Filing at a Glance

Company: Penn Mutual Life Insurance Company

Product Name: Application-Life 2011 - PML	SERFF Tr Num: PNMU-127110237	State: Arkansas
TOI: L08 Life - Other	SERFF Status: Closed-Approved-Closed	State Tr Num: 48521
Sub-TOI: L08.000 Life - Other	Co Tr Num: APPLICATION-LIFE 2011 - PML	State Status: Approved-Closed
Filing Type: Form		Reviewer(s): Linda Bird
	Authors: Nancy Yannuzzi, Rita Bellew	Disposition Date: 04/26/2011
	Date Submitted: 04/18/2011	Disposition Status: Approved-Closed
Implementation Date Requested: On Approval		Implementation Date:

State Filing Description:

General Information

Project Name: Application-Life 2011 - PML	Status of Filing in Domicile: Pending
Project Number: Application-Life 2011 - PML	Date Approved in Domicile:
Requested Filing Mode: Review & Approval	Domicile Status Comments:
Explanation for Combination/Other:	Market Type: Individual
Submission Type: New Submission	Individual Market Type:
Overall Rate Impact:	Filing Status Changed: 04/26/2011
	State Status Changed: 04/26/2011
Deemer Date:	Created By: Rita Bellew
Submitted By: Rita Bellew	Corresponding Filing Tracking Number: Application-Life 2011 - PML

Filing Description:

The Penn Mutual Life Insurance Company is submitting the following forms for your review and approval:

Form / Title / Form Replaced

PM1143-R1 / Application for Life Insurance Part I / PM1143 Version 10/08
893-R1 / Application Part II Medical Declarations / NONE

Application PM1143-R1 will be used to apply for all of our existing individual life insurance policies and for those that will be approved by your department in the future. Application PM1143-R1 will be used by our subsidiary, Penn Insurance and Annuity Company (NAIC Company Code: 850-93262) as well.

Once approved, application PM1143-R1 will be replacing PM1143 Version 10/08 which was approved by your department on 01-29-09.

Form 893-R1 is the form that will be used when conducting a medical exam for insurance underwriting.

We have bracketed the variable information on application PM1143-R1. The enclosed Statement of Variability (SOV) describes the variability of this information.

Company and Contact

Filing Contact Information

Rita Bellew, State Filing Coordinator	bellew.rita@pennmutual.com	
VIM C3G	215-956-8290 [Phone]	
Philadelphia, PA 19172	215-956-8145 [FAX]	

Filing Company Information

Penn Mutual Life Insurance Company	CoCode: 67644	State of Domicile: Pennsylvania
VIM C3G	Group Code: 850	Company Type: Life Insurance and Annuity
Philadelphia, PA 19172	Group Name: Penn Mutual Life Ins. Co.	State ID Number:
(215) 956-8893 ext. [Phone]	FEIN Number: 23-0952300	

Filing Fees

Fee Required?	Yes
Fee Amount:	$50.00
Retaliatory?	No
Fee Explanation:	
Per Company:	No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Penn Mutual Life Insurance Company	$50.00	04/18/2011	46688753

SERFF Tracking Number:	*PNMU-127110237*	*State:*	*Arkansas*
Filing Company:	*Penn Mutual Life Insurance Company*	*State Tracking Number:*	*48521*
Company Tracking Number:	*APPLICATION-LIFE 2011 - PML*		
TOI:	*L08 Life - Other*	*Sub-TOI:*	*L08.000 Life - Other*
Product Name:	*Application-Life 2011 - PML*		
Project Name/Number:	*Application-Life 2011 - PML/Application-Life 2011 - PML*		

Penn Mutual Life Insurance Company	$50.00	04/26/2011	46961472

Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Linda Bird	04/26/2011	04/26/2011

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	04/18/2011	04/18/2011	Rita Bellew	04/26/2011	04/26/2011

Disposition

Disposition Date: 04/26/2011

Implementation Date:

Status: Approved-Closed

Comment:

Rate data does NOT apply to filing.

SERFF Tracking Number:	*PNMU-127110237*	*State:*	*Arkansas*
Filing Company:	*Penn Mutual Life Insurance Company*	*State Tracking Number:*	*48521*
Company Tracking Number:	*APPLICATION-LIFE 2011 - PML*		
TOI:	*L08 Life - Other*	*Sub-TOI:*	*L08.000 Life - Other*
Product Name:	*Application-Life 2011 - PML*		
Project Name/Number:	*Application-Life 2011 - PML/Application-Life 2011 - PML*		

Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification		Yes
Supporting Document	Application		No
Supporting Document	Statement of Variability		Yes
Form	Application for Life Insurance Part I		Yes
Form	Application Part II Medical Declarations		Yes

Objection Letter

Objection Letter Status	Pending Industry Response
Objection Letter Date	04/18/2011
Submitted Date	04/18/2011
Respond By Date	05/18/2011

Dear Rita Bellew,

This will acknowledge receipt of the captioned filing.

Objection 1
Comment: Regulation 57 wa 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 $50.00 is received.

Please feel free to contact me if you have questions.
Sincerely,
Linda Bird

Response Letter

Response Letter Status	Submitted to State
Response Letter Date	04/26/2011
Submitted Date	04/26/2011

Dear Linda Bird,

Comments:
Thank you for your letter.

Response 1

Comments: Additinal 50.00 has been added to eft serff.

Related Objection 1

Comment:
Regulation 57 wa 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 $50.00 is received.

Changed Items:

No Supporting Documents changed.

No Form Schedule items changed.

No Rate/Rule Schedule items changed.

