

SERFF Tracking Number: AOIC-126829993 State: Arkansas
 Filing Company: Auto-Owners Life Insurance Company State Tracking Number: 48630
 Company Tracking Number:
 TOI: H111 Individual Health - Disability Income Sub-TOI: H111.003 Long Term - Unrelated to marketing
 with employer or association groups
 Product Name: Disability Income
 Project Name/Number: /

Filing at a Glance

Company: Auto-Owners Life Insurance Company

Product Name: Disability Income

SERFF Tr Num: AOIC-126829993 State: Arkansas

TOI: H111 Individual Health - Disability Income

SERFF Status: Closed-Approved-
Closed State Tr Num: 48630

Sub-TOI: H111.003 Long Term - Unrelated to
marketing with employer or association groups

Co Tr Num: State Status: Approved-Closed

Filing Type: Form/Rate

Reviewer(s): Rosalind Minor

Authors: Christie Janell, Veronica
Thelen, Julia Karn

Disposition Date: 05/03/2011

Date Submitted: 04/29/2011

Disposition Status: Approved-
Closed

Implementation Date Requested: On Approval

Implementation Date:

State Filing Description:

General Information

Project Name:

Status of Filing in Domicile: Authorized

Project Number:

Date Approved in Domicile: 11/04/2010

Requested Filing Mode: Review & Approval

Domicile Status Comments: This product has
been reviewed and approved by Michigan, our
state of domicile.

Explanation for Combination/Other:

Market Type: Individual

Submission Type: New Submission

Individual Market Type:

Overall Rate Impact:

Filing Status Changed: 05/03/2011

State Status Changed: 05/03/2011

Deemer Date:

Created By: Veronica Thelen

Submitted By: Julia Karn

Corresponding Filing Tracking Number:

Filing Description:

Auto-Owners Life Insurance Company of Lansing, Michigan submits our new Individual Disability Income Protection Insurance policy, form 61739 (5-10) et al, along with the applicable riders, for your review and approval. We are submitting forms in a John Doe format.

This product includes the following features:

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TOTAL DISABILITY BENEFIT- This Total Monthly Disability Benefit will be paid during a period of Total Disability for any covered Injury or Sickness after any Elimination Period selected.

PARTIAL DISABILITY BENEFIT - If the insured is Partially Disabled due to the Injury or Sickness that caused their Total Disability, immediately after they receive benefit(s) for Total Disability, then a Monthly Benefit amount of one half the Total Monthly Disability Benefit will be paid. Benefits will be paid for up to 6 months, but not after the date on which the number of Total Disability and Partial Disability benefits paid equals the number of months in the Maximum Benefit Period.

TRANSPLANT BENEFIT - If the insured donates one of their organs, or bone marrow, or other body part that can be transplanted, for transfer to another person, then the physical condition that results from the transfer will be deemed a Sickness. If the insured becomes Totally Disabled as a result, then Total Disability Benefits will be payable as for any other Disability. The policy must have been in force for at least 6 months before the donation, for benefits to be payable for this reason.

PREMIUM WAIVER BENEFIT - After the insured has been Disabled for 90 days in a row, we will waive the payment of premiums that become due for the policy and any riders attached to it. We will continue to waive them as long as their Disability continues. All premiums paid that were due during that 90 day period will be returned to the insured. When the insured is no longer Disabled, this waiver of premium ends, and premium payments must resume as of the next premium due date to continue coverage under the policy and its riders.

The following forms are all new and are listed below:

Form 61739 (5-10) - Individual Disability Income Protection Insurance policy - This coverage is designed to provide, to persons insured, coverage for disabilities resulting from a covered injury or sickness. Benefits are subject to any limitations set forth in the policy.

Form 61746 (5-10) - Cost of Living Increase Rider - This rider provides an increase in monthly benefits for Disability under the policy after the insured has been disabled for 12 months in a row. While the insured remains Disabled, the benefit amount is increased each year by 3% compounded annually, until the benefit doubles.

Form 61745 (5-10) - Business Overhead Expense Rider - This rider provides coverage for defined expenses for business owners in the event of a covered Injury or Sickness that results in Total Disability.

Form 61729 (4-10) - Business Owner Return-To-Work Rider - This rider provides a limited extension of your Total

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Disability Benefits, if you recover for your Total Disability before benefits are paid for the Maximum Benefit Period.

Form 61732 (5-10) - Coordinating Additional Insurance Rider - This rider provides an additional Monthly Benefit Amount for your Total Disability or Partial Disability less any amount received from other benefit programs such as Social Security Disability benefits, Worker's Compensation disability benefits, and Federal, state or local retirement and disability fund benefits.

Form 61744 (5-10) - First Day Hospital Confined Rider - This rider provides for payment of Total Disability Benefit amounts, during the Elimination Period, if you are Confined in a Hospital due to your Total Disability.

Form 61728 (4-10) - Guaranteed Insurability Rider - This rider allows you to increase your Total Disability Benefit amount prior to your 58th birthday. Your health status will not be considered, other than proof that you are not disabled.

Form 61748 (5-10) - Own Occupation Five Year Rider - This rider lengthens the time period described in the policy definition of Own Occupation Period. This time period is increased from 24 months to 60 months.

Form 61749 (5-10) - Own Occupation To Age 67 Rider - This rider lengthens the time period described in the policy definition of Own Occupation Period. This time period is increased, from 24 months, to the number of months from the completion of the Elimination Period to the date you attain age 67.

Form 61747 (5-10) - Residual Disability Rider - This rider provides a monthly benefit if you return to your Regular Occupation while Residually Disabled.

Form 61743 (5-10) - Spousal Catastrophic Disability Rider - This rider provides a monthly benefit to you if your Spouse suffers a Catastrophic Disability while this rider is in force.

Form 61762 (9-10)-Business Overhead Expense Rider Addendum – This form is an addendum to the Joint Life and/or Disability and APP-CELERATOR® applications when the applicant chooses the Business Overhead Expense Rider. This addendum gathers information about the business for underwriting purposes.

Form 61781 (9-10)-Spousal Catastrophic Disability Rider Addendum – This form is an addendum to the Joint Life and/or Disability and APP-CELERATOR® applications when the applicant chooses the Spousal Catastrophic Disability Rider. This addendum gathers underwriting information on the applicant's spouse for catastrophic disability only.

Form 61763 (9-10)-Outline of Coverage - This form outlines of the Disability Income Protection Coverage applied for and issued to the applicant. It gives the applicant a summary of the benefits, including limitations and exclusions as well as the amount being charged per payment mode. The Outline of Coverage is issued at time of application and again

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with policy issue if the policy is issued other than originally applied for.

Form 1003 (3-11) Paramed - This form is completed by a Medical Examiner when a medical exam is ordered for the applicant during the underwriting process.

The following forms were previously approved by your state and are being replaced:

Forms 1002 (1-08), 61446 (1-08) and 61447 (1-08) were approved on 9/10/2008 with a SERFF tracking number of AOIC-125575189. The changes to the above mentioned applications were made to incorporate new sections and questions to underwrite the new Disability Income product being filed. No Flesch score was added to the APP-CELERATOR® Addendum because our teleunderwriters read this form to the applicant and allow the applicant to ask clarifying questions.

Form 1002 (9-10) Joint Life and/or Disability Application replaces Form 1002 (1-08) Joint Life Application. It is the application we use when there is more than one applicant such as a spouse or children.

Form 61011 (9-10) APP-CELERATOR® Application replaces form 61446 (1-08) APP-CELERATOR® Application and form 61447 (9-10) APP-CELERATOR® Addendum replaces form 61447 (1-08) APP-CELERATOR® Addendum. The APP-CELERATOR® is not used the same as our Joint application. The agent and the applicant complete this form which includes just five health questions. The agent and applicant sign the APP-CELERATOR®, then the agent faxes the application to ExamOne, an independent lab. Shortly after the application is received, an experienced professional from ExamOne contacts the applicant via telephone and asks the applicant the questions listed on form 61447 (9-10) APP-CELERATOR® Addendum. The ExamOne professional receives a Voice Signature from the applicant on form 61447 (9-10). When Voice Signature is used, the Addendum, (a hard copy) will print out with the answers given by the applicant along with a comment on the signature line that a voice signature is on file. A hard copy of the Addendum form will be attached to the application and policy contract, if issued. (Note: Voice Signature is only used for questionnaire-type forms after the applicant completes and submits the APP-CELERATOR® Application which does not use Voice Signature).

Form 10246 (4-11) Statement of Insurability replaces 10246 (2-05), which is used for policy reinstatement. 10246 (2-05) was approved by the Arkansas Insurance Department on 7/12/2005 with a tracking number of: LIF-AR-02-06232005-01.

The target market for this product are individuals, ages 18 through 60. The policy is guaranteed renewable to age 67.

We use the direct sales approach by agents to market our product.

We use a percentage of the standard rate for special rating. This can range from 1.25% to 2.00% of the standard rating.

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Attached you will find a copy of our Aviation Exclusion Provision, form 1059 (6-85) that can be attached to this policy when the insured is a pilot, an officer or member of a flight crew, or is being flown for the purpose of descending from an aircraft.

Our products are marketed with an illustration.

The attached forms are submitted in final printed format and are subject only to minor modifications, such as company address, logo and phone number, typographical errors, paper stock, ink, and adaptation to computer printing.

Company and Contact

Filing Contact Information

Veronica Thelen, Methods and Procedure Specialist
 P.O. Box 30325
 Lansing, MI 48909
 thelen.veronica@aoins.com
 517-886-8531 [Phone]

Filing Company Information

Auto-Owners Life Insurance Company
 P.O. Box 30325
 Lansing, MI 48917
 CoCode: 61190
 Group Code: 280
 Group Name: Auto-Owners Ins Group
 State of Domicile: Michigan
 Company Type: LAH
 State ID Number:
 (800) 346-0346 ext. [Phone]
 FEIN Number: 38-1814333

Filing Fees

Fee Required? No
 Retaliatory? No
 Fee Explanation:
 Per Company: No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Auto-Owners Life Insurance Company	\$0.00	04/29/2011	
Auto-Owners Life Insurance Company	\$1,000.00	05/02/2011	47152722

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Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Rosalind Minor	05/03/2011	05/03/2011

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	Rosalind Minor	05/02/2011	05/02/2011	Julia Karn	05/02/2011	05/02/2011

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Disposition

Disposition Date: 05/03/2011

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	Approved-Closed	Yes
Supporting Document	Application	Approved-Closed	Yes
Supporting Document	Health - Actuarial Justification	Approved-Closed	No
Supporting Document	Outline of Coverage	Approved-Closed	Yes
Supporting Document	Statement of Variability	Approved-Closed	Yes
Form	Policy Front Jacket	Approved-Closed	Yes
Form	Data Page	Approved-Closed	Yes
Form	Policy Pages	Approved-Closed	Yes
Form	First Day Hospital Confined Rider	Approved-Closed	Yes
Form	Cost of Living Increase Rider	Approved-Closed	Yes
Form	Own Occupation Five Year Rider	Approved-Closed	Yes
Form	Business Owner Return-To-Work Rider	Approved-Closed	Yes
Form	Business Overhead Expense Rider	Approved-Closed	Yes
Form	Coordinating Additional Insurance Rider	Approved-Closed	Yes
Form	Guaranteed Insurability Rider	Approved-Closed	Yes
Form	Spousal Catastrophic Disability Rider	Approved-Closed	Yes
Form	Residual Disability Rider	Approved-Closed	Yes
Form	Own Occupation to Age 67 Rider	Approved-Closed	Yes
Form	Business Owner Expense Rider	Approved-Closed	Yes
Form	Addendum		
Form	Spousal Catastrophic Disability Rider	Approved-Closed	Yes
Form	Addendum		
Form	Policy Back Jacket	Approved-Closed	Yes
Form	Outline of Coverage	Approved-Closed	Yes
Form	Aviation Exclusion Provision	Approved-Closed	Yes
Form	Paramed	Approved-Closed	Yes
Form	Statement of Insurability	Approved-Closed	Yes
Rate	Rate Manual	Approved-Closed	Yes

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Objection Letter

Objection Letter Status Pending Industry Response
Objection Letter Date 05/02/2011
Submitted Date 05/02/2011

Respond By Date

Dear Veronica Thelen,

This will acknowledge receipt of the captioned filing.

Objection 1

- Policy Front Jacket, 61739 (5-10) (Form)
- Data Page, 61737 (5-10) (Form)
- Policy Pages, 61740 (5-10) (Form)
- First Day Hospital Confined Rider, 61744 (5-10) (Form)
- Cost of Living Increase Rider, 61746 (5-10) (Form)
- Own Occupation Five Year Rider, 61748 (5-10) (Form)
- Business Owner Return-To-Work Rider, 61729 (4-10) (Form)
- Business Overhead Expense Rider, 61745 (5-10) (Form)
- Coordinating Additional Insurance Rider, 61732 (5-10) (Form)
- Guaranteed Insurability Rider, 61728 (4-10) (Form)
- Spousal Catastrophic Disability Rider, 61743 (5-10) (Form)
- Residual Disability Rider, 61747 (5-10) (Form)
- Own Occupation to Age 67 Rider, 61749 (5-10) (Form)
- Business Owner Expense Rider Addendum, 61762 (9-10) (Form)
- Spousal Catastrophic Disability Rider Addendum, 61781 (9-10) (Form)
- Policy Back Jacket, 61711 (1-10) (Form)
- Outline of Coverage, 61763 (9-10) (Form)
- Aviation Exclusion Provision, 1059 (6-85) (Form)
- Paramed, 1003 (3-11) (Form)
- Statement of Insurability, 10246 (4-11) (Form)

Comment:

Our filing fees under Rule and Regulation 57 have been updated. Please review the General Instructions for ArkansasLH or Rule and Regulation 57.

The fee for this submission is \$50.00 per form for a total of \$1,000.00. Please submit the \$1,000.00 for this submission.

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We will begin our review of this submission upon receipt of the filing fee.

Please feel free to contact me if you have questions.

Sincerely,
Rosalind Minor

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Response Letter

Response Letter Status Submitted to State
Response Letter Date 05/02/2011
Submitted Date 05/02/2011

Dear Rosalind Minor,

Comments:

Thank you for your response.

Response 1

Comments: The Filing Fee tab has been updated to reflect the \$1000.00 fee. We apologize for the oversight.

Related Objection 1

Applies To:

- Policy Front Jacket, 61739 (5-10) (Form)
- Data Page, 61737 (5-10) (Form)
- Policy Pages, 61740 (5-10) (Form)
- First Day Hospital Confined Rider, 61744 (5-10) (Form)
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- Spousal Catastrophic Disability Rider Addendum, 61781 (9-10) (Form)
- Policy Back Jacket, 61711 (1-10) (Form)
- Outline of Coverage, 61763 (9-10) (Form)
- Aviation Exclusion Provision, 1059 (6-85) (Form)
- Paramed, 1003 (3-11) (Form)
- Statement of Insurability, 10246 (4-11) (Form)

Comment:

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We will begin our review of this submission upon receipt of the filing fee.

Changed Items:

No Supporting Documents changed.

No Form Schedule items changed.

No Rate/Rule Schedule items changed.

Please do not hesitate to contact me if you have any further questions.

Sincerely,
Christie Janell, Julia Karn, Veronica Thelen

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Form Schedule

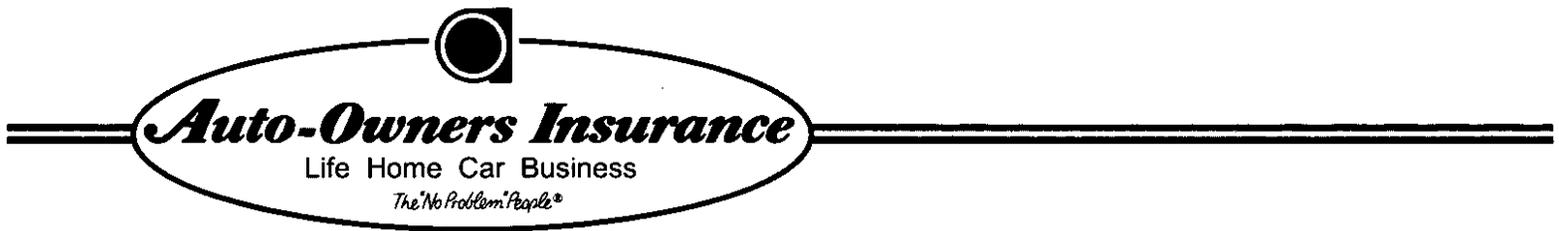
Lead Form Number:

Schedule Item	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
Approved-Closed 05/03/2011	61739 (5-10)	Policy Jacket	Policy Front Jacket	Initial		56.900	61739 (5-10) Policy Front Jacket john doe_stock.pdf
Approved-Closed 05/03/2011	61737 (5-10)	Data/Declaration Pages	Data Page	Initial		0.000	Data Page 61737 (5-10) John Doe.pdf
Approved-Closed 05/03/2011	61740 (5-10)	Policy/Contract Certificate	Policy Pages	Initial		47.800	61740 (5-10) Policy Pages base.pdf
Approved-Closed 05/03/2011	61744 (5-10)	Policy/Contract Certificate: Amendment, Insert Page, Endorsement or Rider	First Day Hospital Confined Rider	Initial		46.100	61744 First Day Hospital Confined Rider_brackets.pdf
Approved-Closed 05/03/2011	61746 (5-10)	Policy/Contract Certificate: Amendment, Insert Page, Endorsement or Rider	Cost of Living Increase Rider	Initial		51.700	61746 COLA Rider john doe.pdf
Approved-	61748 (5-	Policy/Contract	Own Occupation Five	Initial		57.100	61748 Own

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<i>TOI:</i>	H111 Individual Health - Disability Income	<i>Sub-TOI:</i>	H111.003 Long Term - Unrelated to marketing with employer or association groups
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<i>Project Name/Number:</i>	/		
Closed 10) 05/03/2011	ract/Fratern Year Rider al Certificate: Amendmen t, Insert Page, Endorseme nt or Rider		Occupation Five Year Rider_bracket s.pdf
Approved- 61729 (4- Closed 10) 05/03/2011	Policy/Cont Business Owner ract/Fratern Return-To-Work al Rider Certificate: Amendmen t, Insert Page, Endorseme nt or Rider	Initial 45.200	61729 Business Owner Return-To- Work Rider_bracket s.pdf
Approved- 61745 (5- Closed 10) 05/03/2011	Policy/Cont Business Overhead ract/Fratern Expense Rider al Certificate: Amendmen t, Insert Page, Endorseme nt or Rider	Initial 49.900	61745 Business Overhead Expense Rider_bracket s.pdf
Approved- 61732 (5- Closed 10) 05/03/2011	Policy/Cont Coordinating ract/Fratern Additional Insurance al Rider Certificate: Amendmen t, Insert Page, Endorseme nt or Rider	Initial 47.200	61732 (5-10) Coordinating Additional Insurance Rider_bracket s.pdf
Approved- 61728 (4- Closed 10)	Policy/Cont Guaranteed ract/Fratern Insurability Rider	Initial 49.200	61728 (4-10) Guaranteed

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<i>Project Name/Number:</i>	/		
05/03/2011	al Certificate: Amendmen t, Insert Page, Endorseme nt or Rider		Insurability Rider_bracket s.pdf
Approved- 61743 (5- Closed 10) 05/03/2011	Policy/Cont Spousal Catastrophic Initial ract/Fratern Disability Rider al Certificate: Amendmen t, Insert Page, Endorseme nt or Rider	44.600	61743 Spousal Catastrophic Disability Rider_bracket s.pdf
Approved- 61747 (5- Closed 10) 05/03/2011	Policy/Cont Residual Disability Initial ract/Fratern Rider al Certificate: Amendmen t, Insert Page, Endorseme nt or Rider	56.900	61747 (5-10) Residual Disability Rider_bracket s.pdf
Approved- 61749 (5- Closed 10) 05/03/2011	Policy/Cont Own Occupation to Initial ract/Fratern Age 67 Rider al Certificate: Amendmen t, Insert Page, Endorseme nt or Rider	56.100	61749 (5-10) Own Occupation to Age 67 Rider_bracket s.pdf
Approved- 61762 (9- Closed 10) 05/03/2011	Application/ Business Owner Initial Enrollment Expense Rider Form Addendum	50.600	61762 BOE Addendum john doe.pdf

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Product Name:	Disability Income		
Project Name/Number:	/		
Approved- Closed 05/03/2011	61781 (9-10) Application/ Spousal Catastrophic Enrollment Disability Rider Form Addendum	Initial	52.900 61781 Spousal Addendum john doe.pdf
Approved- Closed 05/03/2011	61711 (1-10) Policy Jacket Policy Back Jacket Jacket	Initial	0.000 61711 (1-10) Back Jacket_stock.pdf
Approved- Closed 05/03/2011	61763 (9-10) Outline of Coverage Outline of Coverage Coverage	Initial	60.800 61763 (9-10) Outline of Coverage john doe.pdf
Approved- Closed 05/03/2011	1059 (6-85) Policy/Cont ract/Fraternal Certificate: Amendment, Insert Page, Endorsement or Rider	Initial	58.000 1059 (6-85) Aviation Exclusion Provision.pdf
Approved- Closed 05/03/2011	1003 (3-11) Policy/Cont ract/Fraternal Certificate: Amendment, Insert Page, Endorsement or Rider	Initial	1003 (3-11) Paramed.pdf
Approved- Closed 05/03/2011	10246 (4-11) Application/ Enrollment Form Statement of Insurability	Revised	Replaced Form #: 52.400 10246 (2-05) Previous Filing #: LIFE-AR-02-06232005-01 10246 (4-11) Statement of Insurability.pdf



Auto-Owners Insurance

Life Home Car Business

The "No Problem" People®

Insured: [JOHN DOE]
Number: [## ##### #]
Plan: DISABILITY INCOME

OUR PROMISE

We, Auto-Owners Life Insurance Company, agree to insure You for the benefits described in this Policy, subject to its provisions.

LEGAL CONTRACT

READ THIS POLICY CAREFULLY. This is a legal contract between You and Us. This Policy is issued in consideration of the statements made in the application and payment of the first premium as shown in the Policy Data page. A copy of the application is attached to this Policy and will be deemed to be a part of this Policy. A guide to the Policy's contents is on page 2.

RIGHT TO CHANGE PREMIUMS

We have the right to change the premium rates for all insured persons in the same class as this Policy. If We change the premium rates in this Policy, the change will take effect on the anniversary of the Policy Date that next follows the change in class premium rates. The Policy Date is shown in the Policy Data page.

IMPORTANT NOTICE ABOUT STATEMENTS IN THE APPLICATION

Please read the application attached to this Policy. Omissions and misstatements in the application could cause an otherwise valid claim to be denied or cause the Policy to be void. If any information in the application is not correct, notify Us immediately.

RIGHT TO CANCEL

If for any reason You decide not to keep this Policy, send it to Us within 30 days after receiving it. You can return this Policy to Us or the agent who sold You this Policy. We will treat the Policy as though it had never been issued. We will promptly refund any premium paid.

Signed for Auto-Owners Life Insurance Company at Lansing, Michigan, on the Policy Date.

[*Joe Secretary*]
Secretary

[*John President*]
President

**INDIVIDUAL DISABILITY INCOME PROTECTION INSURANCE POLICY
GUARANTEED RENEWABLE TO AGE 67**

Auto-Owners Life Insurance Company

POLICY GUIDE

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Auto-Owners Life Insurance Company

(Herein Called the Company)
Lansing, Michigan 48909-8160

POLICY DATA

INSURED:	[JOHN DOE]	POLICY NUMBER:	[###-#####-#]
OWNER:	[JOHN DOE]	POLICY DATE:	[MONTH DAY, YEAR]
PLAN:	DISABILITY INCOME	PREMIUM CLASS:	[SMOKER, NON-SMOKER]
GENDER:	[MALE, FEMALE]	OCCUPATIONAL CLASS:	[AAAA, AAA, AA, A, B]
ISSUE AGE:	[18-60]	BIRTH DATE:	[MONTH DAY, YEAR]
		INITIAL PREMIUM MODE:	[ANNUAL, SEMI-ANNUAL, QUARTERLY, MONTHLY]

SCHEDULE OF BENEFITS AND PREMIUMS

<u>COVERAGE</u>	<u>BENEFIT</u>	<u>ANNUAL PREMIUM*</u>
TOTAL BASE POLICY DISABILITY BENEFIT (NON-COORDINATED)		[\$##,###.##]
TOTAL DISABILITY MONTHLY BENEFIT	[\$500.00-\$2,000.00]	
ELIMINATION PERIOD	[30, 60, 90, 180, 365] DAYS	
MAXIMUM BENEFIT PERIOD		
[2 YEARS, 5 YEARS, TO AGE 67]		
[ADDITIONAL BENEFITS**]		
[3% COST OF LIVING INCREASE RIDER		[\$##,###.##]
[BUSINESS OWNER RETURN-TO-WORK RIDER		[\$##,###.##]
[BUSINESS OVERHEAD EXPENSE RIDER		[\$##,###.##]
MAXIMUM MONTHLY BENEFIT AMOUNT:	[\$1,000.00-\$10,000.00]	
ELIMINATION PERIOD:	[30, 60, 90, 180, 365] DAYS	
MAXIMUM BENEFIT PERIOD:	[12, 18, 24] MONTHS	
[COORDINATING ADDITIONAL INSURANCE RIDER		[\$##,###.##]
MONTHLY BENEFIT AMOUNT:	[\$100.00-\$2,000.00]	
[FIRST DAY HOSPITAL CONFINED RIDER		[\$##,###.##]
[GUARANTEED INSURABILITY RIDER		[\$##,###.##]
[OWN OCCUPATION FIVE YEAR RIDER		[\$##,###.##]
[OWN OCCUPATION TO AGE 67 RIDER		[\$##,###.##]
[RESIDUAL DISABILITY RIDER		[\$##,###.##]
[SPOUSAL CATASTROPHIC DISABILITY RIDER		[\$##,###.##]
MONTHLY BENEFIT AMOUNT:	[\$250.00-\$2,000.00]	
TOTAL ANNUAL PREMIUM:		[\$##,###.##]

PREMIUM MODE OPTIONS

<u>PREMIUM MODE</u>	<u>TOTAL PREMIUM</u>
[MONTHLY:	[\$##,###.##]
[QUARTERLY:	[\$##,###.##]
[SEMI-ANNUAL:	[\$##,###.##]
[ANNUAL:	[\$##,###.##]

* PREMIUMS REMAIN LEVEL UNLESS ADJUSTED FOR ALL POLICYHOLDERS IN YOUR CLASS IN ACCORDANCE WITH THE RENEWAL PROVISIONS IN THIS POLICY.
[**SEE RIDER PROVISIONS FOR COVERAGE DETAILS.]

DEFINITIONS

As used in this Policy:

We, Us, Our or **Ours** means Auto-Owners Life Insurance Company.

You, Your or **Yours** means the Insured as shown in the Policy Data page, whose coverage under this Policy has become effective.

Actively at Work means performing the material and substantial duties of Your Regular Occupation for at least 30 hours per week, at:

- Your regular place of employment; or
- any business location to which You are required to travel.

Age means Your age on Your last birthday.

Complications of Pregnancy means any of these:

- a condition that requires a Hospital stay, in the event a pregnancy is not terminated, and whose diagnosis is distinct from but adversely affected by pregnancy or is caused by pregnancy. This does not include conditions such as, but not limited to, false labor, occasional spotting, physician prescribed rest during the pregnancy, morning sickness, or similar conditions associated with the management of a difficult pregnancy that do not constitute a classifiably distinct complication of pregnancy; or
- a non-elective Caesarean section; or
- an extra-uterine or ectopic pregnancy; or
- a spontaneous or induced termination of pregnancy during a period of gestation in which a viable birth is not possible.

Current Income means Your monthly Earned Income during a period of Disability.

Disability/Disabled means:

- Total Disability/Totally Disabled; or
- Partial Disability/Partially Disabled.

Earned Income means Your gross earnings from Your personal activity in any profession(s) or business(es). If Your vocation involves ownership of any portion of any profession or business, including any corporation, Earned Income includes Your share of the earnings of that profession or business due to that ownership. We will deduct from gross earnings any amount that is deductible as a business expense for federal income tax purposes.

Earned Income does not include:

- investment income, rent or royalties; or
- deferred compensation; or
- retirement income; or
- other disability income benefits in force or applied for.

Elimination Period means the number of days You must be Totally Disabled before benefits become payable for any Total Disability. Unless stated elsewhere in this Policy, no benefits are payable until the Elimination Period is satisfied.

