not been paid in cash or applied under a payment option.

Termination

This Policy will terminate if all outstanding loans and loan interest exceed the Cash Value.

Deferment

We may delay paying values for up to six months from the date We receive Your Written Request. We cannot, however, defer payment of any values if the amount is to be used to pay a premium to Us.

GENERAL PROVISIONS

Entire Contract

The Entire Contract consists of this Policy, the application, and riders or endorsements attached to this Policy. All statements made by, or by the authority of, the applicant for the issuance, reinstatement or renewal of this Policy shall be deemed representations and not warranties. No statement will be used to contest this Policy or to contest a claim under it, unless it appears in an application, is a material misrepresentation [and could have been used to contest coverage under the policy that provided coverage prior to this Policy.]

Modifications

No agent has the authority to modify, change or waive any provision of this Policy. A modification will only be valid if it is in writing and approved either by Our President, a Vice President, the Secretary, an Assistant Secretary or a Registrar. We may request You submit this Policy for endorsement to show any change.

Incontestability

We will not contest this Policy after it has been in force during the Insured's life for two years from the [Policy Date] [original policy's issue date].

If this Policy is reinstated, this provision will be measured from the reinstatement date and any contest will be based only on statements in the reinstatement application.

This provision does not apply to any provision for Waiver of Premiums or Accidental Death Benefits.

Suicide

If the Insured commits suicide within two years from the Policy Date, the Proceeds will not be paid. Instead, the Beneficiary will receive an amount equal to the premiums paid, less Indebtedness.

Protection of Payments

Unless You and We agree to it, or unless otherwise provided in this Policy, no one entitled to receive benefits under this Policy may commute, pledge, sell or assign any part of such benefits. To the extent permitted by law, such benefits shall not be subject to the claims of any Beneficiary's creditors or to legal process against any Beneficiary.

Misstatement of Age or Sex

If the Insured's Age or sex is misstated in the application, the Face Amount will be adjusted. The adjusted amount will be the Face Amount the premium paid would have provided based on the Insured's correct Age or sex. The Age shown on page 3 is the Insured's Age on his last birthday as of the Policy Date.

Nonparticipation

This Policy does not participate in the distribution of Our surplus. As a result, no dividends will be paid under this Policy.

Unearned Premium Refund

Upon cancellation of this Policy by You, We will refund the unearned premiums for the remainder of the term for which premiums have been paid.

SETTLEMENT OPTIONS

GENERAL POLICY SETTLEMENT PROVISIONS

PAYMENT OF POLICY PROCEEDS. If the Policy proceeds are less than \$5,000, We will pay them to the Beneficiary in one sum. If the Policy proceeds are \$5,000 or more, We will pay them to the Beneficiary in one sum, unless one of the optional methods of Policy settlement is chosen.

CHOOSING AN OPTIONAL METHOD OF SETTLEMENT. At any time before the Insured's death, an optional method of Policy settlement may be chosen. If the Insured dies and an option has not yet been chosen, then the Beneficiary may choose an option. We must receive a Written Request informing Us of the option chosen. If the Beneficiary is other than an individual, the options are available only with Our consent.

FREQUENCY OF PAYMENTS. If Option 1, 2 or 3 is chosen, We will make payments every 1 year, 6 months, 3 months or 1 month. The frequency of payments must be specified at the time the option is chosen. If Option 4 or 5 is chosen, We will make payments every 1 month. If any payment under an option would be less than \$50, We may make payments less frequently so that each payment is at least \$50.

FIRST PAYMENT. Depending on the frequency of payments specified, the first payment under Option 1 is payable 1 year, 6 months, 3 months or 1 month from the date of the Insured's death. The first payment under any other option is payable when we receive sufficient proof of the Insured's death.

If the amount that could be purchased by a single premium of \$1,000 at Our regular annuity rates in effect at the time the first installment is payable is larger than the amount of the first monthly installment for each \$1,000 applied under Option 3, 4 or 5, We will pay the larger amount as the benefit under the option. We will furnish this amount upon request.

DEATH OF BENEFICIARY. At the Beneficiary's death, We will pay the amounts below in one sum to the Beneficiary's estate, unless We are directed otherwise at the time the option is chosen:

1. Under Option 1, the amount which was left on deposit with Us to accumulate with interest plus any unpaid interest.
2. Under Option 2, 3 or 5, the commuted value of the amount payable at the Beneficiary's death as provided under the option chosen. The commuted value will be based on interest at the rate which would have been used to compute the first installment of the installments remaining to be paid at the Beneficiary's death.

PROTECTION AGAINST CREDITORS. Unless provided otherwise at the time an option is chosen, the Beneficiary may neither commute, anticipate, assign, alienate nor otherwise encumber any payment under an option. Payments under any option are exempt from the claims of creditors and from legal process to the extent the law permits.

SETTLEMENT AGREEMENT. In exchange for this Policy, We will issue a settlement agreement stating the terms of the option chosen.

ADDITIONAL INTEREST EARNINGS. We may pay interest earnings beyond those guaranteed in Options 1 and 2. If We do, We will determine the amount of the additional interest earnings and how they are paid.

OPTIONAL METHODS OF POLICY SETTLEMENT

OPTION 1 - INTEREST PAYMENTS. We will hold the Policy proceeds as principal and pay the interest to the Beneficiary. The interest rate will be 3% per year compounded annually. We will pay the interest every 1 year, 6 months, 3 months or 1 month, as specified at the time this option is chosen. At the death of the Beneficiary, We will make payment as stated in "Death of Beneficiary."

OPTION 2 - INSTALLMENTS OF A SPECIFIED AMOUNT. We will pay the Policy proceeds to the Beneficiary in equal installments every 1 year, 6 months, 3 months or 1 month. The amount of the equal installment payments and the frequency of payments must be specified at the time this option is chosen. After each payment, We will add interest to that portion of the policy proceeds applied under this option which has not yet been paid as installments. The interest rate will be 3% per year compounded annually. Installments will be paid to the Beneficiary until the amount applied under this option, including interest, is exhausted. The total of the installments paid each year must be at least 5% of the proceeds applied under this option. If the Beneficiary dies before the amount applied is exhausted, We will pay the unpaid installments as stated in "Death of Beneficiary."

OPTION 3 - INSTALLMENTS FOR A SPECIFIED PERIOD. We will pay the Policy proceeds in equal installments to the Beneficiary for the number of years specified at the time this option is chosen. Payments will be made every 1 year, 6 months, 3 months or 1 month, as specified at the time this option is chosen. The amount of the equal installments for each \$1,000 applied under this option is shown in the following table. These amounts are calculated at an interest rate of 3% per year compounded annually. If the Beneficiary dies before the number of years specified ends, We will pay the unpaid installments as stated in "Death of Beneficiary."

Number of years Specified	Amount of Installments		Number of Years Specified	Amount of Installments		Number of Years Specified	Amount of Installments	
	Annual	S.A.		Annual	S.A.		Annual	S.A.
1	\$1,000.00	\$503.70	8	\$138.31	\$69.67	15	\$81.33	\$40.96
2	507.39	255.57	9	124.69	62.81	16	77.29	38.93
3	343.23	172.89	10	113.82	57.33	17	73.74	37.14
4	261.19	131.56	11	104.93	52.85	18	70.59	35.56
5	211.99	106.78	12	97.54	49.13	19	67.78	34.14
6	179.22	90.27	13	91.29	45.98	20	65.26	32.87
7	155.83	78.49	14	85.95	43.29			

Number of years Specified	Amount of Installments		Number of Years Specified	Amount of Installments		Number Of Years Specified	Amount of Installments	
	Quarterly	Monthly		Quarterly	Monthly		Quarterly	Monthly
1	\$252.78	\$84.47	8	\$34.96	\$11.68	15	\$20.56	\$6.87
2	128.26	42.86	9	31.52	10.53	16	19.54	6.53
3	86.76	28.99	10	28.77	9.61	17	18.64	6.23
4	66.02	22.06	11	26.52	8.86	18	17.84	5.96
5	53.59	17.91	12	24.66	8.24	19	17.13	5.73
6	45.30	15.14	13	23.08	7.71	20	16.50	5.51
7	39.39	13.16	14	21.73	7.26			

OPTION 4 - LIFE ANNUITY. We will pay equal monthly installments to the Beneficiary for as long as he lives. The amount of each installment for each \$1,000 applied under this option is shown in the table below. The values in the table are based on the Annuity 2000 Mortality Table at 3% interest.

Age * of Beneficiary	Amount of Installment		Age * of Beneficiary	Amount of Installment	
	Male	Female		Male	Female
40	\$3.54	3.38	63	\$5.37	4.92
41	3.58	3.41	64	5.52	5.04
42	3.63	3.45	65	5.69	5.18
43	3.67	3.49	66	5.86	5.32
44	3.72	3.53	67	6.04	5.47
45	3.78	3.57	68	6.24	5.64
46	3.83	3.62	69	6.45	5.82
47	3.89	3.67	70	6.67	6.01
48	3.95	3.72	71	6.90	6.21
49	4.01	3.77	72	7.16	6.44
50	4.08	3.83	73	7.43	6.68
51	4.15	3.89	74	7.71	6.94
52	4.22	3.95	75	8.02	7.22
53	4.30	4.01	76	8.35	7.52
54	4.38	4.08	77	8.70	7.85
55	4.46	4.15	78	9.08	8.21
56	4.55	4.23	79	9.48	8.60
57	4.65	4.31	80	9.91	9.02
58	4.75	4.40	81	10.37	9.47
59	4.86	4.49	82	10.86	9.96
60	4.98	4.59	83	11.38	10.50
61	5.10	4.69	84	11.94	11.07
62	5.23	4.80	85	12.54	11.69

*Use the Beneficiary's age on the date of the Insured's death.

Amounts for other ages will be provided upon request.

OPTION 5 - LIFE ANNUITY WITH PERIOD CERTAIN. We will pay equal monthly installments to the Beneficiary for as long as he lives with a period certain of 10 or 20 years. If the Beneficiary dies before the period certain ends, the period certain installments which have not been paid will be paid as stated in "Death of Beneficiary." The amount of the equal monthly installments for the ten and twenty year period certain is shown in the table below. The amounts shown are for each \$1,000 applied under this option. The values in the table are based on the Annuity 2000 Mortality Table at 3% interest.

