

SERFF Tracking Number: STFL-126971730 State: Arkansas  
Filing Company: State Farm Life Insurance Company State Tracking Number: 47759  
Company Tracking Number: SFL11080-04  
TOI: L09I Individual Life - Flexible Premium Sub-TOI: L09I.001 Single Life  
Adjustable Life  
Product Name: 11080-04 UL (Unisex)  
Project Name/Number: 11080-04 UL (Unisex)/11080-04 UL (Unisex)

## Filing at a Glance

Company: State Farm Life Insurance Company

Product Name: 11080-04 UL (Unisex)

TOI: L09I Individual Life - Flexible Premium

Adjustable Life

Sub-TOI: L09I.001 Single Life

Filing Type: Form

SERFF Tr Num: STFL-126971730 State: Arkansas

SERFF Status: Closed-Approved- State Tr Num: 47759

Closed

Co Tr Num: SFL11080-04

Author: Steve Crum

Date Submitted: 01/20/2011

State Status: Approved-Closed

Reviewer(s): Linda Bird

Disposition Date: 04/05/2011

Disposition Status: Approved-Closed

Implementation Date:

Implementation Date Requested: 08/27/2011

State Filing Description:

## General Information

Project Name: 11080-04 UL (Unisex)

Project Number: 11080-04 UL (Unisex)

Requested Filing Mode: Review & Approval

Explanation for Combination/Other:

Submission Type: New Submission

Overall Rate Impact:

Deemer Date:

Submitted By: Steve Crum

Filing Description:

NAIC # 69108

FEIN #37-0533090

Dear Sir or Madam:

Status of Filing in Domicile:

Date Approved in Domicile:

Domicile Status Comments:

Market Type: Individual

Individual Market Type:

Filing Status Changed: 04/05/2011

State Status Changed: 01/25/2011

Created By: Steve Crum

Corresponding Filing Tracking Number:

Enclosed for your consideration is the following new individual life insurance policy form:

11080-04 Flexible Premium Adjustable Life Insurance Policy

11080-04 is a participating Universal Life policy, although we do not expect to pay dividends. The maximum monthly issue charge, maximum monthly expense charge, and maximum premium charge percentage are shown on page 3.

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Monthly deductions are made at the beginning of each policy month. The current monthly cost of insurance rates is adjustable. The maximum monthly cost of insurance rates is shown in the policy and is guaranteed. The minimum initial basic amount is \$50,000 for ages 20-54 and \$25,000 for ages 0-19 and 55-85. The issue ages are 0-85. 11080-04 will be issued only for business that is subject to the Supreme Court Norris Decision and includes changes to comply with the mandates of that decision. The word "sex" has been deleted from the Monthly Cost of Insurance Rates, Basis of Computation, and Error in Age provision. Guaranteed values and reserves for this form are based on the 2001 CSO Mortality Table. The actuarial memorandum for form 11080-04 is enclosed, and the policy will be illustrated.

Form 11080-04 replaces form 08080, which was approved by your department on October 16 , 2007 under SERFF tracking number STFL-125310529.

The significant changes to form 11080-04 include:

- Added a new rate class at \$250,000 and are making the Super Preferred class available at \$100,000
- Revised expense charges
- Revised maximum issue age
- Revised guaranteed interest rate and loan interest rates
- Addition of allowing the applicant to choose between the Guideline Premium Test and Cash Value Accumulation Test as to which definition of life insurance test will apply to his/her policy
- Revised Incontestability and Limited Death Benefit Provisions

The life insurance application that will be used with this form is 1000704 AR.2, which was approved by your department on January 3, 2011 under SERFF tracking number STFL-126931804.

We intend to waive the right to contest the response to the question regarding juvenile smoking status as referenced in the Juvenile Insured Smoker/Nonsmoker Mortality Table section.

In order to comply with Act 312 regarding interest on policy proceeds and refund of premiums, we will be using Arkansas – Form 1. The letter, a sample of which is attached, will be addressed either to a claimant or to a State Farm Life agent. If the original is sent to an agent, (a) a copy will be sent to the beneficiary; and (b) the following statement will be included in the agent's letter: "A copy of this letter is being mailed to the beneficiary." The beneficiary will then be made aware of the requirements of Act 312. The wording for this letter was discussed in a telephone conversation with Mr. Joe Musgrove and Mr. John States of our company.

To comply with Ark. Code Ann. 23-79-138 and Bulletins 6-87 and 11-88, enclosed is form 03905-04.1, which is given to each policyholder with the policy.

To comply with Regulation 49, we provide the policyholder with enclosed form 03906-04.1, Limitations and Exclusions

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Under the Arkansas Life and Health Insurance Guaranty Association Act.

This form will be marketed exclusively through State Farm agents.

The effective date for this new form will be August 27, 2011.