Days of Total Disability used to satisfy the Elimination Period need not be consecutive. However, You must accrue the Elimination Period days during a period that starts on the first day of Total Disability, and ends no later than 31 days following the end of the number of consecutive days of the Elimination Period. The Elimination Period is shown in the Policy Data page.

Family Member means:

- Your spouse, child, brother, sister, parent or grandparent; or
- any person related to You in the same degree by blood, marriage or civil union; or
- anyone living in Your household; or
- a business partner.

Gainful Employment means Your Regular Occupation, as well as any job for which You are reasonably fitted by education, training or experience.

Hospital means a public or private institution that meets all of these conditions:

- it is operated according to law; and
- it provides 24-hour medical care, diagnosis and treatment to sick and injured persons on an inpatient basis; and
- diagnostic and surgical services provided are supervised by one or more Physicians; and
- registered nurses are on duty or on call, on a 24-hour basis; and
- care is provided either on the hospital's premises, or in facilities available to the hospital on a pre-arranged basis.

Hospital does not mean:

- a convalescent, nursing, rest or extended care facility; nor
- a facility operated exclusively for the treatment of the aged or of drug addicts or alcoholics; even if such facility may be operated as a separate institution by a Hospital.

Injury means an accidental bodily injury to You that:

- occurs while this Policy is in force; and
- is not contributed to by Sickness; and
- results in Total Disability within 90 days after the date of the accident.

If You suffer 2 or more injuries as a result of the same accident, they are considered the same Injury.

Issue Age means Your Age on the Policy Date, as shown in the Policy Data page.

Loss of Income means the amount determined by subtracting Your Current Income from the amount of Your Pre-Disability Income.

Maximum Benefit Period means the longest period of time We will pay benefits under this Policy for any one period of continuous Disability. The Maximum Benefit Period for Total Disability is shown in the Policy Data page.

Medicare means the Health Insurance for the Aged Act, Title XVIII of the Social Security Amendments of 1965, as then constituted or later amended.

Mental or Nervous Disorder means any mental or emotional disease or disorder without demonstrable organic cause, as listed in:

- the Diagnostic and Statistical Manual for Mental Disabilities ("DSM") published by the American Psychiatric Association; or
- the guideline used by the American Psychiatric Association, if the DSM is no longer used that is current on the date You become Totally Disabled.

A Mental or Nervous Disorder must first manifest itself while this Policy is in force, subject to the provisions in the Limitations section of this Policy.

Mental or Nervous Disorder includes, but is not limited to, a disorder related to alcohol or drug substance abuse or dependency.

Mental or Nervous Disorder does not include:

- dementia that results from stroke, trauma or infections; or
- degenerative disease such as Alzheimer's disease.

Own Occupation Period means 24 months, commencing with the completion of the Elimination Period.

Partial Disability/Partially Disabled means that, due to the occurrence of a condition that is caused by an Injury, Sickness, or Mental or Nervous Disorder, that:

- You are not able to perform one or more of the material and substantial duties of Your Regular Occupation; or You are able to perform all of the material and substantial duties of Your Regular Occupation, but You can work no more than 80% of the time You worked in Your Regular Occupation prior to Your Disability; and
- You have a Loss of Income of at least 20% of Your Pre-Disability Income.

To be Partially Disabled, You must be under the care of a Physician, whose area of practice is appropriate for treatment of the Injury, Sickness, or Mental or Nervous Disorder causing Your Partial Disability, based on prevailing medical standards. However, if We receive written proof satisfactory to Us, from the Physician, that You have reached Your maximum point of recovery and are still Partially Disabled, We will not require You to see, or be under the care of, the Physician on a regular basis.

The loss of a professional or occupational license for any reason does not, by itself, mean You are Partially Disabled.

Physician means a person, other than You or a Family Member, who:

- is a licensed medical practitioner or professional in the state in which he or she practices; and
- practices and diagnoses within the scope of his or her license for the service or treatment given.

Policy means the entire contract that consists of:

- the base policy; and
- the application, a copy of which is attached; and
- any attached riders or amendments. These documents add provisions to, or change the terms of, the base policy.

Pre-Disability Income means the greater of:

- Your average monthly Earned Income for the 12-month period ending on the date Your Total Disability began; or
- Your average monthly Earned Income for the 24-month period ending on the date Your Total Disability began.

Pre-Existing Condition means any mental or physical condition for which:

- You consulted a Physician; or
- You received any medical treatment or services; or
- You have undergone diagnostic procedures; or
- You have taken any prescription drugs or medications; or

- a prudent person would have sought medical advice, care or treatment;
- during the 24-month period ending on the Policy Date shown in the Policy Data page.

Regular Occupation means Your occupation when You became Totally Disabled. For example, if You have limited Your practice to a professionally recognized specialty in medicine or law, the specialty will be deemed Your Regular Occupation.

Sickness means an illness, disease or physical condition, including Complications of Pregnancy, that first manifests itself while this Policy is in force, subject to the provisions in the Limitations section of this policy.

Total Disability/Totally Disabled means that, due to the occurrence of a condition that is caused by an Injury, Sickness, or Mental or Nervous Disorder, that:

- during the Own Occupation Period, You are not able to perform the material and substantial duties of Your Regular Occupation; and
- after the Own Occupation Period, You are not able to perform the material and substantial duties of any

occupation for which You are reasonably fitted by education, training or experience.

To be Totally Disabled, You must be under the care of a Physician, whose area of practice is appropriate for treatment of the Injury, Sickness, or Mental or Nervous Disorder causing Your Total Disability, based on prevailing medical standards. However, if We receive written proof satisfactory to Us, from the Physician, that You have reached Your maximum point of recovery and are still Totally Disabled, We will not require You to see, or be under the care of, the Physician on a regular basis.

You will not be considered Totally Disabled on any day that You are working in Gainful Employment.

The loss of a professional or occupational license for any reason does not, by itself, mean You are Totally Disabled.

Total Disability Monthly Benefit means the amount We will pay each month for Total Disability, subject to the provisions in the Total Disability Benefit section of this Policy. The Total Disability Monthly Benefit is shown in the Policy Data page.

BENEFITS

DISABILITY BENEFIT PAYMENTS

We will only pay one benefit under this Policy for concurrent Disabilities due to Injury, Sickness, or Mental and Nervous Disorder. We will not pay a benefit for both Total Disability and Partial Disability at the same time.

If You recover from Your Total Disability or Partial Disability after part of a month, We will pay for that part of that month at a daily rate of 1/30th of the applicable monthly benefit amount.

TOTAL DISABILITY BENEFIT

If You become Totally Disabled, We agree to pay the Total Disability Monthly Benefit. This amount will be paid:

- for the period of Your Total Disability that starts at the end of the Elimination Period; and
- while You continue to be Totally Disabled; but not after the end of the Maximum Benefit Period.

PARTIAL DISABILITY BENEFIT

If You are Partially Disabled, immediately following a period of Total Disability for which Total Disability benefits were payable to You, We agree to pay a Partial

Disability monthly benefit amount equal to 50% of the Total Disability Monthly Benefit.

This amount will be paid while You continue to be Partially Disabled, but not after the earlier of:

- the date on which 6 monthly Partial Disability benefits have been paid; or
- the date on which the total number of monthly Total Disability and Partial Disability benefit payments equals the length, in months, of the Maximum Benefit Period.

RECURRENT DISABILITY

If Your Total Disability or Partial Disability recurs, from the same or related causes, it will be deemed a continuation of the previous Total Disability or Partial Disability, unless You have been Actively at Work for 6 or more consecutive months before the recurrence.

You will not be subject to a new Elimination Period, or a new Maximum Benefit Period, for recurring Disabilities.

TRANSPLANT BENEFIT

If You donate:

- a body organ; or
- bone marrow; or
- any other transplantable body part;

for transfer to another person, Your physical condition that results from the transfer process is deemed a Sickness for purposes of this Policy.

If You become Totally Disabled as a result, We will pay benefits as for any other Disability, provided Your donation takes place at least 6 months after the Policy Date, and while this Policy is in force.

PREMIUM WAIVER BENEFIT

After You have been Disabled for 90 consecutive days,

We will waive the payment of any premiums, for this Policy and any riders attached to it, that become due. The premium waiver includes:

- a refund of any premiums paid that were due during that 90-day period; and
- those premiums that become due while You remain Disabled.

This Policy and its riders will then stay in force, without payment of premium, as long as You remain Disabled. When You are no longer Disabled, the waiver of premium ends. If the waiver of premium ends, premium payments must resume, as of the next premium due date, to continue Your coverage under this Policy and its riders.

EXCLUSIONS AND LIMITATIONS

EXCLUSIONS

We will not pay benefits under this Policy or any attached rider for:

- any Disability caused by war or any act of war, whether declared or undeclared, or by any other armed conflict; or
- any Disability caused or contributed to by Your intentionally self-inflicted injury or sickness, except that this does not include the voluntary donation of any portion of Your body as described in the Transplant Benefit; or
- any Disability due to normal pregnancy, childbirth or elective abortion, except that this does not include Complications of Pregnancy; or
- any Disability caused by Your active participation in a riot or insurrection; or
- any Disability that results from Your military service of any country or authority, except during active duty for training of less than 60 days; or
- any Disability caused by Your engaging in any act or occupation that is a felony according to the law of the jurisdiction where such cause occurred; or

- any Disability that exists during any period of time You are confined for any reason in a penal or correctional institution.

LIMITATIONS

We will not pay benefits for a Disability that is caused by a Pre-Existing Condition unless, on the date You become Disabled, this Policy has been continuously in effect for 24 months.

However, if You fully disclosed such Pre-Existing Condition in Your application for this Policy, and the condition is accepted by Us, then that condition is not subject to this limitation.

After 2 years from the Policy Date, We will not reduce or deny benefits for a Disability caused by a Pre-Existing Condition, unless that condition is excluded by name in a rider attached to this Policy.

Subject to all other terms of this Policy, We agree to pay benefits for Disability caused by a Mental or Nervous Disorder, subject to a limit of 24 monthly benefits during Your lifetime for all such Disabilities.

PREMIUM PROVISIONS

PREMIUM PAYMENTS

The premium is the amount We charge at regular intervals to keep this Policy in force. Premiums may be paid on an annual, semi-annual, quarterly or monthly basis. The Initial Premium Mode, and amount of Initial Premium, are shown in the Policy Data page. All premiums are payable at Our home office in Lansing, Michigan.

The first premium is due on the Policy Date. If the first

premium is not paid, this Policy is never in force. Subsequent premiums are due on the first day following the period for which the prior premium was paid.

RIGHT TO CHANGE PREMIUMS

We may change the premium rates for this Policy if the same change is made for all insured persons in the same class as this Policy, but not more than once in any 12-month period. We will give You 31 days advance written notice of the change in premium rates.

The premium rates may also be changed at the time the terms of this Policy are changed. Such terms include, but are not limited to, the Total Disability Monthly Benefit, the Elimination Period and the Maximum Benefit Period.

You may change the Premium Mode by writing to Us, which is subject to Our approval. You may make this change at any time other than during a period in which You are Disabled. The change in Premium Mode will take effect on the applicable premium due date next following Our approval.

GRACE PERIOD

Each premium due, after the first, must be paid within 31 days after the due date, to keep this Policy in force. The Policy stays in force during this grace period. The Policy will terminate, however, on the day after the end of the grace period. If You become Totally Disabled during the grace period, We will deduct any due and unpaid premium from any benefit payments made.

REINSTATEMENT

If a premium is not paid by the end of the grace period, this Policy ceases to be in force. You have the right to request that it be reinstated.

If We, or one of Our authorized agents, accept a premium without requiring an application, the Policy is reinstated as of the date We receive the premium.

If We or one of Our authorized agents require an application to reinstate this Policy, and We or the agent issue You a conditional receipt for the premium, then this Policy will be reinstated as of:

- the date We approve the application; or
- the 45th day after the date of the conditional receipt, if We have not previously notified You in writing of Our approval or disapproval.

The reinstated policy will only cover Disabilities that result from:

- Injury that occurs on or after the reinstatement date; and
- Sickness, or Mental or Nervous Disorder, that first manifests itself more than 10 days after the reinstatement date.

In all other respects, Your rights and Our rights under the reinstated policy remain the same, subject to the provisions of any riders added to the reinstated policy on the reinstatement date.

PREMIUM REFUND UPON YOUR DEATH

If You die while this Policy is in force, We will refund any premium paid for the period that starts on the first day of the month following the date of Your death.

For a refund to be made, Our home office must receive written notice of Your death, in a form that is satisfactory to Us. The notice must be received by Us while this Policy is in force.

SUSPENSION WHILE IN MILITARY

You have the right to suspend Your coverage under this Policy, if:

- You enter military service of any country or authority, except for active duty training purposes of less than 60 days; and
- You send Us a written request for the suspension.

We will refund any premium already paid for the period that starts on the suspension date.

During the period of suspension:

- this Policy will not be in force; and
- no monthly benefits or Premium Waiver Benefit will be available; and
- no premium payments will be required.

You may reinstate this Policy following its suspension, without evidence of insurability, if:

- You send us a written request to reinstate coverage, within 6 years after the date it was suspended; and
- Your request is dated no later than 30 days after Your military service ended.

When We receive Your request, We will require payment of the pro rata premium for the period from Your request date to the next regular premium due date. Your regular premium payment amount will apply as of that next due date, at the premium rate that would have been in effect had Your Policy not been suspended. The reinstated Policy will take effect on the date We receive Your pro rata premium.

The reinstated Policy will only cover Disabilities that result from:

- Injury that occurs on or after the reinstatement date; and
- Sickness, or Mental or Nervous Disorder, that first manifests itself more than 10 days after the reinstatement date.

RENEWAL PROVISIONS

GUARANTEED RENEWABLE TO AGE 67

Your insurance under this Policy is guaranteed to be renewable, until the anniversary of the Policy Date that next follows Your 67th birthday. To renew, the required premium must be paid, subject to the grace period.

We reserve the right to change premiums for a class, as stated in the Right to Change Premiums provision.

You may also request cancellation of this Policy, by written notice to Us. If You do so, the Policy will cancel as of the date We receive Your notice. We will not, however, refund any portion of any modal premiums already paid that were due before the date of Your notice.

If Your Policy terminates on the anniversary of the Policy Date on or next following the date You attain age 67, We will refund any premium paid for the period that starts on this termination date.

EFFECT OF TERMINATION

If this Policy terminates for any reason, the termination will not affect any claim for benefits under this Policy that:

- is incurred prior to the termination date; and
- would be payable to You under the terms of this Policy, had the Policy stayed in force.

CLAIM PROVISIONS

NOTICE OF CLAIM

Written notice of a claim must be given to Us within 30 days after any covered loss starts, or as soon as reasonably possible after that. Someone acting for You may give notice on Your behalf. Send the notice to Us, at Our home office in Lansing, Michigan, or to any of Our authorized agents. The notice must include Your name and the policy number shown in the Policy Data page.

CLAIM FORMS

When We receive Your notice of a claim, We will send You claim forms. These forms ask for information to prove Your loss. We will send the forms within 15 days after You give Us the notice of claim. If We do not send You the forms within 15 days, You may submit Your written proof of loss. The proof must describe how the loss occurred, its nature and extent. The proof of loss must be given within the time stated in the Proof of Loss provision.

PROOF OF LOSS

Written proof of loss satisfactory to Us for a periodic payment due for a continuing loss must be given to Us within 90 days after the end of each period for which We are liable. This includes proof of Disability, any Loss of Income, if applicable, and any other proof required to substantiate the claim. Proof of any Loss of Income may include, but is not limited to, copies of applicable personal and/or business income tax returns and financial records of any business entity of which You own any portion.

If You fail to give Us proof of loss within this period

because it is not reasonably possible to do so, We will not reduce Your claim. However, You must give Us proof of loss within one year after the 90-day time limit unless You are legally unable to do so.

EXAMINATIONS AND AUTOPSY

We may require You to have one or more examinations, including any related tests, by a Physician of Our choice, while a claim is pending or ongoing. We may request an autopsy to be made if permitted by law. We may require a financial examination to be done by Us or a financial examiner We choose. We will pay the costs of any examination We require. Costs of examinations are the actual charges of the Physician or specialists We select to conduct them. If You fail to submit to such examinations, We will stop paying benefits.

TIME OF PAYMENT OF CLAIMS

When We receive sufficient proof of loss, We will pay benefits for continuing Disability at the end of each month as they become due. Any balance due at the end of Your Disability will be paid as soon as We receive sufficient proof of loss.

PAYMENT OF CLAIMS

All claims will be paid to You, unless stated otherwise in this Policy. Any claims that are payable to You that are unpaid at Your death will be paid either to the beneficiary or to Your estate if no beneficiary is named.

If a claim is payable to:

- Your estate; or
- any person who cannot execute a valid release;

We may pay up to \$2,500 to any of Your Family Members who We consider entitled to the payment. Any such payment We make in good faith fulfills Our obligation to the extent of that payment.

ASSIGNMENT OF CLAIMS

You may assign the claims otherwise payable to You, to be paid to another person or entity, by written request to Us. You may change this assignment at any time. The signed request must be sent to Our home office. No assignment will be valid until We receive the request. The assignment will take effect on the date the request is signed.

We are not responsible for the validity or tax consequences of an assignment. We will not be liable for any act taken by Us, or any payment made by Us, before We received the request for an assignment.

NOTICE OF DECISION ON YOUR CLAIM

We will send You written notice of Our decision on Your claim within 45 days after We receive Your proof of loss. If We partially or fully deny Your claim, Our notice will include:

- the reason(s) for Our denial; and
- reference to wording in this Policy on which We base Our denial; and
- a description of any additional information, documents or proof of loss that You must submit in order to obtain benefits, and an explanation of why We need the additional information to pay Your claim.

GENERAL PROVISIONS

THE CONTRACT

This insurance is provided in consideration of Our receipt of Your application and Your payment of all required premiums. The entire contract between You and Us consists of:

- the Policy, as defined; and
- any subsequently approved applications and revisions to the Policy Data page.

All statements made by You in Your application are, in the absence of fraud, deemed representations and not warranties. No statement made by You will be used to void this Policy, or a subsequent revision to this Policy, unless it is contained in Your initial or subsequent application.

This Policy may be revised at any subsequent time while the Policy is in force, by rider or amendment form signed

CLAIM APPEAL PROCEDURE

If We partially or fully deny Your claim for benefits, and You disagree or do not understand the reasons for the denial, You may:

- request a review of the denial; and
- request, at no cost to You, reasonable access to, and copies of, all documents, records and other information that are relevant to the claim; and
- submit, in writing, any data, documents or comments that You believe are relevant to Our review of the denial.

Your appeal must be submitted, in writing, within 180 days after You receive Our notice of denial. We will review all information, and send You written notice of the results of Our review, within 45 days after We receive the appeal.

Someone acting on Your behalf may make an appeal for You.

LEGAL ACTIONS

You cannot start legal action against Us for benefits under this Policy until 60 days after You give Us proof of loss as described in the Proof of Loss provision. You cannot start legal action more than 3 years after the date proof of loss is required to be furnished.

by Our executive officer. The terms of the rider or amendment will be without prejudice to any loss incurred prior to the effective date of the form. If the rider or amendment restricts any coverage, the form must also be signed by You. Our agents cannot alter or amend this Policy in any way, nor waive any of its conditions or restrictions.

CONFORMITY TO LAW

Any provision of this Policy that conflicts with the laws of the state in which the Policy is issued is amended to conform to the minimum requirements of such laws.

CLERICAL ERRORS

A clerical error in this Policy or a delay in keeping Policy records:

- will not deny insurance that would otherwise have

- been granted; and
- will not extend insurance that would otherwise have ceased.

A fair adjustment of premium and/or benefits will be determined, so that You and We are in the same position that You and We would have been in, had the error or delay not occurred.

INCONTESTABILITY

In the absence of fraud, no statement made by You:

- in Your application for this Policy will be used to:
 - void this Policy, as of the date the Policy has been in effect for 2 years; or
 - deny a claim for Disability that starts after the Policy has been in effect for 2 years;
- in Your subsequent application for a rider, benefit or reinstatement of this Policy will be used to:
 - void the subsequent rider, benefit or reinstated policy, as of the date the subsequent rider, benefit or reinstated policy has been in effect for 2 years; or
 - deny a claim for Disability that starts after the subsequent rider, benefit or reinstated policy has been in effect for 2 years.

MISSTATEMENTS

If Your Age or gender has been misstated, We will adjust the benefits of this Policy to reflect the coverage that would have been purchased at the correct Age or gender.

We will refund Your premium payment, if:

- We would not have issued this Policy at Your correct Age; or
- coverage under the Policy would have ended before We accepted the premium for such coverage.

The premium refund will only cover premiums paid for coverage not received.

NOTICES

A change, assignment or other request from You will not affect Us until:

- it has been signed by You, when required; and
- We have received it at Our home office in Lansing, Michigan; and
- We have approved it, when required.

AUTHORIZATION

We may require You to give Us proper authorization so

that We may obtain certain information. This applies to information needed to determine Your eligibility for, and Our payment of, benefits under this Policy.

OWNERSHIP

You own this Policy, unless a different owner is named in Your application form or in a later written request for change of ownership according to the Policy Assignments provision.

The owner of this Policy has:

- the sole rights to the privileges and benefits provided by this Policy except that benefits will be paid as stated in the Claim Provisions section of this Policy; and
- the sole right to control the Policy.

These rights include naming a successor owner without the consent of any other person, unless that consent is required by law.

BENEFICIARY

The beneficiary is the person or entity named in Your application to receive benefits after Your death. You may name any person or entity as beneficiary. You may change the beneficiary at any time, unless You have named an irrevocable beneficiary. A change in beneficiary will take effect on the date Your request to Us is signed.

If 2 or more beneficiaries are named, each will receive an equal portion of the benefit, unless You indicate otherwise.

Consent of a named beneficiary is not required to:

- assign this Policy; or
- name a new beneficiary; or
- make any other change to this Policy.

POLICY ASSIGNMENTS

You, or the owner of this Policy if You are not the owner, may assign this Policy at any time while it is in force, by written request to Us. The signed request must be sent to Our home office. No assignment will be valid until We receive the request. The assignment will take effect on the date the request is signed.

We are not responsible for the validity or tax consequences of an assignment. We will not be liable for any act taken by Us, or any payment made by Us, before We received the request for an assignment.

FIRST DAY HOSPITAL CONFINED RIDER

This Rider is attached to and made a part of Your Policy. This Rider is effective on the Rider Date shown on the Policy Data page. If no Rider Date is shown, this Rider is effective on the Policy Date.

This Rider is subject to all provisions of the Policy that do not conflict with the provisions of this Rider. Coverage under this Rider is contingent on payment of the premium for this Rider, shown in the Policy Data page.

IN GENERAL

This Rider provides for payment of benefits for Total Disability during the Elimination Period, if You are Confined in a Hospital due to Your Total Disability.

DEFINITION

As used in this Rider:

Confined/Confinement means a stay as a resident inpatient in a Hospital for at least 24 consecutive hours because of Your Total Disability. Confinement must be recommended and supervised by a Physician. A stay in a Hospital due to donation of transplantable body part for transfer to another person is not considered Confinement under this Rider.

BENEFIT

If you are confined in a Hospital during the Elimination Period, We will pay a pro rata portion of the monthly benefits for Total Disability for each day of Confinement:

- during the Elimination Period; and
- while You remain Totally Disabled.

This benefit also applies to these optional benefits, if part of Your Policy:

- the Coordinating Additional Insurance Rider; and
- the Business Overhead Expense Rider; and
- Total Disability Monthly Benefit increases under the Guaranteed Insurability Rider.

This benefit does not apply to any other optional benefits that are part of Your Policy.

This benefit will not change the Elimination Period or the Maximum Benefit Period of the Policy.

TERMINATION OF THIS RIDER

This Rider will terminate on the earliest of these dates:

- the date the Policy terminates; or
- the date We receive Your notice to Us to cancel this Rider; or
- the day after the end of the grace period for which a premium for this Rider is due and not paid.

Signed for Auto-Owners Life Insurance Company at Lansing, Michigan, on the effective date of this Rider.

[Joe Secretary]

Secretary

[John President]

President

3% COST OF LIVING INCREASE RIDER

This Rider is attached to and made a part of Your Policy. This Rider is effective on the Rider Date shown on the Policy Data page. If no Rider Date is shown, this Rider is effective on the Policy Date.

This Rider is subject to all provisions of the Policy that do not conflict with the provisions of this Rider. Coverage under this Rider is contingent on payment of the premium for this Rider, shown in the Policy Data page.

IN GENERAL

This Rider provides for adjustments to the amount of monthly benefits for Disability that are payable to You under the Policy and select Riders shown in Your Policy Data page.

ELIGIBILITY

To receive increases in monthly benefit amounts:

- Your Disability must begin while this Rider is in effect; and
- You must be Disabled for 12 months.

COST OF LIVING INCREASES

Cost of Living Increases will be applied to the following benefit amounts:

- the Total Disability Monthly Benefit, including increases in the Total Disability Monthly Benefit purchased under the Guaranteed Insurability Rider, if elected; and
- the Monthly Benefit Amount for the Coordinating Additional Insurance Rider, if elected.

Your adjusted monthly benefit is calculated by applying the monthly benefit by the factor from the following table:

Year of Disability	Factor	Year of Disability	Factor
1	1.000		
2	1.030	14	1.469
3	1.061	15	1.513
4	1.093	16	1.558
5	1.126	17	1.605
6	1.159	18	1.653
7	1.194	19	1.702
8	1.230	20	1.754
9	1.267	21	1.806
10	1.305	22	1.860
11	1.344	23	1.916
12	1.384	24	1.974
13	1.426	25+	2.000

Cost of Living Increases will end on the date Your Disability ends. If You become Disabled again, and the new Disability occurs while this Rider is in force, Your monthly benefit amounts in the first 12 months of Disability will be equal to the amounts shown in the Policy Data page, before Cost of Living Increases were applied. Cost of Living Increases will be applied to the new Disability as described above.

TERMINATION OF THIS RIDER

This Rider will terminate on the earliest of these dates:

- the date the Policy terminates; or
- the date We receive Your notice to Us to cancel this Rider; or
- the day after the end of the grace period for which a premium for this Rider is due and not paid.

Signed for Auto-Owners Life Insurance Company at Lansing, Michigan, on the effective date of this Rider.

[Signature]

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OWN OCCUPATION FIVE YEAR RIDER

This Rider is attached to and made a part of Your Policy. This Rider is effective on the Rider Date shown on the Policy Data page. If no Rider Date is shown, this Rider is effective on the Policy Date.

This Rider is subject to all provisions of the Policy that do not conflict with the provisions of this Rider. Coverage under this Rider is contingent on payment of the premium for this Rider, shown in the Policy Data page.

BENEFIT

The definition of Own Occupation Period appearing in the Definitions section of Your Policy, is amended to read as follows:

Own Occupation Period means 60 months, commencing with the completion of the Elimination Period.

TERMINATION OF THIS RIDER

This Rider will terminate on the earliest of these dates:

- the date the Policy terminates; or
- the date We receive Your notice to Us to cancel this Rider; or
- the day after the end of the grace period for which a premium for this Rider is due and not paid.

Signed for Auto-Owners Life Insurance Company at Lansing, Michigan, on the effective date of this Rider.

[Joe Secretary]

Secretary

[John President]

President

BUSINESS OWNER RETURN-TO-WORK RIDER

This Rider is attached to and made a part of Your Policy. This Rider is effective on the Rider Date shown on the Policy Data page. If no Rider Date is shown, this Rider is effective on the Policy Date.

This Rider is subject to all provisions of the Policy that do not conflict with the provisions of this Rider. Coverage under this Rider is contingent on payment of the premium for this Rider, shown in the Policy Data page.

IN GENERAL

This Rider provides a Business Owner Return-To-Work benefit, if:

- You have a Recovery from Your Total Disability while this Rider is in force; and
- monthly benefits for that Total Disability had not, as of the date of Recovery, been paid to the end of the Maximum Benefit Period for Total Disability shown in the Policy Data page.

DEFINITION

As used in this Rider, **Recovery** means that:

- You return to being Actively at Work in Your Regular Occupation as an owner of the business; and
- Your return occurs within 30 days following the last day of a period of Total Disability, for which a Total Disability benefit was paid to You.