Age * of Beneficiary	Ten Years Male	Ten Years Female	Twenty Years Male	Twenty Years Female	Age * of Beneficiary	Ten Years Male	Ten Years Female	Twenty Years Male	Twenty Years Female
40	\$ 3.53	3.37	3.50	3.35	63	\$ 5.23	4.84	4.75	4.57
41	3.57	3.41	3.53	3.39	64	5.35	4.95	4.82	4.64
42	3.62	3.44	3.57	3.42	65	5.48	5.07	4.88	4.71
43	3.66	3.48	3.62	3.46	66	5.62	5.20	4.94	4.78
44	3.71	3.52	3.66	3.50	67	5.77	5.33	5.00	4.85
45	3.76	3.57	3.70	3.54	68	5.92	5.47	5.06	4.92
46	3.81	3.61	3.75	3.58	69	6.07	5.62	5.11	4.99
47	3.87	3.66	3.80	3.62	70	6.23	5.78	5.16	5.05
48	3.92	3.71	3.85	3.66	71	6.39	5.94	5.21	5.11
49	3.98	3.76	3.90	3.71	72	6.56	6.11	5.25	5.17
50	4.05	3.81	3.95	3.76	73	6.73	6.29	5.29	5.22
51	4.11	3.87	4.00	3.81	74	6.90	6.48	5.33	5.27
52	4.18	3.93	4.06	3.86	75	7.08	6.67	5.36	5.31
53	4.25	3.99	4.12	3.92	76	7.25	6.86	5.39	5.35
54	4.33	4.06	4.18	3.97	77	7.43	7.06	5.41	5.38
55	4.41	4.13	4.24	4.03	78	7.61	7.26	5.43	5.40
56	4.49	4.20	4.30	4.09	79	7.78	7.46	5.45	5.43
57	4.58	4.28	4.36	4.15	80	7.95	7.66	5.46	5.45
58	4.68	4.36	4.43	4.22	81	8.11	7.86	5.47	5.46
59	4.78	4.45	4.49	4.28	82	8.27	8.05	5.48	5.48
60	4.88	4.54	4.56	4.35	83	8.42	8.23	5.49	5.49
61	4.99	4.63	4.62	4.42	84	8.56	8.40	5.50	5.49
62	5.10	4.73	4.69	4.49	85	8.69	8.55	5.50	5.50

*Use the Beneficiary's age on the date of the Insured's death.

Amounts for other ages will be provided upon request.

Family Life Insurance Company

Home Office: [Houston, TX]

Administrative Office: [10700 Northwest Freeway, Houston, TX 77092]
[(800) 877-7705]

ENDOWMENT LIFE INSURANCE POLICY

Proceeds payable on the Maturity Date or if the Insured dies while this Policy is in force

Premiums are payable [during the lifetime of the Insured]

[for the number of years stated on the Policy Schedule]

Non-Participating

FAMILY LIFE INSURANCE COMPANY
Home Office: [Houston, TX]
Administrative Office: [10700 Northwest Freeway, Houston, TX 77092]
[(800) 877-7705]

INSURED'S LEVEL TERM INSURANCE RIDER

This Rider is made a part of the Policy to which it is attached provided coverage is in force with respect to the Insured. It is issued in consideration of the statements made in the application and the payment, in advance, of the first premium shown in the application. The terms of the Policy also apply to this Rider which are not inconsistent with the terms of this Rider.

EFFECTIVE DATE

The Effective Date of this Rider is the Policy Date of the Policy to which this Rider is attached.

BENEFIT

The Company will pay the benefit provided by this Rider upon receipt of due proof that the Insured died while this Rider was in force.

BENEFICIARY

The Beneficiary of this Rider is the Beneficiary shown in the Policy to which this Rider is attached.

PREMIUMS

While this Rider is in effect, Premiums are due and may be changed according to the terms of the Policy.

CHANGE IN BENEFIT AMOUNT

At any time after the first Policy Year and upon Written Request, the benefit amount may be decreased. A decrease will be effective on the Premium due date on or next following receipt of the request by the Company. The benefit amount may not be decreased to an amount less than \$100,000. Decreases in the benefit amount will change the Premium. Increases in the benefit amount may not be made.

CONVERSION

The insurance on the Insured may be converted to a new Policy on any Premium due date prior to the earlier of the Policy Anniversary on which:

1. The Policy becomes paid up; or
2. The Policy or this Rider terminates for any other reason; or
3. The Insured attains age 65; or
4. The end of the 20 year term period for this Rider.

The benefit converted, without evidence of insurability, may not be more than the benefit of this Rider at the time of conversion. The policy may be on any plan then being issued by the Company, except term insurance. The premium for the new Policy will be based on the Insured's attained age, gender and underwriting class on the conversion date.

The conversion will be made upon receipt of a Written Request. The new Policy will not be effective until the Company receives the first premium for it. Riders may be included only with the Company's consent.

TERMINATION

This Rider will terminate on the earliest of the following dates:

- 1. The end of the 20 year term period for this Rider;
- 2. The first Policy Anniversary following the Insured's 70th birthday;
- 3. The date the Insured converts coverage under this Rider to a new Policy; or
- 4. The date the Policy becomes paid up or is terminated for any reason;
- 5. When any premium for this Rider is not paid before the end of the Grace Period; or
- 6. When You give Us a written request to do so.

INCONTESTABILITY

This Rider will be incontestable after it has been in force during the lifetime of the Insured for two years from the Effective Date of this Rider.

SUICIDE OF INSURED

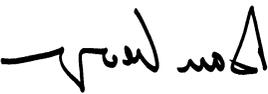
If the Insured should die by suicide while sane or insane, within two years from the Effective Date of this Rider, the Rider Benefit will be limited to the return of premiums paid for this Rider.

GENERAL PROVISIONS

This Rider has no Cash Value.

Signed at the Administrative Office of the Company and effective on the same day as the Policy:


 [Mary Lou Rainey, Secretary]


 Dan George, President]

FAMILY LIFE INSURANCE COMPANY
Home Office: [Houston, TX]
Administrative Office: [10700 Northwest Freeway, Houston, TX 77092]
[(800) 877-7705]

ADDITIONAL INSURED'S LEVEL TERM INSURANCE RIDER

This Rider is made a part of the Policy to which it is attached provided coverage is in force with respect to the Insured. It is issued in consideration of the statements made in the application and the payment, in advance, of the first premium shown in the application. The terms of the Policy also apply to this Rider which are not inconsistent with the terms of this Rider.

EFFECTIVE DATE

The Effective Date of this Rider is the Policy Date of the Policy to which this Rider is attached.

BENEFIT

The Company will pay the benefit provided by this Rider upon receipt of due proof that the Additional Insured died while this Rider was in force.

ADDITIONAL INSURED

Additional Insured means the person named in the application as the Additional Insured.

BENEFICIARY

The Beneficiary of this Rider is the Insured, if living. Otherwise, the beneficiary is the estate of the primary Insured.

PREMIUMS

While this Rider is in effect, Premiums are due and may be changed according to the terms of the Policy.

CHANGE IN BENEFIT AMOUNT

Any time after the first Policy Year and upon Written Request, the benefit amount may be decreased. A decrease will be effective on the Premium due date on or next following receipt of the request by the Company. The benefit amount may not be decreased to an amount less than \$100,000. Decreases in the benefit amount will change the Premium. Increases in the benefit amount may not be made.

CONVERSION

The insurance on the Additional Insured may be converted to a new Policy on any Premium due date prior to the earlier of the Policy Anniversary on which:

1. The Policy becomes paid up; or
2. The Policy Maturity Date occurs; or
3. The Policy terminates for any other reason; or
4. The Additional Insured attains age 65; or
5. The end of the 20 year term period for this Rider.

The benefit converted, without evidence of insurability, may not be more than the benefit of this Rider at the time of conversion. The Policy may be on any plan then being issued by the Company, except term insurance. The premium for the new Policy will be based on the Additional Insured's attained age, gender and underwriting class on the conversion date.

The conversion will be made upon receipt of a Written Request. The new Policy will not be effective until the Company receives the first premium for it. Riders may be included only with the Company's consent.

DEATH OF THE INSURED

If the Insured dies, the Additional Insured will have 31 days in which to convert this Rider, subject to all non-conflicting provisions in the Conversion section.

TERMINATION

This Rider will terminate on the earliest of the following dates:

1. The end of the 20 year term period for this Rider;
2. The first Policy anniversary following the Additional Insured's 70th birthday;
3. The date the Additional Insured converts to a new Policy; or
4. The date the Policy becomes paid up or is terminated for any reason; or
5. When any premium for this Rider is not paid before the end of the Grace Period; or
6. When You give Us a written request to do so.

INCONTESTABILITY

This Rider will be incontestable after it has been in force during the lifetime of the Additional Insured for two years from the Effective Date of this Rider.

SUICIDE OF ADDITIONAL INSURED

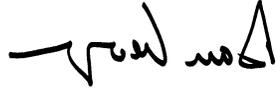
If the Additional Insured should die by suicide while sane or insane, within two years from the Effective Date of this Rider, the Rider Benefit will be limited to the return of premiums paid for this Rider.

GENERAL PROVISIONS

This Rider has no Cash Value.

Signed at the Administrative Office of the Company and effective on the same day as the Policy:


[Mary Lou Rainey, Secretary]


Dan George, President]

FAMILY LIFE INSURANCE COMPANY
Home Office: [Houston, TX]
Administrative Office: [10700 Northwest Freeway, Houston, TX 77092]
[(800) 877-7705]

INSURED SPOUSE'S LEVEL TERM INSURANCE RIDER

This Rider is made a part of the Policy to which it is attached provided coverage is in force with respect to the Insured. It is issued in consideration of the statements made in the application and the payment, in advance, of the first premium shown in the application. The terms of the Policy also apply to this Rider which are not inconsistent with the terms of this Rider.

EFFECTIVE DATE

The Effective Date of this Rider is the Policy Date of the Policy to which this Rider is attached.

BENEFIT

The Company will pay the benefit provided by this Rider upon receipt of due proof that the Insured Spouse died while this Rider was in force.

INSURED SPOUSE

Insured Spouse means the legal spouse of the Insured named in the application as the spouse.

BENEFICIARY

The beneficiary of this Rider is the Insured, if living. Otherwise, the beneficiary is the estate of the primary Insured.

PREMIUMS

While this Rider is in effect, Premiums are due and may be changed according to the terms of the Policy.

CHANGE IN BENEFIT AMOUNT

Any time after the first Policy Year and upon Written Request, the benefit amount may be decreased. A decrease will be effective on the Premium due date on or next following receipt of the request by the Company. The benefit amount may not be decreased to an amount less than \$100,000. Decreases in the benefit amount will change the Premium. Increases in the benefit amount may not be made.