## Company and Contact

### Filing Contact Information

Steve Crum, Tech - Contracts & Compliance steve.crum.pgyt@statefarm.com  
 1 State Farm Plaza 309-763-9006 [Phone]  
 Bloomington, IL 61710-0001 309-766-8483 [FAX]

### Filing Company Information

State Farm Life Insurance Company CoCode: 69108 State of Domicile: Illinois  
 1 State Farm Plaza Group Code: Company Type:  
 Bloomington, IL 61710-0001 Group Name: State ID Number:  
 (309) 766-4541 ext. [Phone] FEIN Number: 37-0533090

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## Filing Fees

Fee Required? Yes  
 Fee Amount: \$50.00  
 Retaliatory? Yes  
 Fee Explanation: Voucher ID# 15043968  
 Per Company: No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
State Farm Life Insurance Company	\$50.00	01/20/2011	43950521

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## Correspondence Summary

### Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Linda Bird	04/05/2011	04/05/2011
Approved-Closed	Linda Bird	01/25/2011	01/25/2011

### Amendments

Schedule	Schedule Item Name	Created By	Created On	Date Submitted
Form	Flexible Premium Adjustable Life Insurance Policy	Rhonda Brackman	04/04/2011	04/04/2011
Supporting Document	Actuarial Memorandum and Certification of Compliance	Rhonda Brackman	04/04/2011	04/04/2011

### Filing Notes

Subject	Note Type	Created By	Created On	Date Submitted
Request to re-open filing	Note To Filer	Linda Bird	03/22/2011	03/22/2011
Request to re-open filing	Note To Reviewer	Rhonda Brackman	03/21/2011	03/21/2011

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## **Disposition**

Disposition Date: 04/05/2011

Implementation Date:

Status: Approved-Closed

Comment: Company has updated form 11080-04 on the specification pages 3 & 4 and updated the Actuarial Memorandum to reflect changes in the original filing.

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		Yes
Supporting Document	Health - Actuarial Justification		No
Supporting Document	Outline of Coverage		No
Supporting Document (revised)	Actuarial Memorandum and Certification of Compliance		No
Supporting Document	Actuarial Memorandum and Certification of Compliance	Replaced	No
Supporting Document	Certificate of Compliance Reg-19		Yes
Supporting Document	AR Form1 New Albany		Yes
Supporting Document	Certificate of Compliance (Reg 34)		Yes
Supporting Document	Forms 03905-04.1 and 03906-04.1		Yes
Supporting Document	Consent to Submit Rates		Yes
Supporting Document	Certificate of Compliance Bulletin No. 11-83		Yes
Form (revised)	Flexible Premium Adjustable Life Insurance Policy		Yes
Form	Flexible Premium Adjustable Life Insurance Policy	Replaced	Yes

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## Disposition

Disposition Date: 01/25/2011

Implementation Date:

Status: Approved-Closed

Comment:

Rate data does NOT apply to filing.

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Supporting Document	Application		Yes
Supporting Document	Health - Actuarial Justification		No
Supporting Document	Outline of Coverage		No
Supporting Document (revised)	Actuarial Memorandum and Certification of Compliance		No
Supporting Document	Actuarial Memorandum and Certification of Compliance	Replaced	No
Supporting Document	Certificate of Compliance Reg-19		Yes
Supporting Document	AR Form1 New Albany		Yes
Supporting Document	Certificate of Compliance (Reg 34)		Yes
Supporting Document	Forms 03905-04.1 and 03906-04.1		Yes
Supporting Document	Consent to Submit Rates		Yes
Supporting Document	Certificate of Compliance Bulletin No. 11-83		Yes
Form (revised)	Flexible Premium Adjustable Life Insurance Policy		Yes
Form	Flexible Premium Adjustable Life Insurance Policy	Replaced	Yes

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**Amendment Letter**

Submitted Date: 04/04/2011

**Comments:**

Please note the updated copy of form 11080-04 on the Form Schedule tab. The specification pages 3&4 in this form have been updated to offer a higher guaranteed interest rate than what was filed with your Department originally. No other changes have been made to this form.

Also, an updated copy of the Actuarial Memorandum for form 11080-04 has been attached to the Supporting Documentation tab to reflect this change in the guaranteed interest rate. The attachments to the Actuarial Memorandum were not affected.

Please let me know if you have questions, or need additional information. We look forward to receiving approval of this update.

Respectfully,  
 Rhonda Brackman, Analyst  
 L/H Contracts & Compliance Department

**Changed Items:**

**Form Schedule Item Changes:**

**Form Schedule Item Changes:**

Form Number	Form Type	Form Name	Action	Form Action Other	Previous Filing #	Replaced Form #	Readability Score	Attachments
11080-04	Policy/Contr act/Fraternal Certificate	Flexible Premium Adjustable Life Insurance Policy	Initial				56.000	11080 04 UL UNISEX bracket 20110107_ complete_refile.pdf

**Supporting Document Schedule Item Changes:**

**User Added -Name: Actuarial Memorandum and Certification of Compliance**

Comment: See Attachments  
 UL 2011\_(11080)\_Certification of compliance.pdf

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UL 2011\_(11080)\_GPT & CVAT percentages Attachment 1.pdf  
UL 2011\_(11080)\_Guar COI Attachment 2.pdf  
UL 2011\_(11080)\_Excess Expense Allowances Attachment 3(a).pdf  
UL 2011\_(11080)\_Surrender Charge Attachment 3(b).pdf  
UL 2011\_(11080)\_Actuarial Memo\_refile.pdf

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**Note To Filer**

**Created By:**

Linda Bird on 03/22/2011 01:23 PM

**Last Edited By:**

Linda Bird

**Submitted On:**

03/22/2011 01:23 PM

**Subject:**

Request to re-open filing

**Comments:**

Filing has been re-opened in order for corrections to be made to the original submission.