Thank you,
Rita Bellew

Sincerely,
Nancy Yannuzzi, Rita Bellew

Form Schedule

Lead Form Number: PM1143-R1

Schedule Item Status	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
	PM1143-R1	Application/ Enrollment Form	Application for Life Insurance Part I	Initial		0.000	PM1143-R1.pdf
	893-R1	Application/ Enrollment Form	Application Part II Medical Declarations	Initial		0.000	893-R - Medical Declarations.pdf

CHECK BOX OF APPLICABLE COMPANY

☐ **The Penn Mutual Life Insurance Company**
Philadelphia, PA 19172

☐ **The Penn Insurance and Annuity Company**
Philadelphia, PA 19172

Application for Life Insurance

PART 1

A. PROPOSED INSURED 1 (PI 1)

1. Name of First Insured (First, Middle, Last)
2. Sex ☐ Male ☐ Female
3. Date of Birth Month Day Year
4. Social Security No. — —
5. Birth Place
6. Citizen of (Country)
7. For Non-US citizen Visa # and Type (attach copy)
8. Residence: Street City State Zip
9. Years at this Address
10. Marital Status ☐ M ☐ D ☐ S ☐ W
11. Home Phone No. ( )
12. Email Address
13. Occupation (include duties)
14. Drivers License State and No.
15. Employer
16. How Long
17. Area Code and Business Phone No. ( )
18. Street City State Zip

B. PROPOSED INSURED 2 (PI 2)

Complete for

☐ *Survivorship Plan*

☐ *Additional Insured Rider*

(If multiple additional insureds complete form PM5023)

If info for PI 1 is same as PI 2 indicate same.

1. Name of Second Insured (First, Middle, Last)
2. Sex ☐ Male ☐ Female
3. Date of Birth Month Day Year
4. Social Security No. — —
5. Birth Place
6. Citizen of (Country)
7. For Non-US citizen Visa # and Type (attach copy)
8. Residence: Street City State Zip
9. Years at this Address
10. Marital Status ☐ M ☐ D ☐ S ☐ W
11. Home Phone No. ( )
12. Email Address
13. Relationship to First Insured
14. Occupation (include duties)
15. Drivers License State and No.
16. Employer
17. How Long
18. Area Code and Business Phone No. ( )
19. Street City State Zip

C. PLAN OF INSURANCE

1. Plan Name

DEATH BENEFIT

2. Face Amt. (Base Only) $ _____ + 3. Supplement Term Face Amt. $ _____ = 4. Total Initial Coverage $ _____

DEATH BENEFIT OPTION (UL and VUL only)

5. Check One ☐ Level Death Benefit ☐ Increasing Death Benefit

PREMIUM TEST (UL and VUL only)

6. Check One ☐ Guideline Premium ☐ Cash Value

D. ADDITIONAL BENEFITS AND RIDERS *Select desired benefits and riders for product plan elected in Section C*	Product	Available Elected Riders
	Accumulation Builder II IUL	☐ Accidental Death Benefit $_____ ☐ Additional Insured Rider (Complete Section B of application) $ _____ ☐ Business Accounting Benefit ☐ Cash Value Enhancement Rider ☐ Children's Term Insurance Agreement ☐ Disability Completion Benefit ☐ Guaranteed Insurability Agreement $_____ ☐ Overloan Protection Rider ☐ Return of Premium Rider ☐ Supplemental Term Rider $_____ ☐ Waiver of Monthly Deductions ☐ Other _____
	Diversified Growth VUL *Complete form PM0304-R2 (PM0304-RS in NY and VT) and all forms required by your broker dealer for variable life business.*	☐ Accidental Death Benefit $_____ ☐ Additional Insured Rider (Complete Section B of application) $ _____ ☐ Business Accounting Benefit ☐ Cash Value Enhancement Rider ☐ Children's Term Insurance Agreement ☐ Disability Completion Benefit ☐ Extended No-Lapse Guarantee Rider ☐ Guaranteed Insurability Agreement $ _____ ☐ Overloan Protection Rider ☐ Return of Premium Rider ☐ Supplemental Term Rider $ _____ ☐ Waiver of Monthly Deductions ☐ Other _____

	Flexible Choice Whole Life	☐ Accidental Death Benefit $ _____
		☐ Children's Term Insurance Agreement
		☐ Flexible Protection Rider $ _____
		☐ Guaranteed Insurability Agreement $_____
		☐ Overloan Protection Rider
		☐ Paid Up Additions (Select only one and complete question 4 in Section M)
		  ☐ Accelerated Permanent Paid Up Additions Rider
		  ☐ Enhanced Permanent Paid Up Additions Rider
		☐ Waiver of Premium (Select only one)
		  ☐ Waiver of Premium Rider
		  ☐ Enhanced Waiver of Premium Rider
		☐ Other _____

D. ADDITIONAL BENEFITS AND RIDERS (Continued)

Select desired benefits and riders for product plan elected in Section C

Product	Available Elected Riders
Guaranteed Protection UL	☐ Accidental Death Benefit $ _____ ☐ Additional Insured Rider (Complete Section B of application) $ _____ ☐ Business Accounting Benefit ☐ Children's Term Insurance Agreement ☐ Disability Completion Benefit ☐ Guaranteed Insurability Agreement $ _____ ☐ Overloan Protection Rider ☐ Waiver of Monthly Deductions ☐ Other _____
Guaranteed Term 10-15-20	☐ Accidental Death Benefit $ _____ ☐ Children's Term Insurance Agreement ☐ Waiver of Premium Rider – Option A ☐ Waiver of Premium Rider – Option B ☐ Other _____
Survivorship Growth VUL *Complete form PM0304-R2 (PM0304-RS in NY and VT) and all forms required by your broker dealer for variable life business.*	☐ Enhanced Coverage Rider $ _____ ☐ Estate Growth Benefit % _____ ☐ Estate Preservation Term Insurance Rider $ _____ ☐ Guaranteed Continuation of Policy (all states except NJ, NY, TX) ☐ Return of Premium Rider ☐ Single Life Flexible Period Term Rider $ _____ ☐ Other _____
Survivorship Plus IUL	☐ Estate Growth Benefit % _____ ☐ Estate Preservation Term Insurance Rider $ _____ ☐ Extended No-Lapse Guarantee Rider ☐ First Death Benefit Rider $ _____ ☐ Overloan Protection Rider ☐ Return of Premium Rider ☐ Single Life Flexible Period Term Rider $ _____ ☐ Supplemental Term Rider $ _____ ☐ Other _____

E. CHILDREN'S TERM INSURANCE BENEFIT

If more than six, complete form PM5023

Child's Name (First, Middle Initial, Last)	Relationship to the Insured	Date of Birth mm/dd/yyyy	Age Nearest Birthday	Height (Ft., Inches)	Weight	Specified Amount
		/ /				$
		/ /				
		/ /				
		/ /				
		/ /				
		/ /				