BENEFITS UNDER THIS RIDER

If You have a Recovery, We agree to pay monthly Business Owner Return-To-Work benefits as follows:

- benefits start to accrue on the date Your Total Disability ends.
- benefits will be paid for a duration of:
 - 1 month, if the number of monthly Total Disability benefits You had received for Your Total Disability was 3 or less;
 - 2 months, if the number of monthly Total Disability benefits You had received for Your Total Disability was more than 3 but less than 9;
 - 3 months, if the number of monthly Total Disability benefits You had received for Your Total Disability was 9 or more.

In no event will:

- monthly Total Disability benefits under the Policy, including any paid for the same Disability under the Recurrent Disability provision; and
- monthly benefits under this Rider;

be paid after the date the total of such payments equals the length, in months, of the Maximum Benefit Period.

The amount of any monthly Business Owner Return-To-Work benefit equals 50% of the amount of the monthly benefit for Total Disability.

This benefit also applies to these optional benefits, if part of Your Policy:

- the Coordinating Additional Insurance Rider; and
- the 3% Cost of Living Increase Rider; and
- Total Disability Monthly Benefit increases under the Guaranteed Insurability Rider.

This benefit does not apply to any other optional benefits that are part of Your Policy.

Benefit payments under this Rider are in addition to any other payment that may be due under the Policy or under any other rider to the Policy.

TERMINATION OF THIS RIDER

This Rider will terminate on the earliest of these dates:

- the date the Policy terminates; or
- the date the business, or Your ownership of the business, is ended; or
- the date We receive Your notice to Us to cancel this Rider; or
- the day after the end of the grace period for which a premium for this Rider is due and not paid.

Signed for Auto-Owners Life Insurance Company at Lansing, Michigan, on the effective date of this Rider.

[Joe Secretary]

Secretary

[John President]

President

BUSINESS OVERHEAD EXPENSE RIDER

This Rider is attached to and made a part of Your Policy. This Rider is effective on the Rider Date shown on the Policy Data page. If no Rider Date is shown, this Rider is effective on the Policy Date.

This Rider is subject to all provisions of the Policy that do not conflict with the provisions of this Rider. Coverage under this Rider is contingent on payment of the premium for this Rider, shown in the Policy Data page.

IN GENERAL

This Rider provides a Business Overhead Expense benefit, for Covered Business Overhead Expenses, if You become Totally Disabled while this Rider is in force.

DEFINITIONS

As used in this Rider:

Covered Business Overhead Expenses mean the expenses You incur each month to maintain an open office while You remain an owner of the business. The expenses must be normal and customary in the operation of Your business or profession. If You are in business with another person, Covered Business Overhead Expenses only include the portion of the expenses that You are liable for.

Covered Business Overhead Expenses **include**:

- salaries and employer-paid benefits for employees, including Your Family Member who was continuously employed by the business for at least 12 months immediately prior to the date You became Totally Disabled and who serves an appropriate business function; and
- payroll taxes incurred while benefits under this Rider are payable; and
- business insurance, such as property, liability and professional responsibility insurance; and
- business utilities, such as electricity, telephone, heat and water; and
- operating costs and depreciation for office equipment; and
- lease expenses for office equipment, for a lease greater than one year in duration; and
- rental payments or payment of the interest for a loan or mortgage on the business premises, unless the business premises is located in Your home; and
- property tax payments, unless the business premises is located in Your home; and
- other fixed business expenses.

Covered Business Overhead Expenses **do not include**:

- salary and employer-paid expenses, or any other remuneration or employer contribution for You, or for a person hired to replace You, or for any principal in Your business or any member of Your profession; and
- the cost of raw goods, inventory, or office supplies used in the business; and
- payment of the principal for a loan or mortgage on the business premises; and
- depreciation of the business premises for federal tax purposes; and
- salary and employer-paid benefits for Your Family Member who was not continuously employed by the business for at least 12 months immediately prior to the date You became Totally Disabled or who does not serve an appropriate business function; and
- employee bonuses; and
- any other production-type expenses; and
- any expenses that We reasonably determine are not normal and customary expenses in the operation of Your business or profession; and
- any expenses that were not regularly incurred in the normal and customary operation of Your business or profession before You became Totally Disabled; and
- any expense that is not deductible for federal income tax purposes.

Elimination Period means the number of days You must be Totally Disabled before benefits become payable under this Rider. The Elimination Period for this Rider is shown in the Policy Data page.

Days of Total Disability used to satisfy the Elimination Period need not be consecutive. However, You must accrue the Elimination Period days during a period that starts on the first day of Total Disability, and ends no later than 31 days following the end of the number of consecutive days of the Elimination Period.

Maximum Benefit Period means the longest period of time We will pay monthly benefits under this Policy during Your lifetime. The Maximum Benefit Period for

this Rider is shown in the Policy Data page. In the event that there is any Unused Benefit Carryover, as described below, at the end of the Maximum Benefit Period, the period of time We will pay monthly benefits will be extended, but for no longer than 3 months.

Maximum Monthly Benefit Amount means the maximum benefit that will be paid for each month of Total Disability under this Rider. The Maximum Monthly Benefit Amount for this Rider is shown on the Policy Data page.

BENEFITS UNDER THIS RIDER

If You become Totally Disabled, Business Overhead Expense benefits will be paid:

- for the period of Your Total Disability that starts at the end of the Elimination Period; and
- while You continue to be Totally Disabled;

but not after the end of the Maximum Benefit Period.

Business Overhead Expense benefits are payable for Covered Business Overhead Expenses that are incurred in subsequent months while you remain Totally Disabled while this Rider is in force.

The amount of each monthly benefit is the lesser of:

- the amount of Covered Business Overhead Expenses incurred in that month; and
- the Maximum Monthly Benefit Amount, plus the amount of any available Unused Benefit Carryover, as described below.

If a monthly benefit is payable for part of a month, We will pay for that part of that month the lesser of:

- 1/30th of the amount of Covered Business Overhead Expenses incurred in that month, for each day of Disability; or
- 1/30th of the Maximum Monthly Benefit Amount for each day of Disability; plus the amount of any available Unused Benefit Carryover, as described below.

Signed for Auto-Owners Life Insurance Company at Lansing, Michigan, on the effective date of this Rider.

[Joe Secretary]

Secretary

[John President]

President

Benefit payments under this Rider are in addition to any other payment that may be due under the Policy or under any other rider to the Policy.

Unused Benefit Carryover: If Your Covered Business Overhead Expenses are less than the Maximum Monthly Benefit Amount during a month in which Business Overhead Expense benefits are payable, the unused portion of the maximum can be carried forward and added to the Maximum Monthly Benefit Amount for any subsequent month in which Business Overhead Expense benefits are payable. Any Unused Benefit Carryover will be reduced by any benefits paid in excess of the Maximum Monthly Benefit Amount.

In this way, You may receive more than the Maximum Monthly Benefit Amount in Business Overhead Expense benefits in a later month, but only for Covered Business Overhead Expenses incurred prior to the end of the Maximum Benefit Period.

TERMINATION OF THIS RIDER

This Rider will terminate on the earliest of these dates:

- the date the Policy terminates; or
- the date the business, or Your ownership of the business, is ended; or
- the date We receive Your notice to Us to cancel this Rider; or
- the day after the end of the grace period for which a premium for this Rider is due and not paid.

COORDINATING ADDITIONAL INSURANCE RIDER

This Rider is attached to and made a part of Your Policy. This Rider is effective on the Rider Date shown on the Policy Data page. If no Rider Date is shown, this Rider is effective on the Policy Date.

This Rider is subject to all provisions of the Policy that do not conflict with the provisions of this Rider. Coverage under this Rider is contingent on payment of the premium for this Rider, shown in the Policy Data page.

IN GENERAL

This Rider provides an additional monthly benefit for Your Total Disability or Partial Disability. This monthly benefit does not duplicate benefits that may be provided by the Other Benefit Programs described in this Rider.

DEFINITION

As used in this Rider:

Other Benefit Programs means:

- Social Security Disability Benefits: this includes primary and family disability income benefits. "Social Security" means the Federal Social Security Act, as now written or as it may be changed or replaced.
- Worker's Compensation Disability Benefits: this includes disability income benefits from any workers' compensation or employer's liability or occupational disease law or plan, whether federal or state.
- Any federal, state or local retirement and disability fund benefit: this includes any disability compensation under any governmental retirement and disability fund. Any payments resulting from Your retirement will be considered as disability benefits.

Other Benefit Programs does not include any state personal injury protection law or plan.

BENEFIT

We will pay a monthly benefit under this Rider, if:

- You become Disabled while this Rider is in force; and
- a monthly benefit for Total Disability or Partial Disability is payable under the Policy; and
- You furnish Us the evidence described in the Proof of Other Benefit Programs Payments provision of this Rider.

TOTAL DISABILITY BENEFIT UNDER THIS RIDER

If You are receiving a monthly Total Disability Benefit under this Policy, We will pay an additional monthly amount equal to:

- the Monthly Benefit Amount for this Coordinating Additional Insurance Rider as shown in the Policy Data page, less
- the amount of benefits from Other Benefit Programs that are due to Your Injury, Sickness or Mental or Nervous Disorder; and
 - that are paid to You or to Your Family Member or to a third party on Your behalf in the same month; or
 - for which You or Your Family Member are eligible during the same month.

If the amount of benefits from Other Benefit Programs for the month is greater than the Monthly Benefit Amount for this Rider, then the monthly benefit payable for Total Disability under this Rider is zero.

Once benefits begin under any Other Benefit Program, no monthly benefit under this Rider will be adjusted to reflect an increase in that Other Benefit Program that is due to a cost of living adjustment.

If You receive an award from an Other Benefit Program in a lump sum that covers more than one month, We will divide the award into equal monthly amounts. The number of monthly amounts will be based on the period covered by the award. If this period is not shown in the award notice, We will consider the award to have been paid in 60 equal monthly payments. If the award is for a period for which We have already paid You monthly benefits under this Rider, You must reimburse Us immediately for any overpayment. If the award is for a future period, We will reduce future monthly benefits that may be due You under this Rider.

PARTIAL DISABILITY BENEFIT UNDER THIS RIDER

If You are receiving a monthly Partial Disability Benefit under this Policy, We will pay an additional monthly amount equal to 50% of the Monthly Benefit Amount for this Coordinating Additional Insurance Rider as shown in the Policy Data page.

DURATION OF BENEFITS

Monthly benefits under this Rider accrue once monthly benefits for Total Disability or Partial Disability are payable under the Policy.

The additional monthly benefits will be payable until the earliest of:

- the date Your Disability ends; or
- the date Total Disability Benefits or Partial Disability Benefits under the Policy end; or
- the date the Policy terminates; or
- the date this Rider terminates.

PROOF OF OTHER BENEFIT PROGRAMS PAYMENTS

The amount of benefits under Other Benefit Programs affects benefit amounts under this Rider. Before payments can be made under this Rider, We must receive satisfactory evidence on the status of payments under Other Benefit Programs. For each Other Benefit Program, this includes:

- Proof that an application has been made for payments under the Other Benefit Program.
- Written authorization for Us to receive information on the status of that application.
- Proof that the application has been approved or disapproved.

- If disapproved, proof that the appeals process has been followed and approval or disapproval received.
- If the application or appeal has been approved, proof of the amounts payable under the Other Benefit Program.

We have the right to pursue any further appeals process that may be available to You. Any appeal by Us will be at no cost to You.

We also have the right, at any time, to require proof that You continue to be Disabled and that You are, or are not, receiving an Other Benefit Program benefit.

TERMINATION OF THIS RIDER

This Rider will terminate on the earliest of these dates:

- the date the Policy terminates; or
- the date We receive Your notice to Us to cancel this Rider; or
- the day after the end of the grace period for which a premium for this Rider is due and not paid.

Signed for Auto-Owners Life Insurance Company at Lansing, Michigan, on the effective date of this Rider.

[Joe Secretary]

Secretary

[John President]

President

GUARANTEED RENEWABLE TO AGE 67

GUARANTEED INSURABILITY RIDER

This Rider is attached to and made a part of Your Policy. This Rider is effective on the Rider Date shown on the Policy Data page. If no Rider Date is shown, this Rider is effective on the Policy Date.

This Rider is subject to all provisions of the Policy that do not conflict with the provisions of this Rider. Coverage under this Rider is contingent on payment of the premium for this Rider, shown in the Policy Data page.

IN GENERAL

This Rider provides You the right to increase the amount of Your Total Disability Monthly Benefit, from time to time, without evidence of medical insurability other than proof that You are not Disabled.

BENEFIT

You may increase the amount of Your Total Disability Monthly Benefit, subject to these rules:

- The first increase may not be made until Your Policy has been in force for at least 2 years. You may elect additional increases after that, while this Rider is in force, provided the effective date of a later increase is at least 2 years after the prior increase date.
- Increases may only take effect on an anniversary of the Policy Date shown on the Policy Data page. You must request the increase within the 60 day period that ends on the date You wish the increase to take effect.
- You must be Actively at Work, and not Disabled, for the 60 day period that ends on the date the increase takes effect.
- You must submit a written application for each increase, including proof of Your Earned Income sufficient to qualify for the elected increase.
- The amount of increase available to You will be determined by our underwriting guidelines in effect at the time of Your election, with consideration of factors such as Your Earned Income, occupation, Age and other disability insurance in force or applied for.
- For each increase, the maximum amount that You may apply for is equal to 50% of Your Total Disability Monthly Benefit as of the Policy Date.
- The maximum amount allowed for all increases under this Rider is equal to 2 times Your Total Disability Monthly Benefit as of the Policy Date.
- The minimum amount allowed for each increase is \$100. You may apply for a lesser amount, if the

total of all increases under this Rider, including this amount, would be equal to 2 times Your Total Disability Monthly Benefit as of the Policy Date.

- You must be less than Age 58 at the time of Your election.

The increase is effective on the anniversary of the Policy Date requested, provided that the application is approved and the initial premium for the increase in the Total Disability Monthly Benefit is paid.

The premium will be based on:

- Your premium rate class as of the date this Rider became effective; and
- Your attained Age as of the effective date of the increase.

The premium will be the same as premium that would be paid by new applicants as of the effective date of the increase.

A new Policy Data page will be issued at the time an increase becomes effective.

The increase in Total Disability Monthly Benefit will provide benefits only with respect to Disabilities that begin after the effective date of the increase.

TERMINATION OF THIS RIDER

This Rider will terminate on the earliest of these dates:

- the date the Policy terminates; or
- the anniversary of the Policy Date on or next following the date You attain Age 58; or
- the date the sum of all increases under this Rider equals 2 times Your Total Disability Monthly Benefit as of the Policy Date; or
- the date We receive Your notice to Us to cancel this Rider; or
- the day after the end of the grace period for which a premium for this Rider is due and not paid.

Signed for Auto-Owners Life Insurance Company at Lansing, Michigan, on the effective date of this Rider.

[Joe Secretary]

[John President]

SPOUSAL CATASTROPHIC DISABILITY RIDER

This Rider is attached to and made a part of Your Policy. This Rider is effective on the Rider Date shown on the Policy Data page. If no Rider Date is shown, this Rider is effective on the Policy Date.

This Rider is subject to all provisions of the Policy that do not conflict with the provisions of this Rider. Coverage under this Rider is contingent on payment of the premium for this Rider, shown in the Policy Data page.

IN GENERAL

This Rider provides a monthly Catastrophic Disability benefit, if You or Your Spouse give Us satisfactory proof that Your Spouse has suffered a Catastrophic Disability while this Rider is in force.

DEFINITIONS

As used in this Rider:

Activities of Daily Living means these functions of daily life:

- **Bathing** means cleaning the body by tub, shower or sponge bath, including getting in and out of the tub or shower, and reaching head and body parts for soaping, rinsing and drying.
- **Continence** means the ability to maintain control of bowel and bladder functions or, when unable to do so, the ability to perform associated personal hygiene, including caring for a catheter or an ostomy.
- **Dressing** means putting on and taking off all items of clothing and any necessary braces, fasteners, or artificial limbs.
- **Eating** means feeding oneself by getting food into the body from a receptacle such as a plate, cup, or table, or from a feeding tube or intravenous device.
- **Toileting** means getting to and from the toilet, getting on and off the toilet, and performing associated personal hygiene.
- **Transferring** means moving into or out of a bed, chair or wheelchair, with or without the aid of equipment such as support or other mechanical devices.

Catastrophic Disability/Catastrophically Disabled means that, as a result of Your Spouse's accidental bodily injury, pregnancy, sickness or Mental or Nervous Disorder, Your Spouse:

- is unable to perform 2 or more Activities of Daily Living without Hands-On Assistance; or
- requires Substantial Supervision for his or her health or safety due to Severe Cognitive Impairment.

As used in this Rider, "Mental or Nervous Disorder" refers to disorders listed in the manual or guideline used by the American Psychiatric Association that is current on the date the Spouse becomes Catastrophically Disabled.

Hands-On Assistance means physical assistance of another person, without which the Spouse would be unable to perform an Activity of Daily Living.

Severe Cognitive Impairment means a loss of, or deterioration in, intellectual capacity that is comparable to, and includes, Alzheimer's Disease and similar forms of irreversible dementia. This loss or deterioration in intellectual capacity is measured by clinical evidence and standardized tests approved by Us that reliably measure impairment in short-term or long-term memory, orientation as to people, places or time, and deductive or abstract reasoning.

Spouse means the person who is named in Your application as insured under this Rider. Your Spouse must meet these conditions:

- must be either Your married Spouse; or Your partner who lives with You and performs the activities of homemaker in Your household. These activities may include, but are not limited to, meal preparation, laundry and light housekeeping; and
- must not work for wage or profit, or must work for wage or profit for less than 20 hours per week.

Substantial Supervision means continual supervision by another person that is needed to protect Your Spouse from threats to his or her health or safety, such as may result from wandering. This may include cueing by:

- verbal prompting or gestures; or
- other similar demonstrations.

BENEFITS UNDER THIS RIDER

After Your Spouse has been Catastrophically Disabled for 60 consecutive days, We will pay the Monthly Benefit Amount for the Spousal Catastrophic Disability Rider shown in the Policy Data page. This amount will be paid while Your Spouse continues to be Catastrophically Disabled. The Catastrophic Disability must begin while this Rider is in force. A maximum of 24 months of benefits will be paid under this Rider during Your Spouse's lifetime.

Benefits are paid to You. If any monthly benefits are payable after Your death, they will be paid to Your Spouse, or to the estate of Your Spouse.

If a monthly benefit is payable for part of a month, We will pay for that part of that month at a daily rate of 1/30th of the monthly benefit amount.

Benefit payments under this Rider are in addition to any other payment that may be due under the Policy or under any other Rider to the Policy.

TERMINATION OF THIS RIDER

This Rider will terminate on the earliest of these dates:

- the date the Policy terminates; or
- the date of Your death or the date of Your Spouse's death; or
- the date that the Spouse named in Your application no longer satisfies the definition of Spouse; or
- the anniversary of the Policy Date coinciding with or next following the date of Your Spouse's 65th birthday; or
- the date We receive Your notice to Us to cancel this Rider; or
- the day after the end of the grace period for which a premium for this Rider is due and not paid.

Signed for Auto-Owners Life Insurance Company at Lansing, Michigan, on the effective date of this Rider.

[Joe Secretary]

Secretary

[John President]

President

RESIDUAL DISABILITY RIDER

This Rider is attached to and made a part of Your Policy. This Rider is effective on the Rider Date shown on the Policy Data page. If no Rider Date is shown, this Rider is effective on the Policy Date.

This Rider is subject to all provisions of the Policy that do not conflict with the provisions of this Rider. Coverage under this Rider is contingent on payment of the premium for this Rider, shown in the Policy Data page.

The Policy is amended as follows:

- The Partial Disability Benefit provision, and the definitions of Loss of Income and Partial Disability/Partially Disabled, are deleted.
- All other references to "Partial Disability" and "Partially Disabled" are replaced with "Residual Disability" or "Residually Disabled," as appropriate.
- If You have elected the Coordinating Additional Insurance Rider, that Rider is amended to delete the Partial Disability Benefit under this Rider provision.
- The following provisions are added:

DEFINITIONS

As used in this Rider:

Loss of Income means the amount determined by subtracting Your Current Income from the amount of Your Pre-Disability Income. The difference must equal at least 15% of Pre-Disability Income to be considered Loss of Income. If Loss of Income is 85% or more of Pre-Disability Income, We will consider it to be 100% of Pre-Disability Income.

Residual Disability/Residually Disabled means, due to the occurrence of a condition caused by an Injury, Sickness, or Mental or Nervous Disorder, You have a Loss of Income; and

- during the Own Occupation Period - You are not able to perform one or more of the material and substantial duties of Your Regular Occupation; or You are able to perform all of the material and substantial duties of Your Regular Occupation, but You can work no more than 80% of the time You worked in Your Regular Occupation prior to Your Disability.
- after the Own Occupation Period - You are not able to perform one or more of the material and substantial duties of any occupation for which You are reasonably fitted by education, training or experience; or You are able to perform all of the material and substantial duties of any occupation for which You are reasonably fitted by education, training or experience, but You can work no more than 80% of the time You worked in Your Regular Occupation prior to Your Disability.

To be Residually Disabled, You must be under the care of a Physician, whose area of practice is appropriate for treatment of the Injury, Sickness, or Mental or Nervous

Disorder causing Your Disability, based on prevailing medical standards. However, if We receive written proof satisfactory to Us, from the Physician, that You have reached Your maximum point of recovery and are still Residually Disabled, We will not require You to see, or be under the care of, the Physician on a regular basis.

The loss of a professional or occupational license for any reason does not, by itself, mean You are Residually Disabled.

BENEFIT

If You are Residually Disabled, immediately after a period of Total Disability for which Total Disability benefits were payable to You, We agree to pay the monthly benefit described below.

This benefit will be paid to You while You continue to be Residually Disabled, but not after the date on which the total number of Total Disability and Residual Disability benefit payments equal the length, in months, of the Maximum Benefit Period shown in the Policy Data page.

The Residual Disability monthly benefit amount is determined by this formula:

$$A/B \times C = D, \text{ where;}$$

A equals the amount of Loss of Income;
B equals the amount of Pre-Disability Income;
C equals the sum of:

- the Total Disability Monthly Benefit including increases in the Total Disability Monthly Benefit purchased under the Guaranteed Insurability Rider, if elected; and
- the Monthly Benefit Amount for the Coordinating Additional Insurance Rider, if elected; and

D equals the Residual Disability monthly benefit amount.

During the 6 months immediately following a period of Total Disability, You will be considered to be in the Own Occupation Period for purposes of determining eligibility for benefits under this rider. The Residual Disability monthly benefit amount during this period is the greater of the following:

- **D** calculated above, or
- 50% x **C**.

We may require any evidence that We need, to determine Your Current Income and Pre-Disability Income, prior to and during a period of Residual Disability. From time to time, We may require a certified audit to verify such evidence.

Residual Disability monthly benefits are not payable for any period when a Total Disability monthly benefit is payable.

TERMINATION OF THIS RIDER

This Rider will terminate on the earliest of these dates:

- the date the Policy terminates; or
- the date We receive Your notice to Us to cancel this Rider; or
- the day after the end of the grace period for which a premium for this Rider is due and not paid.

Signed for Auto-Owners Life Insurance Company at Lansing, Michigan, on the effective date of this Rider.

[Joe Secretary]

Secretary

[John President]

President

OWN OCCUPATION TO AGE 67 RIDER

This Rider is attached to and made a part of Your Policy. This Rider is effective on the Rider Date shown on the Policy Data page. If no Rider Date is shown, this Rider is effective on the Policy Date.

This Rider is subject to all provisions of the Policy that do not conflict with the provisions of this Rider. Coverage under this Rider is contingent on payment of the premium for this Rider, shown in the Policy Data page.

BENEFIT

The definition of Own Occupation Period appearing in the Definitions section of Your Policy, is amended to read as follows:

Own Occupation Period means the period commencing with the completion of the Elimination Period and ending on the date You attain Age 67.

TERMINATION OF THIS RIDER

This Rider will terminate on the earliest of these dates:

- the date the Policy terminates; or
- the date We receive Your notice to Us to cancel this Rider; or
- the day after the end of the grace period for which a premium for this Rider is due and not paid.

Signed for Auto-Owners Life Insurance Company at Lansing, Michigan, on the effective date of this Rider.

[Joe Secretary]

Secretary

[John President]

President

Auto-Owners Life Insurance Company

P.O. BOX 30325
LANSING, MI 48909
(517) 323-1200

As continuation of my Disability Income application to the Auto-Owners Life Insurance Company, I submit the following addendum for the use of underwriting the Business Overhead Expense Rider. I understand this will be part of the contract and I declare that this information is complete and true, and no material facts have been withheld.

BUSINESS OVERHEAD EXPENSE RIDER ADDENDUM

Name John Doe Birth Date 05/05/1981
 Social Security No. 555-55-5555 Percentage of Ownership 100 %
 Monthly Benefit Amount \$ 2,000 Benefit Period 12 month 18 month 24 month
 Elimination Period 30 days 60 days

Using the Proposed Insured's percentage of ownership in the business, insert the Proposed Insured's share of the average monthly tax deductible business expenses from the most recently completed tax year as reported on IRS forms and supporting schedules. Please indicate "N/A" when not applicable.

1. Rent.....	\$ 750.00
2. Lease.....	\$
3. Mortgage.....	\$
4. Real estate taxes.....	\$ 28.00
5. Other taxes (<i>itemize</i>).....	\$ 120.00
6. Technology (e.g. telephone, internet, computer, etc.).....	\$ 220.00
7. Vehicle and machinery leases/payments.....	\$ 82.00
8. Heat/Electricity.....	\$ 150.00
9. Professional dues and license fees.....	\$ 100.00
10. Maintenance.....	\$ 60.00
11. Interest on business loans.....	\$
12. Depreciation or principal on business loans (<i>other than loans on business premises</i>).....	\$
<i>(Enter the larger of monthly depreciation expense or monthly principal on business loans).</i>	
13. Insurance premiums.....	\$ 200.00
14. Legal and professional fees.....	\$ 25.00
15. Employees' salaries.....	\$ 923.00
<i>(Do not include salaries of employees in the same occupation as the Proposed Insured or family member employees employed by the business for less than 12 continuous months).</i>	
16. Payroll taxes.....	\$ 210.00
17. Other normal expenses.....	\$
a. (<i>explain</i>).....	
TOTAL	\$ 2,868.00

18. Do you have any Business Overhead Expense insurance in force or pending?
 (provide details below) Yes No
 19. If yes, is the policy applied for replacing or likely to replace any existing Business
 Overhead Expense Insurance?..... Yes No

Insured's Name	Company	Issue Date	BOE Monthly Amount

John Doe 11/11/2010 Joe Agent 11/11/2010
 Signature of Proposed Insured Date Signature of Agent Date

Auto-Owners Life Insurance Company

P.O. BOX 30325
LANSING, MI 48909
(517) 323-1200

As continuation of my Disability Income application to the Auto-Owners Life Insurance Company, I submit the following addendum for the use of underwriting the Spousal Catastrophic Disability Rider. I understand this will be part of the contract and I declare that this information is complete and true, and no material facts have been withheld.

The monthly benefit amount will be equal to 50% of the base monthly benefit amount up to \$2000 a month. The benefit period is two years. The elimination period is 60 days.

SPOUSAL CATASTROPHIC DISABILITY RIDER ADDENDUM

Name Jane Doe Date of Birth 05/05/1981 Place of Birth any town, USA

Social Security No. 555-55-5551 Height 5'5" Weight 125

- 1. Are you a US citizen? (if no, please provide valid resident card) Yes No
- 2. Are you employed? Yes No
If yes, please answer questions 2a-2d
a. Employer's name and address _____
b. Do you work from home? Yes No
c. Hours worked per week for wage or profit? _____
d. Monthly income? _____
- 3. What activities do you perform at home? (e.g. housekeeping, childcare, etc) _____
- 4. Have you smoked one or more cigarettes within the last 12 months? Yes No
a. Have you used tobacco in any form within the last 24 months? Yes No

If any of the following questions are left blank or answered "yes," please contact Life Underwriting.