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**Note To Reviewer**

**Created By:**

Rhonda Brackman on 03/21/2011 01:49 PM

**Last Edited By:**

Rhonda Brackman

**Submitted On:**

03/21/2011 01:50 PM

**Subject:**

Request to re-open filing

**Comments:**

By way of this "Note to Reviewer", I am requesting this filing be re-opened to submit the following updated supporting documentation items:

The Actuarial Memorandum and specification pages 3&4 have been revised as a decision was made to offer a higher guaranteed interest rate than what was filed with your Department originally.

Form 11080-04 has not been implemented.

Respectfully,

Rhonda Brackman, Analyst

L/H Contracts & Compliance Department

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## Form Schedule

**Lead Form Number: 11080-04**

Schedule Item Status	Form Number	Form Type Form Name	Action	Action Specific Data	Readability	Attachment
	11080-04	Policy/Cont Flexible Premium ract/Fratern Adjustable Life al Insurance Policy Certificate	Initial		56.000	11080 04 UL UNISEX bracket 20110107_ complete_refil e.pdf

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## Supporting Document Schedules

	<b>Item Status:</b>	<b>Status Date:</b>
<b>Satisfied - Item:</b> Flesch Certification		
<b>Comments:</b> See Attached		
<b>Attachment:</b> CERFLESH - forms 11080-04.pdf		

	<b>Item Status:</b>	<b>Status Date:</b>
<b>Satisfied - Item:</b> Application		
<b>Comments:</b> See Attached Application which was approved by your department on 1-3-2011 under SERFF tracking # STFL-126931804.		
<b>Attachment:</b> 1000704 AR.2 Life App_ Bracketed.pdf		

	<b>Item Status:</b>	<b>Status Date:</b>
<b>Bypassed - Item:</b> Outline of Coverage		
<b>Bypass Reason:</b> Not Applicable		
<b>Comments:</b>		

	<b>Item Status:</b>	<b>Status Date:</b>
<b>Satisfied - Item:</b> Certificate of Compliance Reg-19		
<b>Comments:</b> See Attached		
<b>Attachment:</b> ARREG19 11080-04.pdf		

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

**Satisfied - Item:** AR Form1 New Albany

**Comments:**

See Attached

**Attachment:**

AR\_Form1\_NewAlbany.pdf

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

**Satisfied - Item:** Certificate of Compliance (Reg 34)

**Comments:**

See Attached

**Attachment:**

AR\_11080\_comply reg 34.pdf

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

**Satisfied - Item:** Forms 03905-04.1 and 03906-04.1

**Comments:**

See Attachments

**Attachments:**

AR\_03906-04.1.pdf

Form\_03905-04.1.pdf

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

**Satisfied - Item:** Consent to Submit Rates

**Comments:**

See Attached

**Attachment:**

11080-04 ARCONSENT\_INDET\_PREM.pdf

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**Item Status:**

**Status  
Date:**

**Satisfied - Item:** Certificate of Compliance Bulletin  
No. 11-83

**Comments:**

See Attachment

**Attachment:**

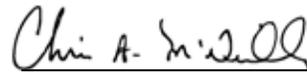
AR\_11080\_comply Bulletin 11-83.pdf

**STATE FARM LIFE INSURANCE COMPANY**  
One State Farm Plaza (B2)  
Bloomington, IL 61710

**CERTIFICATE**

The following term(s) meet the minimum reading ease score using the Flesch reading ease test.  
Unless indicated, each form has been scored separately.

<u>Form #</u>	<u>Flesch Reading Ease Score</u>
11080-04	56



Chris A. McNeilly, Assistant Secretary

January 15, 2011

Date



## Application for Individual Life Insurance

### 1. Type of Application *(Check one)*

- a.  New Business
- b.  Change of Plan/Added Benefits       Universal Life Increase      Existing Plan Number(s): \_\_\_\_\_  
 Term Conversion with Increase in Amount       Select Term Re-entry