F. DIVIDEND OPTIONS

Universal Life

☐ Cash

☐ Credited to Cash Value

Traditional Plans

☐ Cash ☐ Accumulate at Interest

☐ Paid-up Additions ☐ Other _____

☐ Premium Reduction (Not available with Penn Check or Salary Allotment)

G. OWNER

*Complete **only** if Owner is other than Proposed Insured 1. If Trust, give name of Trust, Trustee and date of Trust*

***Note:** If Owner is a Trust or Insured's business **omit** questions 4, 9.*

1. Name(s) (First, Middle, Last) of Owner(s) or Complete Name of Entity

2. Relationship to Proposed Insured

3. Address (Street, City, County, State, Zip)

4. Date of Birth

5. Soc. Sec. # / Tax ID

6. Telephone # ( )

7. Name of Trustee(s)

8. Date of Trust

9. Occupation

10. Email Address

H. CONTINGENT OWNER

Complete only if Contingent Owner is other than Proposed Insured 1. If Trust, give name of Trust, Trustee and date of Trust

***Note:** If Contingent Owner is a Trust or Insured's business **omit** questions 4, 9.*

1. Name(s) (First, Middle, Last) of Owner(s) or Complete Name of Entity

2. Relationship to Proposed Insured

3. Address (Street, City, County, State, Zip)

4. Date of Birth

5. Soc. Sec. # / Tax ID

6. Telephone # ( )

7. Name of Trustee(s)

8. Date of Trust

9. Occupation

10. Email Address

I. PAYOR

Complete only if Payor is other than the Proposed Insured or Owner or if a different address is requested.

1. Name(s) (First, Middle, Last) of Payor(s)

2. Relationship to Proposed Insured

3. Address: (Street, City, State, Zip)

4. Mailing Address (if different from above): (Street, City, State, Zip)

5. Soc. Sec. # or Tax ID #

6. Email Address

7. What is the amount of life insurance carried on the life of the payor? _____

Please provide details as to why the Payor is paying the premiums. _____

J. PRIMARY BENEFICIARY

Note: If no beneficiary survives the insured, proceeds revert to the Estate of the Insured.

Unless otherwise indicated, the share of any beneficiary reflected in Sections H, I or J below, who predeceases the insured, will be split equally among the surviving beneficiaries as reflected in the applicable section

Name	Date of Birth or Date of Trust	Soc. Sec. or Tax ID #	Relationship	%

K. CONTINGENT BENEFICIARY

Name	Date of Birth or Date of Trust	Soc. Sec. or Tax ID #	Relationship	%

L. RIDER BENEFICIARY

If no beneficiary is named or survives the insured, proceeds revert to the owner.

Name	Date of Birth or Date of Trust	Soc. Sec. or Tax ID #	Relationship	%

M. PREMIUM

Penn Check is only available for premiums of $25.00 or more

If money was collected with this application, please complete and submit the Temporary Insurance Agreement (TIA). No TIA can be provided unless premium has been collected. Must complete Section M if selecting Penn Check billing mode or policy will be issued quarterly.

1. Billing Mode: ☐ Single Premium ☐ Annual ☐ Semi-annual ☐ Quarterly
   ☐ Penn Check add to existing account # _____
   ☐ Draft initial premium when policy issued (Only available for Penn Check monthly)
   ☐ Salary Allotment add to existing account # _____

2. Total premium to be billed _____

3. Additional premium expected via 1035 exchange _____ ; or dump-in _____

4. PUA Rider for Whole Life
   a) Initial premium to be used for PUA _____ b) Annual Payment Limit to be used for PUA _____
   c) Additional premium to be used for lump sum PUA from 1035 exchange _____; from dump-in _____

5. Automatic Premium Loan for Whole Life ☐ Yes ☐ No

6. Premium allocation for Indexed Flexible Premium Adjustable Life

   I elect to have _____ % of my premium payment allocated directly to the Indexed Account.

   I elect to have _____ % of my premium payment allocated to the DCA Account.

   The remaining premium will be allocated to the Fixed Account. This election will continue for new premium payments until I elect a change. Note: If electing the Survivorship Plus IUL Extended No-Lapse Guarantee Rider, the allocation to the Fixed Account will be restricted.

   Each premium payment or transfer from the Fixed Account will create a new segment. A change in the allocation percentage will not take effect until the next payment date. Transfers from an Indexed Account segment can only be made on the segment maturity date, which is 1 year from the date the premium is posted to the Indexed Account.

7. What is the source of the premiums? (indicate all that apply for any part of the premium)

   a. ☐ Applicant's personal income
   b. ☐ Applicant's personal liquid assets
   c. ☐ Applicant's personal illiquid assets
   d. ☐ Applicant's family member, including spouse (identify and describe their source below)
   e. ☐ Premium finance company (identify lender below)
   f. ☐ Mortgage or home equity loan (identify lender below)
   g. ☐ Other person or entity (identify and describe their source below)
   h. ☐ Annuity payments (identify type of annuity, source of annuity premiums, reasons for annuity below)

   If anyone other than the applicant is paying any part of the premium, describe any arrangement which has been established or is being considered for repayment by the applicant, the insured if other than the applicant, or any trust established by the insured or the applicant. Indicate whether any such promised or potential repayment will or would come from the policy cash value or death benefit, and describe any other source of repayment.

   _____

   _____

N. PENN CHECK ACCOUNT INFORMATION

Complete only if Penn Check mode is selected and this is a new account. Also attach a Void Check or deposit slip

1. Bank Name

2. Bank Routing and Account No.

3. Account Type

☐ Checking ☐ Savings ☐ Pershing ☐ Other

4. Draw Date:

☐ 1st ☐ 8th ☐ 15th ☐ 22nd

5. Bank Address (Street, City, County, State, Zip)

6. Name (First, Middle, Last) of First Depositor

7. Name (First, Middle, Last) of Second Depositor

O. INTENT TO TRANSFER & LIFE EXPECTANCY EVALUATION

1. Is there any arrangement that has been established, or is being considered, to transfer the policy, or any part of the policy, or any interest in the policy (including a collateral assignment)?