CONVERSION

The insurance on the Insured Spouse may be converted to a new Policy on any Premium due date prior to the earlier of the Policy Anniversary on which:

1. The Policy becomes paid up; or
2. The Policy Maturity Date occurs; or
3. The Policy terminates for any other reason; or
4. The Insured Spouse attains age 65; or
5. The end of the 20 year term period for this Rider.

The Insured Spouse may also convert this insurance to a new policy within 60 days following the date the Insured Spouse is no longer a legal spouse of the Insured due to divorce or legal separation.

The benefit converted, without evidence of insurability, may not be more than the benefit of this Rider at the time of conversion. The Policy may be on any plan then being issued by the Company, except term insurance. The premium for the new Policy will be based on the Insured Spouse's attained age, gender and underwriting class on the conversion date.

The conversion will be made upon receipt of a Written Request. The new Policy will not be effective until the Company receives the first premium for it. Riders may be included only with the Company's consent.

DEATH OF THE INSURED

If the Insured dies, the Insured Spouse will have 31 days in which to convert this Rider, subject to all non-conflicting provisions in the Conversion section.

TERMINATION

This Rider will terminate on the earliest of the following dates:

1. The end of the 20 year term period for this Rider;
2. The first Policy anniversary following the Insured Spouse's 70th birthday;
3. The date the Insured Spouse converts to a new Policy; or
4. The date the Policy becomes paid up or is terminated for any reason; or
5. When any premium for this Rider is not paid before the end of the Grace Period; or
6. The date the Insured Spouse is no longer a legal spouse of the Insured due to divorce or legal separation; or
7. When You give Us a written request to do so.

INCONTESTABILITY

This Rider will be incontestable after it has been in force during the lifetime of the Insured Spouse for two years from the Effective Date of this Rider.

SUICIDE OF INSURED SPOUSE

If the Insured Spouse should die by suicide while sane or insane, within two years from the Effective Date of this Rider, the Rider Benefit will be limited to the return of premiums paid for this Rider.

GENERAL PROVISIONS

This Rider has no Cash Value.

Signed at the Administrative Office of the Company and effective on the same day as the Policy:



[Mary Lou Rainey, Secretary



Dan George, President]

FAMILY LIFE INSURANCE COMPANY

[Administrative Office: 10700 Northwest Freeway, Houston, Texas 77092]

PART I, Application for Life Insurance

1. Proposed Insured/Applicant (First, Middle, Last) up to 21 characters				2. Home Phone		3. Work Phone		
4. Address		City		State		Zip Code		
5. E-mail Address		6. Social Security #		7. Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female				
8. Date of Birth (Mo./Day/Yr.)		9. Age	10. Height ft. in.	11. Weight lbs.	12. Place of Birth (City, State, Country)			
13. Employer Name								
14. Employer Address		City		State		Zip Code		
15. Annual Salary		16. Years at current occupation		17. Occupation and Duties				
18. Owner's Name (if other than Proposed Insured/Applicant)*				19. Owner's Home Phone		20. Owner's Fax Number		
21. Owner's Address		City		State		Zip Code		
22. Owner's E-mail Address		23. Owner's Relationship to Insured		24. Owner's Social Security # or Tax ID #				
25. Plan of Insurance <input type="checkbox"/> Term Life (Family Protection Select) <input type="checkbox"/> Endowment Life (Family Protection Premier)		26. Requested Effective Date _____			27. Face Amount \$ _____			
28. Rate/Class of Insurance Requested (if available) <input type="checkbox"/> Preferred Non-Nicotine <input type="checkbox"/> Preferred Nicotine <input type="checkbox"/> Standard Non-Nicotine <input type="checkbox"/> Standard Nicotine Has any Proposed Insured used any tobacco products or nicotine products in any form within the past 12 months? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, provide name of Proposed Insured _____								
Term Life (Family Protection Select)								
29. Initial Term Period: <input type="checkbox"/> 10 Years <input type="checkbox"/> 15 Years <input type="checkbox"/> 20 Years <input type="checkbox"/> 25 Years <input type="checkbox"/> 30 Years		30. Optional Riders: <input type="checkbox"/> Waiver of Premium <input type="checkbox"/> ADB Amt. \$ _____ <input type="checkbox"/> Child Rider # of Units _____ <input type="checkbox"/> Additional Insured Term Rider \$ _____ <input type="checkbox"/> Spouse Term Rider \$ _____						
31. Premium Mode: <input type="checkbox"/> Monthly PAC <input type="checkbox"/> Quarterly <input type="checkbox"/> Semi-Annual <input type="checkbox"/> Annual <input type="checkbox"/> Other _____				32. Modal Premium (w/Optional Riders): \$ _____				
Endowment Policy (Family Protection Premier)								
33. Payment Options: <input type="checkbox"/> Single Pay <input type="checkbox"/> 3 Pay <input type="checkbox"/> 5 Pay <input type="checkbox"/> 10 Pay <input type="checkbox"/> 20 Pay <input type="checkbox"/> Paid up at 65 <input type="checkbox"/> Continuous Pay		34. Optional Riders Not available for Single Pay, 3 Pay, 5 Pay or 10 Pay: <input type="checkbox"/> Waiver of Premium <input type="checkbox"/> ADB Amt. \$ _____ <input type="checkbox"/> Child Rider # of Units _____ <input type="checkbox"/> Primary Insured 20 Year Term Rider \$ _____ <input type="checkbox"/> Additional Insured 20 Year Term Rider \$ _____ <input type="checkbox"/> Spouse 20 Year Term Rider \$ _____						
35. Premium Mode other than single pay: <input type="checkbox"/> Monthly PAC <input type="checkbox"/> Quarterly <input type="checkbox"/> Semi-Annual <input type="checkbox"/> Annual <input type="checkbox"/> Other _____				36. Modal Premium other than single pay (w/Optional Riders): \$ _____				
37. Automatic Premium Loan <i>other than single Pay</i>: The APL Option authorizes Family Life Insurance Company to pay premiums not paid by the end of the grace period by taking a loan against any available Loan Value under the Policy. If the available Loan Value is not sufficient to pay the premium then due, the policy may terminate. <input type="checkbox"/> Check here to include the Automatic Premium Loan (APL) Option.								
If Additional Insured Rider, Insured Spouse Rider or Child Rider, is desired please provide us with the information for each additional insured below:								
Name(s) of Other Proposed Insured(s)		Relationship	Social Security #	Date of Birth	Place of Birth	Height	Weight	Smoker/ Non-Smoker
						ft. in.	lbs.	
						ft. in.	lbs.	
						ft. in.	lbs.	
						ft. in.	lbs.	
						ft. in.	lbs.	
Occupation and Duties <input type="checkbox"/> Additional Insured <input type="checkbox"/> Insured Spouse				Annual Income:				

*If designated Beneficiary is a Trust, enclose copy of the Trust

38. Beneficiary(ies) - If designated Beneficiary is a Trust, enclose copy of the Trust		If percentage shares are not given, they will be equal.		
Primary (Full Name)	Age	Relationship to Proposed Insured	% Share	
Contingent (Full Name)	Age	Relationship to Proposed Insured	% Share	

Information on Life Insurance Policies Now in Force

Life Insurance Company	Policy #	Effective Date	Amt. of Life Ins.	Amt of Acc. Death
Life Insurance/Annuities Now In Force			\$	\$
or Application Currently Pending			\$	\$
If none, please check: <input type="checkbox"/>			\$	\$

40. Is the proposed insurance intended to replace or otherwise reduce in value an existing insurance or annuity policy? Yes No
If "Yes", give details in the Remarks/Special Requests. Also complete Replacement Form.

Declaration of Insurability - ALL PROPOSED INSUREDS

	YES	NO
41. Has insurance ever been declined, postponed, rated or modified for any Proposed Insured or does any Proposed Insured have any application for life or health insurance pending in any company?	<input type="checkbox"/>	<input type="checkbox"/>
42. Within the next two years, does any Proposed Insured intend to work, travel or reside outside of the country for more than 30 days?	<input type="checkbox"/>	<input type="checkbox"/>
43. Has any Proposed Insured, within the past two (2) years, made, or does any Proposed Insured currently contemplate making any flights as a pilot, student pilot or member of a flight crew? (If yes, complete Aviation Questionnaire.)	<input type="checkbox"/>	<input type="checkbox"/>
44. Has any Proposed Insured, within the past two (2) years, engaged in, or does any Proposed Insured currently intend to engage in parachuting, hang gliding, scuba diving, mountain climbing, spelunking, or organized racing? (If yes, complete Sports Questionnaire.)	<input type="checkbox"/>	<input type="checkbox"/>
45. Has any Proposed Insured, within the past seven (7) years, been treated for or been advised by a medical professional to have treatment for or to reduce or discontinue intake of alcohol or prescription drugs? (If yes, complete Alcohol Usage Questionnaire or Drug Usage Questionnaire.)	<input type="checkbox"/>	<input type="checkbox"/>
46. Has any Proposed Insured, within the past seven (7) years, used: heroin, morphine, marijuana, cocaine, barbiturates, amphetamines, hallucinogenic drugs or other narcotics which was not prescribed by a physician? (If yes, complete Drug Usage Questionnaire.)	<input type="checkbox"/>	<input type="checkbox"/>
47. Has any Proposed Insured, within the past five (5) years, had a driver's license suspended or revoked? (If yes, provide details)	<input type="checkbox"/>	<input type="checkbox"/>
48. Within the past three (3) years, has any Proposed Insured been convicted of driving while under the influence of drugs or alcohol? (If yes, provide details)	<input type="checkbox"/>	<input type="checkbox"/>
49. Has any Proposed Insured been charged with but not convicted of the violation of any law, or fined more than \$200 for the violation of any law, in the past seven (7) years? (If yes, provide details)	<input type="checkbox"/>	<input type="checkbox"/>
50. Has any Proposed Insured, within the past 7 years been diagnosed as having or been treated for or ever had medical advice for treatment of high blood pressure, cardiac disease or cardiac disorder, chest pain, stroke, brain disease, respiratory or pulmonary disease, cancer, tumors, cysts, leukemia, or pancreatic disorder, thyroid, adrenal, lymphatic or other glands, diabetes, sleep apnea, alzheimer's disease, kidney or liver disease including hepatitis, emotional problems, nervous system disease, psychiatric disease, circulatory disease, congenital defects, lupus, crohn's disease, blood disorders, digestive disorders, or intestinal, biliary or rectum disorders?	<input type="checkbox"/>	<input type="checkbox"/>
51. Has any Proposed Insured ever been diagnosed as having, or been treated by a medical professional for, Acquired Immune Deficiency Syndrome (AIDS) or AIDS-Related Complex (ARC) or any immune deficiency related disorder or tested positive for antibodies to the HIV virus?	<input type="checkbox"/>	<input type="checkbox"/>
52. Has any Proposed Insured ever been diagnosed or sought treatment for any disease or disorder or prescribed medication for a condition not listed above?	<input type="checkbox"/>	<input type="checkbox"/>
53. Is any Proposed Insured currently taking any prescribed medication?	<input type="checkbox"/>	<input type="checkbox"/>
54. Has any Proposed Insured consulted a physician, had tests performed such as an EKG, X-ray, blood test, or been hospitalized for any reason in the past five (5) years or been advised to have surgery which has not been completed?	<input type="checkbox"/>	<input type="checkbox"/>
55. Is Business Insurance being applied for? (If yes, complete Business Insurance Questionnaire.)	<input type="checkbox"/>	<input type="checkbox"/>
56. Please provide the full name, address and phone number of your personal physician, medical group or clinic that provides you with medical service. (If none, please check: <input type="checkbox"/>)		

Name	Phone Number		
Street Address	City	State	Zip Code

WARNING: 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 may be guilty of a crime and may be subject to fines and confinement in prison.