### 2. Proposed Insured 1 *(Print name in full)*

<input checked="" type="checkbox"/> Mr. Last Name		First Name			Middle Initial	
a. <input type="checkbox"/> Ms. [Doe]		[John]			[J]	
b. Mailing Address		City		State	ZIP Code	
[123 Main St.]		[Bloomington]		[AR]	[61701]	
c. Social Security or Tax Identification Number		Driver's License Number		State	Sex	Birth Date (mm/dd/yyyy)
[000-00-0000]		[D000 0000 0000]		[AR]	[M]	[08/22/1975]
d. Marital Status		Height	Weight	State of Birth	United States or Canadian Citizen?	
[Married]		[5   10]	[195]	[AR]	Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
e. Occupation		Employer's Name				
[Attorney]		[Self]				
Do job duties involve work in one of the following occupation categories: amusement, sports, construction, explosives, diving, liquor, logging, mining, gas, or oil? <i>(If yes, explain exact duties.)</i>						Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

f. \_\_\_\_\_

### 3. Proposed Insured 2 *(Additional Insured or Payor, print name in full)*

<input type="checkbox"/> Mr. Last Name		First Name			Middle Initial	
a. <input type="checkbox"/> Ms.						
b. Social Security or Tax Identification Number		Driver's License Number		State	Sex	Birth Date (mm/dd/yyyy)
c. Marital Status		Height	Weight	State of Birth	United States or Canadian Citizen?	
					Yes <input type="checkbox"/> No <input type="checkbox"/>	
d. Occupation		Employer's Name				
Do job duties involve work in one of the following occupation categories: amusement, sports, construction, explosives, diving, liquor, logging, mining, gas, or oil? <i>(If yes, explain exact duties.)</i>						Yes <input type="checkbox"/> No <input type="checkbox"/>

e. \_\_\_\_\_

### 4. Applicant/Owner *(Complete 4 if not Proposed Insured 1, print name in full)*

Last Name		First Name		Middle Initial	Social Security or Tax Identification Number	
a. [Doe]		[Jane]		[A]	[000-00-0000]	
b. Mailing Address		City		State	ZIP Code	
[123 Main St.]		[Bloomington]		[AR]	[61701]	

**Successor Owner** *(Required unless the Applicant/Owner is a Trust or Corporation)*

Last Name		First Name			Middle Initial
c. [Doe]		[Jill]			[A]



**9. Universal Life / Second to Die**

a. Initial Basic Amount: \$ \_\_\_\_\_  Universal Life  Second to Die

b. Death Benefit: *(Complete for new policy only.)*  
 If no option is chosen, policy provisions determine the option.  
 Option 1 - Basic Amount  Option 2 - Basic Amount plus Account Value

c. Riders/Benefits applied for: *(Check Ratebook for availability of riders.)*  
 Waiver of Monthly Deduction (PI 1 only)  Yes  No

**Universal Life ONLY**

- Guaranteed Insurability Option \$ \_\_\_\_\_
- Children's Term Rider \_\_\_\_\_ Units
- Level Term (PI 2) \$ \_\_\_\_\_
- Accelerated Death Benefit for Long-Term Care

**Second to Die ONLY**

- Level Term (PI 1) \$ \_\_\_\_\_
- Level Term (PI 2) \$ \_\_\_\_\_
- Second to Die 4-Year Level Term

d. Dividend Option:  
 If no option is chosen, policy provisions determine the option.  
 Addition to Account Value  Cash

e. IRS Definition of life insurance test: *(only applicable to Universal Life)*  
 Cash Value Accumulation  Guideline Premium

f. Planned Premium:  
 Mode chosen:  Annual  SFPP Existing SFPP Account Number: \_\_\_\_\_  
 Other Special Monthly: \_\_\_\_\_  
 Amount to be billed each payment date: \$ \_\_\_\_\_  
 Amount of premium submitted with Application: \$ \_\_\_\_\_

g. Increase in Basic Amount for Universal Life only: *(Do not complete for new policy.)* \$ \_\_\_\_\_

**10. Beneficiary Designation - Proposed Insured 1**

Completion of this section will replace all previous rider and policy designations for this policy. If a Change of Plan or an addition in coverage, this designation will replace previous designations for this insured. If the Basic Plan is Second to Die, this designation applies only if Proposed Insured 1 is the Survivor or insured under a Level Term (PI 1) rider.

Primary Beneficiary - Full Name	Relationship
[Jane A Doe]	[Spouse]
Successor Beneficiary - Full Name	Relationship
[Jill A Doe]	[Child]

**11. Beneficiary Designation - Proposed Insured 2**

Complete for Additional Insured's rider only if the Beneficiary provision in the rider is NOT desired. If this section is completed, the Payment of Benefit provision of the policy will control rather than the Beneficiary provision of such rider. "Additional Insured" would be used in place of the "Insured". If a Change of Plan or an addition in coverage, this designation will replace previous designations for this insured. If the Basic Plan is Second to Die, this designation applies only if Proposed Insured 2 is the Survivor or insured under a Level Term (PI 2) rider.

