

SERFF Tracking Number: PNMU-127110238 State: Arkansas  
Filing Company: Penn Insurance and Annuity Company State Tracking Number: 48522  
Company Tracking Number: APPLICATION-LIFE 2011, PIA  
TOI: L08 Life - Other Sub-TOI: L08.000 Life - Other  
Product Name: Application-Life 2011, PIA  
Project Name/Number: Application-Life 2011, PIA/Application-Life 2011, PIA

## Filing at a Glance

Company: Penn Insurance and Annuity Company

Product Name: Application-Life 2011, PIA

TOI: L08 Life - Other

Sub-TOI: L08.000 Life - Other

Filing Type: Form

Implementation Date Requested: On Approval

State Filing Description:

SERFF Tr Num: PNMU-127110238 State: Arkansas

SERFF Status: Closed-Approved-  
Closed State Tr Num: 48522

Co Tr Num: APPLICATION-LIFE State Status: Approved-Closed  
2011, PIA

Authors: Nancy Yannuzzi, Rita  
Bellew

Date Submitted: 04/18/2011

Reviewer(s): Linda Bird

Disposition Date: 04/26/2011

Disposition Status: Approved-  
Closed

Implementation Date:

## General Information

Project Name: Application-Life 2011, PIA

Project Number: Application-Life 2011, PIA

Requested Filing Mode: Review & Approval

Explanation for Combination/Other:

Submission Type: New Submission

Overall Rate Impact:

Deemer Date:

Submitted By: Rita Bellew

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

Status of Filing in Domicile: Pending

Date Approved in Domicile:

Domicile Status Comments:

Market Type: Individual

Individual Market Type:

Filing Status Changed: 04/26/2011

State Status Changed: 04/26/2011

Created By: Rita Bellew

Corresponding Filing Tracking Number:  
Application-Life 2011, PIA

SERFF Tracking Number: PNMU-127110238 State: Arkansas  
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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 Insurance and Annuity Company CoCode: 93262 State of Domicile: Delaware  
 VIM C3G Group Code: 850 Company Type: Life and Annuity  
 Philadelphia, PA 19172 Group Name: Penn Mutual Life Ins. State ID Number:  
 Co.  
 (215) 956-8893 ext. [Phone] FEIN Number: 23-2142731  
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## Filing Fees

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

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Penn Insurance and Annuity Company	\$50.00	04/18/2011	46689137
Penn Insurance and Annuity Company	\$50.00	04/26/2011	46961509

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## 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

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## **Disposition**

Disposition Date: 04/26/2011

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	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

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## 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 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 \$50.00 is received.

Please feel free to contact me if you have questions.

Sincerely,

Linda Bird

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## 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: Additional 50.00 has been added to eft serff.

### 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 \$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

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## 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**

<b>A. PROPOSED INSURED 1 (PI 1)</b>	1. Name of First Insured (First, Middle, Last)			2. Sex <input type="checkbox"/> Male <input type="checkbox"/> 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 <input type="checkbox"/> M <input type="checkbox"/> D <input type="checkbox"/> S <input type="checkbox"/> 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>B. PROPOSED INSURED 2 (PI 2)</b>  <i>Complete for</i>  <input type="checkbox"/> Survivorship Plan  <input type="checkbox"/> Additional Insured Rider  <i>(If multiple additional insureds complete form PM5023)</i>  <i>If info for PI 1 is same as PI 2 indicate same.</i>	1. Name of Second Insured (First, Middle, Last)			2. Sex <input type="checkbox"/> Male <input type="checkbox"/> 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 <input type="checkbox"/> M <input type="checkbox"/> D <input type="checkbox"/> S <input type="checkbox"/> 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		
<b>C. PLAN OF INSURANCE</b>	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 <input type="checkbox"/> Level Death Benefit			<input type="checkbox"/> Increasing Death Benefit			
PREMIUM TEST (UL and VUL only)		6. Check One <input type="checkbox"/> Guideline Premium			<input type="checkbox"/> Cash Value			