Please provide details for any "YES" answers, to include name(s) of Proposed Insured(s) diagnosis, dates, duration and names and addresses of all attending physicians and medical facilities. Use the section below to provide details.

Question #	Insured	Details

57. Driver's License Number(s):

Name of Proposed Insured	Driver's License Number	Country Issued

58. Has any of the Proposed Insured's immediate family relatives (parents/siblings) been diagnosed or received medical treatment for diabetes, cancer, cardiovascular disease or cerebrovascular disease (such as stroke or aneurysm)?

Insured? Yes No Additional Insured Rider? Yes No Spouse Rider? Yes No Child Rider? Yes No

59. Please provide us with information regarding any proposed insured's immediate family relatives (parents/siblings)

	Insured				Additional Insured Rider			
	Age if Living	Disease Listed Above	Cause of Death	Age at Death	Age if Living	Disease Listed Above	Cause of Death	Age at Death
Father								
Mother								
Brother or Sister								
Brother or Sister								
Brother or Sister								
Brother or Sister								
Number Living								
Number Dead								

	Spouse Rider				Child Rider			
	Age if Living	Disease Listed Above	Cause of Death	Age at Death	Age if Living	Disease Listed Above	Cause of Death	Age at Death
Father								
Mother								
Brother or Sister								
Brother or Sister								
Brother or Sister								
Brother or Sister								
Number Living								
Number Dead								

60. If our underwriting indicates that we cannot give you the lowest rate for the Plan of Insurance, will you consider a higher rate?

PERSONAL STATEMENT - To be completed if amount applied for and in force with Family Life is over \$500,000

61. Personal Finances:

Total Assets \$	Total Liabilities \$	Net Worth \$	Income from Occupation \$	Income from Other Sources \$
--------------------	-------------------------	-----------------	------------------------------	---------------------------------

62. I have not and will not contribute any illegally obtained funds to the policy. _____ Initial

I hereby acknowledge that all funds shall be paid directly to Family Life either by check, wire, or credit card payment and that any funds given to any intermediary will be at my sole risk. _____ Initial

63. What is the purpose of this insurance?

64. Have you or your company ever filed for bankruptcy? Yes No If yes, provide full details (add additional sheets if necessary):

REMARKS/SPECIAL REQUESTS:

Additions and Corrections (for Home Office use only)

I/we represent to The Family Life Insurance Company (hereafter Family Life) that to the best of my knowledge and belief the statements made on this application are true, complete and correctly recorded. I/we agree that Family Life can rely on these statements. I/we agree that this application (a) shall consist of Part 1 and if required any medical exam form, any supplemental application, policy modification or acceptance form attached to, or incorporated herein by reference, or otherwise made a part hereof and (b) will be the basis for any policy issued on this application.

NO AGENT OR MEDICAL EXAMINER CAN WAIVE THE ANSWER TO ANY QUESTION IN THIS APPLICATION NOR DECIDE ON INSURABILITY NOR WAIVE ANY OF FAMILY LIFE'S UNDERWRITING REQUIREMENTS NOR MAKE OR CHANGE ANY CONTRACT. FAMILY LIFE SHALL HAVE NO KNOWLEDGE OF STATEMENTS MADE BY OR TO THE AGENT OR MEDICAL EXAMINER UNLESS SUCH STATEMENTS ARE SHOWN ON THE APPLICATION.

I/we agree that acceptance of a policy issued on this application includes any corrections, additions or changes made by Family Life in the "Additions and Corrections" Section of this application. However, I/we understand that the "Additions and Corrections" Section of the application will not be used to change the amount, age at issue, class of risks, benefits, premiums or plan of insurance unless such change is agreed to by me/us in writing.

I/we authorize any licensed physician, medical practitioner, hospital, clinic, pharmacy or pharmacy related facility or other medical related facility, insurance company, the MIB, Inc., other health care provider or governmental agency to provide Family Life Insurance Company or its reinsurers any and all medical records or knowledge, including entire medical records, to determine insurance and claim eligibility. This authorization will be valid for 30 months from the date signed. A photographic copy of this authorization shall be as valid as the original.

I/we acknowledge receipt of the Information Practices Notice and MIB, Inc. Pre-Notice.

I/we understand that disclosure of information to Family Life may subject the information to redisclosure in accordance with Family Life's privacy policy and MIB, Inc. rules. This authorization may be revoked at any time. Notice of revocation may be sent, in writing, to Family Life at its Administrative Office address. Revocation of this authorization may result in declining your application, and no policy issued.

Additionally, as the Applicant for the policy and the Proposed Insured, I hereby certify and acknowledge that this application is being submitted to Family Life at its Administrative Office, and that such application must be received, reviewed, evaluated, and underwritten there in accordance with Family Life's underwriting practices and policies, and that a policy of insurance must be issued there as agreed to by Family Life, and delivered to me while I am in good health, and with full payment by me of the required premium for the policy issued to me, before I will be insured as applied for and I further certify and acknowledge that all future payments of premiums for such insurance must be submitted to and received by Family Life in [Houston, Texas, U.S.A.], in order to maintain such policy in force in accordance with its terms and conditions.

Conditional Receipt

Received from _____ the sum of \$ _____ paid with an application to Family Life Insurance Company.

ALL CHECKS SHOULD BE MADE PAYABLE TO FAMILY LIFE INSURANCE COMPANY. DO NOT MAKE CHECKS PAYABLE TO THE AGENT OR LEAVE THE PAYEE BLANK.

The application bears the same date as the receipt.

We agree to insure each Proposed Insured person, according to the terms of the policy applied for, on the effective date defined below, subject to the following terms and conditions precedent:

1. Your payment at least equals the minimum initial premium for the coverage applied.
2. Your check is honored the first time it is presented for payment.
3. We receive the application within 30 days and all medical examinations or tests within 60 days of the date of this receipt.
4. We are satisfied that each Proposed Insured person was insurable and acceptable under our underwriting rules for the plan and amount of coverage exactly as applied for on the effective date, which is the latest of:
 - a. The date of the application;
 - b. The date of the latest medical examinations and tests required by our underwriting rules; or
 - c. The date, if any, specifically requested in the application.

Coverage under this receipt is also subject to these limitations:

1. The maximum amount payable under this receipt is the smaller of:
 - a. The amount of all death benefits applied for in the application, including any accidental or supplemental death benefits, if applicable; or
 - b. \$250,000, if any Proposed Insured person is age 0-59, less the amount of insurance benefits payable by us on the death of the Primary Insured under any other current applications and conditional receipts or
 - c. \$100,000, if any Proposed Insured person is Age 60 or older, less the amount of insurance benefits payable by us on the death of the Primary Insured under any other current applications and conditional receipts.
2. Coverage ends, without notice, on the earlier of 60 days from the effective date or the date of notification of approval, declination or cancellation of the application. The policy and insurance applied for will take effect on the date the application is approved. In no event will coverage under this receipt and under the policy issued under this application be effective at the same time.
3. Coverage is void in the event of death by suicide or self-inflicted injury, while sane or insane.
4. No agent is authorized to alter or waive any of the above conditions or any of Family Life's rights or requirements.
5. If any one of the conditions in this receipt is not fulfilled, our only liability is for the refund of any payment made.

I have read and understood the terms of the Conditional Receipt.

Dated this _____ day of _____, 20 _____

By: _____
Signature of Agent

Signature of Proposed Insured/Owner

Notice Information Practices, Including the Fair Credit Reporting Act Notice and MIB, Inc. Notice

Thank you for your application. It is the major source of information about you which we use in evaluating your application and reviewing your policy. However, we wish to inform you that an investigative consumer report may be ordered as to your insurability. If an investigative consumer report is prepared in connection with this application, you may request to be interviewed in connection with preparation of this report. This report may include, if applicable, information as to your character, general reputation, personal characteristics and mode of living as may be obtained through interviews with family members, friends, neighbors and associates. If you would like to know whether such a report was ordered and if so, receive additional information as to its nature and scope, including the name, address and phone number of the reporting agency, we will be pleased to furnish this information upon your written request to our Home Office at the address below. You may receive a copy of such report by contacting the reporting agency. Our experience shows that information from investigative reports does not have any adverse effect on our underwriting decision. However, if it should, we will notify you in writing of this fact as well as provide you the identity by name and address of the reporting agency. You may then wish to discuss the matter with that agency. We usually will not disclose information about you without your prior written authorization. However, in certain situations we may disclose some of this information about you to third parties having a business interest in an insurance transaction involving you, or having a contract with us to perform part of our insurance function. This could include disclosures to persons or organizations that will use the information for sales purposes, unless you indicate to us that you do not want the information disclosed for this purpose. You have the right to obtain access to certain items of information we have collected about you, and you have the further right to request correction of information if you feel it is inaccurate. If you wish to have a more detailed description of our information practices, we will be pleased to furnish this information upon request to our Home Office at the address below.

MIB, Inc. Notice

While the information regarding your insurability treated as confidential, Family Life or its reinsurers may make a brief report thereon to the Medical Information Bureau, a non-profit membership organization of life insurance companies, which operates an information exchange Bureau on behalf of its members. Should you apply for life or health insurance, or submit a claim for benefits to another member company, the Medical Information Bureau, upon request from that member company, will supply the information in its file. Upon written request from you, the Bureau will arrange disclosure of any information it may have in your file. If you question the accuracy of the information in the Bureau's file, you may contact the Bureau and seek correction in accordance with the procedure set forth in the Federal Fair Credit Reporting Act. The address of the Bureau's information offices is 50 Braintree Hill Park, Suite 400, Braintree, MA 02184-8734, Telephone (866) 692-6901 (TTY 866-346-3642). We or our reinsurers may also release information in our file to other life insurance companies to whom you apply for life or health insurance or to whom a claim for benefits may be submitted.