Primary Beneficiary - Full Name	Relationship
---------------------------------	--------------

Successor Beneficiary - Full Name	Relationship
-----------------------------------	--------------

**12. Complete 12 if CTR applied for.** *List children under age 18 (if none, so state)*

Last Name, First Name, MI <i>(If last name different, explain.)</i>	Relationship to Proposed Insured 1	Birth Date			Amount Now Insured For
		Month	Day	Year	
					\$

**Complete 13-15 if CTR applied for OR Proposed Insured 1 is under age 16.**

**13.** In the last 10 years, has Proposed Insured 1 or any children named in question 12, been diagnosed, treated, or been given advice by a member of the medical profession for: *(If yes, check all that apply and explain.)* Yes  No

- |   |  |  |
|---|--|--|
| <b>a.</b> <input type="checkbox"/> birth defect   | <b>e.</b> <input type="checkbox"/> mental disorder | <b>i.</b> <input type="checkbox"/> impairment of sight, hearing, or speech |
| <b>b.</b> <input type="checkbox"/> asthma         | <b>f.</b> <input type="checkbox"/> seizure         | <b>j.</b> <input type="checkbox"/> diabetes                                |
| <b>c.</b> <input type="checkbox"/> kidney disease | <b>g.</b> <input type="checkbox"/> heart murmur    | <b>k.</b> <input type="checkbox"/> anemia                                  |
| <b>d.</b> <input type="checkbox"/> leukemia       | <b>h.</b> <input type="checkbox"/> cancer          |  |

**14.** Has Proposed Insured 1 or any children named in question 12, ever been diagnosed by a member of the medical profession or tested positive for Human Immunodeficiency Virus (AIDS virus) or Acquired Immune Deficiency Syndrome (AIDS)? *(If yes, explain.)* Yes  No

**15.** In the last 3 years, has Proposed Insured 1 or any children named in question 12, seen a doctor for any reason not previously explained excluding any routine physical examination with normal findings? *(If yes, explain.)*

**16. Complete for all Applications**

Proposed Insured 1 or Applicant, if other than Proposed Insured 1: Yes No

a. Do you own any life insurance or annuities on yourself or others? [   ]

b. If yes, is this policy a replacement of any of those policies? [   ]

c. What is the total amount of life insurance in force on you from all companies (excluding group insurance)?

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

d. Is anyone now applying for life or health insurance on you with any other company? [   ] PI 1 PI 2

	Yes	No	Yes	No
[ <input type="radio"/> <input checked="" type="radio"/> ]	[ <input type="radio"/> <input checked="" type="radio"/> ]	[ <input type="radio"/> <input checked="" type="radio"/> ]	[ <input type="radio"/> <input type="radio"/> ]	[ <input type="radio"/> <input type="radio"/> ]