- 5. Are you currently pregnant? (for females only) Yes No
- 6. Do you currently need assistance or supervision of another person in performing any of the following activities: Bathing, eating, toileting, controlling bowel or bladder, dressing, walking, taking medication or transferring from bed to chair? Yes No
- 7. Do you currently use an oxygen tank, respirator, catheter, cane, crutches, wheelchair or walker? Yes No
- 8. Are you currently confined to a hospital or nursing home, or are you receiving adult day care services? Yes No
- 9. Are you currently receiving paid or unpaid home health care services? Yes No
- 10. Are you currently receiving at-home physical, occupational, speech or respiratory therapy? Yes No
- 11. Within the last 12 months, have you: Consulted a healthcare professional for, been diagnosed with, or received medical advice or treatment from a healthcare professional

for, any of the following: Rheumatoid arthritis, internal cancer or malignant melanoma, chronic lung disease requiring oxygen, heart attack, stroke (CVA)/transient ischemic attack? Yes No

12. Within the last 5 years, have you been diagnosed with, received medical advice, or treatment from a healthcare professional or had any known indication of any of the following: Mental or nervous disorder requiring psychiatric treatment, organic brain disorder, Alzheimer's disease, senile dementia or other senility disorders or alcohol or drug use, chronic liver disease/cirrhosis, pancreatitis or pulmonary fibrosis, polycystic kidney disease or chronic kidney disease requiring dialysis/renal failure, cerebral palsy or Parkinson's disease, multiple sclerosis, amyotrophic later sclerosis (Lou Gehrig's disease), epilepsy, neuropathy, paralysis or muscular dystrophy, cardiomyopathy or myasthenia gravis, osteoarthritis, degeneration of the spinal cord, spinal cord injury or paraplegia, leukemia or organ or bone marrow transplant? Yes No

13. Are you currently receiving, or have you received with the past year: any treatment, attention or advice from a licensed medical or health care practitioner for any condition related to your loss of ability to see, hear or speak? Yes No

14. Within the past 5 years, have you been medically treated for or diagnosed as having either Acquired Immune Deficiency Syndrome (AIDS) or AIDS-Related Complex (ARC)? Yes No

Signed in the state of Any state this 11 day of November 2010

John Doe
(Signature of Proposed Insured)

Jane Doe
(Signature of Spouse)

Joe Agent
(Signature of Agent)

Joe Agent Agency 1, 01-01-01
(Agent's Name- Please Print) (Agency & Producer Codes)



Auto-Owners Insurance

Life Home Car Business

The "No Problem" People®

61711

61711

12/19/88

**THIS POLICY PROVIDES SICKNESS AND/OR
ACCIDENT BENEFITS AS SELECTED BY THE INSURED
GUARANTEED RENEWABLE TO AGE 67**

61711 (1-10)

Auto-Owners Life Insurance Company

LANSING, MICHIGAN 48909-8160

Auto-Owners Life Insurance Company

P.O. Box 30325
Lansing, MI 48909-7825

[NOTICE: Read this outline of coverage carefully. It is not identical to the outline of coverage provided upon application, and the coverage originally applied for has *not* been issued.]

**INDIVIDUAL DISABILITY INCOME PROTECTION INSURANCE POLICY
REQUIRED OUTLINE OF COVERAGE
FOR POLICY FORM 61739**

READ YOUR POLICY CAREFULLY – This outline of coverage provides a very brief description of the important features of Your policy. This is not the insurance contract and only the actual policy provisions will control. The policy itself sets forth in detail the rights and obligations of both You and Your insurance company (herein called "We", "Us", "Our"). It is, therefore, important that You **READ YOUR POLICY CAREFULLY!**

Caution: The issuance of the policy will be based on Your responses to the questions in Your application. A copy of Your application will be made part of the policy. If Your answers are incorrect or untrue, We may have the right to deny benefits or rescind Your policy. The best time to clear up any questions is now, before a claim arises! If, for any reason, any of Your answers are incorrect, contact Us at the address shown above.

DISABILITY INCOME PROTECTION COVERAGE – Policies of this category are designed to provide, to persons insured, coverage for disabilities resulting from a covered injury or sickness. Benefits are subject to any limitations set forth in the policy. Coverage is *not* provided for basic hospital or medical or surgical expenses, or for major medical expenses.

BENEFITS

Total Disability Benefit..... Included
Premium: \$ [248.00] Per [semi-ann]
If an Injury or a Sickness causes You to be Totally Disabled, a benefit of \$ [2,000] per month will be paid to You. Payments start after the [60] day Elimination Period is satisfied. Benefits will be paid up to the [2 year] Maximum Benefit Period.

Partial Disability Benefit..... Included
If You are Partially Disabled due to the Injury or Sickness that caused Your Total Disability, immediately after You receive benefit(s) for Total Disability, then a Monthly Benefit Amount of one half the Total Monthly Disability Benefit will be paid. Benefits will be paid for up to 6 months, but not after the date on which the number of Total Disability and Partial Disability benefits paid equals the number of months in the Maximum Benefit Period.

Transplant Benefit..... Included
If You donate one of Your organs, or bone marrow, or other body part that can be transplanted, for transfer to another person, then the physical condition that results from the transfer will be deemed a Sickness. If You become Totally Disabled as a result, then Total Disability Benefits will be payable as for any other Disability. Your policy must have been in force for at least 6 months before Your donation, for benefits to be payable for this reason.

Premium Waiver Benefit..... Included
After You have been Disabled for 90 days in a row, We will waive the payment of premiums that become due for the policy and any riders attached to it. We will continue to waive them for as long as Your Disability continues. All premiums paid that were due during that 90 day period will be returned to You. When You are no longer Disabled, this waiver of premium ends, and You must resume premium payments as of the next premium due date to continue Your coverage under the policy and its riders.

Optional 3% Cost of Living Increase Rider, Form 61746 Included Not Included
Premium: \$ _____ Per _____

This rider provides an increase in monthly benefits for Disability under the policy after You have been Disabled for 12 months in a row. While You remain Disabled, Your benefit amount is increased each year by 3% compounded annually, until the benefit doubles.

This rider also applies to:

- the Total Disability Monthly Benefit increases purchased under the Guaranteed Insurability Rider; and
 - the Monthly Benefit Amount for the Coordinating Additional Insurance Rider;
- if included with Your policy.

Optional Business Overhead Expense Rider, Form 61745 Included Not Included
Premium: \$ _____ Per _____

This rider provides benefits if You incur Covered Business Owner Expenses while You are Totally Disabled and while this rider is in force. The monthly benefit is the lesser of the actual amount of Covered Business Overhead Expenses incurred in that month, and \$ _____. This benefit has an Elimination Period of _____ days of Total Disability. This benefit has a Maximum Benefit Period during Your lifetime of _____ months.

Optional Business Owner Return-To-Work Rider, Form 61729 Included Not Included
Premium: \$ _____ Per _____

This rider provides a limited extension of Your Total Disability Benefits, if You recover from Your Total Disability before benefits are paid for the Maximum Benefit Period. To qualify, You must return to Actively at Work status in Your Regular Occupation within 30 days after the last day of a period of Total Disability for which a Total Disability Benefit was paid. Benefits will then be extended, from 1 to 3 months, based on the number of Total Disability Benefits You had received before Your Recovery. The extended benefit amount under this rider equals 50% of the Total Disability Benefit above. The Maximum Benefit Period applies to the total number of Total Disability Benefit payments under Your policy plus any extended payments under this rider.

This rider also applies to:

- the Monthly Benefit Amount for the Coordinating Additional Insurance Rider; and
 - the 3% Cost of Living Increase Rider; and
 - the Total Disability Monthly Benefit increases purchased under the Guaranteed Insurability Rider;
- if included with Your policy.

Optional Coordinating Additional Insurance Rider, Form 61732 Included Not Included
Premium: \$ _____ Per _____

This rider provides a monthly benefit in addition to the Total Disability Benefit or Partial Disability Benefit above. The amount of this monthly benefit equals \$ _____, less the amount of any benefits from Other Benefit Programs that are payable to You or Your Family Member, or for which You or Your Family Member are eligible, for the same month.

Other Benefit Programs include:

- Social Security disability benefits; and
- Worker's Compensation disability benefits; and
- federal, state or local retirement and disability fund benefits.

This monthly benefit will be paid while Your Disability continues, but not after the date that Total Disability benefits or Partial Disability benefits under the policy end.

Optional First Day Hospital Confined Rider, Form 61744 Included Not Included
Premium: \$ _____ Per _____

This rider provides for payment of Total Disability Benefit amounts, during the Elimination Period, if You are Confined in a Hospital because of Your Total Disability. We will pay a pro rata portion of the Total Disability Benefit amount for each day of such Confinement during the Elimination Period while You remain Totally Disabled.

This rider also applies to:

- the Total Disability Monthly Benefit increases purchased under the Guaranteed Insurability Rider; and
 - the Monthly Benefit Amount for the Coordinating Additional Insurance Rider; and
 - the Business Overhead Expense Rider;
- if included with Your policy.

Optional Guaranteed Insurability Rider, Form 61728 Included Not Included
Premium: \$ _____ Per _____

This rider allows You to increase Your Total Disability Benefit amount prior to Your 58th birthday. Your health status will not be considered, other than proof that You are not Disabled. An increase can only take effect on an anniversary of Your Policy Date, and only after Your policy has been in force for at least 2 years. Increases must be at least 2 years apart. Increases are subject to Our underwriting requirements. The amount of any increase is subject to a minimum of \$100.00, and a maximum of 50% of Your Total Disability Benefit amount on Your Policy Date. The maximum amount for all increases is 2 times Your Total Disability Benefit amount on Your Policy Date.

Optional Own Occupation Five Year Rider, Form 61748 Included Not Included
Premium: \$ _____ Per _____

This rider lengthens the time period described in the policy definition of Own Occupation Period. This time period is increased from 24 months to 60 months.

Optional Own Occupation To Age 67 Rider, Form 61749 Included Not Included
Premium: \$ _____ Per _____

This rider lengthens the time period described in the policy definition of Own Occupation Period. This time period is increased, from 24 months, to the number of months from the completion of the Elimination Period to the date You attain age 67.

Optional Residual Disability Rider, Form 61747 Included Not Included
Premium: \$ _____ Per _____

This rider provides a monthly benefit if You return to Your Regular Occupation while Residually Disabled. If this return follows immediately after You receive a Total Disability Benefit, and You suffer a loss of 15% or more of Your Pre-Disability Income, then We will pay a Residual Disability benefit. Your benefit is based on the percent of income lost as a result of Your Disability. We will pay this benefit while Your Residual Disability continues, but not after the date on which the number of Total Disability and Residual Disability benefits paid equals the number of months in the Maximum Benefit Period.

Optional Spousal Catastrophic Disability Rider, Form 61743 Included Not Included
Premium: \$ _____ Per _____

This rider provides a monthly benefit to You of \$ _____, if Your Spouse suffers a Catastrophic Disability while this rider is in force. Your Spouse must be unable to perform 2 or more Activities of Daily Living without Hands-On Assistance, or must require Substantial Supervision due to a Severe Cognitive Impairment, in order to qualify. Your Spouse must be Catastrophically Disabled for 60 days in a row. Benefits can then be paid while the Catastrophic Disability continues. A maximum of 24 months of benefits will be paid during the Spouse's lifetime.

EXCLUSIONS AND LIMITATIONS

Exclusions – Benefits will not be paid under Your policy or any attached riders, for:

- any Disability caused by war or any act of war, whether declared or undeclared, or by any other armed conflict; or
- any Disability caused or contributed to by Your intentionally self-inflicted injury or sickness, except that this does not include a voluntary donation described in the Transplant Benefit; or
- any Disability due to normal pregnancy, childbirth or elective abortion, except that this does not include Complications of Pregnancy; or
- any Disability caused by Your active participation in a riot or insurrection; or
- any Disability that results from Your military service of any country or authority, except during active duty for training of less than 60 days; or

AVIATION EXCLUSION PROVISION

PROVISION

If any insured person:

- is a pilot, officer or member of the crew of any kind of aircraft; *or*
- is giving or receiving any kind of training or instruction or has any duties aboard such aircraft; *or*
- is being flown for the purpose of descent from such aircraft while in flight; *and*
- he or she dies as a direct result of operating, riding in or descending from that aircraft;

- the premiums actually paid plus interest at 3% per year from their due dates; *Less*
- any loan or loan interest.

These limitations also apply to:

- any Reduced Paid-Up Insurance or Extended Term Insurance provided in the Non-Forfeiture Provisions; *and*
- any policy to which this policy may be changed or converted.

then the death benefit payable under the policy will be:

Signed for Auto-Owners Life Insurance Company at Lansing, Michigan, on the effective date.

(Secretary)

(President)

ANSWERS MADE TO THE MEDICAL EXAMINER

Forming part of an application for insurance to

AUTO-OWNERS LIFE INSURANCE COMPANY, P.O. BOX 30325, LANSING, MICHIGAN 48909

Part II

Proposed Insured _____ Birth Date: _____
First Name Middle Name Last Name Month Day Year

1. a. Name, address and phone number of your personal physician _____
(If none, so state)
 b. Date and reason last consulted (if within 5 years) _____

2. Have you EVER been treated for or EVER had any known indication of:
- | | | |
|---|--------------------------|--------------------------|
| a. Disorder of eyes, ears, nose or throat? | <input type="checkbox"/> | <input type="checkbox"/> |
| b. Dizziness, epilepsy, fainting, convulsions, headache, speech defect, paralysis or stroke, or mental or nervous disorder? | <input type="checkbox"/> | <input type="checkbox"/> |
| c. Shortness of breath, persistent hoarseness or cough, blood spitting, bronchitis, pleurisy, asthma, emphysema, tuberculosis or chronic respiratory disorder? | <input type="checkbox"/> | <input type="checkbox"/> |
| d. Chest pain, palpitation, high blood pressure, rheumatic fever, heart murmur, heart attack, or other disorder of heart or blood vessels? | <input type="checkbox"/> | <input type="checkbox"/> |
| e. Jaundice, intestinal bleeding, ulcer, hernia, appendicitis, colitis, diverticulitis, hemorrhoids, recurrent indigestion, or other disorder of the stomach, intestines, liver or gallbladder? | <input type="checkbox"/> | <input type="checkbox"/> |
| f. Sugar, albumin, blood or pus in urine, venereal disease, stone or other disorder of kidney, bladder, prostate or reproductive organs? | <input type="checkbox"/> | <input type="checkbox"/> |
| g. Diabetes, thyroid or other endocrine disorders? | <input type="checkbox"/> | <input type="checkbox"/> |
| h. Neuritis, sciatica, rheumatism, arthritis, gout, or disorder of the muscles or bones, including the spine, back or joints? | <input type="checkbox"/> | <input type="checkbox"/> |
| i. Deformity, lameness or amputation? | <input type="checkbox"/> | <input type="checkbox"/> |
| j. Disorder of skin, lymph glands, cyst, tumor or cancer? | <input type="checkbox"/> | <input type="checkbox"/> |
| k. Acquired Immune Deficiency Syndrome, AIDS Related Complex or AIDS related conditions? | <input type="checkbox"/> | <input type="checkbox"/> |
| l. Allergies, leukemia, anemia or other disorder of the blood? | <input type="checkbox"/> | <input type="checkbox"/> |
| m. Excessive use of alcohol or any drugs? | <input type="checkbox"/> | <input type="checkbox"/> |
| n. Disorder of menstruation, pregnancy or breasts? | <input type="checkbox"/> | <input type="checkbox"/> |

DETAILS of "Yes" answers. IDENTIFY QUESTION NUMBER, CIRCLE APPLICABLE ITEMS: Include diagnoses, dates, duration, and names and addresses of all attending physicians and medical facilities.

3. Had any mental or physical disorder not listed above?

4. Have you used tobacco in any form within the last 24 months?

If so, please explain _____

5. *Other than above*, have you within the past five years:
- | | | |
|--|--------------------------|--------------------------|
| a. Had a checkup, consultation, illness, injury or surgery? | <input type="checkbox"/> | <input type="checkbox"/> |
| b. Been a patient in a hospital, clinic, sanatorium or other medical facility? | <input type="checkbox"/> | <input type="checkbox"/> |
| c. Had an electrocardiogram, X-ray or other diagnostic test? | <input type="checkbox"/> | <input type="checkbox"/> |
| d. Been advised to have any diagnostic test, hospitalization or surgery which was not completed? | <input type="checkbox"/> | <input type="checkbox"/> |

6. Have you ever had military service deferment, rejection or discharge because of a physical or mental condition?

7. Have you ever requested or received a pension, benefits, or payment because of an injury, sickness or disability?

8. Family History: Tuberculosis, diabetes, cancer, high blood pressure, heart or kidney disease, mental illness or suicide?

	Age if Living?	Present Health?	Age at Death?	Cause of Death?
Father				
Mother				
Brothers and Sisters				
No. Living				
No. Dead				

I declare that the statements and answers shown above are true and complete to the best of my knowledge and belief, and I agree that they shall be considered the basis of any insurance issued.

Dated at _____ this _____ day of _____,

Witness _____ M.D. _____
(Signature of Medical Examiner) (Signature of Proposed Insured)

STATEMENT OF INSURABILITY

It is not necessary to send the policy with this request.

I, _____ (_____)
 Complete Name Street Address City State Zip Telephone

hereby apply for: Reinstatement Select Rates Reduction in Policy Rate Removal of Exclusion
 Other _____ Policy No. _____

The following questions must be answered individually by each insured adult or by the parent or guardian of any insured child who is less than 16 years old.

	Proposed Insured		Additional Adult Insd.		Children	
	YES	NO	YES	NO	YES	NO
1. a. Proposed Insured's: Height _____ Weight _____						
b. Additional Adult Insured's: Height _____ Weight _____						
c. Children: Height _____ Weight _____						
2. Has any Insured, since the issue date of this policy or within the last 10 years if more recent, been diagnosed or treated for the following: (If yes, give details in #11)						
a. Heart attack, murmur, rheumatic fever, high blood pressure, stroke, vascular, chest pain or other disease or disorder of the heart, blood vessels or blood?	<input type="checkbox"/>					
b. Diabetes, sugar or albumin in the urine, any disorder of the kidneys, bladder, prostate, reproductive organs, enlarged lymph nodes, immunodeficiency disorder, lupus or gout?	<input type="checkbox"/>					
c. Stomach or intestinal disorders, Crohn's, ulcerative colitis, ulcer, cancer, tumor, thyroid, used or currently using illegal drugs, or treatment for use of alcohol or drugs?	<input type="checkbox"/>					
d. Disorder of the lungs, COPD, respiratory trouble, asthma, emphysema, sleep apnea or tuberculosis?	<input type="checkbox"/>					
e. Epilepsy, paralysis, convulsions, Alzheimer's, brain or nervous system disorder, mental disorders, depression, anxiety, stress, arthritis, impairment of limb, sight, hearing or speech?	<input type="checkbox"/>					
f. Any illness, injury, examination or medical attention within the past 5 years not stated above?	<input type="checkbox"/>					
3. Has any Insured been advised by any physician or other practitioner to have any additional diagnostic testing, hospitalization or surgery which was not completed or do you have any results pending?	<input type="checkbox"/>					
4. Has any Insured been absent from employment or school due to injury or sickness in the last 5 years? (If yes, give details in #11)	<input type="checkbox"/>					
5. Has any application for insurance on the life of any Insured ever been declined, postponed or rated? (If yes, give details in #11)	<input type="checkbox"/>					
6. Has any Insured changed occupation, military or aviation status in the last 5 years? (If yes, give details in #11)	<input type="checkbox"/>					
7. Has any Insured used tobacco in any form within the last 24 months? (If yes, give details in #11)	<input type="checkbox"/>					
a. Has any Insured smoked one (1) or more cigarettes within the last 12 months?	<input type="checkbox"/>					
8. Is any Insured now pregnant? How many months? Any complications? (If yes, give details in #11)	<input type="checkbox"/>					

9. What is the name, address and phone number of your personal physician? _____
 a. When was the date and the reason of your last visit? _____ Results? _____ (Give details in #11)

10. What is Insured's present income per month? _____ Any other Life or Disability Income insurance in force? If yes, please provide the following details for Disability Income insurance: Benefit Amount \$ _____ Benefit Period _____ Waiting Period _____

11. Give details of Questions #2, 3, 4, 5, 6, 7 and 8 above answered "Yes."

Insured's Name	Description of Disease or Injury	Date	Treatment or Other Details	Name and Address of Attending Physician

It is agreed that: (A) All answers to the above questions are complete and true to the best of my knowledge and belief; (B) All representations made here are material; (C) Any change, addition to or reinstatement of said policy granted by us on this application shall be contestable during the two years from the date it is made, for fraud or misrepresentation of any material facts stated herein; (D) No action taken under item (C) will be effective until this application is approved by us. Such approval must be during my lifetime and while my health or any family member insured under this policy is the same as it was on the date of this application; (E) Any action taken under item (C) will be subject to the conditions in this application and provisions of the policy.

I AUTHORIZE the release of information to Auto-Owners Life Insurance Company. This release will also apply to its reinsurers, insurance support organizations and their representatives. It may concern me or my health. It may also concern my child or my child's health. Medical, financial or personal details may be released. Also to be released are data about drug use, alcoholism or mental illness. This will be used by underwriters, Company Officers and medical personnel to evaluate claims. They may also use it to consider Life or Health insurance and/or benefits applied for by me.

Data may be released by physicians or practitioners. It may also be released by hospitals, clinics or other medical facilities. The V.A. and/or the MIB, Inc. may release data. My employer and any consumer reporting agencies may also release data. Insurance companies and their reinsurers who may have information of care, treatment or advice about me or my child may also release it.

I UNDERSTAND that this authorization is valid for 24 months from the date it is signed. A copy of it is also valid.

I ACKNOWLEDGE having received a copy. I also received a copy of the NOTICE OF INSURANCE INFORMATION PRACTICES.

I wish to have an interview if an investigative consumer report is made for this application.

Signed at _____ this _____ day of _____, _____
 City and State

 (Signature of Proposed Insured or Parent, if minor)

 (Agent's Signature)

 (Signature of Additional Adult Insured age 16 and over)

Received from _____ who has this day applied for Insurance Coverage to be issued by Auto-Owners Life Insurance Company, Lansing, Michigan, the sum of \$ _____ by _____ (check, cash, etc.)

No change of, addition to, or reinstatement of this policy shall be effective until this application is approved by the Company at its Home Office in Lansing, Michigan during the Insured's lifetime and while his/her health, or other family member insured under this policy, is the same as it was on the date this application was completed as represented above, and subject to the conditions set forth in this application and the provisions of the policy.

Signed: Agent _____ Date _____

AUTO-OWNERS LIFE INSURANCE • P.O. BOX 30325 • LANSING, MICHIGAN 48909

TO BE DETACHED AND RETAINED BY PROPOSED INSURED NOTICE OF INSURANCE INFORMATION PRACTICES

This Life and Health insurance form gives personal data about the persons to be covered. Sometimes, we may need to seek more personal data from other sources. If we ask for any investigative consumer report, you have the right to ask for an interview with the reporting agency. All such personal data is treated as confidential. In some cases, however, that data may be disclosed to others without an authorization. You have a right of access to this personal data. You may also correct any errors in the data we might collect. You can learn more about these rights and our practices upon request.

MIB, INC.

Information regarding your insurability will be treated as confidential. Auto-Owners Life Insurance Company or its reinsurers may, however, make a brief report thereon to the MIB, Inc., formerly known as Medical Information Bureau, a not-for-profit membership organization of insurance companies, which operates an information exchange on behalf of its members. If you apply to another MIB member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, MIB, upon request, will supply such company with the information about you in its file.

Upon receipt of a request from you, MIB will arrange disclosure of any information in your file. Please contact MIB at 866-692-6901 (TTY 866-346-3642). If you question the accuracy of the information in MIB's file, you may contact MIB and seek a correction in accordance with the procedures set forth in the federal Fair Credit Reporting Act. The address of MIB's information office is 50 Braintree Hill Park, Suite 400, Braintree, Massachusetts 02184-8734.

Auto-Owners Life Insurance Company, or its reinsurers, may also release information in its file to other insurance companies to whom you may apply for life or health insurance, or to whom a claim for benefits may be submitted. Information for consumers about MIB may be obtained on its website at www.mib.com.

CONSUMER AND/OR INVESTIGATIVE CONSUMER REPORTS

You need to know that when you apply for insurance with us, we may ask for a report from a consumer reporting agency. The report could include interviews with you, your neighbors, friends, etc. What we learn is used to determine insurability. It may cover data as to character, reputation, personal characteristics, and mode of living. Data gathered for such a report may be kept by the agency preparing it and disclosed to others.

If you write to us, we will tell you if such a report was made. We will also tell you the nature and scope of the report. This will be done in a reasonable time once we receive your letter. We will also tell you who made the report. You can then contact them to see and get a copy of the report.

MEDICAL RECORD INFORMATION

We underwrite each application to help keep the price reasonable. This also helps each person to pay a fair share of the cost in line with the risk each represents. To do this we ask about your physical or mental condition, medical history or treatment. Your application gives some of these answers. We may ask your doctor, hospital, etc., for more details. We may ask you to take an examination. You have the right to amend or correct any personal information we collect. Medical data goes only to a doctor you name. Write us if you want to do this. Write to Auto-Owners Life, Underwriting Division, Box 30325, Lansing, MI 48909.

AUTHORIZATION AND ACKNOWLEDGEMENT

I AUTHORIZE the release of information to Auto-Owners Life Insurance Company. This release will also apply to its reinsurers, insurance support organizations and their representatives. It may concern me or my health. It may also concern my child or my child's health. Medical, financial or personal details may be released. Also to be released are data about drug use, alcoholism or mental illness. This will be used by underwriters, Company Officers and medical personnel to evaluate claims. They may also use it to consider Life or Health insurance and/or benefits applied for by me.

Data may be released by physicians or practitioners. It may also be released by hospitals, clinics or other medical facilities. The V.A. and/or the MIB, Inc. may release data. My employer and any consumer reporting agencies may also release data. Insurance companies and their reinsurers who may have information of care, treatment or advice about my child may also release it.

I UNDERSTAND that this authorization is valid for 24 months from the date it is signed. A copy of it is also valid.

I ACKNOWLEDGE having received a copy. I also received a copy of the NOTICE OF INSURANCE INFORMATION PRACTICES.