To obtain further information contact: Family Life Insurance Company [10700 Northwest Freeway, Houston, Texas 77092]

FAMILY LIFE INSURANCE COMPANY

Administration Office: [10700 Northwest Freeway, Houston, Texas 77092]

Alcohol Usage Questionnaire

Name of Applicant (please print)

1. Do you presently use alcoholic beverages? Yes No

Quantity used:

	Beer	Wine	Liquor
Daily			
Weekly			
Monthly			

2. Did you ever drink substantially more than at present? Yes No

Dates: From _____ To _____

	Beer	Wine	Liquor
Daily			
Weekly			
Monthly			

3. Why did you change your drinking habits?

4. Are you now or have you ever been a member of Alcoholics Anonymous? Yes No

Give details: _____

5. Have you ever consulted a doctor or received treatment because of your drinking habits? Yes No

(If "Yes," give name and address of any doctor, hospital or treatment center): _____

6. Have you ever been arrested for driving while under the influence of alcohol? Yes No

(If "Yes," give details): _____

Additional details:

I represent that the above answers are true, complete, and correctly recorded. I agree that the above answers shall form a part of my application and that the Company can rely on these answers.

Dated at _____ this _____ day of _____, _____.

Witness

Proposed Insured

FAMILY LIFE INSURANCE COMPANY

[10700 Northwest Freeway, Houston, Texas 77092]

Business Insurance Questionnaire

1. Policy Number	2. Name of Proposed Insured	3. Date of Birth			
4. Name of Business					
5. Type of Organization <input type="checkbox"/> Proprietorship <input type="checkbox"/> Partnership <input type="checkbox"/> Corporation					
6. Purpose of Insurance		(name of Creditor)			
<input type="checkbox"/> Key Person <input type="checkbox"/> Stock Purchase <input type="checkbox"/> Buy-Sell Agreement <input type="checkbox"/> Creditor:					
Is insurance requested by creditor? <input type="checkbox"/> Yes <input type="checkbox"/> No	Amount of Loan \$ _____	Duration of Loan (in Years and Months)			
Purpose of Loan					
<input type="checkbox"/> Other Purchase – explain:					
7. Percentage ownership of business					
Business Insurance on all other Key Individuals or Owners of this business					
Name	Amount Applied for	Amount in Force	Name of Company	% Ownership of Business	Active in Business
_____	\$ _____	\$ _____	_____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No
_____	\$ _____	\$ _____	_____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No
_____	\$ _____	\$ _____	_____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No
8. Circumstances of Application <input type="checkbox"/> Solicitation by Agent <input type="checkbox"/> Inquiry by Applicant <input type="checkbox"/> Other (explain)					
9. How was amount of application determined? (Attach copies of relevant calculations)					

Who determined amount of application?					

10. Business finances (Attach copies of company financial statements if available: earnings, statements and balance sheets) Net Profit after taxes for the past 3 years:					
Assets	\$ _____	Year:	_____	\$ _____	
Liabilities	\$ _____	Year:	_____	\$ _____	
Net Worth	\$ _____	Year:	_____	\$ _____	
11. Insurance in force on Proposed Insured					
	Amount	Annual Premium			
a. Personal	\$ _____	\$ _____			
b. Business	\$ _____	\$ _____			
Insurance applied for with Family Life	\$ _____	\$ _____			
Applied for with other Companies (explain below)	\$ _____	\$ _____			
Total	\$ _____	\$ _____			

12. Income of Proposed Insured

- a. Annual Salary \$ _____
- b. Bonuses, Stock Options \$ _____
- c. Dividends, Interest, etc. \$ _____
- d. Other income (describe) \$ _____
- Total \$ _____
- e. Undistributed profits \$ _____
- f. Present net worth of Proposed Insured \$ _____

13. Is there a written buy-sell agreement?

Yes No (if "Yes", attach copy if available)

Fair Market Value

\$ _____

14. Business Banking references (including lending institution if insurance to cover business loan)

Bank Name:

Business Accountants and Attorneys:

Address:

Address:

Phone Number:

Phone Number:

I represent that the above answers are true, complete, and correctly recorded. I agree that the above answers shall form a part of my application and that the Company can rely on these answers.

Signed at _____ this _____ day of _____, _____

Witness (Agent)

Signature of Applicant

Underwriting Financial Questionnaire

Name of Proposed Insured/Applicant

Date of Birth

AGENT'S SUMMARY Please provide us with your calculations and comments concerning the amount of insurance being applied for:

Date

Signature of Agent

Agent's Code

FAMILY LIFE INSURANCE COMPANY

Administrative Office: [10700 Northwest Freeway, Houston, Texas 77092]

Drug Usage Questionnaire

Name of Applicant (please print) _____

- | | | |
|--|--------------------------|--------------------------|
| 1. Are you now using or have you ever used the following drugs: | Yes | No |
| (a) Opium derivatives: heroin, morphine, Demerol, methadone? | <input type="checkbox"/> | <input type="checkbox"/> |
| (b) Barbiturates: Amytal, Phenobarbital, Seconal, Nembutol, Pentobarbital? | <input type="checkbox"/> | <input type="checkbox"/> |
| (c) Marijuana: hashish or cannabis? | <input type="checkbox"/> | <input type="checkbox"/> |
| (d) Amphetamines: Benzedrine, Dexedrine or Methedrine? | <input type="checkbox"/> | <input type="checkbox"/> |
| (e) Cocaine? | <input type="checkbox"/> | <input type="checkbox"/> |
| (f) Hallucinogens: LSD, DMT, mescaline, peyote, or psilocybin? | <input type="checkbox"/> | <input type="checkbox"/> |
| (g) Other: _____ | | |

2. If "Yes," give details:

Type	Usual Quantity	Frequency	Dates	
			From	To

- | | | |
|---|--------------------------|--------------------------|
| 3. Have you ever sought medical treatment because of drug usage? | Yes | No |
| If "Yes," state dates, names of doctors and institutions consulted: _____ | <input type="checkbox"/> | <input type="checkbox"/> |

Additional details: _____

I represent that the above answers are true, complete, and correctly recorded. I agree that the above answers shall form a part of my application and that the Company can rely on these answers.

Dated at _____ this _____ day of _____, _____.

Witness

Proposed Insured

FAMILY LIFE INSURANCE COMPANY

[10700 Northwest Freeway, Houston, Texas 77092]

MILITARY AND SPORTS QUESTIONNAIRE

Proposed Insured (please print) _____	Birthdate (mo/day/year) _____
---------------------------------------	-------------------------------

Military Questionnaire

1. Branch of service? _____
2. Date you entered or plan to enter services _____
3. Date of your anticipated release? _____
4. If presently in the military, where are you stationed? _____
5. Permanent address _____
6. Give a brief description of your military duties. _____
7. Have you been alerted for, volunteered for, or anticipate any duty outside the United States? (If "Yes", give details.)
 Yes No _____

I represent to Family Life Insurance Company that the above answers are true, complete, and correctly recorded to the best of my knowledge and belief. I agree that the above answers shall form a part of my application and that the Company can rely on these answers.

Dated at _____ this _____ day of _____, _____.

 Witness Proposed Insured

Sports Activities Questionnaire

Do you, have you ever, or do you expect to engage in:

1. Scuba diving? Yes No Are you a certified scuba diver? Yes No
 Name of certifying organization? _____
 How long have you been scuba diving? _____ How often? _____
 Date of last dive? _____ Average depth? _____ Maximum depth? _____
 Date of last dive to maximum depth? _____ Maximum time underwater? _____
 Have you ever done underwater recovery or salvage work? Yes No
2. Skydiving or parachute jumping? Yes No How long have you been skydiving? _____
 How often? _____ Total number of jumps made? _____
 Do you belong to any sky divers association or club? Yes No
 Name of organization? _____
 Are all jumps made under auspices of your association or club? Yes No _____
3. Hang gliding? Yes No How long have you been hang gliding? _____
 How often? _____ Total number of flights made? _____
 Do you belong to any hang gliders association or club? Yes No
 Name of organization? _____
 Are all flights under the auspices of your association or club? (If not, give details) Yes No _____
4. Racing, performance testing or stunt driving – automobiles, motorcycle, motorboat, etc.? Yes No
 How long have you been participating? _____ Date of last event? _____
 Location of last event? _____ Describe type of track _____
 Engine size and horse power _____ Maximum speed attained _____
 Types and number of events and mileage in past 12 months, past 1 to 2 years, and estimated for next 12 months? (Include midget, sport car, stock car, modified, championship, drag, go-cart, motorcycle, motorboat, hydroplane, etc.)

Types of Events	Past 12 months		Past 1 to 2 years		Est. Next 12 months	
	Number	Miles	Number	Miles	Number	Miles

5. Give details of other activities (mountain climbing, spelunking, skiing, etc.) _____

I represent to Family Life Insurance Company that the above answers are true, complete, and correctly recorded to the best of my knowledge and belief. I agree that the above answers shall form a part of my application and that the Company can rely on these answers.

Dated at _____ this _____ day of _____, _____.

 Witness Proposed Insured

Family Life Insurance Company

P.O. Box 924408
Houston, TX 77292-4408
(800) 877-7705

SUPPLEMENTAL QUESTIONNAIRE

Applicant's Name: _____ Date of Birth: ____/____/____

SPORTS

Do you engage in exhibitions, competitive sports, scuba diving, mountain climbing or parachuting? Yes No

ALL FORMS OF RACING - Please provide the type of vehicle _____, the engine size (_____), the maximum speed attained (_____mph), the average speed (_____mph), the sanctioning body of the events (NASCAR, other _____), the type of racing (drag, stock car, sprint car, motorcycle, other _____), the distance traveled during the race (_____miles), and the frequency of participation in racing events (_____ / year).

SCUBA DIVING - Please provide the maximum depth typically dived to (_____feet), the frequency of SCUBA diving activity (_____ / year), equipment used (snorkel or gas), the locations where diving occurs (lakes, ship wreckage, caves, rivers, oceans, other _____), and diving qualifications/certifications held (_____).

PARACHUTING / SKY DIVING – Please provide which of the following describes the nature of the activity (military, recreational, competitive, stunt person, base jumping, or other _____), are the jumps (static line or free fall), how many total jumps to date (____), how many jumps are intended in the next year (____), details of any membership to a professional sky diving associations or clubs (_____), and what is the maximum feet that will be jumped from (____).