   ☐ Yes ☐ No If Yes, explain.

2. Has there been a life expectancy evaluation of the insured in the past 2 years or is there an arrangement which has been established or is being considered to perform one in the future?

   ☐ Yes ☐ No If Yes, explain.

3. Have you settled a life insurance policy in the past 5 years?

   ☐ Yes ☐ No If yes, indicate which policy (listed in Section P) was settled and explain.

P. LIFE INSURANCE IN FORCE OR PENDING

	PI 1	PI 2	AIR/Child Rider
1. Have you ever applied for life, health or disability insurance and been declined, postponed or charged an increased premium?	☐ YES ☐ NO	☐ YES ☐ NO	
2. Do you have any formal or informal applications pending with any other life insurance company now?	☐ YES ☐ NO	☐ YES ☐ NO	

If answered "Yes" to above questions, please give details for each Proposed Insured including Company, Face Amount, and total amount to be placed for Question # 2.

Proposed Insured 1 _____

Proposed Insured 2 _____

3. Does any proposed insured, including additional insured or children, have any existing life insurance or annuities in force?	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO

4. List all Insurance In Force on any Proposed Insured. **If none, check this box.** ☐

Insured's Name & Company	Business or Personal	Face Amount	Policy Number	Issue Year	Is this Policy being Replaced or Changed?	Check if 1035 Exchange
					☐ Yes ☐ No	☐
					☐ Yes ☐ No	☐
					☐ Yes ☐ No	☐
					☐ Yes ☐ No	☐
					☐ Yes ☐ No	☐

Q. REPLACEMENT AND 1035 EXCHANGE INFORMATION

Complete only if there is existing life insurance and/or annuity coverage

1. a) Are you considering stopping premium payments, surrendering, replacing, forfeiting, assigning to the insurer or reducing your benefits under an existing policy or contract? ☐ YES ☐ NO

   b) Are you considering using or borrowing funds from your existing policies or contracts to pay premiums due on the new or applied for policy? ☐ YES ☐ NO

   If answered "Yes" to either question, please complete and sign all required replacement forms.

2. If 1035 Exchange, will loan be carried over? ☐ YES ☐ NO If Yes, amount of loan $_____

3. Loan Election for policy with an Indexed Loan feature.

   Loans being carried over to a policy with an Indexed Loan feature must elect the option to apply to the transferred loan.

   Please make one of the following selections: ☐ Traditional Loan Option ☐ Indexed Loan Option

R. FINANCIAL NEEDS/ BENEFITS

Give reasons for insuring the life of each insured

Financial needs/benefits (check all that apply)

- ☐ Death Benefit/Death Benefit Protection
- ☐ Retirement Funding
- ☐ Estate Planning
- ☐ Charitable Giving
- ☐ Debt Protection
- ☐ Other_____
- ☐ Deferred Compensation
- ☐ Savings, Accumulation
- ☐ Education/College Funding
- ☐ Key Person
- ☐ Buy/Sell

S. TOBACCO AND/OR NICOTINE USE

1. Does any person proposed for coverage, **currently use or have they ever used** tobacco or products in any form containing nicotine? (e.g., cigarettes, cigars, pipes, chewing tobacco, nicotine gum, nicotine patches, Hookah, or any other nicotine delivery system)

   Proposed Insured 1 ☐ YES ☐ NO Proposed Insured 2 ☐ YES ☐ NO

2. If "Yes":

   Proposed Insured 1 Type _____ Frequency _____ Date Last Used _____

   Proposed Insured 2 Type _____ Frequency _____ Date Last Used _____

T. PERSONAL PHYSICIAN

If no personal physician, list physician last consulted, date and reason last consulted

Must be answered for all proposed insureds

1. **Proposed Insured 1**: Physician Name	2. Phone No. ( )	3. Date Last Seen
4. Address: (Street, City, State, Zip)		
5. Reason Last Seen:		
6. **Proposed Insured 2**: Physician Name	7. Phone No. ( )	8. Date Last Seen
9. Address: (Street, City, State, Zip)		
10. Reason Last Seen:		

U. PERSONAL INFORMATION

Complete for all Proposed Insureds or if minor child, the applicant information is required.

Provide details to any yes answers in "Details" Section

If Other Income is 0, indicate 0

	PI 1	PI 2
1. Annual earned income from occupation (After deduction of business expenses)	$	$
2. Other income (give source) _____	$	$
3. Net Worth _____	$	$

	PI 1 YES	PI 1 NO	PI 2 YES	PI 2 NO	CHILD RIDER YES	CHILD RIDER NO
4. Has any Proposed Insured declared bankruptcy? (If "Yes" has it been discharged and date of discharge)	☐	☐	☐	☐		
5. Does any Proposed Insured intend to reside or travel outside the United States within the next 24 months? (If "Yes" complete foreign travel questionnaire **EXCEPT** for vacations of not more than 2 weeks duration, provide complete details including Dates, Destinations, and Duration in the Details section)	☐	☐	☐	☐	☐	☐
6. Is any Proposed Insured a member, or intending to become a member, of any armed forces or military reserve? (If Yes, complete PS1017)	☐	☐	☐	☐	☐	☐
7. Within the past three years, has any Proposed Insured:						
(a) Flown or taken instruction as a pilot or crew member or intend to do so? (If "Yes", complete Aviation Supplement)	☐	☐	☐	☐	☐	☐
(b) Engaged in any kind of racing, scuba or sky diving, hang gliding, mountain or rock climbing, or other hazardous avocation or intend to do so? (If "Yes", complete appropriate questionnaire)	☐	☐	☐	☐	☐	☐
(c) Been convicted of a moving violation or had their driver's license suspended or revoked?	☐	☐	☐	☐	☐	☐
(d) Been convicted of a DUI (driving under the influence of alcohol or drugs)?	☐	☐	☐	☐	☐	☐
8. Has any proposed insured been convicted of, or currently charged with, the commission of any criminal offense – other than the violation of a motor vehicle law – within the last 10 years?	☐	☐	☐	☐	☐	☐
9. Is there any family history of cancer, diabetes, heart disease, Huntington's Chorea, neuromuscular disorder, stroke, TIA (transient ischemic attack) or other cerebrovascular disorder? If yes, give details to include the family member, diagnosis and age at diagnosis.	☐	☐	☐	☐	☐	☐
10. Is any Proposed Insured currently receiving, or within the past 10 years have they received or applied for, any disability benefits, including Workers Compensation, Social Security Disability Insurance, or any other form of disability insurance? (If Yes, give details)	☐	☐	☐	☐	☐	☐

Detail of any YES answers in Section U: _____

V. MEDICAL HISTORY

Complete for all Proposed Insureds not requiring an examination (see Penn Mutual medical evidence chart for details). Completion for Proposed Insureds being examined is optional, but encouraged.