INSURANCE FRAUD

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

AUTO-OWNERS LIFE INSURANCE • P.O. BOX 30325 • LANSING, MICHIGAN 48909

SERFF Tracking Number: AOIC-126829993 State: Arkansas
 Filing Company: Auto-Owners Life Insurance Company State Tracking Number: 48630
 Company Tracking Number:
 TOI: H111 Individual Health - Disability Income Sub-TOI: H111.003 Long Term - Unrelated to marketing
 with employer or association groups
 Product Name: Disability Income
 Project Name/Number: /

Rate/Rule Schedule

Schedule Item Status:	Document Name:	Affected Form Numbers: (Separated with commas)	Rate Action:	Rate Action Information:	Attachments
Approved-Closed 05/03/2011	Rate Manual	61739 (5-10) et al	New		AODI Rate Manual 61739 v2.pdf

Auto-Owners Life Insurance Company
 Individual Disability Income Insurance Policy
 Form # 61739, et al
 Rate Manual

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Premium Adjustments:

1. The Policy Fee is \$50
2. Premium rates for Smokers are 120% of rates as shown for Non-Smokers.
3. Substandard premiums may be charged. The substandard premium is a percentage of the standard premium.
4. Modal premium factors are as follows:

Semi-Annual	52.0%
Quarterly	26.5%
Monthly	8.6%

Auto-Owners Life Insurance Company
 Individual Disability Income Insurance Policy
 Policy Form # 61739

Benefit Period 2 Years
 Occupation Class AAAA
 Non-Smoker

Base Policy Annual Premiums per \$100 Monthly Benefit, by Gender and Elimination Period in days

Issue Age	Male 30	Male 60	Male 90	Male 180	Female 30	Female 60	Female 90	Female 180
18-25	13.51	11.76	6.73	5.85	18.38	15.12	8.28	7.28
26	13.91	12.08	6.86	5.95	19.10	15.71	8.54	7.49
27	14.33	12.41	7.00	6.06	19.86	16.32	8.82	7.72
28	14.76	12.74	7.15	6.17	20.65	16.95	9.11	7.94
29	15.20	13.09	7.29	6.28	21.46	17.61	9.40	8.18
30	15.66	13.45	7.44	6.39	22.31	18.29	9.70	8.42
31	16.26	13.89	7.67	6.57	23.41	19.07	10.11	8.73
32	16.88	14.35	7.91	6.75	24.55	19.88	10.52	9.06
33	17.53	14.82	8.15	6.93	25.76	20.73	10.96	9.39
34	18.20	15.31	8.40	7.12	27.02	21.61	11.42	9.74
35	18.90	15.81	8.66	7.32	28.34	22.53	11.89	10.10
36	19.51	16.29	9.06	7.67	29.25	23.13	12.37	10.49
37	20.14	16.78	9.47	8.04	30.19	23.75	12.87	10.90
38	20.79	17.29	9.90	8.42	31.16	24.39	13.39	11.33
39	21.47	17.81	10.35	8.82	32.16	25.04	13.93	11.77
40	22.16	18.35	10.82	9.25	33.20	25.71	14.49	12.23
41	22.84	18.89	11.28	9.67	33.75	26.03	14.85	12.55
42	23.54	19.44	11.77	10.11	34.30	26.35	15.22	12.88
43	24.26	20.01	12.27	10.57	34.87	26.68	15.60	13.22
44	25.00	20.60	12.80	11.05	35.45	27.01	15.98	13.56
45	25.76	21.20	13.35	11.56	36.03	27.35	16.38	13.92
46	26.91	22.09	13.99	12.14	36.71	27.75	16.79	14.31
47	28.12	23.01	14.67	12.76	37.41	28.15	17.21	14.72
48	29.38	23.97	15.38	13.41	38.11	28.55	17.65	15.14
49	30.69	24.97	16.12	14.10	38.83	28.96	18.09	15.57
50	32.07	26.02	16.90	14.81	39.57	29.38	18.54	16.01
51	33.66	27.26	17.95	15.80	40.47	29.98	19.10	16.61
52	35.32	28.56	19.07	16.85	41.40	30.59	19.67	17.22
53	37.07	29.92	20.26	17.96	42.34	31.21	20.26	17.86
54	38.90	31.34	21.51	19.16	43.31	31.84	20.86	18.52
55	40.83	32.83	22.85	20.43	44.30	32.49	21.48	19.21
56	42.53	34.16	24.06	21.63	46.47	33.39	22.49	20.20
57	44.39	35.62	25.40	22.96	48.96	34.36	23.61	21.29
58	46.45	37.18	26.90	24.42	51.87	35.42	24.84	22.49
59	48.73	38.89	28.59	26.03	55.32	36.60	26.22	23.83
60	51.29	40.75	30.51	27.82	59.48	37.91	27.76	25.32

Smoker: Multiply by 120%
 Policy Fee = \$50

Auto-Owners Life Insurance Company
 Individual Disability Income Insurance Policy
 Policy Form # 61739

Benefit Period 2 Years
 Occupation Class AAA
 Non-Smoker

Base Policy Annual Premiums per \$100 Monthly Benefit, by Gender and Elimination Period in days

Issue Age	Male 30	Male 60	Male 90	Male 180	Female 30	Female 60	Female 90	Female 180
18-25	15.30	13.34	7.37	6.38	21.46	17.63	9.46	8.34
26	15.80	13.73	7.53	6.50	22.38	18.37	9.80	8.60
27	16.31	14.12	7.68	6.62	23.35	19.14	10.14	8.88
28	16.84	14.52	7.84	6.74	24.35	19.94	10.50	9.16
29	17.38	14.94	8.01	6.87	25.39	20.77	10.87	9.44
30	17.94	15.37	8.17	7.00	26.49	21.64	11.25	9.74
31	18.65	15.90	8.45	7.22	27.88	22.64	11.75	10.13
32	19.38	16.45	8.74	7.44	29.34	23.68	12.28	10.53
33	20.14	17.03	9.04	7.68	30.88	24.77	12.83	10.95
34	20.93	17.62	9.34	7.92	32.50	25.92	13.40	11.38
35	21.75	18.23	9.66	8.17	34.20	27.11	14.00	11.84
36	22.51	18.82	10.13	8.58	35.37	27.87	14.61	12.34
37	23.29	19.42	10.63	9.01	36.57	28.66	15.25	12.86
38	24.10	20.05	11.15	9.46	37.82	29.46	15.91	13.41
39	24.94	20.70	11.69	9.94	39.10	30.29	16.61	13.98
40	25.81	21.36	12.26	10.44	40.44	31.15	17.33	14.57
41	26.66	22.02	12.84	10.95	41.14	31.58	17.80	14.98
42	27.55	22.69	13.44	11.48	41.85	32.02	18.28	15.41
43	28.46	23.38	14.07	12.05	42.58	32.46	18.77	15.84
44	29.40	24.10	14.73	12.64	43.32	32.92	19.28	16.29
45	30.37	24.84	15.42	13.26	44.07	33.37	19.80	16.75
46	31.81	25.96	16.21	13.98	44.93	33.86	20.31	17.25
47	33.32	27.12	17.05	14.75	45.81	34.36	20.84	17.76
48	34.89	28.34	17.93	15.56	46.71	34.86	21.38	18.28
49	36.55	29.62	18.85	16.41	47.62	35.37	21.94	18.82
50	38.28	30.95	19.82	17.31	48.55	35.89	22.51	19.38
51	40.27	32.49	21.12	18.51	49.69	36.65	23.21	20.12
52	42.36	34.11	22.51	19.80	50.86	37.43	23.94	20.89
53	44.55	35.80	23.99	21.17	52.06	38.23	24.70	21.69
54	46.87	37.58	25.56	22.64	53.28	39.04	25.47	22.52
55	49.30	39.45	27.23	24.21	54.53	39.87	26.28	23.38
56	51.42	41.11	28.70	25.69	56.27	41.03	27.53	24.61
57	53.75	42.92	30.34	27.31	58.22	42.27	28.90	25.97
58	56.33	44.87	32.18	29.10	60.41	43.62	30.43	27.46
59	59.22	46.99	34.26	31.09	62.90	45.08	32.14	29.12
60	62.45	49.32	36.63	33.31	65.76	46.69	34.06	30.98

Smoker: Multiply by 120%
 Policy Fee = \$50

Auto-Owners Life Insurance Company
 Individual Disability Income Insurance Policy
 Policy Form # 61739

Benefit Period 2 Years
 Occupation Class AA
 Non-Smoker

Base Policy Annual Premiums per \$100 Monthly Benefit, by Gender and Elimination Period in days

Issue Age	Male 30	Male 60	Male 90	Male 180	Female 30	Female 60	Female 90	Female 180
18-25	18.57	14.97	9.86	8.45	28.75	22.16	12.48	10.47
26	18.92	15.24	10.08	8.64	29.53	22.74	12.81	10.75
27	19.28	15.51	10.30	8.84	30.33	23.33	13.14	11.04
28	19.65	15.83	10.53	9.04	31.15	23.94	13.48	11.33
29	20.02	16.28	10.77	9.24	32.00	24.57	13.83	11.64
30	20.40	16.75	11.01	9.45	32.87	25.21	14.19	11.95
31	20.94	17.33	11.36	9.77	33.82	25.89	14.60	12.33
32	21.49	17.93	11.72	10.09	34.79	26.59	15.03	12.72
33	22.07	18.56	12.10	10.43	35.79	27.31	15.48	13.13
34	22.81	19.21	12.48	10.78	36.82	28.25	15.93	13.54
35	23.71	19.87	12.88	11.14	37.88	29.55	16.40	13.98
36	24.54	20.51	13.51	11.73	38.86	30.38	17.04	14.58
37	25.39	21.17	14.16	12.35	39.87	31.24	17.72	15.21
38	26.27	21.85	14.85	13.00	41.22	32.11	18.41	15.87
39	27.18	22.56	15.57	13.69	42.62	33.02	19.14	16.56
40	28.13	23.28	16.33	14.41	44.08	33.95	19.90	17.28
41	29.06	24.00	17.15	15.21	44.84	34.42	20.65	18.01
42	30.03	24.73	18.02	16.06	45.62	34.90	21.44	18.78
43	31.02	25.48	18.93	16.95	46.41	35.38	22.26	19.58
44	32.05	26.27	19.89	17.89	47.22	36.02	23.11	20.41
45	33.10	27.08	20.90	18.88	48.04	36.83	23.99	21.28
46	34.67	28.30	22.13	20.07	49.12	37.75	25.02	22.24
47	36.32	29.56	23.44	21.33	50.32	38.69	26.09	23.25
48	38.03	30.89	24.82	22.67	51.55	39.65	27.20	24.30
49	39.84	32.29	26.29	24.09	52.82	40.64	28.36	25.40
50	41.73	33.74	27.84	25.60	54.11	41.66	29.58	26.55
51	43.89	35.41	29.43	27.16	55.32	42.70	31.16	28.05
52	46.91	38.52	31.11	28.82	56.57	43.76	32.82	29.63
53	50.68	41.93	32.89	30.57	57.84	44.85	34.57	31.31
54	54.75	45.65	34.77	32.44	59.14	45.97	36.42	33.07
55	59.15	49.70	36.75	34.42	60.46	47.12	38.36	34.94
56	61.49	51.68	38.02	35.43	63.21	48.70	39.54	36.16
57	64.13	53.91	39.45	36.56	66.31	50.38	40.85	37.50
58	67.18	56.47	41.10	37.85	69.86	52.18	42.29	39.00
59	70.73	59.44	43.01	39.31	73.94	54.10	43.91	40.68
60	74.93	62.95	45.28	41.02	78.71	56.18	45.74	42.58

Smoker: Multiply by 120%
 Policy Fee = \$50

Auto-Owners Life Insurance Company
 Individual Disability Income Insurance Policy
 Policy Form # 61739

Benefit Period 2 Years
 Occupation Class A
 Non-Smoker

Base Policy Annual Premiums per \$100 Monthly Benefit, by Gender and Elimination Period in days

Issue Age	Male 30	Male 60	Male 90	Male 180	Female 30	Female 60	Female 90	Female 180
18-25	26.99	22.26	15.49	12.75	35.62	28.03	17.15	13.94
26	27.49	22.63	15.77	13.00	36.62	28.78	17.57	14.32
27	28.00	23.01	16.05	13.25	37.65	29.56	17.99	14.70
28	28.52	23.40	16.35	13.50	38.71	30.36	18.42	15.09
29	29.05	23.79	16.64	13.77	39.80	31.18	18.86	15.50
30	29.58	24.19	16.95	14.03	40.92	32.02	19.31	15.91
31	30.23	24.70	17.40	14.43	42.04	32.87	19.92	16.43
32	30.90	25.21	17.87	14.83	43.18	33.75	20.55	16.98
33	31.58	25.74	18.35	15.25	44.36	34.64	21.20	17.53
34	32.27	26.28	18.85	15.68	45.58	35.56	21.87	18.11
35	32.98	26.83	19.35	16.12	46.82	36.50	22.56	18.71
36	33.94	27.61	20.15	16.83	48.00	37.47	23.42	19.51
37	34.92	28.41	20.99	17.57	49.21	38.45	24.32	20.34
38	35.94	29.24	21.85	18.34	50.45	39.47	25.26	21.20
39	36.98	30.09	22.76	19.14	51.72	40.51	26.23	22.11
40	38.05	30.97	23.70	19.98	53.03	41.58	27.24	23.05
41	39.23	31.94	24.77	20.96	54.22	42.54	28.19	23.92
42	40.45	32.94	25.89	21.98	55.44	43.51	29.17	24.83
43	41.70	33.97	27.05	23.06	56.68	44.52	30.19	25.77
44	42.99	35.03	28.28	24.19	57.95	45.54	31.24	26.74
45	44.32	36.13	29.55	25.38	59.25	46.59	32.33	27.75
46	46.16	37.59	31.23	26.88	60.72	47.77	33.57	28.88
47	48.08	39.11	33.01	28.47	62.22	48.98	34.85	30.06
48	50.08	40.69	34.88	30.15	63.76	50.22	36.19	31.28
49	52.17	42.33	36.86	31.93	65.33	51.49	37.57	32.55
50	54.34	44.04	38.96	33.82	66.95	52.79	39.01	33.87
51	56.37	46.13	41.18	35.86	68.28	53.94	40.92	35.65
52	58.48	48.31	43.53	38.03	69.63	55.12	42.93	37.52
53	60.67	50.60	46.01	40.33	71.01	56.32	45.04	39.49
54	62.94	52.99	48.63	42.77	72.42	57.55	47.25	41.56
55	66.25	55.66	51.41	45.36	73.85	58.81	49.58	43.74
56	68.87	57.88	53.33	47.02	77.75	60.40	51.02	45.18
57	71.83	60.38	55.50	48.90	82.18	62.09	52.61	46.75
58	75.24	63.24	58.00	51.04	87.25	63.90	54.37	48.51
59	79.21	66.57	60.91	53.53	93.12	65.81	56.33	50.48
60	83.92	70.50	64.38	56.43	100.00	67.87	58.55	52.70

Smoker: Multiply by 120%
 Policy Fee = \$50

Auto-Owners Life Insurance Company
 Individual Disability Income Insurance Policy
 Policy Form # 61739

Benefit Period 2 Years
 Occupation Class B
 Non-Smoker

Base Policy Annual Premiums per \$100 Monthly Benefit, by Gender and Elimination Period in days

Issue Age	Male 30	Male 60	Male 90	Male 180	Female 30	Female 60	Female 90	Female 180
18-25	31.50	26.04	18.17	14.87	38.83	31.32	19.99	16.25
26	32.12	26.50	18.50	15.16	39.93	32.17	20.49	16.70
27	32.75	26.97	18.84	15.46	41.07	33.03	21.00	17.16
28	33.39	27.44	19.18	15.76	42.24	33.92	21.52	17.64
29	34.04	27.93	19.53	16.06	43.44	34.83	22.06	18.13
30	34.71	28.42	19.88	16.38	44.67	35.76	22.61	18.63
31	35.47	29.01	20.40	16.82	45.95	36.72	23.34	19.26
32	36.23	29.61	20.94	17.28	47.26	37.70	24.09	19.92
33	37.02	30.22	21.49	17.75	48.61	38.71	24.87	20.60
34	37.82	30.85	22.05	18.24	50.00	39.74	25.67	21.30
35	38.64	31.49	22.63	18.74	51.43	40.81	26.50	22.03
36	39.75	32.40	23.53	19.54	52.82	41.87	27.50	22.94
37	40.88	33.33	24.47	20.38	54.26	42.96	28.53	23.89
38	42.05	34.30	25.45	21.25	55.74	44.08	29.60	24.88
39	43.25	35.29	26.46	22.16	57.25	45.23	30.71	25.91
40	44.49	36.31	27.51	23.11	58.81	46.41	31.86	26.99
41	45.96	37.49	28.76	24.23	60.20	47.49	32.97	28.03
42	47.47	38.70	30.06	25.40	61.63	48.60	34.11	29.10
43	49.04	39.95	31.41	26.63	63.09	49.74	35.29	30.23
44	50.66	41.25	32.83	27.91	64.59	50.90	36.51	31.39
45	52.33	42.59	34.32	29.26	66.12	52.09	37.78	32.60
46	54.63	44.40	36.27	31.00	67.91	53.45	39.28	33.96
47	57.04	46.30	38.33	32.84	69.75	54.84	40.83	35.39
48	59.55	48.27	40.52	34.79	71.64	56.27	42.45	36.87
49	62.17	50.33	42.82	36.85	73.58	57.74	44.13	38.41
50	64.90	52.48	45.26	39.04	75.58	59.24	45.88	40.02
51	67.41	54.56	47.81	41.39	77.22	60.61	48.15	42.13
52	70.02	56.73	50.50	43.87	78.90	62.00	50.53	44.34
53	72.73	58.99	53.35	46.51	80.62	63.43	53.03	46.67
54	75.55	61.33	56.35	49.30	82.38	64.89	55.65	49.12
55	78.48	63.77	59.52	52.26	84.17	66.38	58.40	51.70
56	81.33	66.35	62.00	54.38	88.95	68.22	60.07	53.39
57	84.53	69.28	64.81	56.78	94.39	70.17	61.92	55.24
58	88.22	72.62	68.07	59.53	100.63	72.26	63.96	57.30
59	92.51	76.51	71.88	62.73	107.85	74.48	66.23	59.61
60	97.56	81.11	76.43	66.48	116.34	76.86	68.80	62.21

Smoker: Multiply by 120%
 Policy Fee = \$50

Auto-Owners Life Insurance Company
 Individual Disability Income Insurance Policy
 Policy Form # 61739

Benefit Period 5 Years
 Occupation Class AAAA
 Non-Smoker

Base Policy Annual Premiums per \$100 Monthly Benefit, by Gender and Elimination Period in days

Issue Age	Male 30	Male 60	Male 90	Male 180	Male 365	Female 30	Female 60	Female 90	Female 180	Female 365
18-25	18.97	17.31	9.27	8.11	7.07	24.90	21.68	11.42	10.32	9.05
26	19.44	17.69	9.40	8.22	7.16	25.68	22.40	11.76	10.62	9.31
27	19.92	18.09	9.53	8.33	7.25	26.49	23.14	12.10	10.92	9.57
28	20.41	18.49	9.67	8.44	7.34	27.32	23.91	12.45	11.24	9.84
29	20.91	18.90	9.80	8.55	7.44	28.17	24.70	12.81	11.56	10.11
30	21.42	19.32	9.94	8.66	7.54	29.06	25.52	13.19	11.89	10.40
31	22.64	20.31	10.47	9.11	7.92	31.00	27.04	13.98	12.56	10.95
32	23.93	21.36	11.03	9.57	8.32	33.06	28.65	14.82	13.27	11.54
33	25.29	22.45	11.62	10.06	8.74	35.27	30.36	15.70	14.02	12.16
34	26.72	23.61	12.24	10.57	9.18	37.62	32.17	16.64	14.81	12.81
35	28.24	24.82	12.89	11.11	9.65	40.13	34.09	17.64	15.65	13.49
36	28.77	25.23	13.29	11.49	10.02	41.27	34.82	18.22	16.14	13.93
37	29.30	25.64	13.70	11.88	10.40	42.43	35.57	18.81	16.65	14.39
38	29.85	26.07	14.13	12.29	10.80	43.63	36.33	19.42	17.17	14.86
39	30.40	26.50	14.57	12.71	11.21	44.86	37.11	20.05	17.71	15.34
40	30.97	26.94	15.02	13.15	11.64	46.12	37.91	20.70	18.26	15.85
41	32.43	28.14	15.95	14.00	12.46	47.68	38.95	21.54	18.99	16.55
42	33.97	29.41	16.95	14.92	13.33	49.29	40.03	22.41	19.74	17.29
43	35.57	30.73	18.01	15.89	14.27	50.95	41.13	23.31	20.53	18.07
44	37.25	32.11	19.13	16.92	15.27	52.66	42.26	24.26	21.34	18.87
45	39.02	33.55	20.33	18.02	16.35	54.44	43.42	25.24	22.19	19.72
46	39.97	34.25	20.88	18.57	16.93	54.96	43.52	25.51	22.48	20.07
47	40.95	34.98	21.44	19.14	17.53	55.48	43.61	25.78	22.78	20.43
48	41.95	35.72	22.02	19.72	18.15	56.00	43.71	26.05	23.07	20.80
49	42.98	36.47	22.62	20.33	18.79	56.54	43.81	26.33	23.38	21.18
50	44.03	37.24	23.23	20.95	19.46	57.07	43.90	26.61	23.68	21.56
51	46.80	39.02	25.08	22.46	20.90	60.82	46.22	27.95	24.83	22.52
52	49.82	40.92	27.13	24.12	22.47	65.02	48.74	29.40	26.06	23.56
53	53.13	42.97	29.40	25.94	24.20	69.74	51.51	30.99	27.40	24.67
54	56.76	45.17	31.93	27.94	26.10	75.10	54.55	32.72	28.86	25.87
55	60.78	47.55	34.77	30.14	28.19	81.22	57.90	34.62	30.46	27.17
56	64.47	49.51	36.99	31.86	29.72	88.28	61.63	36.70	32.20	28.58
57	68.55	51.64	39.47	33.75	31.37	96.52	65.78	39.02	34.12	30.11
58	73.10	53.94	42.25	35.84	33.20	106.26	70.43	41.59	36.24	31.78
59	78.19	56.45	45.39	38.13	35.20	117.93	75.69	44.47	38.61	33.62
60	83.93	59.18	48.96	40.68	37.43	132.17	81.68	47.71	41.24	35.64

Smoker: Multiply by 120%
 Policy Fee = \$50

Auto-Owners Life Insurance Company
 Individual Disability Income Insurance Policy
 Policy Form # 61739

Benefit Period 5 Years
 Occupation Class AAA
 Non-Smoker

Base Policy Annual Premiums per \$100 Monthly Benefit, by Gender and Elimination Period in days

Issue Age	Male 30	Male 60	Male 90	Male 180	Male 365	Female 30	Female 60	Female 90	Female 180	Female 365
18-25	21.35	19.61	10.18	8.93	7.75	28.60	24.98	13.03	11.79	10.38
26	21.95	20.11	10.36	9.08	7.87	29.68	25.96	13.46	12.19	10.71
27	22.58	20.63	10.54	9.22	8.00	30.80	26.97	13.91	12.59	11.04
28	23.21	21.16	10.72	9.37	8.13	31.96	28.03	14.37	13.01	11.39
29	23.87	21.70	10.91	9.52	8.26	33.17	29.12	14.85	13.45	11.75
30	24.55	22.26	11.10	9.68	8.39	34.43	30.26	15.34	13.90	12.12
31	25.97	23.43	11.72	10.20	8.84	36.83	32.17	16.31	14.71	12.79
32	27.48	24.67	12.38	10.75	9.32	39.41	34.20	17.33	15.57	13.51
33	29.07	25.98	13.07	11.33	9.82	42.16	36.37	18.42	16.48	14.26
34	30.76	27.35	13.80	11.95	10.35	45.11	38.66	19.58	17.44	15.06
35	32.54	28.80	14.58	12.59	10.90	48.26	41.11	20.81	18.46	15.90
36	33.33	29.39	15.11	13.08	11.37	49.88	42.15	21.60	19.13	16.49
37	34.13	30.00	15.65	13.58	11.85	51.55	43.21	22.42	19.82	17.11
38	34.95	30.62	16.22	14.11	12.35	53.28	44.30	23.27	20.53	17.74
39	35.80	31.25	16.81	14.66	12.87	55.07	45.42	24.15	21.27	18.40
40	36.66	31.90	17.41	15.22	13.42	56.92	46.57	25.07	22.04	19.09
41	38.41	33.36	18.54	16.24	14.40	58.80	47.84	26.08	22.94	19.95
42	40.24	34.89	19.73	17.32	15.45	60.74	49.14	27.14	23.86	20.86
43	42.16	36.49	21.00	18.48	16.58	62.74	50.48	28.24	24.83	21.81
44	44.17	38.17	22.35	19.72	17.79	64.81	51.86	29.38	25.84	22.81
45	46.27	39.92	23.80	21.03	19.09	66.95	53.27	30.57	26.89	23.84
46	47.66	40.93	24.56	21.77	19.84	67.65	53.46	30.98	27.30	24.32
47	49.09	41.96	25.34	22.53	20.62	68.35	53.65	31.39	27.71	24.81
48	50.56	43.02	26.15	23.32	21.43	69.07	53.83	31.82	28.13	25.31
49	52.08	44.10	26.99	24.13	22.28	69.79	54.02	32.25	28.56	25.82
50	53.64	45.21	27.85	24.98	23.16	70.52	54.21	32.68	28.99	26.34
51	57.06	47.38	30.12	26.84	24.90	74.72	56.75	34.35	30.40	27.56
52	60.80	49.71	32.64	28.87	26.82	79.35	59.50	36.17	31.92	28.87
53	64.90	52.22	35.43	31.11	28.93	84.49	62.46	38.15	33.58	30.28
54	69.42	54.93	38.55	33.57	31.25	90.24	65.67	40.31	35.38	31.81
55	74.41	57.84	42.06	36.29	33.82	96.70	69.16	42.70	37.35	33.48
56	79.01	60.28	44.81	38.40	35.69	103.99	72.99	45.33	39.51	35.29
57	84.12	62.92	47.89	40.71	37.74	112.32	77.16	48.25	41.88	37.27
58	89.81	65.78	51.35	43.25	40.00	121.90	81.76	51.51	44.50	39.45
59	96.22	68.90	55.27	46.08	42.51	133.04	86.84	55.17	47.43	41.85
60	103.45	72.31	59.76	49.23	45.30	146.14	92.49	59.30	50.70	44.50

Smoker: Multiply by 120%
 Policy Fee = \$50

Auto-Owners Life Insurance Company
 Individual Disability Income Insurance Policy
 Policy Form # 61739

Benefit Period 5 Years
 Occupation Class AA
 Non-Smoker

Base Policy Annual Premiums per \$100 Monthly Benefit, by Gender and Elimination Period in days

Issue Age	Male 30	Male 60	Male 90	Male 180	Male 365	Female 30	Female 60	Female 90	Female 180	Female 365
18-25	27.99	23.51	14.69	12.87	10.88	43.19	35.22	18.83	16.43	13.34
26	28.29	23.77	14.91	13.12	11.10	44.12	35.97	19.25	16.87	13.73
27	28.60	24.03	15.13	13.38	11.32	45.07	36.74	19.68	17.32	14.13
28	28.91	24.30	15.35	13.64	11.55	46.05	37.53	20.12	17.79	14.54
29	29.23	24.56	15.58	13.90	11.79	47.04	38.33	20.57	18.27	14.97
30	29.54	24.83	15.81	14.17	12.02	48.05	39.15	21.03	18.76	15.40
31	30.93	25.99	16.70	14.99	12.74	50.10	40.84	22.03	19.69	16.21
32	32.38	27.20	17.64	15.86	13.50	52.23	42.60	23.07	20.68	17.06
33	33.90	28.46	18.64	16.78	14.31	54.46	44.44	24.16	21.71	17.95
34	35.49	29.79	19.68	17.75	15.16	56.77	46.36	25.30	22.79	18.89
35	37.16	31.68	20.79	18.78	16.07	59.19	48.36	26.50	23.93	19.88
36	37.78	32.33	21.46	19.50	16.75	60.21	49.14	27.25	24.73	20.64
37	38.40	33.00	22.16	20.26	17.47	61.25	49.94	28.02	25.56	21.42
38	39.04	33.68	22.87	21.04	18.22	62.30	50.75	28.81	26.42	22.23
39	39.69	34.38	23.61	21.86	19.00	63.38	51.58	29.63	27.31	23.08
40	40.35	35.09	24.37	22.70	19.82	64.47	52.42	30.47	28.23	23.95
41	42.43	36.70	26.13	24.44	21.43	66.75	54.32	32.09	29.82	25.43
42	44.60	38.38	28.01	26.31	23.17	69.11	56.29	33.81	31.49	27.01
43	46.90	40.14	30.03	28.32	25.06	71.55	58.33	35.61	33.27	28.68
44	49.31	41.99	32.20	30.48	27.09	74.08	60.44	37.51	35.14	30.45
45	51.84	43.91	34.52	32.81	29.29	76.70	62.64	39.51	37.12	32.33
46	53.05	45.02	35.88	34.03	30.65	77.99	63.51	40.79	38.31	33.45
47	54.29	46.16	37.29	35.29	32.07	79.31	64.40	42.11	39.54	34.61
48	55.62	47.32	38.75	36.59	33.56	80.65	65.31	43.47	40.81	35.81
49	57.29	48.51	40.28	37.95	35.12	82.01	66.22	44.88	42.11	37.05
50	59.00	49.73	44.46	40.41	36.74	83.40	67.15	47.81	43.46	38.33
51	62.77	52.53	47.76	43.42	39.47	88.42	69.82	50.19	45.63	40.45
52	66.88	56.57	51.43	46.75	42.50	93.97	72.66	52.79	47.99	42.77
53	71.39	61.08	55.53	50.48	45.89	100.15	75.68	55.65	50.59	45.34
54	76.36	66.16	60.15	54.68	49.71	107.05	78.91	58.80	53.45	48.19
55	81.85	71.90	65.36	59.42	54.02	114.83	82.36	62.29	56.63	51.35
56	86.77	77.38	70.35	63.95	58.14	123.64	86.06	66.50	60.45	54.95
57	94.46	83.65	76.05	69.14	62.85	133.72	90.03	71.40	64.91	59.01
58	103.48	90.88	82.62	75.11	68.28	145.35	94.31	76.98	69.98	63.62
59	114.17	99.50	90.45	82.23	74.59	158.90	98.92	83.38	75.80	68.91
60	127.05	110.68	100.62	91.15	82.05	174.91	103.91	90.79	82.53	75.03

Smoker: Multiply by 120%
 Policy Fee = \$50

Auto-Owners Life Insurance Company
 Individual Disability Income Insurance Policy
 Policy Form # 61739

Benefit Period 5 Years
 Occupation Class A
 Non-Smoker

Base Policy Annual Premiums per \$100 Monthly Benefit, by Gender and Elimination Period in days