Please provide details of any exhibitions or competitive sports participated in and that are not covered under the above questioning:

FOREIGN TRAVEL

Do you intend or expect any future travel outside of the United States? Yes No

Country	Date	Duration of visit	Frequency of visit	Reason for visit
Will your travel include visiting non-urban or remote area(s)? <input type="checkbox"/> Yes <input type="checkbox"/> No				
If yes, please provide details: _____				

AVIATION

Have you ever or do you intend to fly as a pilot or crew member?

Yes No

Please advise any of the following capacities which you (have flown or intend to fly): military, crop dusting, flight instructor, fire fighting, test pilot, survey work, police, crew, commercial pilot, recreational pilot, stunt pilot, glider, or other _____

_____. Are you currently a student pilot?

Yes No

Please provide details of any certifications / licenses held _____.

Describe any accidents or incidents, including dates: _____

FLYING HOURS

	Civilian Pilot	Civilian Crew member	Military Pilot	Military Crew member
Past 12 Months				
12-24 Months ago				
Est. Next 12 Months				

ADDITIONAL REMARKS:

I declare that the answers I have given are, to the best of my knowledge, true and that I have not withheld any material information that may influence the assessment or acceptance of this application.

I agree that this form will constitute part of my application for life insurance and that failure to disclose any material fact to me may invalidate my contract.

Dated at _____ on (mm/dd/yy) _____ / _____ / _____

Witness

Proposed insured

FAMILY LIFE INSURANCE COMPANY
10700 Northwest Freeway
Houston, Texas 77092

IMPORTANT INFORMATION

If You have questions about Your Policy or a claim You have filed, please contact Your insurance company or Your agent:

FAMILY LIFE INSURANCE COMPANY
10700 Northwest Freeway
Houston, Texas 77092
(800) 877-7705

Agent: _____

Address: _____

Telephone: _____

If We at Family Life Insurance Company fail to provide You with reasonable and adequate service, You should feel free to contact the Arkansas Department of Insurance at:

Arkansas Department of Insurance
Consumer Services Division
1200 West Third Street
Little Rock, AR 72201-1904
Telephone: (501) 371-2640

SERFF Tracking Number: CEUL-127071604 State: Arkansas
 Filing Company: Family Life Insurance Company State Tracking Number: 48198
 Company Tracking Number:
 TOI: L071 Individual Life - Whole Sub-TOI: L071.101 Fixed/Indeterminate Premium - Single Life
 Product Name: Whole Life
 Project Name/Number: /

Supporting Document Schedules

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

	Item Status:	Status Date:
Satisfied - Item: Application		
Comments:		
Attachment: FL-LFAPP 0810.pdf		

	Item Status:	Status Date:
Satisfied - Item: Cover Letter		
Comments:		
Attachment: WL Cover Letter-AR.pdf		

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

	Item Status:	Status Date:
Satisfied - Item: Regulation 19 Certification		

SERFF Tracking Number: CEUL-127071604 State: Arkansas
Filing Company: Family Life Insurance Company State Tracking Number: 48198
Company Tracking Number:
TOI: L071 Individual Life - Whole Sub-TOI: L071.101 Fixed/Indeterminate Premium - Single Life
Product Name: Whole Life
Project Name/Number: /

Comments:

Attachment:

AR2.pdf

Item Status:

Status

Date:

Satisfied - Item: Guaranty Notice

Comments:

Attachment:

GAA Notice A.pdf

F A M I L Y L I F E

CERTIFICATION

I, Mary Lou Rainey, Secretary for Family Life Insurance Company, hereby certify that the following form(s) has the following readability score as calculated by the Flesch Reading Ease Test set forth by your state, and meets the minimum reading ease requirements set forth by the state of Arkansas.

<u>FORM NUMBER</u>	<u>FORM NAME</u>	<u>READABILITY SCORE</u>
FWL2010	Whole Life Policy	52.3
FLI20YTR2010	Insured's Level Term Insurance Rider	58.0
FLAI20YTR2010	Additional Insured's Level Term Insurance Rider	53.6
FLS20YTR2010	Insured Spouse's Level Term Insurance Rider	57.8

DATE: 3/9/2011

Mary Lou Rainey

Mary Lou Rainey, Secretary

Family Life Insurance Company
10700 Northwest Freeway
Houston, Texas 77092

Phone: 713-529-0045
Toll Free: 800-669-9030
Fax: 713-821-6551



FAMILY LIFE INSURANCE COMPANY

[Administrative Office: 10700 Northwest Freeway, Houston, Texas 77092]

PART I, Application for Life Insurance

1. Proposed Insured/Applicant (First, Middle, Last) up to 21 characters				2. Home Phone		3. Work Phone		
4. Address		City		State		Zip Code		
5. E-mail Address			6. Social Security #		7. Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female			
8. Date of Birth (Mo./Day/Yr.)		9. Age	10. Height ft. in.	11. Weight lbs.	12. Place of Birth (City, State, Country)			
13. Employer Name								
14. Employer Address		City		State		Zip Code		
15. Annual Salary		16. Years at current occupation		17. Occupation and Duties				
18. Owner's Name (if other than Proposed Insured/Applicant)*				19. Owner's Home Phone		20. Owner's Fax Number		
21. Owner's Address		City		State		Zip Code		
22. Owner's E-mail Address			23. Owner's Relationship to Insured		24. Owner's Social Security # or Tax ID #			
25. Plan of Insurance <input type="checkbox"/> Term Life (Family Protection Select) <input type="checkbox"/> Endowment Life (Family Protection Premier)			26. Requested Effective Date _____			27. Face Amount \$ _____		
28. Rate/Class of Insurance Requested (if available) <input type="checkbox"/> Preferred Non-Nicotine <input type="checkbox"/> Preferred Nicotine <input type="checkbox"/> Standard Non-Nicotine <input type="checkbox"/> Standard Nicotine Has any Proposed Insured used any tobacco products or nicotine products in any form within the past 12 months? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, provide name of Proposed Insured _____								
Term Life (Family Protection Select)								
29. Initial Term Period: <input type="checkbox"/> 10 Years <input type="checkbox"/> 15 Years <input type="checkbox"/> 20 Years <input type="checkbox"/> 25 Years <input type="checkbox"/> 30 Years			30. Optional Riders: <input type="checkbox"/> Waiver of Premium <input type="checkbox"/> ADB Amt. \$ _____ <input type="checkbox"/> Child Rider # of Units _____ <input type="checkbox"/> Additional Insured Term Rider \$ _____ <input type="checkbox"/> Spouse Term Rider \$ _____					
31. Premium Mode: <input type="checkbox"/> Monthly PAC <input type="checkbox"/> Quarterly <input type="checkbox"/> Semi-Annual <input type="checkbox"/> Annual <input type="checkbox"/> Other _____				32. Modal Premium (w/Optional Riders): \$ _____				
Endowment Policy (Family Protection Premier)								
33. Payment Options: <input type="checkbox"/> Single Pay <input type="checkbox"/> 3 Pay <input type="checkbox"/> 5 Pay <input type="checkbox"/> 10 Pay <input type="checkbox"/> 20 Pay <input type="checkbox"/> Paid up at 65 <input type="checkbox"/> Continuous Pay			34. Optional Riders Not available for Single Pay, 3 Pay, 5 Pay or 10 Pay: <input type="checkbox"/> Waiver of Premium <input type="checkbox"/> ADB Amt. \$ _____ <input type="checkbox"/> Child Rider # of Units _____ <input type="checkbox"/> Primary Insured 20 Year Term Rider \$ _____ <input type="checkbox"/> Additional Insured 20 Year Term Rider \$ _____ <input type="checkbox"/> Spouse 20 Year Term Rider \$ _____					
35. Premium Mode other than single pay: <input type="checkbox"/> Monthly PAC <input type="checkbox"/> Quarterly <input type="checkbox"/> Semi-Annual <input type="checkbox"/> Annual <input type="checkbox"/> Other _____				36. Modal Premium other than single pay (w/Optional Riders): \$ _____				
37. Automatic Premium Loan <i>other than single Pay</i>: The APL Option authorizes Family Life Insurance Company to pay premiums not paid by the end of the grace period by taking a loan against any available Loan Value under the Policy. If the available Loan Value is not sufficient to pay the premium then due, the policy may terminate. <input type="checkbox"/> Check here to include the Automatic Premium Loan (APL) Option.								
If Additional Insured Rider, Insured Spouse Rider or Child Rider, is desired please provide us with the information for each additional insured below:								
Name(s) of Other Proposed Insured(s)		Relationship	Social Security #	Date of Birth	Place of Birth	Height	Weight	Smoker/ Non-Smoker
						ft. in.	lbs.	
						ft. in.	lbs.	
						ft. in.	lbs.	
						ft. in.	lbs.	
						ft. in.	lbs.	
Occupation and Duties <input type="checkbox"/> Additional Insured <input type="checkbox"/> Insured Spouse						Annual Income:		

*If designated Beneficiary is a Trust, enclose copy of the Trust

38. Beneficiary(ies) - If designated Beneficiary is a Trust, enclose copy of the Trust		If percentage shares are not given, they will be equal.		
Primary (Full Name)	Age	Relationship to Proposed Insured	% Share	
Contingent (Full Name)	Age	Relationship to Proposed Insured	% Share	

Information on Life Insurance Policies Now in Force

Life Insurance Company	Policy #	Effective Date	Amt. of Life Ins.	Amt of Acc. Death
Life Insurance/Annuities Now In Force			\$	\$
or Application Currently Pending			\$	\$
If none, please check: <input type="checkbox"/>			\$	\$

40. Is the proposed insurance intended to replace or otherwise reduce in value an existing insurance or annuity policy? Yes No
If "Yes", give details in the Remarks/Special Requests. Also complete Replacement Form.