**D. ADDITIONAL BENEFITS AND RIDERS**

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

Product	Available Elected Riders
<p>Accumulation Builder II IUL</p>	<ul style="list-style-type: none"> <li><input type="checkbox"/> Accidental Death Benefit \$ _____</li> <li><input type="checkbox"/> Additional Insured Rider (Complete Section B of application) \$ _____</li> <li><input type="checkbox"/> Business Accounting Benefit</li> <li><input type="checkbox"/> Cash Value Enhancement Rider</li> <li><input type="checkbox"/> Children's Term Insurance Agreement</li> <li><input type="checkbox"/> Disability Completion Benefit</li> <li><input type="checkbox"/> Guaranteed Insurability Agreement \$ _____</li> <li><input type="checkbox"/> Overloan Protection Rider</li> <li><input type="checkbox"/> Return of Premium Rider</li> <li><input type="checkbox"/> Supplemental Term Rider \$ _____</li> <li><input type="checkbox"/> Waiver of Monthly Deductions</li> <li><input type="checkbox"/> Other _____</li> </ul>
<p>Diversified Growth VUL</p> <p><i>Complete form PM0304-R2 (PM0304-RS in NY and VT) and all forms required by your broker dealer for variable life business.</i></p>	<ul style="list-style-type: none"> <li><input type="checkbox"/> Accidental Death Benefit \$ _____</li> <li><input type="checkbox"/> Additional Insured Rider (Complete Section B of application) \$ _____</li> <li><input type="checkbox"/> Business Accounting Benefit</li> <li><input type="checkbox"/> Cash Value Enhancement Rider</li> <li><input type="checkbox"/> Children's Term Insurance Agreement</li> <li><input type="checkbox"/> Disability Completion Benefit</li> <li><input type="checkbox"/> Extended No-Lapse Guarantee Rider</li> <li><input type="checkbox"/> Guaranteed Insurability Agreement \$ _____</li> <li><input type="checkbox"/> Overloan Protection Rider</li> <li><input type="checkbox"/> Return of Premium Rider</li> <li><input type="checkbox"/> Supplemental Term Rider \$ _____</li> <li><input type="checkbox"/> Waiver of Monthly Deductions</li> <li><input type="checkbox"/> Other _____</li> </ul>
<p>Flexible Choice Whole Life</p>	<ul style="list-style-type: none"> <li><input type="checkbox"/> Accidental Death Benefit \$ _____</li> <li><input type="checkbox"/> Children's Term Insurance Agreement</li> <li><input type="checkbox"/> Flexible Protection Rider \$ _____</li> <li><input type="checkbox"/> Guaranteed Insurability Agreement \$ _____</li> <li><input type="checkbox"/> Overloan Protection Rider</li> <li><input type="checkbox"/> Paid Up Additions (Select only one and complete question 4 in Section M) <ul style="list-style-type: none"> <li><input type="checkbox"/> Accelerated Permanent Paid Up Additions Rider</li> <li><input type="checkbox"/> Enhanced Permanent Paid Up Additions Rider</li> </ul> </li> <li><input type="checkbox"/> Waiver of Premium (Select only one) <ul style="list-style-type: none"> <li><input type="checkbox"/> Waiver of Premium Rider</li> <li><input type="checkbox"/> Enhanced Waiver of Premium Rider</li> </ul> </li> <li><input type="checkbox"/> Other _____</li> </ul>

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

<b>E. CHILDREN'S TERM INSURANCE BENEFIT</b>  <i>If more than six, complete form PM5023</i>	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
			/ /				\$
			/ /				
			/ /				
			/ /				
			/ /				

<b>F. DIVIDEND OPTIONS</b>	<b>Universal Life</b> <input type="checkbox"/> Cash <input type="checkbox"/> Credited to Cash Value	<b>Traditional Plans</b> <input type="checkbox"/> Cash <input type="checkbox"/> Paid-up Additions <input type="checkbox"/> Premium Reduction (Not available with Penn Check or Salary Allotment)	<input type="checkbox"/> Accumulate at Interest <input type="checkbox"/> Other _____
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<b>G. OWNER</b>  <i>Complete <b>only</b> if Owner is other than Proposed Insured 1. If Trust, give name of Trust, Trustee and date of Trust</i>  <b>Note: If Owner is a Trust or Insured's business omit questions 4, 9.</b>	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	