*(If yes, in Explanations state company and amounts.)*

**Applications (Ages 16 & up): Complete 17-22**

	PI 1		PI 2											
	Yes	No	Yes	No										
17. Have you used tobacco or other nicotine products in any form in the last 36 months? <i>(If yes, please provide month/year last used: PI 1 _____ / _____ PI 2 _____ / _____)</i> <span style="margin-left: 100px;"><small>Month Year Month Year</small></span>	[ <input type="radio"/> <input checked="" type="radio"/> ]	[ <input type="radio"/> <input type="radio"/> ]	[ <input type="radio"/> <input type="radio"/> ]	[ <input type="radio"/> <input type="radio"/> ]										
18. In the last 10 years, have you been diagnosed, treated, or been given advice by a member of the medical profession for: <i>(If yes, explain.)</i> <i>(Check all that apply)</i>	[ <input type="radio"/> <input checked="" type="radio"/> ]	[ <input type="radio"/> <input type="radio"/> ]	[ <input type="radio"/> <input type="radio"/> ]	[ <input type="radio"/> <input type="radio"/> ]										
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<table style="width: 100%; border: none;"> <tr> <td style="width: 50%; text-align: center;"><b>PI 1</b></td> <td style="width: 50%; text-align: center;"><b>PI 2</b></td> </tr> <tr> <td style="border: none;">a. <input type="checkbox"/> <input type="checkbox"/> cancer or tumor</td> <td style="border: none;">c. <input type="checkbox"/> <input type="checkbox"/> heart disease or disorder, chest pain, high blood pressure</td> </tr> <tr> <td style="border: none;">b. <input type="checkbox"/> <input type="checkbox"/> diabetes</td> <td style="border: none;">d. <input type="checkbox"/> <input type="checkbox"/> stroke or transient ischemic attack (TIA)</td> </tr> </table>	<b>PI 1</b>	<b>PI 2</b>	a. <input type="checkbox"/> <input type="checkbox"/> cancer or tumor	c. <input type="checkbox"/> <input type="checkbox"/> heart disease or disorder, chest pain, high blood pressure	b. <input type="checkbox"/> <input type="checkbox"/> diabetes	d. <input type="checkbox"/> <input type="checkbox"/> stroke or transient ischemic attack (TIA)	<table style="width: 100%; border: none;"> <tr> <td style="width: 50%; text-align: center;"><b>PI 1</b></td> <td style="width: 50%; text-align: center;"><b>PI 2</b></td> </tr> </table>	<b>PI 1</b>	<b>PI 2</b>					
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b. <input type="checkbox"/> <input type="checkbox"/> diabetes	d. <input type="checkbox"/> <input type="checkbox"/> stroke or transient ischemic attack (TIA)													
<b>PI 1</b>	<b>PI 2</b>													
19. Have you ever been diagnosed by a member of the medical profession or tested positive for Human Immunodeficiency Virus (AIDS virus) or Acquired Immune Deficiency Syndrome (AIDS)? <i>(If yes, explain.)</i>	[ <input type="radio"/> <input checked="" type="radio"/> ]	[ <input type="radio"/> <input type="radio"/> ]	[ <input type="radio"/> <input type="radio"/> ]	[ <input type="radio"/> <input type="radio"/> ]										
20. In the last 5 years, have you for any reason not previously explained: <i>(If yes, explain.)</i>	[ <input type="radio"/> <input checked="" type="radio"/> ]	[ <input type="radio"/> <input type="radio"/> ]	[ <input type="radio"/> <input type="radio"/> ]	[ <input type="radio"/> <input type="radio"/> ]										
a. seen a doctor or psychologist?	[ <input type="radio"/> <input checked="" type="radio"/> ]	[ <input type="radio"/> <input type="radio"/> ]	[ <input type="radio"/> <input type="radio"/> ]	[ <input type="radio"/> <input type="radio"/> ]										
b. had medication prescribed <b>other than</b> medications for cold, flu, seasonal allergies (i.e. hay fever), or birth control? <i>(If yes, list and explain.)</i>	[ <input type="radio"/> <input checked="" type="radio"/> ]	[ <input type="radio"/> <input type="radio"/> ]	[ <input type="radio"/> <input type="radio"/> ]	[ <input type="radio"/> <input type="radio"/> ]										
c. had or been advised by a member of the medical profession to have treatment or a test (except for Human Immunodeficiency Virus) in any lab, clinic, or hospital?	[ <input type="radio"/> <input checked="" type="radio"/> ]	[ <input type="radio"/> <input type="radio"/> ]	[ <input type="radio"/> <input type="radio"/> ]	[ <input type="radio"/> <input type="radio"/> ]										
d. been told by a member of the medical profession surgery was necessary?	[ <input type="radio"/> <input checked="" type="radio"/> ]	[ <input type="radio"/> <input type="radio"/> ]	[ <input type="radio"/> <input type="radio"/> ]	[ <input type="radio"/> <input type="radio"/> ]										
21. In the last 3 years, have you: <i>(If yes, explain.)</i>	[ <input type="radio"/> <input checked="" type="radio"/> ]	[ <input type="radio"/> <input type="radio"/> ]	[ <input type="radio"/> <input type="radio"/> ]	[ <input type="radio"/> <input type="radio"/> ]										
a. been convicted of or pleaded guilty to any felony or any moving violations or driving under the influence of alcohol or drugs?	[ <input type="radio"/> <input checked="" type="radio"/> ]	[ <input type="radio"/> <input type="radio"/> ]	[ <input type="radio"/> <input type="radio"/> ]	[ <input type="radio"/> <input type="radio"/> ]										
b. engaged in any type of aviation activity (other than as a passenger); or is any such activity planned in the next 6 months?	[ <input type="radio"/> <input checked="" type="radio"/> ]	[ <input type="radio"/> <input type="radio"/> ]	[ <input type="radio"/> <input type="radio"/> ]	[ <input type="radio"/> <input type="radio"/> ]										
c. engaged in avocations such as mountain/rock climbing, vehicle racing, SCUBA/skin diving, sky diving, ballooning, or hang gliding; or is any such activity planned in the next 6 months?	[ <input type="radio"/> <input checked="" type="radio"/> ]	[ <input type="radio"/> <input type="radio"/> ]	[ <input type="radio"/> <input type="radio"/> ]	[ <input type="radio"/> <input type="radio"/> ]										
22. Do you plan to leave or travel from the United States or Canada in the next 6 months? <i>(If yes, explain.)</i>	[ <input type="radio"/> <input checked="" type="radio"/> ]	[ <input type="radio"/> <input type="radio"/> ]	[ <input type="radio"/> <input type="radio"/> ]	[ <input type="radio"/> <input type="radio"/> ]										

**23. Applications (Ages 16 and up): Complete 23**

Proposed Insured 1 or Applicant, if other than Proposed Insured 1:

- a. Have you entered into or made any plans to enter into any agreement or contract to sell or assign the ownership of, or a beneficial interest in the policy you are applying for? *(If yes, explain.)* [  Yes  No ]
- b. Have you received or do you anticipate receiving any type of inducement, fee, or compensation as an incentive to purchase the policy you are applying for? *(If yes, explain.)* [  Yes  No ]
- c. Have you ever received any inducement, fee or compensation as an incentive to purchase, sell, transfer or assign a life insurance or annuity policy? *(If yes, explain.)* [  Yes  No ]
- d. Have you ever sold, transferred or assigned any life insurance or annuity policy to a third party, such as a viatical settlement entity, life settlement entity, insurance company, other secondary market provider, or premium financing entity? *(If yes, explain.)* [  Yes  No ]