Provide details to any yes answers in "Details" Section W

	Proposed Insured 1	Proposed Insured 2
1. Height (in shoes)	ft. in.	ft. in.
2. Weight (clothed)	lbs.	lbs.
3. Weight change in last year?	☐ Yes ☐ No Increase Decrease	☐ Yes ☐ No Increase Decrease
If yes, circle increase or decrease	No. of lbs. _____ Reason: _____	No. of lbs. _____ Reason: _____
4. Birth weight if under 6 mo. old	lbs.	lbs.

	PI 1		PI 2		CHILD RIDER	
	YES	NO	YES	NO	YES	NO
5. Are you presently taking any medication, supplements or homeopathic remedies either prescribed or over the counter?	☐	☐	☐	☐	☐	☐
6. During the past 10 years have you had, or been told that you have, or been treated by a member of the medical profession for:						
a. High blood pressure, chest discomfort, heart attack, heart murmur, circulatory or heart disorder?	☐	☐	☐	☐	☐	☐
b. Diabetes, sugar in urine, thyroid disorder, elevated cholesterol or other endocrine or metabolic disorder?	☐	☐	☐	☐	☐	☐
c. Asthma, bronchitis, emphysema, shortness of breath, sleep apnea or any other lung or respiratory disorder?	☐	☐	☐	☐	☐	☐
d. Hepatitis, cirrhosis, ulcer, colitis or other disorder of the stomach, liver or digestive system?	☐	☐	☐	☐	☐	☐
e. Anemia, leukemia or other blood or clotting disorder?	☐	☐	☐	☐	☐	☐
f. Arthritis, gout, back or joint pain, bone fracture, muscle disorder, or any disorder of the skin?	☐	☐	☐	☐	☐	☐
g. Seizures, stroke, fainting, paralysis, falls, loss of consciousness, mental or emotional disorder or any other disorder of the brain or nervous system?	☐	☐	☐	☐	☐	☐
h. Alzheimer's disease, dementia, memory impairment, Parkinson's disease or any other progressive neurological disease?	☐	☐	☐	☐	☐	☐
i. Cancer, tumor, polyp or cyst?	☐	☐	☐	☐	☐	☐
j. Kidney, bladder, urinary, reproductive organ, breast or prostate disorder?	☐	☐	☐	☐	☐	☐
k. Disorder of eyes, ears, nose or throat?	☐	☐	☐	☐	☐	☐
l. Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC), or any disorder of the immune system or a positive blood test for antibodies to the HIV virus?	☐	☐	☐	☐	☐	☐
7. a. Have you ever used any controlled substances such as: amphetamines, barbiturates, hallucinogens, heroin, morphine, cocaine, marijuana, opiates or any prescription drug, except as prescribed by a physician?	☐	☐	☐	☐	☐	☐
b. Have you ever been advised to limit or discontinue the use of alcohol or drugs, sought or received treatment, counseling or participated in a group for alcohol or drug use?	☐	☐	☐	☐	☐	☐
8. Other than previously stated, have you within the past 5 years:						
a. Consulted a physician or any other practitioner, had a check-up, illness, surgery or been hospitalized?	☐	☐	☐	☐	☐	☐
b. Had an electrocardiogram, exercise treadmill test, echocardiogram, X-ray, blood test or other diagnostic test?	☐	☐	☐	☐	☐	☐
c. Been advised to have, or scheduled, any diagnostic test, hospitalization or surgery which was not completed?	☐	☐	☐	☐	☐	☐
d. Received or applied for disability benefits due to any medical impairment?	☐	☐	☐	☐	☐	☐

V. MEDICAL HISTORY (continued)

**Complete amount of insurance only if Proposed Insured is under age 17*

9. Family History

Have any of your immediate family members (parents, brothers and sisters) died or been diagnosed as having diabetes, heart disease, cancer, stroke or kidney disease prior to age 60? ☐ Yes ☐ No

	Ages(s) (if living)	Ages(s) (at death)	State of Health or Cause of Death	Amount of Insurance*
Father				
Mother				
Brother(s)				
Sisters(s)				

DETAILS FOR MEDICAL HISTORY QUESTIONS

Question No. and Letter	Person	Date	Details (include full names and address of physicians, hospitals, etc.