<b>H. CONTINGENT OWNER</b>  <i>Complete <b>only</b> if Contingent Owner is other than Proposed Insured 1. If Trust, give name of Trust, Trustee and date of Trust</i>  <b>Note: If Contingent Owner is a Trust or Insured's business omit questions 4, 9.</b>	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	

<b>I. PAYOR</b>  <i>Complete <b>only</b> if Payor is other than the Proposed Insured or Owner or if a different address is requested.</i>	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.**

- 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 # \_\_\_\_\_
- Total premium to be billed \_\_\_\_\_
- Additional premium expected via 1035 exchange \_\_\_\_\_ ; or dump-in \_\_\_\_\_
- 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 \_\_\_\_\_
- Automatic Premium Loan for Whole Life     Yes     No
- 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.
- 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.

\_\_\_\_\_

\_\_\_\_\_

<b>N. PENN CHECK ACCOUNT INFORMATION</b>  <i>Complete only if Penn Check mode is selected and this is a new account. Also attach a Void Check or deposit slip</i>	1. Bank Name	2. Bank Routing and Account No.	
	3. Account Type <input type="checkbox"/> Checking <input type="checkbox"/> Savings <input type="checkbox"/> Pershing <input type="checkbox"/> Other	4. Draw Date: <input type="checkbox"/> 1 <sup>st</sup> <input type="checkbox"/> 8 <sup>th</sup> <input type="checkbox"/> 15 <sup>th</sup> <input type="checkbox"/> 22 <sup>nd</sup>	
	5. Bank Address (Street, City, County, State, Zip)		
	6. Name (First, Middle, Last) of First Depositor	7. Name (First, Middle, Last) of Second Depositor	

<b>O. INTENT TO TRANSFER &amp; LIFE EXPECTANCY EVALUATION</b>	<p>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)?  <input type="checkbox"/> Yes    <input type="checkbox"/> No    If Yes, explain.</p> <p>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?  <input type="checkbox"/> Yes    <input type="checkbox"/> No    If Yes, explain.</p> <p>3. Have you settled a life insurance policy in the past 5 years?  <input type="checkbox"/> Yes    <input type="checkbox"/> No    If yes, indicate which policy (listed in Section P) was settled and explain.</p>
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<b>P. LIFE INSURANCE IN FORCE OR PENDING</b>		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?	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO				
	2. Do you have any formal or informal applications pending with any other life insurance company now?	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> 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?	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO			
	4. List all Insurance In Force on any Proposed Insured. <b>If none, check this box.</b> <input type="checkbox"/>						
	Insured's Name & Company	Business or Personal	Face Amount	Policy Number	Issue Year	Is this Policy being Replaced or Changed?	Check if 1035 Exchange
						<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/>
						<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/>
						<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/>
						<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/>
						<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/>

**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  Deferred Compensation
- Retirement Funding  Savings, Accumulation
- Estate Planning  Education/College Funding
- Charitable Giving  Key Person
- Debt Protection  Buy/Sell
- Other \_\_\_\_\_

**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. <b>Proposed Insured 1:</b> Physician Name | 2. Phone No.<br>( ) | 3. Date Last Seen |
| 4. Address: (Street, City, State, Zip)       |                     |                   |
| 5. Reason Last Seen:                         |                     |                   |
| 6. <b>Proposed Insured 2:</b> Physician Name | 7. Phone No.<br>( ) | 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*

1. Annual earned income from occupation (After deduction of business expenses)

2. Other income (give source) \_\_\_\_\_

3. Net Worth \_\_\_\_\_

PI 1		PI 2	
\$		\$	
\$		\$	
\$		\$	

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)