Declaration of Insurability - ALL PROPOSED INSUREDS

	YES	NO
41. Has insurance ever been declined, postponed, rated or modified for any Proposed Insured or does any Proposed Insured have any application for life or health insurance pending in any company?	<input type="checkbox"/>	<input type="checkbox"/>
42. Within the next two years, does any Proposed Insured intend to work, travel or reside outside of the country for more than 30 days?	<input type="checkbox"/>	<input type="checkbox"/>
43. Has any Proposed Insured, within the past two (2) years, made, or does any Proposed Insured currently contemplate making any flights as a pilot, student pilot or member of a flight crew? (If yes, complete Aviation Questionnaire.)	<input type="checkbox"/>	<input type="checkbox"/>
44. Has any Proposed Insured, within the past two (2) years, engaged in, or does any Proposed Insured currently intend to engage in parachuting, hang gliding, scuba diving, mountain climbing, spelunking, or organized racing? (If yes, complete Sports Questionnaire.)	<input type="checkbox"/>	<input type="checkbox"/>
45. Has any Proposed Insured, within the past seven (7) years, been treated for or been advised by a medical professional to have treatment for or to reduce or discontinue intake of alcohol or prescription drugs? (If yes, complete Alcohol Usage Questionnaire or Drug Usage Questionnaire.)	<input type="checkbox"/>	<input type="checkbox"/>
46. Has any Proposed Insured, within the past seven (7) years, used: heroin, morphine, marijuana, cocaine, barbiturates, amphetamines, hallucinogenic drugs or other narcotics which was not prescribed by a physician? (If yes, complete Drug Usage Questionnaire.)	<input type="checkbox"/>	<input type="checkbox"/>
47. Has any Proposed Insured, within the past five (5) years, had a driver's license suspended or revoked? (If yes, provide details)	<input type="checkbox"/>	<input type="checkbox"/>
48. Within the past three (3) years, has any Proposed Insured been convicted of driving while under the influence of drugs or alcohol? (If yes, provide details)	<input type="checkbox"/>	<input type="checkbox"/>
49. Has any Proposed Insured been charged with but not convicted of the violation of any law, or fined more than \$200 for the violation of any law, in the past seven (7) years? (If yes, provide details)	<input type="checkbox"/>	<input type="checkbox"/>
50. Has any Proposed Insured, within the past 7 years been diagnosed as having or been treated for or ever had medical advice for treatment of high blood pressure, cardiac disease or cardiac disorder, chest pain, stroke, brain disease, respiratory or pulmonary disease, cancer, tumors, cysts, leukemia, or pancreatic disorder, thyroid, adrenal, lymphatic or other glands, diabetes, sleep apnea, alzheimer's disease, kidney or liver disease including hepatitis, emotional problems, nervous system disease, psychiatric disease, circulatory disease, congenital defects, lupus, crohn's disease, blood disorders, digestive disorders, or intestinal, biliary or rectum disorders?	<input type="checkbox"/>	<input type="checkbox"/>
51. Has any Proposed Insured ever been diagnosed as having, or been treated by a medical professional for, Acquired Immune Deficiency Syndrome (AIDS) or AIDS-Related Complex (ARC) or any immune deficiency related disorder or tested positive for antibodies to the HIV virus?	<input type="checkbox"/>	<input type="checkbox"/>
52. Has any Proposed Insured ever been diagnosed or sought treatment for any disease or disorder or prescribed medication for a condition not listed above?	<input type="checkbox"/>	<input type="checkbox"/>
53. Is any Proposed Insured currently taking any prescribed medication?	<input type="checkbox"/>	<input type="checkbox"/>
54. Has any Proposed Insured consulted a physician, had tests performed such as an EKG, X-ray, blood test, or been hospitalized for any reason in the past five (5) years or been advised to have surgery which has not been completed?	<input type="checkbox"/>	<input type="checkbox"/>
55. Is Business Insurance being applied for? (If yes, complete Business Insurance Questionnaire.)	<input type="checkbox"/>	<input type="checkbox"/>
56. Please provide the full name, address and phone number of your personal physician, medical group or clinic that provides you with medical service. (If none, please check: <input type="checkbox"/>)		

Name	Phone Number		
Street Address	City	State	Zip Code

WARNING: 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 may be guilty of a crime and may be subject to fines and confinement in prison.

Please provide details for any "YES" answers, to include name(s) of Proposed Insured(s) diagnosis, dates, duration and names and addresses of all attending physicians and medical facilities. Use the section below to provide details.

Question #	Insured	Details

57. Driver's License Number(s):

Name of Proposed Insured	Driver's License Number	Country Issued

58. Has any of the Proposed Insured's immediate family relatives (parents/siblings) been diagnosed or received medical treatment for diabetes, cancer, cardiovascular disease or cerebrovascular disease (such as stroke or aneurysm)?

Insured? Yes No Additional Insured Rider? Yes No Spouse Rider? Yes No Child Rider? Yes No

59. Please provide us with information regarding any proposed insured's immediate family relatives (parents/siblings)

	Insured				Additional Insured Rider			
	Age if Living	Disease Listed Above	Cause of Death	Age at Death	Age if Living	Disease Listed Above	Cause of Death	Age at Death
Father								
Mother								
Brother or Sister								
Brother or Sister								
Brother or Sister								
Brother or Sister								
Number Living					Number Living			
Number Dead					Number Dead			

	Spouse Rider				Child Rider			
	Age if Living	Disease Listed Above	Cause of Death	Age at Death	Age if Living	Disease Listed Above	Cause of Death	Age at Death
Father								
Mother								
Brother or Sister								
Brother or Sister								
Brother or Sister								
Brother or Sister								
Number Living					Number Living			
Number Dead					Number Dead			

60. If our underwriting indicates that we cannot give you the lowest rate for the Plan of Insurance, will you consider a higher rate?

PERSONAL STATEMENT - To be completed if amount applied for and in force with Family Life is over \$500,000

61. Personal Finances:

Total Assets \$	Total Liabilities \$	Net Worth \$	Income from Occupation \$	Income from Other Sources \$
--------------------	-------------------------	-----------------	------------------------------	---------------------------------

62. I have not and will not contribute any illegally obtained funds to the policy. _____ Initial

I hereby acknowledge that all funds shall be paid directly to Family Life either by check, wire, or credit card payment and that any funds given to any intermediary will be at my sole risk. _____ Initial

63. What is the purpose of this insurance?

64. Have you or your company ever filed for bankruptcy? Yes No If yes, provide full details (add additional sheets if necessary):

REMARKS/SPECIAL REQUESTS:

Additions and Corrections (for Home Office use only)

I/we represent to The Family Life Insurance Company (hereafter Family Life) that to the best of my knowledge and belief the statements made on this application are true, complete and correctly recorded. I/we agree that Family Life can rely on these statements. I/we agree that this application (a) shall consist of Part 1 and if required any medical exam form, any supplemental application, policy modification or acceptance form attached to, or incorporated herein by reference, or otherwise made a part hereof and (b) will be the basis for any policy issued on this application.

NO AGENT OR MEDICAL EXAMINER CAN WAIVE THE ANSWER TO ANY QUESTION IN THIS APPLICATION NOR DECIDE ON INSURABILITY NOR WAIVE ANY OF FAMILY LIFE'S UNDERWRITING REQUIREMENTS NOR MAKE OR CHANGE ANY CONTRACT. FAMILY LIFE SHALL HAVE NO KNOWLEDGE OF STATEMENTS MADE BY OR TO THE AGENT OR MEDICAL EXAMINER UNLESS SUCH STATEMENTS ARE SHOWN ON THE APPLICATION.

I/we agree that acceptance of a policy issued on this application includes any corrections, additions or changes made by Family Life in the "Additions and Corrections" Section of this application. However, I/we understand that the "Additions and Corrections" Section of the application will not be used to change the amount, age at issue, class of risks, benefits, premiums or plan of insurance unless such change is agreed to by me/us in writing.

I/we authorize any licensed physician, medical practitioner, hospital, clinic, pharmacy or pharmacy related facility or other medical related facility, insurance company, the MIB, Inc., other health care provider or governmental agency to provide Family Life Insurance Company or its reinsurers any and all medical records or knowledge, including entire medical records, to determine insurance and claim eligibility. This authorization will be valid for 30 months from the date signed. A photographic copy of this authorization shall be as valid as the original.

I/we acknowledge receipt of the Information Practices Notice and MIB, Inc. Pre-Notice.

I/we understand that disclosure of information to Family Life may subject the information to redisclosure in accordance with Family Life's privacy policy and MIB, Inc. rules. This authorization may be revoked at any time. Notice of revocation may be sent, in writing, to Family Life at its Administrative Office address. Revocation of this authorization may result in declining your application, and no policy issued.

Additionally, as the Applicant for the policy and the Proposed Insured, I hereby certify and acknowledge that this application is being submitted to Family Life at its Administrative Office, and that such application must be received, reviewed, evaluated, and underwritten there in accordance with Family Life's underwriting practices and policies, and that a policy of insurance must be issued there as agreed to by Family Life, and delivered to me while I am in good health, and with full payment by me of the required premium for the policy issued to me, before I will be insured as applied for and I further certify and acknowledge that all future payments of premiums for such insurance must be submitted to and received by Family Life in [Houston, Texas, U.S.A.], in order to maintain such policy in force in accordance with its terms and conditions.

Conditional Receipt

Received from _____ the sum of \$ _____ paid with an application to Family Life Insurance Company.

ALL CHECKS SHOULD BE MADE PAYABLE TO FAMILY LIFE INSURANCE COMPANY. DO NOT MAKE CHECKS PAYABLE TO THE AGENT OR LEAVE THE PAYEE BLANK.

The application bears the same date as the receipt.

We agree to insure each Proposed Insured person, according to the terms of the policy applied for, on the effective date defined below, subject to the following terms and conditions precedent:

1. Your payment at least equals the minimum initial premium for the coverage applied.
2. Your check is honored the first time it is presented for payment.
3. We receive the application within 30 days and all medical examinations or tests within 60 days of the date of this receipt.
4. We are satisfied that each Proposed Insured person was insurable and acceptable under our underwriting rules for the plan and amount of coverage exactly as applied for on the effective date, which is the latest of:
 - a. The date of the application;
 - b. The date of the latest medical examinations and tests required by our underwriting rules; or
 - c. The date, if any, specifically requested in the application.

Coverage under this receipt is also subject to these limitations:

1. The maximum amount payable under this receipt is the smaller of:
 - a. The amount of all death benefits applied for in the application, including any accidental or supplemental death benefits, if applicable; or
 - b. \$250,000, if any Proposed Insured person is age 0-59, less the amount of insurance benefits payable by us on the death of the Primary Insured under any other current applications and conditional receipts or
 - c. \$100,000, if any Proposed Insured person is Age 60 or older, less the amount of insurance benefits payable by us on the death of the Primary Insured under any other current applications and conditional receipts.
2. Coverage ends, without notice, on the earlier of 60 days from the effective date or the date of notification of approval, declination or cancellation of the application. The policy and insurance applied for will take effect on the date the application is approved. In no event will coverage under this receipt and under the policy issued under this application be effective at the same time.
3. Coverage is void in the event of death by suicide or self-inflicted injury, while sane or insane.
4. No agent is authorized to alter or waive any of the above conditions or any of Family Life's rights or requirements.
5. If any one of the conditions in this receipt is not fulfilled, our only liability is for the refund of any payment made.