SPECIAL INSTRUCTIONS	
NON-CONFORMING ILLUSTRATION ACKNOWLEDGEMENT (NON-VARIABLE ONLY)	An illustration is defined as a presentation or depiction that includes non-guaranteed elements of a policy over a period of years. If an illustration was presented during the sales process and matches the policy applied for, a copy of that illustration must be signed and submitted with the application. If the signed illustration is not submitted, indicate the reason below (Check one): ☐ A. An illustration was not presented to me ☐ B. An illustration was presented to me, however, the policy applied for is different than as illustrated ☐ C. An illustration was presented to me on a computer screen (not for use in Michigan) If A, B, or C are checked, I acknowledge, as applicant, that I did not receive and sign an illustration that matches this application for the indicated above. I also understand that an illustration matching the policy at time of issue will be provided for my signature no later than at the time the policy is delivered.
AUTHORIZATION FOR FUND TRANSFER (VARIABLE ONLY)	The agent/registered representative may request transfers of account values pursuant to my instruction unless I check this box. ☐ check if applicable
PENN CHECK AUTHORIZATION	By completing Section N of this application, I authorize monthly payments from my checking or savings account, or from my Pershing Resource Checking or Pro Cash Plus account to the Penn Mutual Life Insurance Company, its subsidiaries, affiliates, and third party administrators (herein Company) for premiums on this policy, beginning with the next periodic payment that comes due under the contract, until such time as a payment cannot be made due to insufficient funds or the Company gives the other parties at least 30 days' advance written notice of the termination of such payment plan. I am able to cancel the payment plan at any time by either calling the Company at 1-800-523-0650 or in writing. Monthly payments will be drawn from my account on or about the date specified in this application. **If no date has been selected in Question 4 of Section N, the draw date will be the 15th of the month.** I further agree that if any such check be dishonored, whether with or without cause and whether intentionally or inadvertently, the Company shall be under no liability whatsoever even though such dishonor results in the forfeiture of insurance.
NOTICE AND CONSENT FOR CORPORATE OWNED INSURANCE	I consent to being insured for an initial maximum amount of insurance as indicated in Section C of this application. I understand that my employer when written in Section G and Section J of this application will be the owner and beneficiary of the life insurance policy and may continue to maintain the insurance coverage beyond the term of my employment.
INDEXED ACCOUNT DISCLOSURE	Premium allocated to a segment of the Indexed Account is eligible to receive index credits based on the performance of Standard & Poor's® * Composite Stock Price Index (S&P 500® Index®*) over the segment's duration, subject to a Participation Percentage and a Cap Percentage. The Participation Percentage and the Cap Percentage are set by the Company but are guaranteed to be no less than the guaranteed minimum percentage amount and minimum interest rate stated in the policy form. "Standard & Poor's®", "S&P 500®", "Standard & Poor's 500®", and "500®" are trademarks of the McGraw-Hill Companies, Inc. and have been licensed for use by The Penn Mutual Life Insurance Company and its affiliates. The Product is not sponsored, endorsed, sold or promoted by Standard & Poor's® and Standard & Poor's® makes no representations regarding the advisability of investing in the Product.
REPRESENTATIONS	I (we), the Proposed Insured(s), and the Applicant(s) if other than the Proposed Insured(s), and the Applicant(s) on behalf of the Proposed Insured(s), if the Proposed Insured(s) is (are) age 17 or less and the Applicant(s) is authorized under applicable law to make such a representation on behalf of the Proposed Insured(s), represent that the statements and answers in this Part I of the application are written as made by me(us) and are complete and true. I(we) the Proposed Insured(s), or the Applicant(s) if other than the Proposed Insured(s) agree that they will be a part of the contract of insurance if issued; that I(we) will be bound by such statements and answers, and that the Company, believing them to be true, will rely and act upon them. I(we) also understand and agree that: 1. **Subject to any coverage provided under the terms and provisions of a Temporary Insurance Agreement, if applicable, no insurance coverage will be in force until the first modal premium is paid in full AND a life insurance policy has been issued and delivered to the policy owner while the health, habits, occupation, financial circumstances and other facts relating to the Proposed Insured(s) and to the Payor, if a Payor Benefit is issued, are the same as described in this Part I of the application, any Part II required by the Company, and any amendments or supplements to them.** 2. Notice to or knowledge of an agent or a medical examiner is not notice to or knowledge of the Company, and no agent or medical examiner is authorized to accept risks, to pass upon acceptability for insurance or to modify any contract of insurance. 3. Acceptance of any policy issued based on this application will be a ratification of any amendments or corrections noted by the Company in the space headed "Home Office Amendments and Corrections", except that if required by state statute or regulation, any change in amount, age, plan of insurance, additional benefits or classification must be agreed to in writing.

FRAUD WARNING

Applies to all states except those specifically listed.

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

District of Columbia, Louisiana, Maryland, Massachusetts, New Mexico, Rhode Island, West Virginia: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

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

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

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

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

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

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

New York: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

Ohio: Any person who, with the intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

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

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

All Other States: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or a statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

AUTHORIZATION

Write in names of all Proposed Insureds.

Name of Proposed Insured 1 (First, Middle, Last) _____ Date of Birth of Proposed Insured 1 (mm/dd/yyyy) ___/___/___

Name of Proposed Insured 2 (First, Middle, Last) _____ Date of Birth of Proposed Insured 2 (mm/dd/yyyy) ___/___/___

I(we), listed above hereby authorize: (a) any physician, health care provider, health plan, medical professional, hospital, clinic, laboratory, pharmacy or other medical or health care facility that has provided payment, treatment or services to me(us)or on my(our) behalf; (b) any insurance company; and, (c) the Medical Information Bureau, Inc. (MIB), to disclose my(our) entire medical record and any other protected health information concerning me(us) to the Underwriting Department of The Penn Mutual Life Insurance Company, its subsidiaries, affiliates, third party administrators and reinsurers (herein Company).

I(we) understand that such information may include records relating to my(our) physical or mental condition such as diagnostic tests, physical examination notes, and treatment histories, which may include information regarding the diagnosis and treatment of human immunodeficiency virus (HIV) infection, sexually transmitted diseases, and mental illness, and the use of alcohol, drugs and tobacco, but shall not include psychotherapy notes.

I(we) acknowledge that any agreements I(we) have made to restrict my(our) protected health information do not apply to the Authorization, and I(we) instruct any physician, health care professional, hospital, clinic, medical facility or other health care provider to release and disclose my(our) entire medical record without restriction.

I(we) understand that this information will be used by the Company to determine eligibility for insurance.

I(we) hereby authorize the Company to disclose any information it obtains about me(us) to the Medical Information Bureau, Inc., or any other life insurance company with which I(we) do business. I understand that the Company will not disclose information it obtains about me(us) except as authorized by this Authorization, as may be required or permitted by law, or as I(we) may further authorize. I(we) understand that if information is redisclosed as permitted by this Authorization, it may no longer be protected by applicable federal privacy law.

I(we) understand that: (a) this Authorization shall be valid for 30 months from the date I(we) sign it; (b) I(we) may revoke it at any time by providing written notice to the Underwriting Department of the Company subject to the rights of any person who acted in reliance on it prior to receiving notice of its revocation; and (c) my(our) authorized representative and I(we) are entitled to receive a copy of the Authorization upon request and (d) a copy of this Authorization shall be as valid as the original.

I(we) acknowledge receiving an MIB, Inc. Notice, a Fair Credit Reporting Act Notice and a Notice of Information Practices and authorize Penn Mutual to obtain an investigative or other consumer report as described in the Fair Credit Reporting Act Notice.