PI 1		PI 2		CHILD RIDER	
YES	NO	YES	NO	YES	NO

Detail of any YES answers in Section U: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

V. MEDICAL HISTORY	Proposed Insured 1				Proposed Insured 2			
	ft.		in.		ft.		in.	
1. Height (in shoes)								
2. Weight (clothed)	lbs.				lbs.			
3. Weight change in last year? If yes, circle increase or decrease	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Increase	Decrease	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Increase	Decrease
	No. of lbs. _____				No. of lbs. _____			
	Reason: _____				Reason: _____			
4. Birth weight if under 6 mo. old	lbs.				lbs.			
			<b>PI 1</b>		<b>PI 2</b>		<b>CHILD RIDER</b>	
			YES NO		YES NO		YES NO	
5. Are you presently taking any medication, supplements or homeopathic remedies either prescribed or over the counter?			<input type="checkbox"/> <input type="checkbox"/>		<input type="checkbox"/> <input type="checkbox"/>		<input type="checkbox"/> <input type="checkbox"/>	
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?			<input type="checkbox"/> <input type="checkbox"/>		<input type="checkbox"/> <input type="checkbox"/>		<input type="checkbox"/> <input type="checkbox"/>	
b. Diabetes, sugar in urine, thyroid disorder, elevated cholesterol or other endocrine or metabolic disorder?			<input type="checkbox"/> <input type="checkbox"/>		<input type="checkbox"/> <input type="checkbox"/>		<input type="checkbox"/> <input type="checkbox"/>	
c. Asthma, bronchitis, emphysema, shortness of breath, sleep apnea or any other lung or respiratory disorder?			<input type="checkbox"/> <input type="checkbox"/>		<input type="checkbox"/> <input type="checkbox"/>		<input type="checkbox"/> <input type="checkbox"/>	
d. Hepatitis, cirrhosis, ulcer, colitis or other disorder of the stomach, liver or digestive system?			<input type="checkbox"/> <input type="checkbox"/>		<input type="checkbox"/> <input type="checkbox"/>		<input type="checkbox"/> <input type="checkbox"/>	
e. Anemia, leukemia or other blood or clotting disorder?			<input type="checkbox"/> <input type="checkbox"/>		<input type="checkbox"/> <input type="checkbox"/>		<input type="checkbox"/> <input type="checkbox"/>	
f. Arthritis, gout, back or joint pain, bone fracture, muscle disorder, or any disorder of the skin?			<input type="checkbox"/> <input type="checkbox"/>		<input type="checkbox"/> <input type="checkbox"/>		<input type="checkbox"/> <input type="checkbox"/>	
g. Seizures, stroke, fainting, paralysis, falls, loss of consciousness, mental or emotional disorder or any other disorder of the brain or nervous system?			<input type="checkbox"/> <input type="checkbox"/>		<input type="checkbox"/> <input type="checkbox"/>		<input type="checkbox"/> <input type="checkbox"/>	
h. Alzheimer's disease, dementia, memory impairment, Parkinson's disease or any other progressive neurological disease?			<input type="checkbox"/> <input type="checkbox"/>		<input type="checkbox"/> <input type="checkbox"/>		<input type="checkbox"/> <input type="checkbox"/>	
i. Cancer, tumor, polyp or cyst?			<input type="checkbox"/> <input type="checkbox"/>		<input type="checkbox"/> <input type="checkbox"/>		<input type="checkbox"/> <input type="checkbox"/>	
j. Kidney, bladder, urinary, reproductive organ, breast or prostate disorder?			<input type="checkbox"/> <input type="checkbox"/>		<input type="checkbox"/> <input type="checkbox"/>		<input type="checkbox"/> <input type="checkbox"/>	
k. Disorder of eyes, ears, nose or throat?			<input type="checkbox"/> <input type="checkbox"/>		<input type="checkbox"/> <input type="checkbox"/>		<input type="checkbox"/> <input type="checkbox"/>	
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?			<input type="checkbox"/> <input type="checkbox"/>		<input type="checkbox"/> <input type="checkbox"/>		<input type="checkbox"/> <input type="checkbox"/>	
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?			<input type="checkbox"/> <input type="checkbox"/>		<input type="checkbox"/> <input type="checkbox"/>		<input type="checkbox"/> <input type="checkbox"/>	
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?			<input type="checkbox"/> <input type="checkbox"/>		<input type="checkbox"/> <input type="checkbox"/>		<input type="checkbox"/> <input type="checkbox"/>	
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?			<input type="checkbox"/> <input type="checkbox"/>		<input type="checkbox"/> <input type="checkbox"/>		<input type="checkbox"/> <input type="checkbox"/>	
b. Had an electrocardiogram, exercise treadmill test, echocardiogram, X-ray, blood test or other diagnostic test?			<input type="checkbox"/> <input type="checkbox"/>		<input type="checkbox"/> <input type="checkbox"/>		<input type="checkbox"/> <input type="checkbox"/>	
c. Been advised to have, or scheduled, any diagnostic test, hospitalization or surgery which was not completed?			<input type="checkbox"/> <input type="checkbox"/>		<input type="checkbox"/> <input type="checkbox"/>		<input type="checkbox"/> <input type="checkbox"/>	
d. Received or applied for disability benefits due to any medical impairment?			<input type="checkbox"/> <input type="checkbox"/>		<input type="checkbox"/> <input type="checkbox"/>		<input type="checkbox"/> <input type="checkbox"/>	