I have read and understood the terms of the Conditional Receipt.

Dated this _____ day of _____, 20 _____

By: _____
Signature of Agent

Signature of Proposed Insured/Owner

Notice Information Practices, Including the Fair Credit Reporting Act Notice and MIB, Inc. Notice

Thank you for your application. It is the major source of information about you which we use in evaluating your application and reviewing your policy. However, we wish to inform you that an investigative consumer report may be ordered as to your insurability. If an investigative consumer report is prepared in connection with this application, you may request to be interviewed in connection with preparation of this report. This report may include, if applicable, information as to your character, general reputation, personal characteristics and mode of living as may be obtained through interviews with family members, friends, neighbors and associates. If you would like to know whether such a report was ordered and if so, receive additional information as to its nature and scope, including the name, address and phone number of the reporting agency, we will be pleased to furnish this information upon your written request to our Home Office at the address below. You may receive a copy of such report by contacting the reporting agency. Our experience shows that information from investigative reports does not have any adverse effect on our underwriting decision. However, if it should, we will notify you in writing of this fact as well as provide you the identity by name and address of the reporting agency. You may then wish to discuss the matter with that agency. We usually will not disclose information about you without your prior written authorization. However, in certain situations we may disclose some of this information about you to third parties having a business interest in an insurance transaction involving you, or having a contract with us to perform part of our insurance function. This could include disclosures to persons or organizations that will use the information for sales purposes, unless you indicate to us that you do not want the information disclosed for this purpose. You have the right to obtain access to certain items of information we have collected about you, and you have the further right to request correction of information if you feel it is inaccurate. If you wish to have a more detailed description of our information practices, we will be pleased to furnish this information upon request to our Home Office at the address below.

MIB, Inc. Notice

While the information regarding your insurability treated as confidential, Family Life or its reinsurers may make a brief report thereon to the Medical Information Bureau, a non-profit membership organization of life insurance companies, which operates an information exchange Bureau on behalf of its members. Should you apply for life or health insurance, or submit a claim for benefits to another member company, the Medical Information Bureau, upon request from that member company, will supply the information in its file. Upon written request from you, the Bureau will arrange disclosure of any information it may have in your file. If you question the accuracy of the information in the Bureau's file, you may contact the Bureau and seek correction in accordance with the procedure set forth in the Federal Fair Credit Reporting Act. The address of the Bureau's information offices is 50 Braintree Hill Park, Suite 400, Braintree, MA 02184-8734, Telephone (866) 692-6901 (TTY 866-346-3642). We or our reinsurers may also release information in our file to other life insurance companies to whom you apply for life or health insurance or to whom a claim for benefits may be submitted.

To obtain further information contact: Family Life Insurance Company [10700 Northwest Freeway, Houston, Texas 77092]

FAMILY LIFE

Scott M. Gadd
Compliance Technician

March 9, 2011

Arkansas Insurance Department

Re: Family Life Insurance Company
NAIC#: 63053 Tax ID: 91-0550883
Endowment Life Policy Filing

Dear Sir/Madam:

The following forms are submitted for your review and approval. These forms are new and do not supercede any previously-submitted forms.

FWL2010	Endowment Life Insurance Policy
FL-LFAPP 0810	Application for Life Insurance
FLI20YTR2010	Insured's 20-year Level Term Rider
FLAI20YTR2010	Additional Insured's 20-year Level Term Rider
FLS20YTR2010	Spouse's 20-year Level Term Rider

(The following are questionnaires that may be used in conjunction with the application, dependent on applicants circumstances.)

FL-AUQ	Alcohol Usage Questionnaire
FL-5030	Business Insurance Questionnaire
FL-DUQ	Drug Usage Questionnaire
FL-MSQ	Military and Sports Questionnaire
C-10	Supplemental Questionnaire

In addition, the following previously accepted forms may be issued with the policy (listed above) which is now being submitted.

FGADR024AR – Accidental Death Benefit Rider – Approved 09/03/03
FGCIB01 – Children's Term Insurance Rider – Approved 09/03/03
FGWPD01 - Waiver of Premium Disability Benefit Rider – Approved 09/03/03

If you have any questions regarding this form or need additional information in order to complete your review, please call or contact me at the numbers/addresses below.

Sincerely,



10700 Northwest Freeway
Houston, Texas 77092
Email: sgadd@ManhattanLife.com

Phone: 713-529-0045 ext. 5107
Toll Free: 800-669-9030, ext. 5107
Fax: 713-821-6551



Statement of Variability

1. The brackets around the Company address and officer's signatures allow for revised information to be inserted in the event these items are changed.
2. The brackets in the Policy Schedule and Table of Policy Values allow for personalization of the policy issued to the Insured.
3. The brackets in certain General Provisions allow for this Policy to also be used as a conversion policy from term coverage.

ARKANSAS CERTIFICATION

Company Name Family Life Insurance Company

Form(s): FWL2010,

FLI20YTR2010

FLAI20YTR2010

FLS20YTR2010

FL-LFAPP 0801

FL-AUQ

FL-5030

FL-DUQ

FL-MSQ

C-10

AR-Notice

This submission meets the provisions of Rule and Regulation 19, "Unfair sex discrimination in the sale of insurance" as well as all applicable requirements of this Department.

Scott Gadd, Compliance Technician
Name and Title

3/17/2011
Date

**LIMITATIONS AND EXCLUSIONS UNDER THE
ARKANSAS LIFE AND HEALTH INSURANCE
GUARANTY ASSOCIATION ACT**

Residents of Arkansas who purchase life insurance, annuities or health and accident insurance should know that the insurance companies licensed in this state to write these types of insurance are members of the Arkansas Life and Health Insurance Guaranty Association (“Guaranty Association”). The purpose of the Guaranty Association is to assure that policy and contract owners will be protected, within certain limits, in the unlikely event that a member insurer becomes financially unable to meet its obligations. If this should happen, the Guaranty Association will assess its other member insurance companies for the money to pay the claims of policy owners who live in Arkansas and, in some cases, to keep coverage in force. The valuable extra protection provided by the member insurers through the Guaranty Association is not unlimited, however. And, as noted in the box below, this protection is not a substitute for consumers' care in selecting insurance companies that are well managed and financially stable.

DISCLAIMER

The Arkansas Life and Health Insurance Guaranty Association (“Guaranty Association”) may not provide coverage for this policy. If coverage is provided, it may be subject to substantial limitations or exclusions and require continued residency in Arkansas. You should not rely on coverage by the Guaranty Association in purchasing an insurance policy or contract.

Coverage is NOT provided for your policy or contract or any portion of it that is not guaranteed by the insurer or for which you have assumed the risk, such as non-guaranteed amounts held in a separate account under a variable life or variable annuity contract.

Insurance companies or their agents are required by law to provide you with this notice. However, insurance companies and their agents are prohibited by law from using the existence of the Guaranty Association to induce you to purchase any kind of insurance policy.

The Arkansas Life and Health Insurance Guaranty Association
425 West Capitol Avenue, Suite 3700
Little Rock, Arkansas 72201

Arkansas Insurance Department
1200 West Third Street
Little Rock, Arkansas 72201-1904

The state law that provides for this safety-net is called the Arkansas Life and Health Insurance Guaranty Association Act (“Act”). Below is a brief summary of the Act's coverages, exclusions and limits. This summary does not cover all provisions of the Act; nor does it in any way change anyone's rights or obligations under the Act or the rights or obligations of the Guaranty Association.

COVERAGE

Generally, individuals will be protected by the Guaranty Association if they live in this state and hold a life, annuity or health insurance contract or policy, or if they are insured under a group insurance contract issued by a member insurer. The beneficiaries, payees or assignees of policy or contract owners are protected as well, even if they live in another state.

EXCLUSIONS FROM COVERAGE

However, persons owning such policies are NOT protected by the Guaranty Association if:

- They are eligible for protection under the laws of another state (this may occur when the insolvent insurer was incorporated in another state whose guaranty association protects insureds who live outside that state);
- The insurer was not authorized to do business in this state;
- Their policy or contract was issued by a nonprofit hospital or medical service organization, an HMO, a fraternal benefit society, a mandatory state pooling plan, a mutual assessment company or similar plan in which the policy or contract owner is subject to future assessments, or by an insurance exchange.

The Guaranty Association also does NOT provide coverage for:

- Any policy or contract or portion thereof which is not guaranteed by the insurer or for which the owner has assumed the risk, such as non-guaranteed amounts held in a separate account under a variable life or variable annuity contract;
- Any policy of reinsurance (unless an assumption certificate was issued);
- Interest rate yields that exceed an average rate;
- Dividends and voting rights and experience rating credits;
- Credits given in connection with the administration of a policy by a group contract holder;
- Employers' plans to the extent they are self-funded (that is, not insured by an insurance company, even if an insurance company administers them);
- Unallocated annuity contracts (which give rights to group contractholders, not individuals).
- Unallocated annuity contracts issued to/in connection with benefit plans protected under Federal Pension Benefit Corporation ("FPBC") (whether the FPBC is yet liable or not);
- Portions of an unallocated annuity contract not owned by a benefit plan or a government lottery (unless the owner is a resident) or issued to a collective investment trust or similar pooled fund offered by a bank or other financial institution);
- Portions of a policy or contract to the extent assessments required by law for the Guaranty Association are preempted by State or Federal law;
- Obligations that do not arise under the policy or contract, including claims based on marketing materials or side letters, riders, or other documents which do not meet filing requirements, or claims for policy misrepresentations, or extra-contractual or penalty claims;
- Contractual agreements establishing the member insurer's obligations to provide book value accounting guarantees for defined contribution benefit plan participants (by reference to a portfolio of assets owned by a nonaffiliate benefit plan or its trustees).

LIMITS ON AMOUNT OF COVERAGE

The Act also limits the amount the Guaranty Association is obligated to cover: The Guaranty Association cannot pay more than what the insurance company would owe under a policy or contract.

Also, for any one insured life, the Guaranty Association will pay a maximum of \$300,000 - no matter how many policies and contracts there were with the same company, even if they provided different types of coverages. Within this overall \$300,000 limit, the Association will not pay more than \$300,000 in health insurance benefits, \$300,000 in present value of annuity benefits, or \$300,000 in life insurance death benefits or net cash surrender values - again, no matter how many policies and contracts there were with the same company, and no matter how many different types of coverages. There is a \$1,000,000 limit with respect to any contract holder for unallocated annuity benefits, irrespective of the number of contracts held by the contract holder. These are limitations for which the Guaranty Association is obligated before taking into account either its subrogation and assignment rights or the extent to which those benefits could be provided out of the assets of the impaired or insolvent insurer.