Issue Age	Male 30	Male 60	Male 90	Male 180	Male 365	Female 30	Female 60	Female 90	Female 180	Female 365
18-25	40.69	35.31	23.79	20.46	17.34	53.38	44.71	26.20	22.46	18.90
26	41.17	35.71	24.07	20.76	17.66	54.64	45.77	26.80	23.07	19.48
27	41.66	36.12	24.36	21.06	17.98	55.92	46.85	27.41	23.69	20.08
28	42.16	36.52	24.64	21.37	18.31	57.24	47.95	28.03	24.33	20.70
29	42.66	36.94	24.93	21.69	18.65	58.58	49.08	28.67	24.98	21.33
30	43.17	37.36	25.23	22.01	18.99	59.96	50.24	29.32	25.66	21.99
31	44.91	38.89	26.46	23.09	20.00	62.41	52.31	30.72	26.94	23.19
32	46.72	40.48	27.76	24.23	21.06	64.97	54.47	32.17	28.28	24.46
33	48.60	42.14	29.12	25.43	22.18	67.62	56.71	33.70	29.70	25.79
34	50.55	43.86	30.55	26.69	23.36	70.39	59.05	35.30	31.18	27.20
35	52.59	45.66	32.05	28.01	24.60	73.27	61.48	36.97	32.74	28.68
36	53.34	46.25	32.89	28.85	25.44	74.64	62.60	38.04	33.80	29.77
37	54.09	46.84	33.76	29.71	26.32	76.03	63.73	39.14	34.89	30.90
38	54.86	47.45	34.65	30.60	27.22	77.45	64.89	40.28	36.01	32.07
39	55.64	48.06	35.56	31.52	28.16	78.89	66.07	41.44	37.17	33.29
40	56.43	48.67	36.50	32.46	29.12	80.36	67.26	42.64	38.37	34.55
41	59.27	51.09	38.87	34.65	31.26	83.13	69.62	44.70	40.33	36.52
42	62.25	53.63	41.39	36.99	33.55	85.99	72.05	46.85	42.39	38.60
43	65.39	56.30	44.08	39.48	36.02	88.95	74.57	49.11	44.56	40.80
44	68.68	59.10	46.94	42.14	38.66	92.01	77.17	51.48	46.83	43.13
45	72.14	62.04	49.99	44.98	41.50	95.18	79.87	53.96	49.22	45.59
46	73.81	63.35	51.76	46.68	43.23	97.24	81.30	55.57	50.59	47.02
47	75.53	64.68	53.60	48.44	45.03	99.35	82.76	57.22	52.00	48.51
48	77.28	66.05	55.51	50.27	46.90	101.51	84.24	58.93	53.45	50.03
49	79.08	67.44	57.48	52.17	48.85	103.71	85.76	60.68	54.94	51.61
50	80.91	68.87	61.58	55.98	50.89	105.96	87.29	64.42	58.56	53.24
51	85.71	72.89	66.15	60.14	54.67	112.34	90.76	67.98	61.80	56.18
52	91.05	78.36	71.23	64.76	58.87	119.39	94.45	71.89	65.35	59.41
53	97.01	84.60	76.91	69.92	63.56	127.24	98.38	76.21	69.28	62.98
54	103.74	91.65	83.32	75.75	68.86	136.01	102.58	81.00	73.63	66.94
55	111.39	99.60	90.54	82.31	74.83	145.89	107.06	86.30	78.45	71.32
56	120.65	107.19	97.44	88.58	80.53	157.09	111.87	92.36	83.96	76.33
57	131.34	116.04	105.49	95.77	87.06	169.89	117.03	99.17	90.16	81.96
58	143.88	127.41	115.83	104.04	94.58	184.67	122.60	106.93	97.21	88.37
59	158.75	140.95	128.14	113.65	103.32	201.88	128.59	115.82	105.29	95.72
60	176.66	157.38	143.07	125.41	113.65	222.22	138.72	126.11	114.64	104.22

Smoker: Multiply by 120%
 Policy Fee = \$50

Auto-Owners Life Insurance Company
 Individual Disability Income Insurance Policy
 Policy Form # 61739

Benefit Period 5 Years
 Occupation Class B
 Non-Smoker

Base Policy Annual Premiums per \$100 Monthly Benefit, by Gender and Elimination Period in days

Issue Age	Male 30	Male 60	Male 90	Male 180	Male 365	Female 30	Female 60	Female 90	Female 180	Female 365
18-25	47.41	41.46	28.09	24.21	19.74	59.12	50.17	30.77	26.72	21.92
26	48.06	42.04	28.46	24.60	20.11	60.60	51.33	31.52	27.47	22.63
27	48.73	42.63	28.83	25.00	20.49	62.12	52.52	32.29	28.25	23.36
28	49.40	43.23	29.21	25.41	20.87	63.68	53.73	33.08	29.05	24.11
29	50.08	43.84	29.59	25.82	21.27	65.27	54.97	33.89	29.87	24.89
30	50.77	44.46	29.98	26.24	21.67	66.91	56.24	34.72	30.71	25.69
31	52.86	46.22	31.40	27.49	22.79	69.78	58.62	36.40	32.26	27.11
32	55.04	48.06	32.89	28.80	23.97	72.77	61.10	38.16	33.90	28.60
33	57.31	49.97	34.45	30.17	25.21	75.89	63.68	40.01	35.61	30.18
34	59.68	51.95	36.09	31.61	26.52	79.15	66.37	41.94	37.41	31.84
35	62.14	54.02	37.80	33.12	27.89	82.54	69.18	43.97	39.31	33.59
36	63.13	54.82	38.83	34.13	28.83	84.26	70.45	45.28	40.61	34.88
37	64.13	55.64	39.88	35.18	29.80	86.01	71.74	46.63	41.96	36.22
38	65.15	56.47	40.97	36.25	30.80	87.81	73.05	48.02	43.35	37.61
39	66.19	57.31	42.08	37.36	31.83	89.63	74.39	49.45	44.79	39.06
40	67.25	58.16	43.22	38.50	32.90	91.50	75.75	50.93	46.27	40.56
41	70.63	61.07	45.97	41.03	35.24	94.83	78.46	53.35	48.59	42.83
42	74.18	64.11	48.89	43.72	37.74	98.27	81.25	55.89	51.02	45.22
43	77.91	67.31	51.99	46.58	40.42	101.84	84.15	58.55	53.58	47.75
44	81.83	70.67	55.30	49.63	43.28	105.54	87.15	61.33	56.26	50.42
45	85.95	74.20	58.81	52.89	46.35	109.38	90.26	64.25	59.08	53.25
46	88.47	76.03	61.01	54.90	48.27	112.03	91.97	66.25	60.82	54.97
47	91.06	77.91	63.29	57.00	50.26	114.74	93.71	68.32	62.61	56.74
48	93.73	79.84	65.66	59.17	52.34	117.52	95.48	70.45	64.45	58.57
49	96.47	81.82	68.11	61.43	54.50	120.37	97.28	72.64	66.34	60.46
50	99.30	83.84	70.66	63.78	56.75	123.28	99.12	74.90	68.29	62.41
51	105.19	88.73	76.10	68.57	60.97	130.70	103.06	78.53	71.70	65.86
52	111.74	94.19	82.19	73.95	65.65	138.91	107.25	82.51	75.41	69.64
53	119.06	100.26	89.07	79.95	70.88	148.04	111.71	86.90	79.49	73.83
54	127.32	107.09	96.87	86.76	76.79	158.24	116.48	91.73	83.99	78.47
55	136.71	114.82	105.80	94.49	83.45	169.74	121.57	97.11	88.98	83.60
56	148.07	124.18	114.80	102.13	89.80	182.77	127.03	103.82	94.99	89.48
57	161.19	134.98	125.23	110.93	97.08	197.66	132.89	111.39	101.73	96.08
58	176.58	147.56	137.51	121.19	105.47	214.86	139.22	119.96	109.35	103.59
59	194.83	162.42	152.12	133.29	115.22	234.88	146.02	129.75	118.04	112.21
60	216.81	180.24	169.85	147.74	126.74	258.54	153.39	141.07	128.02	122.17

Smoker: Multiply by 120%
 Policy Fee = \$50

Auto-Owners Life Insurance Company
 Individual Disability Income Insurance Policy
 Policy Form # 61739

Benefit Period To Age 67
 Occupation Class AAAA
 Non-Smoker

Base Policy Annual Premiums per \$100 Monthly Benefit, by Gender and Elimination Period in days

Issue Age	Male 30	Male 60	Male 90	Male 180	Male 365	Female 30	Female 60	Female 90	Female 180	Female 365
18-25	33.32	30.22	16.23	14.03	12.37	43.61	35.95	20.05	19.33	17.30
26	34.86	31.35	16.78	14.41	12.69	45.90	37.57	21.02	20.20	18.02
27	36.48	32.53	17.34	14.81	13.01	48.30	39.26	22.04	21.11	18.77
28	38.17	33.75	17.92	15.21	13.35	50.83	41.03	23.11	22.06	19.56
29	39.94	35.02	18.53	15.62	13.69	53.50	42.88	24.23	23.06	20.37
30	41.80	36.34	19.15	16.04	14.04	56.30	44.81	25.40	24.09	21.22
31	43.82	37.81	20.05	16.75	14.65	60.50	47.35	26.96	25.42	22.30
32	45.94	39.33	20.99	17.48	15.28	65.01	50.03	28.61	26.83	23.43
33	48.17	40.92	21.98	18.25	15.95	69.86	52.86	30.37	28.31	24.62
34	50.50	42.57	23.01	19.05	16.64	75.06	55.86	32.23	29.88	25.87
35	52.95	44.29	24.09	19.89	17.36	80.66	59.02	34.21	31.53	27.18
36	54.61	45.31	25.27	20.84	18.26	85.07	61.20	35.78	32.72	28.15
37	56.33	46.35	26.52	21.84	19.21	89.72	63.46	37.42	33.95	29.16
38	58.11	47.42	27.82	22.88	20.21	94.62	65.81	39.13	35.23	30.21
39	59.94	48.51	29.20	23.98	21.26	99.79	68.24	40.92	36.56	31.29
40	61.83	49.62	30.63	25.12	22.37	105.25	70.76	42.80	37.93	32.41
41	63.30	50.50	31.83	26.14	23.36	107.33	71.39	43.72	38.52	32.97
42	64.80	51.40	33.07	27.21	24.39	109.45	72.02	44.66	39.13	33.54
43	66.35	52.32	34.36	28.31	25.46	111.62	72.66	45.61	39.74	34.12
44	67.92	53.25	35.71	29.46	26.59	113.83	73.31	46.59	40.36	34.70
45	69.54	54.19	37.10	30.66	27.76	116.08	73.96	47.59	40.99	35.30
46	71.94	55.73	38.54	31.84	28.95	120.10	76.05	48.00	41.37	35.66
47	74.43	57.30	40.03	33.07	30.20	124.25	78.20	48.41	41.76	36.01
48	77.01	58.93	41.58	34.34	31.49	128.55	80.42	48.83	42.15	36.37
49	79.67	60.59	43.19	35.67	32.85	133.00	82.69	49.25	42.54	36.74
50	82.43	62.31	44.87	37.04	34.26	137.60	85.03	49.67	42.94	37.10
51	84.23	63.24	46.49	38.33	35.52	138.97	85.88	50.17	43.37	37.47
52	86.07	64.19	48.16	39.67	36.82	140.36	86.74	50.67	43.80	37.85
53	87.95	65.15	49.90	41.05	38.17	141.77	87.61	51.18	44.24	38.23
54	89.87	66.13	51.70	42.49	39.58	143.19	88.49	51.69	44.68	38.61
55	91.84	67.12	53.57	43.97	41.03	144.62	89.37	52.21	45.13	39.00
56	92.76	67.79	54.11	44.52	41.44	146.07	90.27	52.73	45.58	39.39
57	93.69	68.47	54.65	45.07	41.85	147.53	91.17	53.26	46.04	39.78
58	94.63	69.15	55.20	45.64	42.27	149.01	92.08	53.79	46.50	40.18
59	95.58	69.84	55.75	46.21	42.69	150.50	93.00	54.33	46.97	40.58
60	96.54	70.54	56.31	46.78	43.12	152.01	93.93	54.87	47.44	40.99

Smoker: Multiply by 120%
 Policy Fee = \$50

Auto-Owners Life Insurance Company
 Individual Disability Income Insurance Policy
 Policy Form # 61739

Benefit Period To Age 67
 Occupation Class AAA
 Non-Smoker

Base Policy Annual Premiums per \$100 Monthly Benefit, by Gender and Elimination Period in days

Issue Age	Male 30	Male 60	Male 90	Male 180	Male 365	Female 30	Female 60	Female 90	Female 180	Female 365
18-25	38.43	35.09	18.62	16.09	14.17	50.87	42.17	23.34	21.94	20.39
26	40.34	36.51	19.27	16.56	14.56	53.89	44.30	24.56	23.15	21.28
27	42.36	37.99	19.93	17.04	14.96	57.09	46.55	25.85	24.43	22.21
28	44.47	39.53	20.63	17.54	15.37	60.48	48.90	27.20	25.77	23.18
29	46.68	41.14	21.34	18.05	15.79	64.07	51.37	28.62	27.19	24.19
30	49.01	42.80	22.08	18.58	16.23	67.87	53.97	30.12	28.68	25.25
31	51.55	44.64	23.19	19.43	16.97	73.27	57.30	32.09	30.37	26.61
32	54.23	46.56	24.35	20.32	17.75	79.09	60.83	34.19	32.15	28.05
33	57.05	48.56	25.56	21.26	18.57	85.38	64.57	36.43	34.04	29.57
34	60.01	50.64	26.84	22.23	19.43	92.17	68.55	38.82	36.04	31.17
35	63.13	52.82	28.18	23.25	20.32	99.50	72.77	41.37	38.15	32.86
36	65.30	54.22	29.66	24.45	21.44	105.18	75.56	43.41	39.68	34.09
37	67.54	55.66	31.21	25.71	22.62	111.19	78.46	45.55	41.26	35.37
38	69.87	57.13	32.84	27.03	23.86	117.53	81.47	47.80	42.91	36.69
39	72.27	58.65	34.56	28.42	25.17	124.25	84.59	50.16	44.63	38.07
40	74.75	60.20	36.36	29.88	26.56	131.34	87.84	52.64	46.41	39.50
41	76.71	61.36	37.89	31.15	27.77	133.92	88.58	53.81	47.20	40.24
42	78.73	62.53	39.49	32.48	29.04	136.55	89.33	55.00	48.00	40.99
43	80.79	63.73	41.15	33.87	30.37	139.23	90.08	56.22	48.82	41.75
44	82.91	64.95	42.89	35.31	31.75	141.97	90.84	57.46	49.65	42.53
45	85.09	66.19	44.69	36.81	33.21	144.76	91.61	58.74	50.49	43.32
46	88.15	68.14	46.51	38.31	34.70	146.21	92.53	59.33	50.94	43.91
47	91.31	70.14	48.41	39.86	36.27	147.67	93.45	59.92	51.39	44.50
48	94.59	72.20	50.38	41.47	37.91	149.15	94.38	60.52	51.85	45.10
49	97.99	74.32	52.44	43.15	39.62	150.64	95.33	61.12	52.31	45.71
50	101.50	76.50	54.57	44.90	41.41	152.14	96.28	61.74	52.78	46.33
51	103.74	77.61	56.58	46.50	42.94	153.67	97.24	62.35	53.31	46.79
52	106.03	78.73	58.67	48.15	44.54	155.20	98.22	62.98	53.84	47.26
53	108.36	79.87	60.82	49.87	46.19	156.75	99.20	63.61	54.38	47.73
54	110.75	81.03	63.06	51.64	47.90	158.32	100.19	64.24	54.92	48.21
55	113.19	82.20	65.39	53.48	49.68	159.91	101.19	64.88	55.47	48.69
56	114.32	83.02	66.04	54.10	50.18	161.51	102.21	65.53	56.03	49.18
57	115.47	83.85	66.70	54.72	50.68	163.13	103.23	66.19	56.59	49.67
58	116.62	84.69	67.37	55.34	51.19	164.76	104.26	66.85	57.16	50.17
59	117.79	85.54	68.04	55.98	51.70	166.41	105.30	67.52	57.73	50.67
60	118.97	86.40	68.72	56.62	52.22	168.07	106.36	68.20	58.31	51.18

Smoker: Multiply by 120%
 Policy Fee = \$50

Auto-Owners Life Insurance Company
 Individual Disability Income Insurance Policy
 Policy Form # 61739

Benefit Period To Age 67
 Occupation Class AA
 Non-Smoker

Base Policy Annual Premiums per \$100 Monthly Benefit, by Gender and Elimination Period in days

Issue Age	Male 30	Male 60	Male 90	Male 180	Male 365	Female 30	Female 60	Female 90	Female 180	Female 365
18-25	46.12	42.11	29.02	26.72	22.99	61.04	47.65	29.19	27.44	25.79
26	48.41	43.81	30.23	27.73	23.81	64.67	50.06	30.60	28.76	27.04
27	50.83	45.59	31.49	28.79	24.66	68.51	52.60	32.07	30.15	28.34
28	53.36	47.44	32.81	29.88	25.54	72.58	55.26	33.61	31.60	29.70
29	56.02	49.37	34.18	31.02	26.44	76.88	58.05	35.23	33.12	31.13
30	58.81	51.36	35.60	32.20	27.39	81.44	60.99	36.93	34.71	32.63
31	61.86	53.57	37.40	33.73	28.70	87.92	64.75	39.24	36.88	34.71
32	65.08	55.87	39.28	35.32	30.07	94.91	68.74	41.69	39.19	36.92
33	68.46	58.27	41.25	37.00	31.51	102.46	72.96	44.30	41.65	39.27
34	72.01	60.77	43.33	38.75	33.02	110.60	77.46	47.08	44.25	41.77
35	75.76	63.38	45.51	40.59	34.60	119.40	82.23	50.02	47.02	44.43
36	78.36	65.06	47.96	42.83	36.61	126.22	85.38	53.00	49.93	46.56
37	81.05	66.79	50.54	45.20	38.73	133.43	88.66	56.15	53.02	48.79
38	83.84	68.56	53.26	47.70	40.97	141.04	92.06	59.49	56.31	51.13
39	87.52	70.38	56.13	50.34	43.34	149.10	97.76	63.03	59.79	53.57
40	91.50	72.24	59.15	53.12	45.85	157.61	103.97	66.77	63.49	56.14
41	95.09	73.91	62.22	55.94	48.47	160.70	104.46	69.69	65.87	58.26
42	98.81	76.31	65.46	58.90	51.24	163.86	104.94	72.73	68.35	60.46
43	102.69	78.79	68.86	62.02	54.16	167.08	105.43	75.91	70.91	62.74
44	106.71	81.35	72.44	65.30	57.26	170.36	105.93	79.22	73.57	65.11
45	110.89	84.00	76.21	68.76	60.53	173.71	106.42	82.68	76.34	67.57
46	115.35	88.77	80.29	72.47	63.98	175.45	106.77	84.83	78.33	69.62
47	119.99	93.82	84.58	76.37	67.63	177.20	107.12	87.04	80.38	71.74
48	124.81	99.15	89.11	80.48	71.48	178.98	107.47	89.30	82.48	73.92
49	129.82	104.78	93.88	84.81	75.56	180.77	107.83	91.62	84.64	76.16
50	135.04	110.73	98.90	89.38	79.87	182.57	108.80	95.54	86.85	78.48
51	135.83	111.38	101.04	91.36	81.76	184.40	109.88	96.04	87.31	79.19
52	136.62	113.55	103.23	93.39	83.69	186.24	110.99	96.68	87.89	79.90
53	137.41	116.02	105.47	95.45	85.67	188.10	112.10	97.56	88.69	80.63
54	138.21	118.54	107.76	97.57	87.70	189.98	113.21	98.45	89.50	81.36
55	139.02	121.10	110.09	99.73	89.78	191.89	114.34	99.34	90.31	82.10
56	140.41	122.32	111.20	100.73	90.68	193.81	115.48	100.33	91.21	82.92
57	141.81	123.54	112.31	101.74	91.59	195.75	116.63	101.34	92.13	83.75
58	143.23	124.78	113.43	102.76	92.51	197.71	117.80	102.35	93.05	84.59
59	144.66	126.03	114.56	103.79	93.44	199.69	118.98	103.37	93.98	85.44
60	146.11	127.29	115.71	104.83	94.37	201.69	120.17	104.40	94.92	86.29

Smoker: Multiply by 120%
 Policy Fee = \$50

Auto-Owners Life Insurance Company
 Coordinating Additional Insurance Rider
 Rider Form # 61732

Benefit Period 2 Years
 Occupation Class AAAA
 Non-Smoker

Annual Premiums per \$100 Monthly Rider Benefit, by Gender and Elimination Period in days

Issue Age	Male 30	Male 60	Male 90	Male 180	Female 30	Female 60	Female 90	Female 180
18-25	11.97	10.35	5.96	5.02	16.85	13.39	7.36	6.17
26	12.34	10.60	6.06	5.09	17.49	13.86	7.55	6.33
27	12.73	10.85	6.17	5.17	18.15	14.34	7.75	6.49
28	13.12	11.10	6.27	5.25	18.84	14.84	7.95	6.66
29	13.53	11.36	6.38	5.32	19.55	15.35	8.16	6.83
30	13.95	11.63	6.49	5.40	20.29	15.88	8.38	7.00
31	14.42	11.95	6.67	5.54	21.22	16.54	8.71	7.21
32	14.91	12.27	6.84	5.68	22.18	17.23	9.05	7.43
33	15.42	12.61	7.02	5.82	23.19	17.94	9.40	7.65
34	15.94	12.95	7.21	5.97	24.25	18.68	9.77	7.87
35	16.48	13.30	7.40	6.12	25.35	19.46	10.15	8.11
36	17.00	13.72	7.73	6.38	26.08	19.90	10.54	8.41
37	17.54	14.15	8.07	6.64	26.82	20.36	10.95	8.72
38	18.09	14.59	8.43	6.92	27.59	20.83	11.37	9.04
39	18.66	15.05	8.80	7.21	28.38	21.31	11.81	9.37
40	19.25	15.52	9.19	7.51	29.19	21.80	12.27	9.72
41	19.82	15.95	9.56	7.83	29.61	22.03	12.55	9.97
42	20.41	16.39	9.94	8.16	30.03	22.27	12.85	10.23
43	21.02	16.84	10.34	8.51	30.47	22.51	13.15	10.49
44	21.64	17.30	10.76	8.88	30.90	22.76	13.46	10.77
45	22.28	17.78	11.19	9.26	31.35	23.00	13.78	11.04
46	23.26	18.50	11.71	9.69	31.93	23.32	14.11	11.33
47	24.27	19.25	12.26	10.14	32.52	23.64	14.45	11.63
48	25.33	20.03	12.83	10.62	33.12	23.97	14.79	11.93
49	26.44	20.85	13.43	11.11	33.74	24.30	15.15	12.24
50	27.59	21.69	14.05	11.63	34.36	24.64	15.51	12.56
51	28.97	22.74	14.95	12.40	35.18	25.20	16.02	13.06
52	30.41	23.84	15.90	13.22	36.02	25.77	16.55	13.59
53	31.93	24.99	16.91	14.10	36.87	26.36	17.09	14.13
54	33.52	26.20	17.98	15.03	37.75	26.95	17.65	14.70
55	35.19	27.47	19.13	16.02	38.65	27.57	18.24	15.29
56	36.84	28.71	20.23	17.05	40.72	28.46	19.19	16.16
57	38.61	30.08	21.46	18.18	43.09	29.43	20.24	17.11
58	40.60	31.54	22.83	19.44	45.87	30.48	21.38	18.17
59	42.78	33.15	24.38	20.83	49.14	31.64	22.67	19.34
60	45.24	34.90	26.15	22.38	53.08	32.92	24.12	20.66

Smoker: Multiply by 120%

Auto-Owners Life Insurance Company
 Coordinating Additional Insurance Rider
 Rider Form # 61732

Benefit Period 2 Years
 Occupation Class AAA
 Non-Smoker

Annual Premiums per \$100 Monthly Rider Benefit, by Gender and Elimination Period in days

Issue Age	Male 30	Male 60	Male 90	Male 180	Female 30	Female 60	Female 90	Female 180
18-25	13.68	11.74	6.52	5.46	19.84	15.72	8.48	7.08
26	14.10	12.02	6.63	5.53	20.66	16.33	8.74	7.28
27	14.54	12.32	6.75	5.60	21.51	16.97	9.01	7.48
28	14.99	12.62	6.86	5.67	22.40	17.63	9.29	7.69
29	15.46	12.92	6.98	5.74	23.32	18.32	9.58	7.90
30	15.93	13.24	7.09	5.81	24.28	19.03	9.88	8.12
31	16.52	13.68	7.31	5.98	25.46	19.85	10.26	8.42
32	17.13	14.13	7.54	6.15	26.69	20.70	10.66	8.73
33	17.76	14.60	7.77	6.32	27.99	21.58	11.07	9.04
34	18.42	15.08	8.01	6.49	29.35	22.51	11.50	9.37
35	19.10	15.58	8.26	6.68	30.78	23.47	11.94	9.71
36	19.73	16.04	8.63	7.00	31.71	24.08	12.45	10.07
37	20.39	16.52	9.03	7.34	32.68	24.69	12.98	10.44
38	21.06	17.00	9.44	7.70	33.67	25.33	13.53	10.83
39	21.76	17.51	9.86	8.07	34.69	25.98	14.10	11.23
40	22.49	18.02	10.31	8.46	35.74	26.64	14.70	11.64
41	23.20	18.55	10.79	8.85	36.28	26.91	15.07	11.97
42	23.94	19.09	11.29	9.25	36.83	27.17	15.45	12.30
43	24.70	19.65	11.82	9.67	37.38	27.44	15.85	12.65
44	25.49	20.22	12.37	10.12	37.94	27.71	16.25	13.00
45	26.30	20.81	12.94	10.58	38.51	27.99	16.66	13.36
46	27.51	21.73	13.59	11.11	39.24	28.43	17.09	13.74
47	28.77	22.69	14.26	11.67	39.99	28.88	17.52	14.12
48	30.09	23.69	14.97	12.26	40.75	29.33	17.97	14.52
49	31.47	24.74	15.71	12.88	41.52	29.79	18.43	14.92
50	32.91	25.83	16.49	13.53	42.31	30.26	18.90	15.34
51	34.64	27.13	17.56	14.47	43.34	30.96	19.52	15.99
52	36.47	28.50	18.71	15.48	44.39	31.68	20.17	16.66
53	38.39	29.93	19.92	16.56	45.47	32.42	20.84	17.36
54	40.41	31.44	21.22	17.71	46.58	33.17	21.53	18.09
55	42.54	33.02	22.60	18.94	47.72	33.95	22.25	18.85
56	44.58	34.56	23.93	20.20	49.47	35.10	23.41	19.94
57	46.81	36.25	25.42	21.58	51.41	36.33	24.71	21.16
58	49.28	38.09	27.09	23.12	53.58	37.66	26.14	22.47
59	52.05	40.08	28.98	24.82	56.05	39.10	27.73	23.95
60	55.14	42.26	31.13	26.73	58.86	40.68	29.53	25.60

Smoker: Multiply by 120%

Auto-Owners Life Insurance Company
 Coordinating Additional Insurance Rider
 Rider Form # 61732

Benefit Period 2 Years
 Occupation Class AA
 Non-Smoker

Annual Premiums per \$100 Monthly Rider Benefit, by Gender and Elimination Period in days