SPECIAL INSTRUCTIONS	
NON-CONFORMING ILLUSTRATION ACKNOWLEDGEMENT (NON-VARIABLE ONLY)	<p>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):</p> <p><input type="checkbox"/> A. An illustration was not presented to me</p> <p><input type="checkbox"/> B. An illustration was presented to me, however, the policy applied for is different than as illustrated</p> <p><input type="checkbox"/> C. An illustration was presented to me on a computer screen (not for use in Michigan)</p> <p>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.</p>
AUTHORIZATION FOR FUND TRANSFER (VARIABLE ONLY)	<p>The agent/registered representative may request transfers of account values pursuant to my instruction unless I check this box.</p> <p><input type="checkbox"/> check if applicable</p>
PENN CHECK AUTHORIZATION	<p>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. <b>If no date has been selected in Question 4 of Section N, the draw date will be the 15th of the month.</b></p> <p>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.</p>
NOTICE AND CONSENT FOR CORPORATE OWNED INSURANCE	<p>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.</p>
INDEXED ACCOUNT DISCLOSURE	<p>Premium allocated to a segment of the Indexed Account is eligible to receive index credits based on the performance of Standard &amp; Poor's® * Composite Stock Price Index (S&amp;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.</p> <p>"Standard &amp; Poor's®", "S&amp;P 500®", "Standard &amp; 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 &amp; Poor's® and Standard &amp; Poor's® makes no representations regarding the advisability of investing in the Product.</p>
REPRESENTATIONS	<p>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:</p> <ol style="list-style-type: none"> <li><b>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.</b></li> <li>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.</li> <li>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.</li> </ol>