**Applications (Ages 16 & up if NO medical exam is required): Complete 24-26**

- |   |   | PI 1  |                       | PI 2                             |                       |                                  |                       |  |                       |                       |
|---|---|---|-----------------------|----------------------------------|-----------------------|----------------------------------|-----------------------|--|-----------------------|-----------------------|
|   |   | Yes   | No                    | Yes                              | No                    |                                  |                       |  |                       |                       |
| <p><b>24.</b> In the last 10 years, have you for any reason not previously explained, been diagnosed, treated, or been given advice by a member of the medical profession for: <i>(If yes, explain.)</i></p> <p><i>(Check all that apply)</i></p> <table border="0" style="width: 100%;"> <tr> <td style="width: 50%; vertical-align: top;"> <p><b>PI 1</b>    <b>PI 2</b></p> <p>a. <input type="checkbox"/> <input type="checkbox"/> respiratory disorder</p> <p>b. <input type="checkbox"/> <input type="checkbox"/> liver or intestinal disorder</p> </td> <td style="width: 50%; vertical-align: top;"> <p><b>PI 1</b>    <b>PI 2</b></p> <p>c. <input type="checkbox"/> <input type="checkbox"/> mental or nervous disorder</p> <p>d. <input type="checkbox"/> <input type="checkbox"/> blood disorder</p> </td> </tr> </table> | <p><b>PI 1</b>    <b>PI 2</b></p> <p>a. <input type="checkbox"/> <input type="checkbox"/> respiratory disorder</p> <p>b. <input type="checkbox"/> <input type="checkbox"/> liver or intestinal disorder</p> | <p><b>PI 1</b>    <b>PI 2</b></p> <p>c. <input type="checkbox"/> <input type="checkbox"/> mental or nervous disorder</p> <p>d. <input type="checkbox"/> <input type="checkbox"/> blood disorder</p> |                       | [                                | <input type="radio"/> | <input checked="" type="radio"/> | ]                     |  | <input type="radio"/> | <input type="radio"/> |
| <p><b>PI 1</b>    <b>PI 2</b></p> <p>a. <input type="checkbox"/> <input type="checkbox"/> respiratory disorder</p> <p>b. <input type="checkbox"/> <input type="checkbox"/> liver or intestinal disorder</p>   | <p><b>PI 1</b>    <b>PI 2</b></p> <p>c. <input type="checkbox"/> <input type="checkbox"/> mental or nervous disorder</p> <p>d. <input type="checkbox"/> <input type="checkbox"/> blood disorder</p>         |   |                       |                                  |                       |                                  |                       |  |                       |                       |
| <p><b>25.</b> In the last 5 years, have you applied for or received disability benefits; had an injury to your neck, back, arm, or leg; or had any loss of sight or hearing? <i>(If yes, explain.)</i></p>  |   | [   | <input type="radio"/> | <input checked="" type="radio"/> | ]                     | <input type="radio"/>            | <input type="radio"/> |  |                       |                       |
| <p><b>26.</b> In the last 5 years, have you used cocaine, marijuana, methamphetamine, or any other controlled substance or narcotic not prescribed by a member of the medical profession; had medical treatment or counseling for use of alcohol or prescribed or non-prescribed drugs; or been advised by a member of the medical profession to discontinue use of alcohol or prescribed or non-prescribed drugs? <i>(If yes, explain.)</i></p>  |   | [   | <input type="radio"/> | <input checked="" type="radio"/> | ]                     | <input type="radio"/>            | <input type="radio"/> |  |                       |                       |

**27. Explanations:**

*If space below is insufficient, use additional sheets which will be part of this application. Sheets must be signed and dated by Proposed Insured(s), and/or Applicant, and witnessed by Agent.*

**28. Agreements**

Coverage will be effective as of the Policy Date if the following conditions are met: the first premium is paid when this policy is delivered; the Proposed Insureds are living on the delivery date; and, on that delivery date, the information given to the Company is true and complete to the best of the Proposed Insureds' and Applicant's knowledge and belief.

For changes in Basic Amount for a Universal Life Policy, the change will be effective on the Deduction Date on or next following acceptance of the change by the Company if on such Deduction Date the following conditions are met: there is enough Cash Surrender Value to make the required monthly deduction; the Proposed Insureds are all living; and the information given to the Company is true and complete to the best of the Proposed Insureds' and Applicant's knowledge and belief.

However, if a binding receipt has been given and is in effect, its terms apply.

All Proposed Insureds and the Applicant state that the information in this Application and any medical history is true and complete to the best of their knowledge and belief. Information is not true and complete to the best of their knowledge and belief if it misrepresents or omits a fact which a Proposed Insured or the Applicant knew or should have known, regardless whether the misrepresentation or omission was intentional. It is agreed that the Company can investigate the truth and completeness of such information while this policy is contestable.

By accepting this Policy, the Owner agrees to the beneficiaries named and corrections made. No change in plan, amount, benefits, or age at issue may be made on the Application unless the Owner agrees in writing. Only an authorized company officer may change the policy provisions. Neither the agent nor a medical examiner may pass on insurability.

Any policy issued on this Application will be owned by Proposed Insured 1 or the Applicant, if other than Proposed Insured 1.