CERTIFICATION OF OWNER'S TAXPAYER ID

Under penalty of perjury, I the owner certify that:

1. The number shown in this application as my social security number or taxpayer identification number is correct; and
2. I am not subject to backup withholding because I have not been notified by the IRS that I am subject to backup withholding as a failure to report all interest or dividends, or the IRS has notified me that I am no longer subject to backup withholding, or I am exempt from backup withholding.
3. I am a U.S. person (including a U.S. resident alien)

☐ Check this box if you are subject to backup withholding under section 3406(a)(1)(c) of the Internal Revenue Code.

SIGNATURES

Signed and Dated by the Applicant in:

City _____ State _____ Month/Day/Year _____

SIGNATURE OF INSURED – OR PARENT/GUARDIAN IF INSURED IS UNDER THE AGE OF 18

X _____ Proposed Insured 1

X _____ Proposed Insured 2

SIGNATURE OF OWNER AND/OR APPLICANT - IF OTHER THAN THE PROPOSED INSURED

X _____ Owner*

X _____ Applicant

*If a Corporation, the signature and title of any authorized officer other than the Proposed Insured(s) is required and the full name of the corporation must be shown. If a Trust, the signature of the Trustee(s), as required by the Trust document.

SIGNATURE OF PAYOR

X _____ Payor

AGENTS CERTIFICATION

Be sure to check appropriate block.

Each agent present at solicitation must sign.

I certify to the best of my knowledge the answers to the questions in all parts of this application are true and correct. I further certify to the best of my knowledge this policy ☐ **will** ☐ **will not** replace or change any existing life insurance or annuity policy now in force.

X _____ Agent

X _____ Agent

X _____ Agent

X _____ Agent

X _____ Agent

X _____ Agent

HOME OFFICE AMENDMENTS AND CORRECTIONS

Not applicable in Pennsylvania.

The Penn Mutual Life Insurance Company
The Penn Insurance and Annuity Company
Philadelphia, PA 19172

Application Part II
Medical Declarations

Please print all answers

Proposed Insured _____ Date of Birth _____

1. Name and Address of your doctor or health care provider. (If none, so state) _____

_____

Date last consulted: _____ Reason: _____

Diagnosis/results of visit: _____

2. Are you presently taking any medication, supplements or homeopathic remedies either prescribed or over the counter? ☐ Yes ☐ No

If yes, list all treatments and reason for taking: _____

3. During the past 10 years have you had, or been told that you have, or been treated by a member of the medical profession for:

Circle applicable items and give details.	Yes	No	Details of "Yes" Answers
a. High blood pressure, chest discomfort, heart attack, heart murmur, circulatory or heart disorder?	☐	☐	
b. Diabetes, sugar in urine, thyroid disorder, elevated cholesterol or other endocrine or metabolic disorder?	☐	☐	
c. Asthma, bronchitis, emphysema, shortness of breath, sleep apnea or any other lung or respiratory disorder?	☐	☐	
d. Hepatitis, cirrhosis, ulcer, colitis or other disorder of the stomach, liver or digestive system?	☐	☐	
e. Anemia, leukemia or other blood or clotting disorder?	☐	☐	
f. Arthritis, gout, back or joint pain, bone fracture, muscle disorder, or any disorder of the skin?	☐	☐	
g. Seizures, stroke, fainting, paralysis, falls, loss of consciousness, mental or emotional disorder or any other disorder of the brain or nervous system?	☐	☐	
h. Alzheimer's disease, dementia, memory impairment, Parkinson's disease or any other progressive neurological disease?	☐	☐	
i. Cancer, tumor, polyp or cyst?	☐	☐	
j. Kidney, bladder, urinary, reproductive organ, breast or prostate disorder?	☐	☐	
k. Disorder of eyes, ears, nose or throat?	☐	☐	
l. Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC), or any disorder of the immune system or a positive blood test for antibodies to the HIV virus?	☐	☐	
4 a. Have you ever used any controlled substances such as; amphetamines, barbiturates, hallucinogens, heroin, morphine, cocaine, marijuana, opiates or any prescription drug, except as prescribed by a physician?	☐	☐	
b. Have you ever been advised to limit or discontinue the use of alcohol or drugs, sought or received treatment, counseling or participated in a group for alcohol or drug use?	☐	☐	

5. Other than previously stated, have you within the past 5 years:

Details of "Yes" Answers

a. Consulted a physician or any other practitioner, had a check-up, illness, surgery or been hospitalized? ☐ ☐

b. Had an electrocardiogram, exercise treadmill test, echocardiogram, X-ray, blood test or other diagnostic test? ☐ ☐

c. Been advised to have, or scheduled, any diagnostic test, hospitalization or surgery which was not completed? ☐ ☐

d. Received or applied for disability benefits due to any medical impairment? ☐ ☐

Details Continued

6. a. Do you currently use or have you ever used tobacco or products in any form containing nicotine? (cigarettes, cigars, pipes, chewing tobacco, nicotine gum, nicotine patches, Hookah, etc.) ☐ Yes ☐ No

b. If "YES", type and daily amount _____ Date Last Used _____

7. Family History

Have any of your immediate family members (parents, brothers and sisters) died or been diagnosed as having diabetes, heart disease, cancer, stroke or kidney disease prior to age 60? ☐ Yes ☐ No

	Ages(s) (if living)	Ages(s) (at death)	State of Health or Cause of Death
Father			
Mother			
Brother(s)			
Sisters(s)			

I represent that the statements and answers in this Part II are written as made by me and are full, complete and true. I agree that they will be a part of the contract of insurance if issued, that I will be bound by such statements and answers, and the Penn Mutual Life Insurance/Penn Insurance and Annuity Company, believing them to be true, will rely and act upon them.

Signed at (City/State) _____ Date _____

Signature of Person proposed for Insurance _____
(Parent or Guardian, if under age 15)

In presence of _____
(Medical or Paramedical examiner will please sign here)

Medical Examiners Report Part III

1.

a) Height (in shoes)	b) Weight (clothed)	Males Only		
		c) Chest (full inspiration)	d) Chest (forced expiration)	e) Abdomen (at umbilicus)
_____ft. _____ in.	_____ lbs.	_____ in.	_____ in.	_____ in.