**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.



**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

**HOME OFFICE  
AMENDMENTS  
AND  
CORRECTIONS**

*Not applicable in  
Pennsylvania.*

**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?   | <input type="checkbox"/> | <input type="checkbox"/> |  |
| b. Diabetes, sugar in urine, thyroid disorder, elevated cholesterol or other endocrine or metabolic disorder?  | <input type="checkbox"/> | <input type="checkbox"/> |  |
| c. Asthma, bronchitis, emphysema, shortness of breath, sleep apnea or any other lung or respiratory disorder?  | <input type="checkbox"/> | <input type="checkbox"/> |  |
| d. Hepatitis, cirrhosis, ulcer, colitis or other disorder of the stomach, liver or digestive system?   | <input type="checkbox"/> | <input type="checkbox"/> |  |
| e. Anemia, leukemia or other blood or clotting disorder?   | <input type="checkbox"/> | <input type="checkbox"/> |  |
| f. Arthritis, gout, back or joint pain, bone fracture, muscle disorder, or any disorder of the skin?   | <input type="checkbox"/> | <input type="checkbox"/> |  |
| g. Seizures, stroke, fainting, paralysis, falls, loss of consciousness, mental or emotional disorder or any other disorder of the brain or nervous system?   | <input type="checkbox"/> | <input type="checkbox"/> |  |
| h. Alzheimer's disease, dementia, memory impairment, Parkinson's disease or any other progressive neurological disease?  | <input type="checkbox"/> | <input type="checkbox"/> |  |
| i. Cancer, tumor, polyp or cyst?   | <input type="checkbox"/> | <input type="checkbox"/> |  |
| j. Kidney, bladder, urinary, reproductive organ, breast or prostate disorder?  | <input type="checkbox"/> | <input type="checkbox"/> |  |
| k. Disorder of eyes, ears, nose or throat?   | <input type="checkbox"/> | <input type="checkbox"/> |  |
| 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?  | <input type="checkbox"/> | <input type="checkbox"/> |  |
| 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? | <input type="checkbox"/> | <input type="checkbox"/> |  |
| 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?                                    | <input type="checkbox"/> | <input type="checkbox"/> |  |

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) _____ ft. _____ in.	b) Weight (clothed) _____ lbs.	Males Only		
			c) Chest (full inspiration) _____ in.	d) Chest (forced expiration) _____ in.	e) Abdomen (at umbilicus) _____ 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 (5 <sup>th</sup> 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 c. Dyspnea  Yes  No  
 b. Murmur  Yes  No (If yes, complete below) 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	<input type="checkbox"/>	<input type="checkbox"/>	
b. Skin, lymph nodes, blood vessels (including varicose veins)	<input type="checkbox"/>	<input type="checkbox"/>	
c. Nervous system (including reflexes gait, paralysis, weakness, tremors)	<input type="checkbox"/>	<input type="checkbox"/>	
d. Respiratory system	<input type="checkbox"/>	<input type="checkbox"/>	
e. Abdomen (enlarged liver or spleen, palpable mass)	<input type="checkbox"/>	<input type="checkbox"/>	
f. Genito-urinary system (include prostate)	<input type="checkbox"/>	<input type="checkbox"/>	
g. Endocrine system (include thyroid)	<input type="checkbox"/>	<input type="checkbox"/>	
h. Musculoskeletal system (include spine, joints, amputation & deformities)	<input type="checkbox"/>	<input type="checkbox"/>	

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: \_\_\_\_\_

SERFF Tracking Number: PNMU-127110238 State: Arkansas  
Filing Company: Penn Insurance and Annuity Company State Tracking Number: 48522  
Company Tracking Number: APPLICATION-LIFE 2011, PIA  
TOI: L08 Life - Other Sub-TOI: L08.000 Life - Other  
Product Name: Application-Life 2011, PIA  
Project Name/Number: Application-Life 2011, PIA/Application-Life 2011, PIA

## Supporting Document Schedules

	Item Status:	Status Date:
<b>Satisfied - Item:</b> Flesch Certification		
<b>Comments:</b>		
<b>Attachment:</b> Flesch Cert.pdf		

	Item Status:	Status Date:
<b>Satisfied - Item:</b> Statement of Variability		
<b>Comments:</b>		
<b>Attachment:</b> Statement_of_Variability.pdf		

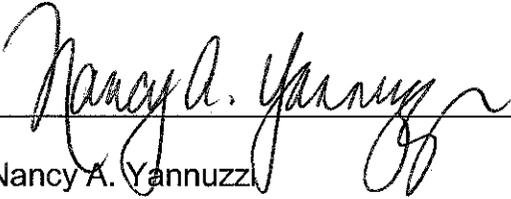
The Penn Mutual Life Insurance Company

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."

<u>Form No.</u>	<u>Title</u>	<u>Flesch Score</u>
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

<u>Page Number</u>	<u>Description</u>
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.