NOTICE: Insurance laws may prohibit the owner of a life insurance policy from entering into any agreement to sell, transfer or assign a life insurance policy prior to the date the policy was issued, or within a period of time specified by state law after the date the policy was issued. The Owner should consult with legal advisors for any questions about these matters.

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.

**Social Security or Tax Identification Number (TIN) Certification**

By signing this application, I certify under penalties of perjury that (1) the TIN shown above is correct, and (2) I am exempt from backup withholding, or that I am not subject to backup withholding either because I have not been notified that I am subject to backup withholding as a result of a failure to report all interest or dividends, or the Internal Revenue Service has notified me that I am no longer subject to backup withholding, (If you are subject to backup withholding, cross out item 2.) and (3) I am a U.S. person (Including a U.S. resident alien).

The Internal Revenue Service does not require your consent to any provision of this document other than the certifications required to avoid backup withholding. (See instructions.)

Date Signed [June 18, 2011]

Signature of Proposed Insured 1 X [John Doe]

Not required if Proposed Insured is under age 16.

at [Bloomington, AR]  
City State

Signature of Proposed Insured 2 X \_\_\_\_\_

SAMPLE

Signature of Agent as Witness to all Signatures X [Mark Smith]

Signature of Applicant X [Jane A. Doe]

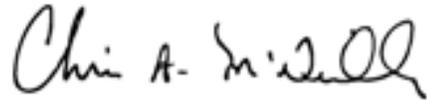
Not required unless applicant is other than Proposed Insured 1. If a firm or corporation is to be the owner, give its name and signature of authorized officer.

**STATE OF ARKANSAS**

**CERTIFICATION**

This is to certify that the forms contained in this submission are in compliance with Arkansas Regulation No. 19:

Form # 11080-04



---

Chris A. McNeilly  
Assistant Secretary

---

January 3, 2011

Date

# State Farm Insurance Companies



New Albany Operations Center  
5400 New Albany Road East  
New Albany, OH 43054

Date

Mr. John Smith  
Street Address  
City, State, Zip Code

Re: Policy No.  
Claim No.  
Insured

Dear Mr. Smith:

Thank you for notifying us of the claim against this policy.

(Variable information)

Arkansas Law requires us to pay 8% interest per year on policy proceeds and refund of premiums if payment is not made within 30 days after our receipt of proof of the insured's death. Such interest accrues from date of death to date of payment.

(Variable information)

Sincerely,

CERTIFICATE OF COMPLIANCE

Sections 6 and 7 of Rule and Regulation 34 have been reviewed and Form 11080 is in compliance. In every case reserves will be greater than or equal to the actual cash surrender values provided for under Form 11080. The reserves will be greater than or equal to the minimum reserves calculated under Regulation 34.

State Farm Life Insurance Company  
Company Name

*Sheila A. Melzer*

Sheila A. Melzer, F.S.A., M.A.A.A.

Actuarial Director II

Title

January 20, 2011

Date

STATE FARM LIFE INSURANCE COMPANY

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

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

**DISCLAIMER**

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

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

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

Arkansas Life and Health Insurance Guaranty Association  
C/o The Liquidation Division  
1023 West Capitol  
Little Rock, Arkansas 72201

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

**SUMMARY**

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

**Coverage**

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

(Please see reverse side.)

## Exclusions from Coverage

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

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

The Guaranty Association also does NOT provide coverage for:

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

## Limits on Amount of Coverage

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

EXHIBIT A (REVISED)

CONSENT TO SUBMIT RATES  
AND/OR COST BASES FOR APPROVAL

The State Farm Life Insurance Company of  
(Company Name)

Bloomington, Illinois does hereby consent  
(City and State)

and agree

A) that all premium rates and/or cost bases both "maximum" and "current or projected", used in relation to policy form number 11080-04 must be filed with the Insurance Commissioner for the State of Arkansas ("Commissioner") at least sixty (60) days prior to their proposed effective date. Such rates and/or cost bases shall be deemed effective sixty (60) days after they are filed with the Commissioner, unless the Commissioner shall approve or disapprove such rates and/or cost bases prior to the expiration of sixty (60) days.

or

B) that where the policy is a flexible or indeterminate premium whole life policy which provides for frequent changes in interest rates based on financial market conditions, the company may file a range of rates it will stay within and will notify the Department at least sixty (60) days prior to any change in the range of rates. The company must also document the method used to calculate its premium and range of rates.

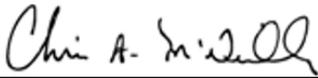
State Farm Life Insurance Company  
(Company)

By: Chris A. McNeilly  
Chris A. McNeilly  
Assistant Secretary

CERTIFICATE OF COMPLIANCE

State Farm Life Insurance Company certifies that we have reviewed the guidelines in Bulletin No. 11-83 and Form 11080-04 complies with these guidelines. The consent form required by Bulletin No. 11-83 is attached.

State Farm Life Insurance Company  
Company Name



\_\_\_\_\_  
Chris A. McNeilly

Assistant Secretary

\_\_\_\_\_  
Title

Date: January 18, 2011