2. a. Have you measured him/her? ☐ Yes ☐ No (b) Have you weighed him/her? ☐ Yes ☐ No

   c. Weight change in the last year : ☐ No Change ☐ Gain ☐ Loss lbs._____Reason _____

3. Blood Pressure (Record only resting readings)

Systolic			
Diastolic (5th phase)			

4. Pulse Rate - Give number per minute _____ ☐ Regular ☐ Irregular Describe irregularity _____

Questions 5 – 9 to be filled out only if exam is performed by an approved physician.

5. Heart - Is there any:

   a. Enlargement ☐ Yes ☐ No
   b. Murmur ☐ Yes ☐ No (If yes, complete below)
   c. Dyspnea ☐ Yes ☐ No
   d. Edema ☐ Yes ☐ No

   ☐ Constant ☐ Inconstant ☐ Transmitted ☐ Localized
   ☐ Systolic ☐ Presystolic ☐ Diastolic
   ☐ Soft (Gr 1-2) ☐ Moderate (Gr 3-4) ☐ Loud (Gr 5-6)

   After exercise: ☐ Increased ☐ Absent ☐ Unchanged ☐ Decreased

6. On examination, is there any abnormality of the following:

	Yes	No	Details of "Yes" answers
a. Eyes, ears, nose, mouth, pharynx	☐	☐	
b. Skin, lymph nodes, blood vessels (including varicose veins)	☐	☐	
c. Nervous system (including reflexes gait, paralysis, weakness, tremors)	☐	☐	
d. Respiratory system	☐	☐	
e. Abdomen (enlarged liver or spleen, palpable mass)	☐	☐	
f. Genito-urinary system (include prostate)	☐	☐	
g. Endocrine system (include thyroid)	☐	☐	
h. Musculosketetal system (include spine, joints, amputation & deformities)	☐	☐	

7. Are you aware of any additional medical history? ☐ Yes ☐ No
8. Are you the applicant's personal physician? ☐ Yes ☐ No
9. Please provide your overall clinical impression of the Proposed Insured: _____

_____

10. Was an interpreter used to complete this form if the Proposed Insured cannot speak or understand English? ☐ Yes ☐ No

    If Yes, interpreter name: _____ relationship: _____

Place of examination ☐ My Office ☐ Applicant's Residence ☐ Applicant's Place of business ☐ Elsewhere _____

Date ___/___/_____ Time _____ City/State _____ Agent or Field Office _____

Name of Examiner _____ Agent or Field Office (3 digit office code) _____

Signature of Examiner _____

Address of Examiner _____

I hereby certify that I have personally examined the Proposed Insured and have correctly and fully reported my findings.

COMPLETE QUESTIONS 10 – 19 IF THE PROPOSED INSURED IS INSURANCE AGE 71 OR OLDER:

10. Did the Proposed Insured require any assistance, either by device (cane, walker, wheelchair, etc.) or third party to arrive at and participate in the exam? ☐ Yes ☐ No

    If YES, provide details: _____

11. Timed Get Up and Go Test: The number of seconds it takes to rise from a chair, walk 10 feet and return to the chair and sit down:

    _____ seconds

12. Ten Word Delayed Word Recall: Of the 10 words provided, indicate the number of words recalled after 5 minutes: _____

13. Does the Proposed Insured require assistance with any of the following activities? (Please check all that apply and provide details)

    ☐ bathing ☐ dressing ☐ eating ☐ toileting ☐ transferring

    Details: _____

14. a) Which of these household activities does the Proposed Insured perform regularly? (Please check all that apply)

    ☐ cleaning ☐ lawn mowing ☐ laundry ☐ shopping ☐ meal preparation ☐ handling finances ☐ using a computer

    b) If the Proposed Insured requires assistance with any of the above activities, please provide details?

    Details: _____

15. Does the Proposed Insured participate in any of the following? (Indicate activity and provide the number of hours per week)

    ☐ hobbies ☐ volunteer work ☐ gainfully employed ☐ other outside activities Hours per week _____

16. Does the Proposed Insured currently drive? ☐ Yes ☐ No If No, reason stopped? _____

    If YES, provide number of miles driven per week. _____ Any accidents? ☐ Yes ☐ No

    If YES, provide details: _____

17. Does the Proposed Insured travel? ☐ Yes ☐ No

    If YES, advise number of times per year _____, when last traveled, and travel plans for the next 12 months:

    _____

18. Has the Proposed Insured had any falls in the past 3 years? ☐ Yes ☐ No

    If YES, indicate number of falls _____ and dates _____

19. Are there other persons living in the Proposed Insured's household? ☐ Yes ☐ No

    If YES, provide details: _____

Signature of Examiner: _____

Supporting Document Schedules

Item Status: **Status Date:**

Satisfied - Item: Flesch Certification

Comments:

Attachment:

Flesch Cert.pdf

Item Status: **Status Date:**

Satisfied - Item: Statement of Variability

Comments:

Attachment:

Statement_of_Variability.pdf

The Penn Mutual Life Insurance Company

CERTIFICATION

"This is to certify that the form listed below is in compliance with the requirements of Ark. Stat. Ann. 66-3251 through 66-3258, cited as the Life and Disability Insurance Policy Language Simplification Act."

Form No.	Title	Flesch Score
PM1143-R1	Application for Life Insurance Part 1	*
893-R1	Application Part II Medical Declarations	*

* Meets the minimum score of 50 achieved when combined with the appropriate policy forms.

Nancy A. Yannuzzi
Senior Manager of Policy Forms

April 8, 2011

THE PENN MUTUAL LIFE INSURANCE COMPANY

STATEMENT OF VARIABILITY

Date: April 1, 2011

Form Number(s): PM1143-R1

Any use of variability shall be administered in a uniform and non-discriminatory manner. Any changes will be filed with the state

Page Number	Description
Pg 2 and 3	A - We placed brackets around the riders because as we get new products approved we'd like to have the option to add these to the application without having to refile the application each time.
Pg 12	B - We have placed brackets around the Fraud Warnings so if a state changes their Fraud Warning, the change can be made to the form without refiling in the all states.