Issue Age	Male 30	Male 60	Male 90	Male 180	Female 30	Female 60	Female 90	Female 180
18-25	16.35	12.56	8.51	6.97	25.51	19.17	10.86	8.54
26	16.64	12.82	8.68	7.12	26.23	19.59	11.11	8.75
27	16.93	13.08	8.84	7.27	26.97	20.01	11.37	8.98
28	17.23	13.38	9.01	7.43	27.73	20.44	11.63	9.20
29	17.54	13.80	9.19	7.59	28.52	20.89	11.90	9.44
30	17.85	14.23	9.37	7.75	29.32	21.34	12.17	9.68
31	18.30	14.72	9.64	7.96	30.06	21.87	12.48	9.94
32	18.77	15.23	9.91	8.17	30.81	22.43	12.80	10.21
33	19.25	15.77	10.20	8.39	31.59	22.99	13.13	10.49
34	19.87	16.33	10.49	8.61	32.38	23.74	13.46	10.78
35	20.64	16.88	10.80	8.84	33.20	24.78	13.80	11.08
36	21.33	17.43	11.30	9.28	34.10	25.47	14.35	11.55
37	22.04	17.98	11.83	9.73	35.02	26.17	14.91	12.04
38	22.78	18.57	12.39	10.21	36.25	26.89	15.50	12.56
39	23.54	19.17	12.97	10.71	37.52	27.63	16.11	13.09
40	24.34	19.78	13.57	11.24	38.86	28.40	16.74	13.65
41	25.14	20.40	14.25	11.83	39.42	28.74	17.34	14.17
42	26.00	21.01	14.97	12.46	40.00	29.10	17.97	14.71
43	26.85	21.66	15.72	13.12	40.57	29.43	18.61	15.26
44	27.74	22.33	16.50	13.81	41.16	29.92	19.28	15.84
45	28.66	23.02	17.33	14.54	41.77	30.55	19.98	16.44
46	30.02	24.04	18.30	15.39	42.64	31.31	20.77	17.14
47	31.45	25.12	19.31	16.29	43.62	32.09	21.59	17.88
48	32.93	26.25	20.39	17.24	44.63	32.90	22.44	18.64
49	34.50	27.44	21.53	18.25	45.66	33.72	23.33	19.44
50	36.13	28.67	22.73	19.31	46.71	34.56	24.25	20.27
51	38.01	30.10	24.03	20.50	47.78	35.46	25.53	21.42
52	40.62	32.73	25.41	21.75	48.88	36.38	26.88	22.63
53	43.89	35.63	26.86	23.09	50.01	37.33	28.30	23.91
54	47.41	38.79	28.40	24.50	51.16	38.30	29.80	25.27
55	51.22	42.23	30.03	26.00	52.34	39.29	31.37	26.70
56	53.49	44.12	31.21	26.91	54.97	40.81	32.49	27.77
57	56.04	46.24	32.55	27.91	57.93	42.42	33.72	28.94
58	58.97	48.66	34.07	29.05	61.31	44.14	35.08	30.27
59	62.38	51.46	35.82	30.32	65.19	45.98	36.60	31.73
60	66.38	54.76	37.90	31.82	69.72	47.98	38.32	33.38

Smoker: Multiply by 120%

Auto-Owners Life Insurance Company
 Coordinating Additional Insurance Rider
 Rider Form # 61732

Benefit Period 2 Years
 Occupation Class A
 Non-Smoker

Annual Premiums per \$100 Monthly Rider Benefit, by Gender and Elimination Period in days

Issue Age	Male 30	Male 60	Male 90	Male 180	Female 30	Female 60	Female 90	Female 180
18-25	24.11	18.82	13.22	10.18	31.67	23.95	14.79	11.29
26	24.45	19.11	13.43	10.35	32.53	24.56	15.12	11.55
27	24.80	19.41	13.64	10.52	33.41	25.18	15.47	11.81
28	25.15	19.71	13.85	10.70	34.32	25.81	15.82	12.08
29	25.51	20.01	14.07	10.88	35.25	26.46	16.18	12.36
30	25.87	20.32	14.29	11.06	36.21	27.13	16.54	12.64
31	26.39	20.71	14.59	11.29	37.15	27.79	16.99	12.99
32	26.93	21.11	14.90	11.53	38.11	28.47	17.45	13.36
33	27.48	21.51	15.22	11.77	39.10	29.17	17.92	13.73
34	28.04	21.92	15.55	12.02	40.11	29.88	18.40	14.11
35	28.61	22.33	15.88	12.27	41.15	30.61	18.90	14.50
36	29.43	22.99	16.55	12.83	42.22	31.42	19.61	15.10
37	30.27	23.66	17.25	13.40	43.32	32.24	20.34	15.73
38	31.13	24.35	17.98	14.00	44.44	33.08	21.11	16.38
39	32.02	25.06	18.75	14.63	45.60	33.95	21.90	17.06
40	32.94	25.80	19.54	15.28	46.78	34.84	22.72	17.76
41	33.98	26.57	20.42	16.03	47.70	35.63	23.48	18.47
42	35.06	27.37	21.34	16.81	48.64	36.43	24.26	19.20
43	36.17	28.19	22.31	17.62	49.60	37.25	25.06	19.96
44	37.31	29.04	23.31	18.48	50.57	38.09	25.90	20.75
45	38.50	29.91	24.37	19.38	51.57	38.94	26.76	21.58
46	39.97	31.07	25.70	20.45	52.79	39.89	27.75	22.38
47	41.51	32.26	27.11	21.59	54.04	40.86	28.77	23.22
48	43.10	33.51	28.59	22.78	55.32	41.85	29.84	24.09
49	44.75	34.80	30.16	24.05	56.62	42.86	30.94	24.99
50	46.47	36.14	31.81	25.38	57.96	43.90	32.08	25.92
51	48.25	37.86	33.59	26.96	59.11	44.88	33.66	27.29
52	50.10	39.65	35.47	28.65	60.29	45.88	35.32	28.73
53	52.03	41.52	37.45	30.44	61.48	46.90	37.05	30.25
54	54.03	43.49	39.55	32.34	62.70	47.95	38.87	31.84
55	56.92	45.67	41.76	34.36	63.94	49.02	40.78	33.52
56	59.45	47.73	43.53	35.81	67.63	50.58	42.18	34.81
57	62.29	50.02	45.52	37.43	71.81	52.24	43.69	36.21
58	65.55	52.65	47.80	39.27	76.59	54.02	45.38	37.76
59	69.33	55.69	50.45	41.41	82.11	55.90	47.25	39.50
60	73.78	59.26	53.58	43.88	88.58	57.93	49.34	41.45

Smoker: Multiply by 120%

Auto-Owners Life Insurance Company
 Coordinating Additional Insurance Rider
 Rider Form # 61732

Benefit Period 2 Years
 Occupation Class B
 Non-Smoker

Annual Premiums per \$100 Monthly Rider Benefit, by Gender and Elimination Period in days

Issue Age	Male 30	Male 60	Male 90	Male 180	Female 30	Female 60	Female 90	Female 180
18-25	28.41	22.65	15.92	12.27	35.10	27.52	17.64	13.53
26	28.93	23.02	16.16	12.47	36.08	28.22	18.04	13.86
27	29.46	23.40	16.41	12.67	37.08	28.94	18.44	14.20
28	30.00	23.78	16.66	12.87	38.10	29.68	18.86	14.55
29	30.54	24.16	16.92	13.07	39.16	30.44	19.29	14.91
30	31.10	24.55	17.18	13.28	40.25	31.21	19.73	15.28
31	31.73	25.03	17.58	13.60	41.34	32.00	20.33	15.75
32	32.38	25.52	17.99	13.94	42.47	32.80	20.96	16.24
33	33.03	26.02	18.41	14.28	43.62	33.63	21.60	16.74
34	33.70	26.53	18.83	14.63	44.81	34.48	22.26	17.26
35	34.39	27.05	19.27	14.98	46.02	35.35	22.94	17.80
36	35.37	27.82	20.04	15.64	47.24	36.28	23.77	18.54
37	36.38	28.61	20.84	16.32	48.48	37.23	24.63	19.32
38	37.42	29.43	21.68	17.03	49.76	38.21	25.51	20.13
39	38.49	30.26	22.55	17.77	51.07	39.21	26.43	20.97
40	39.60	31.12	23.45	18.54	52.42	40.25	27.39	21.85
41	40.83	32.11	24.51	19.42	53.61	41.13	28.31	22.66
42	42.10	33.14	25.62	20.33	54.83	42.03	29.27	23.50
43	43.42	34.19	26.78	21.29	56.07	42.95	30.26	24.37
44	44.77	35.28	27.99	22.29	57.35	43.89	31.28	25.27
45	46.17	36.40	29.25	23.34	58.65	44.85	32.34	26.20
46	48.12	37.90	30.84	24.67	60.19	45.96	33.57	27.24
47	50.15	39.46	32.51	26.08	61.77	47.10	34.85	28.33
48	52.27	41.08	34.28	27.57	63.38	48.27	36.17	29.46
49	54.47	42.77	36.14	29.15	65.05	49.47	37.55	30.64
50	56.77	44.53	38.10	30.82	66.75	50.69	38.98	31.86
51	58.99	46.35	40.22	32.69	68.25	51.92	40.90	33.56
52	61.30	48.25	42.46	34.68	69.79	53.18	42.91	35.35
53	63.69	50.23	44.82	36.79	71.36	54.48	45.03	37.24
54	66.18	52.28	47.32	39.03	72.97	55.80	47.25	39.23
55	68.77	54.42	49.95	41.41	74.61	57.15	49.57	41.33
56	71.59	56.89	52.27	43.31	79.19	59.02	51.22	42.89
57	74.75	59.67	54.91	45.45	84.42	60.98	53.05	44.59
58	78.36	62.85	57.94	47.89	90.40	63.09	55.06	46.49
59	82.54	66.52	61.46	50.71	97.32	65.32	57.28	48.60
60	87.45	70.85	65.67	54.00	105.44	67.72	59.78	50.97

Smoker: Multiply by 120%

Auto-Owners Life Insurance Company
 Coordinating Additional Insurance Rider
 Rider Form # 61732

Benefit Period 5 Years
 Occupation Class AAAA
 Non-Smoker

Annual Premiums per \$100 Monthly Rider Benefit, by Gender and Elimination Period in days

Issue Age	Male 30	Male 60	Male 90	Male 180	Male 365	Female 30	Female 60	Female 90	Female 180	Female 365
18-25	15.31	13.37	7.25	6.32	5.24	20.67	17.14	9.24	7.90	6.44
26	15.66	13.64	7.37	6.39	5.28	21.34	17.68	9.46	8.09	6.55
27	16.03	13.93	7.50	6.46	5.31	22.03	18.25	9.69	8.29	6.65
28	16.40	14.22	7.63	6.53	5.34	22.74	18.83	9.93	8.49	6.76
29	16.78	14.51	7.76	6.60	5.38	23.47	19.43	10.17	8.70	6.87
30	17.17	14.81	7.90	6.67	5.41	24.23	20.05	10.42	8.91	6.98
31	18.01	15.52	8.24	6.93	5.63	25.60	21.17	10.94	9.31	7.31
32	18.90	16.27	8.59	7.20	5.85	27.04	22.35	11.49	9.72	7.65
33	19.82	17.06	8.96	7.47	6.08	28.56	23.60	12.07	10.16	8.00
34	20.79	17.88	9.35	7.76	6.32	30.17	24.92	12.67	10.62	8.37
35	21.81	18.74	9.75	8.07	6.57	31.87	26.32	13.31	11.09	8.76
36	22.26	19.03	10.08	8.35	6.77	32.70	26.70	13.74	11.44	9.02
37	22.72	19.31	10.42	8.64	6.98	33.54	27.09	14.18	11.80	9.28
38	23.19	19.61	10.77	8.95	7.19	34.41	27.49	14.64	12.17	9.56
39	23.67	19.90	11.13	9.26	7.41	35.29	27.89	15.11	12.56	9.84
40	24.16	20.21	11.51	9.59	7.64	36.20	28.29	15.59	12.95	10.13
41	25.21	21.03	12.15	10.17	8.19	37.23	28.98	16.11	13.45	10.59
42	26.31	21.90	12.83	10.79	8.77	38.28	29.69	16.65	13.97	11.08
43	27.46	22.79	13.55	11.44	9.40	39.36	30.42	17.20	14.50	11.60
44	28.65	23.73	14.32	12.14	10.07	40.47	31.16	17.77	15.06	12.14
45	29.90	24.70	15.12	12.87	10.80	41.61	31.92	18.36	15.64	12.70
46	30.66	25.26	15.56	13.26	11.09	41.83	32.24	18.59	15.80	12.87
47	31.44	25.83	16.02	13.66	11.40	42.05	32.56	18.83	15.97	13.03
48	32.24	26.41	16.49	14.07	11.72	42.27	32.88	19.06	16.13	13.21
49	33.06	27.01	16.98	14.49	12.05	42.49	33.21	19.30	16.30	13.38
50	33.90	27.62	17.48	14.93	12.38	42.71	33.55	19.54	16.47	13.56
51	35.93	28.87	18.80	15.98	13.30	45.71	35.09	20.59	17.30	14.23
52	38.12	30.20	20.26	17.14	14.30	49.09	36.75	21.73	18.18	14.96
53	40.53	31.63	21.88	18.42	15.39	52.88	38.59	22.98	19.15	15.74
54	43.16	33.17	23.68	19.82	16.61	57.19	40.60	24.34	20.20	16.59
55	46.06	34.83	25.68	21.35	17.94	62.13	42.81	25.84	21.36	17.51
56	49.37	36.65	27.61	22.82	19.14	68.21	46.06	27.67	22.83	18.65
57	53.04	38.64	29.78	24.44	20.45	75.35	49.68	29.73	24.46	19.88
58	57.14	40.79	32.22	26.24	21.91	83.80	53.76	32.03	26.27	21.24
59	61.75	43.13	34.97	28.22	23.51	93.97	58.39	34.60	28.30	22.74
60	66.97	45.71	38.12	30.44	25.31	106.38	63.67	37.52	30.56	24.41

Smoker: Multiply by 120%

Auto-Owners Life Insurance Company
 Coordinating Additional Insurance Rider
 Rider Form # 61732

Benefit Period 5 Years
 Occupation Class AAA
 Non-Smoker

Annual Premiums per \$100 Monthly Rider Benefit, by Gender and Elimination Period in days

Issue Age	Male 30	Male 60	Male 90	Male 180	Male 365	Female 30	Female 60	Female 90	Female 180	Female 365
18-25	17.39	15.26	8.09	6.97	5.67	24.13	20.06	10.54	9.14	7.34
26	17.85	15.67	8.21	7.05	5.74	25.03	20.79	10.86	9.39	7.52
27	18.32	16.10	8.34	7.13	5.82	25.96	21.56	11.18	9.64	7.70
28	18.81	16.53	8.46	7.21	5.90	26.93	22.35	11.52	9.90	7.89
29	19.30	16.98	8.59	7.29	5.97	27.93	23.17	11.87	10.16	8.08
30	19.81	17.43	8.72	7.37	6.05	28.97	24.02	12.23	10.44	8.28
31	20.82	18.19	9.14	7.68	6.29	30.76	25.35	12.91	10.95	8.66
32	21.87	18.97	9.58	8.00	6.54	32.65	26.75	13.63	11.49	9.06
33	22.98	19.79	10.04	8.33	6.80	34.67	28.22	14.39	12.06	9.47
34	24.14	20.64	10.53	8.67	7.07	36.80	29.78	15.19	12.66	9.91
35	25.37	21.53	11.04	9.03	7.35	39.07	31.42	16.04	13.29	10.37
36	26.01	21.98	11.45	9.41	7.65	40.14	32.11	16.59	13.75	10.74
37	26.67	22.45	11.87	9.80	7.97	41.24	32.83	17.15	14.23	11.12
38	27.34	22.92	12.32	10.21	8.30	42.36	33.55	17.74	14.72	11.51
39	28.03	23.40	12.77	10.64	8.65	43.52	34.30	18.34	15.23	11.92
40	28.74	23.90	13.25	11.08	9.01	44.71	35.06	18.97	15.76	12.35
41	30.04	24.93	14.04	11.79	9.63	45.98	35.91	19.67	16.39	12.93
42	31.39	26.01	14.89	12.55	10.30	47.28	36.78	20.40	17.03	13.54
43	32.81	27.14	15.78	13.35	11.02	48.61	37.67	21.16	17.70	14.18
44	34.30	28.31	16.73	14.21	11.78	49.99	38.58	21.95	18.40	14.84
45	35.85	29.54	17.73	15.12	12.60	51.40	39.52	22.76	19.12	15.54
46	36.90	30.32	18.33	15.63	13.02	52.01	39.60	23.05	19.38	15.81
47	37.98	31.11	18.95	16.15	13.45	52.63	39.68	23.34	19.64	16.09
48	39.09	31.93	19.60	16.69	13.90	53.25	39.75	23.63	19.91	16.37
49	40.24	32.77	20.26	17.25	14.36	53.88	39.83	23.93	20.18	16.65
50	41.42	33.64	20.95	17.83	14.84	54.52	39.91	24.23	20.45	16.94
51	43.92	35.19	22.57	19.13	15.96	57.73	41.93	25.53	21.52	17.83
52	46.64	36.86	24.37	20.53	17.19	61.25	44.13	26.95	22.66	18.79
53	49.62	38.66	26.36	22.08	18.54	65.17	46.50	28.49	23.93	19.81
54	52.91	40.61	28.58	23.78	20.03	69.56	49.06	30.19	25.29	20.94
55	56.54	42.69	31.07	25.66	21.68	74.47	51.86	32.05	26.79	22.17
56	60.65	44.96	33.45	27.46	23.15	80.91	55.31	34.37	28.65	23.65
57	65.23	47.43	36.12	29.43	24.77	88.28	59.07	36.98	30.71	25.27
58	70.37	50.10	39.15	31.61	26.58	96.79	63.25	39.88	32.97	27.07
59	76.17	53.04	42.58	34.05	28.59	106.71	67.89	43.16	35.54	29.05
60	82.73	56.26	46.52	36.78	30.84	118.40	73.05	46.87	38.41	31.25

Smoker: Multiply by 120%

Auto-Owners Life Insurance Company
 Coordinating Additional Insurance Rider
 Rider Form # 61732

Benefit Period 5 Years
 Occupation Class AA
 Non-Smoker

Annual Premiums per \$100 Monthly Rider Benefit, by Gender and Elimination Period in days

Issue Age	Male 30	Male 60	Male 90	Male 180	Male 365	Female 30	Female 60	Female 90	Female 180	Female 365
18-25	21.67	17.85	11.22	9.55	7.45	33.66	26.21	14.39	11.80	8.90
26	21.92	17.98	11.36	9.69	7.56	34.38	26.75	14.68	12.09	9.11
27	22.17	18.11	11.50	9.82	7.68	35.11	27.30	14.98	12.39	9.32
28	22.42	18.24	11.65	9.96	7.79	35.86	27.86	15.29	12.69	9.53
29	22.68	18.38	11.79	10.10	7.91	36.63	28.44	15.60	13.00	9.75
30	22.94	18.51	11.94	10.24	8.03	37.41	29.02	15.91	13.31	9.97
31	23.87	19.25	12.53	10.73	8.44	38.80	30.01	16.54	13.87	10.43
32	24.84	20.03	13.15	11.25	8.87	40.23	31.03	17.18	14.46	10.90
33	25.84	20.83	13.80	11.80	9.32	41.72	32.08	17.85	15.07	11.40
34	26.89	21.66	14.48	12.37	9.80	43.27	33.17	18.55	15.71	11.92
35	27.98	22.90	15.20	12.97	10.29	44.87	34.29	19.28	16.37	12.46
36	28.54	23.44	15.73	13.47	10.69	45.70	34.98	19.84	16.94	12.90
37	29.12	23.99	16.27	13.98	11.10	46.55	35.69	20.42	17.52	13.35
38	29.70	24.55	16.84	14.52	11.52	47.42	36.41	21.02	18.13	13.83
39	30.30	25.13	17.42	15.08	11.96	48.30	37.14	21.64	18.75	14.31
40	30.91	25.72	18.03	15.66	12.42	49.20	37.89	22.27	19.40	14.82
41	32.31	26.84	19.26	16.82	13.41	50.76	39.20	23.42	20.46	15.74
42	33.77	28.00	20.58	18.06	14.47	52.37	40.54	24.62	21.57	16.72
43	35.30	29.23	21.99	19.39	15.62	54.02	41.94	25.89	22.75	17.76
44	36.89	30.50	23.49	20.82	16.86	55.73	43.38	27.22	23.99	18.86
45	38.56	31.83	25.10	22.36	18.20	57.49	44.87	28.62	25.30	20.04
46	39.37	32.48	26.02	23.19	18.91	58.26	45.36	29.44	26.00	20.60
47	40.19	33.13	26.97	24.04	19.64	59.03	45.85	30.28	26.72	21.18
48	41.07	33.79	27.96	24.93	20.40	59.82	46.35	31.14	27.46	21.77
49	42.21	34.47	28.98	25.86	21.20	60.62	46.85	32.02	28.21	22.39
50	43.36	35.17	31.91	27.54	22.02	61.43	47.36	33.98	28.99	23.02
51	46.12	37.15	34.14	29.59	23.65	65.04	49.33	35.69	30.44	24.44
52	49.15	40.01	36.62	31.86	25.47	69.03	51.43	37.55	32.01	26.00
53	52.45	43.19	39.39	34.40	27.49	73.48	53.66	39.59	33.75	27.73
54	56.10	46.79	42.50	37.26	29.79	78.44	56.05	41.84	35.65	29.66
55	60.14	50.85	46.00	40.49	32.37	84.03	58.61	44.34	37.77	31.81
56	64.44	55.33	50.06	44.08	35.29	91.45	61.92	47.85	40.79	34.46
57	70.90	60.47	54.71	48.20	38.66	99.97	65.48	51.95	44.32	37.48
58	78.50	66.43	60.10	52.96	42.54	109.82	69.35	56.63	48.34	40.91
59	87.54	73.52	66.53	58.64	47.08	121.35	73.54	62.01	52.96	44.87
60	98.45	82.70	74.85	65.76	52.46	135.01	78.10	68.27	58.35	49.48

Smoker: Multiply by 120%

Auto-Owners Life Insurance Company
 Coordinating Additional Insurance Rider
 Rider Form # 61732

Benefit Period 5 Years
 Occupation Class A
 Non-Smoker

Annual Premiums per \$100 Monthly Rider Benefit, by Gender and Elimination Period in days

Issue Age	Male 30	Male 60	Male 90	Male 180	Male 365	Female 30	Female 60	Female 90	Female 180	Female 365
18-25	31.57	26.19	17.80	14.49	11.20	41.82	33.23	20.11	15.94	12.31
26	31.87	26.46	18.00	14.68	11.35	42.79	34.02	20.47	16.34	12.62
27	32.18	26.72	18.20	14.87	11.51	43.78	34.82	20.83	16.75	12.94
28	32.49	26.99	18.41	15.06	11.68	44.79	35.64	21.20	17.17	13.27
29	32.80	27.27	18.61	15.26	11.84	45.83	36.48	21.58	17.60	13.61
30	33.12	27.54	18.82	15.46	12.01	46.89	37.34	21.97	18.05	13.95
31	34.44	28.52	19.62	16.16	12.57	48.63	38.72	22.88	18.81	14.58
32	35.81	29.53	20.45	16.88	13.15	50.44	40.14	23.82	19.61	15.24
33	37.23	30.57	21.32	17.64	13.76	52.32	41.62	24.81	20.45	15.92
34	38.71	31.65	22.22	18.43	14.40	54.26	43.15	25.83	21.32	16.64
35	40.26	32.77	23.16	19.26	15.07	56.28	44.74	26.90	22.23	17.39
36	40.79	33.30	23.81	19.82	15.57	57.33	45.49	27.66	22.95	18.05
37	41.33	33.83	24.47	20.39	16.08	58.40	46.25	28.44	23.70	18.73
38	41.88	34.38	25.16	20.97	16.62	59.48	47.03	29.24	24.47	19.44
39	42.43	34.93	25.86	21.58	17.17	60.59	47.82	30.06	25.26	20.17
40	43.00	35.49	26.58	22.20	17.74	61.71	48.62	30.90	26.09	20.94
41	44.83	37.10	28.20	23.68	19.03	63.55	50.22	32.34	27.41	22.17
42	46.75	38.77	29.92	25.26	20.42	65.45	51.87	33.83	28.80	23.47
43	48.74	40.52	31.75	26.95	21.90	67.40	53.58	35.40	30.26	24.85
44	50.82	42.35	33.69	28.75	23.50	69.41	55.34	37.04	31.79	26.31
45	52.99	44.27	35.74	30.67	25.21	71.48	57.16	38.76	33.40	27.86
46	54.40	45.12	37.00	31.70	26.16	72.83	58.13	39.76	34.22	28.51
47	55.85	45.98	38.30	32.78	27.14	74.20	59.11	40.78	35.06	29.18
48	57.34	46.87	39.64	33.89	28.16	75.60	60.11	41.82	35.92	29.86
49	58.86	47.77	41.03	35.04	29.21	77.03	61.13	42.90	36.80	30.56
50	60.43	48.68	43.94	37.46	30.31	78.48	62.16	45.36	39.10	31.27
51	63.78	51.58	47.10	40.24	32.57	83.03	64.45	47.97	41.24	33.00
52	67.51	55.50	50.62	43.33	35.07	88.07	66.90	50.83	43.58	34.90
53	71.65	59.97	54.55	46.79	37.86	93.67	69.49	53.98	46.19	36.99
54	76.34	65.03	58.96	50.69	41.01	99.91	72.26	57.51	49.06	39.32
55	81.66	70.74	63.94	55.08	44.57	106.96	75.22	61.38	52.24	41.89
56	89.39	76.97	69.57	59.97	48.59	116.39	79.47	66.41	56.56	45.43
57	98.36	84.25	76.17	65.59	53.21	127.22	84.05	72.10	61.45	49.42
58	108.90	93.52	84.56	72.09	58.58	139.76	89.03	78.60	67.02	53.99
59	121.44	104.59	94.57	79.66	64.82	154.43	94.43	86.07	73.46	59.26
60	136.58	118.08	106.76	88.93	72.25	171.80	102.99	94.75	80.92	65.38

Smoker: Multiply by 120%

Auto-Owners Life Insurance Company
 Coordinating Additional Insurance Rider
 Rider Form # 61732

Benefit Period 5 Years
 Occupation Class B
 Non-Smoker

Annual Premiums per \$100 Monthly Rider Benefit, by Gender and Elimination Period in days

Issue Age	Male 30	Male 60	Male 90	Male 180	Male 365	Female 30	Female 60	Female 90	Female 180	Female 365
18-25	38.64	32.53	22.17	18.23	13.74	48.26	39.75	24.69	20.08	15.33
26	39.22	32.93	22.45	18.46	13.97	49.43	40.65	25.20	20.61	15.77
27	39.82	33.32	22.73	18.70	14.20	50.63	41.58	25.73	21.16	16.23
28	40.42	33.73	23.01	18.94	14.43	51.86	42.53	26.27	21.72	16.69
29	41.03	34.13	23.30	19.18	14.67	53.11	43.51	26.82	22.30	17.18
30	41.65	34.55	23.59	19.42	14.91	54.40	44.50	27.39	22.89	17.67
31	43.06	35.82	24.59	20.29	15.61	56.53	46.16	28.56	23.94	18.56
32	44.51	37.14	25.63	21.20	16.33	58.75	47.87	29.78	25.03	19.49
33	46.02	38.51	26.71	22.15	17.09	61.05	49.65	31.05	26.18	20.47
34	47.58	39.93	27.84	23.15	17.89	63.45	51.50	32.38	27.38	21.50
35	49.19	41.40	29.01	24.18	18.72	65.93	53.42	33.76	28.63	22.57
36	50.07	42.06	29.84	24.92	19.36	67.25	54.36	34.78	29.56	23.40
37	50.96	42.73	30.68	25.68	20.01	68.60	55.33	35.83	30.52	24.25
38	51.86	43.41	31.55	26.46	20.70	69.98	56.31	36.91	31.51	25.14
39	52.78	44.10	32.44	27.26	21.40	71.38	57.31	38.02	32.54	26.05
40	53.72	44.80	33.36	28.09	22.13	72.82	58.33	39.17	33.60	27.00
41	56.26	46.94	35.37	29.89	23.70	75.29	60.31	41.00	35.28	28.59
42	58.92	49.17	37.51	31.79	25.38	77.86	62.35	42.92	37.04	30.26
43	61.71	51.52	39.77	33.82	27.18	80.51	64.47	44.93	38.89	32.03
44	64.62	53.97	42.17	35.98	29.10	83.25	66.65	47.03	40.84	33.91
45	67.68	56.54	44.71	38.28	31.17	86.09	68.91	49.23	42.88	35.90
46	69.52	57.83	46.36	39.75	32.37	87.97	70.01	50.63	44.03	36.89
47	71.41	59.15	48.06	41.27	33.63	89.89	71.13	52.07	45.22	37.92
48	73.35	60.50	49.83	42.85	34.93	91.86	72.26	53.55	46.43	38.97
49	75.34	61.88	51.66	44.50	36.28	93.87	73.41	55.07	47.68	40.05
50	77.39	63.29	53.56	46.20	37.68	95.92	74.58	56.64	48.96	41.17
51	81.91	66.94	57.58	49.62	40.49	101.58	77.60	59.33	51.52	43.72
52	86.93	71.01	62.08	53.47	43.59	107.84	80.80	62.28	54.30	46.53
53	92.53	75.54	67.16	57.73	47.07	114.82	84.21	65.54	57.36	49.65
54	98.86	80.63	72.92	62.59	50.99	122.58	87.86	69.12	60.73	53.12
55	106.05	86.40	79.50	68.10	55.42	131.35	91.75	73.11	64.48	56.96
56	116.02	94.42	87.16	74.40	60.33	142.88	96.88	78.98	69.58	61.66
57	127.57	103.70	96.07	81.68	66.00	156.06	102.39	85.62	75.32	66.98
58	141.17	114.54	106.58	90.21	72.53	171.36	108.38	93.16	81.83	73.03
59	157.33	127.40	119.15	100.30	80.18	189.24	114.86	101.82	89.28	80.03
60	176.85	142.83	134.43	112.37	89.23	210.42	121.90	111.86	97.88	88.12

Smoker: Multiply by 120%

Auto-Owners Life Insurance Company
 Coordinating Additional Insurance Rider
 Rider Form # 61732

Benefit Period To Age 67
 Occupation Class AAAA
 Non-Smoker

Annual Premiums per \$100 Monthly Rider Benefit, by Gender and Elimination Period in days

Issue Age	Male 30	Male 60	Male 90	Male 180	Male 365	Female 30	Female 60	Female 90	Female 180	Female 365
18-25	23.30	20.32	11.08	9.49	8.08	31.27	24.41	13.95	12.86	10.94
26	24.26	20.99	11.44	9.74	8.30	32.77	25.47	14.54	13.36	11.35
27	25.26	21.68	11.82	10.00	8.53	34.35	26.58	15.15	13.88	11.78
28	26.30	22.39	12.21	10.27	8.77	36.01	27.73	15.79	14.41	12.23
29	27.38	23.12	12.61	10.54	9.01	37.74	28.93	16.46	14.97	12.69
30	28.51	23.88	13.03	10.83	9.25	39.56	30.18	17.15	15.56	13.17
31	29.79	24.84	13.57	11.17	9.53	42.20	31.59	18.10	16.30	13.67
32	31.12	25.84	14.12	11.52	9.82	45.02	33.06	19.11	17.08	14.20
33	32.51	26.88	14.70	11.89	10.11	48.03	34.59	20.17	17.90	14.74
34	33.97	27.95	15.31	12.26	10.42	51.25	36.20	21.29	18.76	15.31
35	35.49	29.08	15.93	12.65	10.73	54.67	37.88	22.48	19.66	15.89
36	36.55	29.77	16.69	13.33	11.24	57.21	39.13	23.38	20.39	16.50
37	37.64	30.48	17.49	14.05	11.76	59.87	40.42	24.32	21.13	17.12
38	38.77	31.21	18.33	14.81	12.31	62.65	41.76	25.30	21.91	17.78
39	39.93	31.95	19.20	15.62	12.89	65.55	43.13	26.31	22.71	18.45
40	41.12	32.71	20.12	16.46	13.49	68.60	44.58	27.37	23.55	19.15
41	42.11	33.26	20.97	17.04	14.10	69.76	44.98	27.94	23.93	19.51
42	43.12	33.81	21.86	17.64	14.73	71.14	45.37	28.52	24.32	19.88
43	44.16	34.38	22.79	18.25	15.40	72.55	45.78	29.11	24.71	20.26
44	45.22	34.95	23.76	18.90	16.09	73.99	46.19	29.71	25.11	20.64
45	46.31	35.53	24.78	19.56	16.82	75.45	46.59	30.33	25.52	21.03
46	47.83	36.45	25.65	20.35	17.44	78.07	47.91	30.63	25.80	21.29
47	49.41	37.39	26.55	21.16	18.09	80.76	49.27	30.94	26.08	21.55
48	51.03	38.36	27.48	22.02	18.76	83.56	50.66	31.25	26.37	21.81
49	52.71	39.35	28.44	22.90	19.45	86.45	52.09	31.56	26.65	22.07
50	54.45	40.36	29.44	23.82	20.17	89.44	53.57	31.88	26.95	22.34
51	55.96	41.36	30.59	24.64	20.94	90.33	54.10	32.20	27.21	22.57
52	57.53	42.37	31.79	25.48	21.73	91.23	54.65	32.52	27.49	22.79
53	59.13	43.41	33.04	26.35	22.55	92.15	55.19	32.84	27.76	23.02
54	60.78	44.47	34.33	27.25	23.40	93.07	55.75	33.17	28.04	23.25
55	62.48	45.57	35.67	28.18	24.28	94.00	56.30	33.50	28.32	23.48
56	64.35	46.60	36.76	29.13	25.07	95.70	59.15	34.55	29.21	24.24
57	66.28	47.66	37.88	30.11	25.88	98.66	60.97	35.62	30.14	25.03
58	68.27	48.74	39.03	31.12	26.72	101.74	62.88	36.73	31.09	25.84
59	70.32	49.84	40.21	32.17	27.59	104.92	64.84	37.88	32.07	26.68
60	72.42	50.97	41.43	33.26	28.48	108.17	66.85	39.05	33.08	27.55

Smoker: Multiply by 120%

Auto-Owners Life Insurance Company
 Coordinating Additional Insurance Rider
 Rider Form # 61732

Benefit Period To Age 67
 Occupation Class AAA
 Non-Smoker

Annual Premiums per \$100 Monthly Rider Benefit, by Gender and Elimination Period in days

Issue Age	Male 30	Male 60	Male 90	Male 180	Male 365	Female 30	Female 60	Female 90	Female 180	Female 365
18-25	27.16	23.81	12.74	10.64	9.26	36.76	29.03	16.34	14.34	12.82
26	28.30	24.66	13.18	10.95	9.47	38.75	30.40	17.11	15.13	13.40
27	29.48	25.54	13.63	11.27	9.69	40.84	31.83	17.92	15.97	14.00
28	30.71	26.45	14.10	11.61	9.91	43.05	33.32	18.76	16.85	14.64
29	32.00	27.40	14.59	11.95	10.14	45.37	34.89	19.64	17.77	15.30
30	33.33	28.38	15.09	12.30	10.37	47.82	36.53	20.57	18.75	15.99
31	35.02	29.54	15.78	12.81	10.78	51.38	38.43	21.82	19.73	16.64
32	36.80	30.75	16.51	13.35	11.21	55.21	40.43	23.16	20.76	17.33
33	38.67	32.02	17.26	13.91	11.65	59.32	42.53	24.57	21.85	18.04
34	40.63	33.33	18.06	14.50	12.11	63.74	44.74	26.07	22.99	18.78
35	42.69	34.70	18.88	15.10	12.59	68.49	47.07	27.66	24.19	19.55
36	44.14	35.47	19.83	15.85	13.24	71.76	48.90	28.87	25.12	20.38
37	45.64	36.26	20.82	16.63	13.92	75.19	50.79	30.13	26.08	21.24
38	47.18	37.07	21.86	17.45	14.64	78.78	52.76	31.45	27.08	22.14
39	48.79	37.90	22.96	18.31	15.40	82.54	54.80	32.82	28.12	23.07
40	50.44	38.75	24.10	19.21	16.19	86.48	56.93	34.25	29.19	24.05
41	51.79	39.67	25.11	20.01	16.95	88.18	57.43	34.99	29.70	24.47
42	53.18	40.61	26.16	20.84	17.74	89.91	57.94	35.73	30.22	24.90
43	54.60	41.57	27.26	21.70	18.57	91.67	58.45	36.49	30.74	25.34
44	56.06	42.56	28.40	22.60	19.44	93.47	58.97	37.27	31.28	25.79
45	57.56	43.57	29.59	23.53	20.35	95.31	59.49	38.07	31.82	26.25
46	59.53	44.76	30.80	24.51	21.21	96.26	60.08	38.48	32.18	26.58
47	61.57	45.99	32.05	25.52	22.10	97.23	60.69	38.90	32.55	26.91
48	63.69	47.24	33.36	26.58	23.04	98.20	61.29	39.33	32.91	27.25
49	65.87	48.53	34.72	27.67	24.02	99.18	61.91	39.76	33.29	27.59
50	68.13	49.86	36.14	28.82	25.03	100.17	62.52	40.20	33.66	27.94
51	70.03	50.95	37.59	29.92	25.98	101.17	63.15	40.60	34.00	28.22
52	71.99	52.07	39.09	31.06	26.96	102.18	63.78	41.00	34.34	28.50
53	73.99	53.20	40.65	32.25	27.98	103.21	64.42	41.41	34.68	28.78
54	76.06	54.37	42.27	33.48	29.04	104.24	65.06	41.83	35.03	29.07
55	78.18	55.56	43.96	34.76	30.14	105.28	65.71	42.25	35.38	29.36
56	80.50	56.80	45.29	35.88	31.10	107.33	67.93	43.55	36.49	30.31
57	82.89	58.06	46.66	37.04	32.09	110.63	70.01	44.89	37.63	31.30
58	85.35	59.35	48.07	38.24	33.11	114.06	72.18	46.28	38.80	32.31
59	87.88	60.68	49.52	39.48	34.17	117.55	74.39	47.70	40.02	33.36
60	90.49	62.03	51.01	40.76	35.25	121.21	76.71	49.18	41.27	34.44

Smoker: Multiply by 120%

Auto-Owners Life Insurance Company
 Coordinating Additional Insurance Rider
 Rider Form # 61732

Benefit Period To Age 67
 Occupation Class AA
 Non-Smoker

Annual Premiums per \$100 Monthly Rider Benefit, by Gender and Elimination Period in days

Issue Age	Male 30	Male 60	Male 90	Male 180	Male 365	Female 30	Female 60	Female 90	Female 180	Female 365
18-25	31.66	27.73	19.42	17.07	14.00	39.68	30.02	19.93	16.76	14.81
26	33.18	28.69	20.11	17.62	14.44	42.04	31.54	20.78	17.56	15.52
27	34.79	29.71	20.83	18.18	14.90	44.53	33.14	21.68	18.41	16.27
28	36.47	30.74	21.58	18.77	15.38	47.18	34.81	22.61	19.29	17.05
29	38.22	31.82	22.35	19.37	15.87	49.97	36.57	23.59	20.22	17.87
30	40.06	32.92	23.16	19.99	16.37	52.94	38.42	24.60	21.19	18.73
31	41.92	34.24	24.19	20.89	17.06	57.15	40.79	25.97	22.52	19.93
32	43.88	35.63	25.27	21.83	17.78	61.69	43.31	27.41	23.93	21.20
33	45.91	37.07	26.39	22.81	18.54	66.60	45.96	28.93	25.43	22.55
34	48.04	38.56	27.57	23.83	19.32	71.89	48.80	30.54	27.02	23.98
35	50.27	40.11	28.80	24.90	20.14	77.61	51.80	32.23	28.71	25.51
36	51.79	41.38	30.41	26.22	21.26	82.04	53.79	33.97	30.49	26.69
37	53.36	42.70	32.11	27.61	22.44	86.73	55.86	35.80	32.38	27.92
38	54.97	44.05	33.91	29.08	23.69	91.68	58.00	37.73	34.38	29.21
39	57.16	45.44	35.81	30.62	25.01	96.92	61.59	39.76	36.51	30.55
40	59.52	46.89	37.81	32.24	26.40	102.45	65.50	41.91	38.77	31.96
41	61.91	47.74	39.72	33.98	27.85	104.46	65.81	43.74	40.22	33.18
42	64.39	49.06	41.72	35.80	29.38	106.51	66.11	45.65	41.73	34.45
43	66.97	50.42	43.82	37.72	31.00	108.60	66.42	47.64	43.30	35.76
44	69.66	51.82	46.03	39.75	32.70	110.73	66.74	49.72	44.92	37.13
45	72.46	53.25	48.35	41.89	34.49	112.91	67.04	51.89	46.61	38.54
46	75.36	56.56	50.82	44.08	36.39	114.08	67.27	53.40	47.83	39.70
47	78.38	60.07	53.41	46.38	38.38	116.00	67.49	54.95	49.08	40.88
48	81.52	63.80	56.13	48.80	40.49	117.96	67.72	56.54	50.36	42.11
49	84.78	67.76	59.00	51.35	42.71	119.95	68.00	58.18	51.68	43.37
50	88.18	71.96	62.00	54.04	45.05	121.97	68.66	60.84	53.03	44.66
51	89.30	72.88	63.90	55.51	46.20	123.20	69.35	61.56	53.55	45.35
52	90.43	74.80	65.86	57.02	47.39	124.43	70.05	62.37	54.16	46.05
53	91.58	76.96	67.88	58.57	48.60	125.67	70.74	63.33	54.90	46.77
54	92.74	79.17	69.96	60.17	49.85	126.93	71.45	64.33	55.66	47.49
55	93.92	81.43	72.10	61.81	51.12	128.20	72.16	65.33	56.42	48.22
56	96.75	83.89	74.32	63.78	52.85	131.75	74.02	67.32	58.20	49.82
57	99.66	86.42	76.60	65.81	54.63	135.74	76.35	69.40	60.05	51.46
58	102.66	89.02	78.96	67.90	56.47	139.86	78.75	71.51	61.95	53.16
59	105.75	91.73	81.38	70.07	58.37	144.10	81.23	73.71	63.91	54.91
60	108.94	94.49	83.88	72.30	60.34	148.47	83.78	75.97	65.94	56.72

Smoker: Multiply by 120%

Auto-Owners Life Insurance Company
 3% Cost of Living Increase Rider
 Rider Form # 61746

Benefit Period 5 Years
 Occupation Class AAAA
 Non-Smoker

Annual Premiums per \$100 Monthly Base and CAI Rider Benefit, by Gender and Elimination Period in days

Issue Age	Male 30	Male 60	Male 90	Male 180	Male 365	Female 30	Female 60	Female 90	Female 180	Female 365
18-25	0.57	0.63	0.26	0.30	0.33	0.67	0.73	0.40	0.38	0.48
26	0.58	0.64	0.27	0.31	0.34	0.68	0.75	0.40	0.40	0.50
27	0.59	0.64	0.28	0.32	0.34	0.69	0.76	0.41	0.42	0.51
28	0.60	0.65	0.29	0.33	0.35	0.70	0.78	0.41	0.44	0.53
29	0.61	0.66	0.30	0.34	0.36	0.71	0.80	0.42	0.47	0.55
30	0.62	0.67	0.31	0.35	0.36	0.72	0.83	0.42	0.49	0.57
31	0.69	0.73	0.34	0.38	0.40	0.81	0.92	0.47	0.54	0.62
32	0.75	0.80	0.38	0.41	0.43	0.91	1.02	0.52	0.59	0.67
33	0.83	0.87	0.41	0.45	0.48	1.02	1.13	0.57	0.65	0.74
34	0.92	0.95	0.46	0.48	0.52	1.15	1.25	0.63	0.71	0.80
35	1.01	1.04	0.50	0.52	0.57	1.29	1.38	0.70	0.78	0.88
36	1.00	1.03	0.51	0.53	0.59	1.33	1.40	0.72	0.79	0.90
37	1.00	1.03	0.52	0.54	0.61	1.37	1.43	0.73	0.81	0.92
38	1.00	1.02	0.54	0.55	0.63	1.41	1.45	0.75	0.83	0.95
39	1.00	1.02	0.55	0.56	0.65	1.46	1.47	0.77	0.85	0.97
40	0.99	1.01	0.56	0.58	0.67	1.50	1.49	0.79	0.87	1.00
41	1.07	1.08	0.61	0.63	0.73	1.59	1.56	0.83	0.91	1.05
42	1.16	1.16	0.66	0.69	0.80	1.69	1.63	0.87	0.95	1.11
43	1.25	1.24	0.71	0.75	0.88	1.80	1.70	0.91	0.99	1.18
44	1.35	1.33	0.77	0.82	0.96	1.91	1.78	0.96	1.03	1.24
45	1.46	1.43	0.84	0.90	1.05	2.02	1.86	1.01	1.08	1.31
46	1.47	1.43	0.84	0.91	1.08	2.05	1.87	1.03	1.10	1.33
47	1.48	1.44	0.84	0.92	1.10	2.07	1.87	1.05	1.12	1.35
48	1.49	1.45	0.84	0.92	1.12	2.09	1.88	1.07	1.14	1.36
49	1.50	1.46	0.85	0.93	1.15	2.12	1.88	1.10	1.16	1.38
50	1.51	1.46	0.85	0.94	1.18	2.14	1.89	1.12	1.18	1.40
51	1.65	1.58	0.95	1.04	1.26	2.27	1.99	1.18	1.25	1.47
52	1.80	1.70	1.07	1.15	1.36	2.44	2.09	1.24	1.31	1.55
53	1.97	1.84	1.21	1.29	1.46	2.61	2.20	1.31	1.39	1.63
54	2.16	1.99	1.36	1.42	1.58	2.81	2.32	1.38	1.46	1.73
55	2.36	2.16	1.54	1.59	1.71	3.04	2.46	1.47	1.56	1.83
56	2.63	2.29	1.68	1.66	1.73	3.49	2.70	1.61	1.63	1.81
57	2.95	2.44	1.83	1.74	1.75	4.04	2.98	1.76	1.73	1.80
58	3.31	2.59	2.01	1.83	1.79	4.72	3.30	1.94	1.83	1.79
59	3.72	2.77	2.21	1.93	1.83	5.55	3.66	2.15	1.93	1.79
60	4.19	2.96	2.45	2.04	1.87	6.61	4.09	2.38	2.06	1.78

Smoker: Multiply by 120%

Auto-Owners Life Insurance Company
 3% Cost of Living Increase Rider
 Rider Form # 61746

Benefit Period 5 Years
 Occupation Class AAA
 Non-Smoker

Annual Premiums per \$100 Monthly Base and CAI Rider Benefit, by Gender and Elimination Period in days

Issue Age	Male 30	Male 60	Male 90	Male 180	Male 365	Female 30	Female 60	Female 90	Female 180	Female 365
18-25	0.63	0.71	0.31	0.32	0.39	0.73	0.80	0.40	0.45	0.54
26	0.65	0.72	0.32	0.33	0.39	0.75	0.84	0.41	0.48	0.57
27	0.67	0.74	0.33	0.34	0.40	0.77	0.87	0.43	0.50	0.59
28	0.68	0.76	0.34	0.35	0.41	0.79	0.90	0.44	0.52	0.62
29	0.70	0.77	0.35	0.36	0.41	0.81	0.94	0.45	0.54	0.64
30	0.72	0.79	0.36	0.37	0.42	0.83	0.98	0.47	0.57	0.67
31	0.79	0.86	0.40	0.41	0.46	0.93	1.07	0.52	0.63	0.73
32	0.87	0.93	0.44	0.44	0.50	1.04	1.18	0.57	0.69	0.80
33	0.96	1.01	0.48	0.48	0.55	1.17	1.30	0.63	0.75	0.87
34	1.06	1.10	0.53	0.52	0.60	1.31	1.43	0.70	0.83	0.95
35	1.18	1.19	0.59	0.57	0.66	1.47	1.58	0.77	0.91	1.04
36	1.17	1.20	0.60	0.59	0.69	1.54	1.63	0.81	0.94	1.08
37	1.16	1.21	0.61	0.61	0.71	1.61	1.68	0.84	0.98	1.12
38	1.16	1.22	0.62	0.64	0.74	1.68	1.73	0.88	1.02	1.16
39	1.15	1.23	0.64	0.66	0.77	1.76	1.79	0.92	1.06	1.20
40	1.14	1.24	0.65	0.69	0.80	1.83	1.84	0.97	1.10	1.25
41	1.25	1.31	0.71	0.76	0.88	1.96	1.93	1.04	1.14	1.31
42	1.36	1.39	0.78	0.83	0.97	2.09	2.01	1.11	1.19	1.38
43	1.49	1.47	0.85	0.91	1.07	2.24	2.10	1.19	1.23	1.45
44	1.63	1.56	0.93	1.00	1.17	2.39	2.19	1.28	1.28	1.52
45	1.78	1.65	1.02	1.09	1.29	2.55	2.29	1.37	1.33	1.60
46	1.80	1.68	1.02	1.10	1.33	2.61	2.30	1.37	1.35	1.62
47	1.82	1.72	1.03	1.12	1.36	2.66	2.31	1.37	1.38	1.65
48	1.84	1.75	1.04	1.13	1.40	2.72	2.32	1.37	1.40	1.67
49	1.86	1.79	1.05	1.15	1.44	2.77	2.33	1.38	1.43	1.69
50	1.88	1.82	1.06	1.16	1.48	2.83	2.34	1.38	1.45	1.72
51	2.05	1.95	1.18	1.28	1.59	2.94	2.43	1.45	1.54	1.81
52	2.23	2.08	1.33	1.42	1.72	3.05	2.54	1.53	1.62	1.91
53	2.44	2.23	1.49	1.58	1.86	3.18	2.66	1.62	1.72	2.03
54	2.67	2.39	1.68	1.75	2.00	3.32	2.78	1.72	1.82	2.15
55	2.92	2.57	1.90	1.95	2.17	3.49	2.91	1.82	1.93	2.28
56	3.27	2.74	2.06	2.03	2.17	4.00	3.18	2.00	2.03	2.26
57	3.64	2.93	2.25	2.13	2.19	4.62	3.48	2.19	2.13	2.24
58	4.08	3.14	2.46	2.23	2.21	5.35	3.82	2.41	2.26	2.23
59	4.58	3.37	2.71	2.34	2.24	6.23	4.20	2.67	2.39	2.23
60	5.17	3.61	2.99	2.46	2.27	7.30	4.62	2.97	2.53	2.22

Smoker: Multiply by 120%

Auto-Owners Life Insurance Company
 3% Cost of Living Increase Rider
 Rider Form # 61746

Benefit Period 5 Years
 Occupation Class AA
 Non-Smoker

Annual Premiums per \$100 Monthly Base and CAI Rider Benefit, by Gender and Elimination Period in days

Issue Age	Male 30	Male 60	Male 90	Male 180	Male 365	Female 30	Female 60	Female 90	Female 180	Female 365
18-25	0.99	0.95	0.57	0.63	0.63	1.50	1.44	0.71	0.74	0.82
26	0.99	0.95	0.57	0.64	0.64	1.52	1.47	0.73	0.77	0.84
27	0.99	0.96	0.57	0.64	0.65	1.54	1.49	0.74	0.80	0.86
28	0.99	0.97	0.57	0.65	0.66	1.57	1.52	0.76	0.83	0.88
29	0.98	0.98	0.57	0.66	0.67	1.59	1.55	0.77	0.87	0.90
30	0.98	0.98	0.58	0.67	0.69	1.62	1.57	0.79	0.90	0.93
31	1.06	1.05	0.63	0.72	0.76	1.73	1.67	0.85	0.98	1.00
32	1.15	1.13	0.70	0.79	0.83	1.85	1.77	0.92	1.06	1.09
33	1.24	1.22	0.77	0.86	0.92	1.98	1.87	1.00	1.14	1.18
34	1.35	1.30	0.84	0.93	1.01	2.12	1.98	1.08	1.24	1.27
35	1.46	1.42	0.92	1.01	1.11	2.27	2.10	1.17	1.34	1.38
36	1.45	1.43	0.94	1.04	1.15	2.29	2.14	1.19	1.37	1.42
37	1.43	1.43	0.95	1.07	1.19	2.32	2.17	1.22	1.40	1.47
38	1.42	1.44	0.97	1.10	1.23	2.35	2.21	1.24	1.42	1.51
39	1.41	1.44	0.98	1.14	1.28	2.38	2.25	1.26	1.45	1.56
40	1.40	1.44	1.00	1.17	1.32	2.41	2.30	1.29	1.48	1.61
41	1.52	1.55	1.10	1.29	1.46	2.52	2.41	1.37	1.58	1.72
42	1.65	1.67	1.22	1.43	1.60	2.64	2.53	1.46	1.68	1.83
43	1.80	1.78	1.35	1.58	1.76	2.76	2.65	1.56	1.79	1.96
44	1.95	1.91	1.50	1.75	1.94	2.89	2.78	1.67	1.91	2.09
45	2.12	2.05	1.66	1.93	2.14	3.02	2.92	1.78	2.03	2.23
46	2.16	2.11	1.70	2.15	2.22	3.10	2.96	1.82	2.07	2.29
47	2.20	2.17	1.73	2.40	2.30	3.18	3.01	1.86	2.11	2.35
48	2.25	2.24	1.77	2.67	2.38	3.26	3.05	1.91	2.15	2.42
49	2.31	2.30	1.81	2.98	2.47	3.34	3.09	1.95	2.19	2.49
50	2.36	2.36	1.96	3.41	2.56	3.42	3.14	2.06	2.23	2.55
51	2.52	2.49	2.16	3.66	2.79	3.61	3.28	2.14	2.46	2.65
52	2.68	2.69	2.38	3.94	3.06	3.82	3.43	2.23	2.73	2.78
53	2.86	2.90	2.63	4.25	3.35	4.06	3.60	2.33	3.04	2.90
54	3.06	3.15	2.92	4.61	3.68	4.32	3.76	2.43	3.40	3.04
55	3.29	3.42	3.24	5.01	4.07	4.62	3.95	2.55	3.79	3.19
56	3.64	3.72	3.49	4.85	4.03	5.20	4.16	2.83	3.82	3.27
57	4.14	4.06	3.79	4.73	4.01	5.87	4.38	3.17	3.86	3.36
58	4.74	4.45	4.11	4.62	4.02	6.67	4.64	3.55	3.94	3.47
59	5.47	4.93	4.52	4.56	4.05	7.61	4.91	4.01	4.02	3.60
60	6.35	5.54	5.02	4.55	4.10	8.75	5.20	4.54	4.12	3.76

Smoker: Multiply by 120%

Auto-Owners Life Insurance Company
 3% Cost of Living Increase Rider
 Rider Form # 61746

Benefit Period 5 Years
 Occupation Class A
 Non-Smoker

Annual Premiums per \$100 Monthly Base and CAI Rider Benefit, by Gender and Elimination Period in days

Issue Age	Male 30	Male 60	Male 90	Male 180	Male 365	Female 30	Female 60	Female 90	Female 180	Female 365
18-25	1.43	1.45	0.98	1.03	1.14	1.82	1.83	1.04	1.12	1.22
26	1.43	1.46	0.98	1.04	1.16	1.86	1.87	1.07	1.15	1.26
27	1.43	1.46	0.98	1.06	1.17	1.89	1.91	1.09	1.18	1.31
28	1.42	1.46	0.97	1.08	1.19	1.93	1.95	1.12	1.21	1.36
29	1.42	1.47	0.97	1.10	1.21	1.97	1.99	1.14	1.24	1.40
30	1.42	1.47	0.97	1.12	1.22	2.01	2.03	1.17	1.28	1.45
31	1.53	1.57	1.06	1.20	1.32	2.14	2.15	1.27	1.38	1.57
32	1.65	1.68	1.15	1.29	1.42	2.28	2.28	1.38	1.48	1.70
33	1.79	1.80	1.25	1.38	1.54	2.43	2.41	1.49	1.60	1.83
34	1.93	1.93	1.36	1.48	1.66	2.59	2.55	1.62	1.72	1.98
35	2.09	2.06	1.48	1.58	1.79	2.77	2.70	1.76	1.85	2.13
36	2.08	2.06	1.49	1.61	1.83	2.81	2.76	1.78	1.90	2.20
37	2.06	2.06	1.50	1.63	1.88	2.85	2.83	1.80	1.95	2.27
38	2.05	2.06	1.52	1.66	1.92	2.90	2.90	1.82	2.01	2.34
39	2.04	2.05	1.53	1.69	1.97	2.94	2.97	1.85	2.06	2.42
40	2.03	2.05	1.54	1.71	2.01	2.99	3.04	1.87	2.12	2.49
41	2.15	2.19	1.68	1.87	2.19	3.14	3.18	2.01	2.25	2.65
42	2.29	2.35	1.84	2.04	2.38	3.30	3.32	2.15	2.38	2.81
43	2.43	2.51	2.01	2.22	2.59	3.46	3.47	2.31	2.53	2.99
44	2.58	2.68	2.19	2.43	2.82	3.64	3.63	2.47	2.68	3.17
45	2.73	2.87	2.39	2.65	3.06	3.82	3.80	2.65	2.84	3.37
46	2.85	2.93	2.45	2.70	3.18	3.91	3.87	2.70	2.92	3.45
47	2.97	3.00	2.51	2.76	3.30	4.01	3.94	2.75	3.00	3.54
48	3.10	3.07	2.57	2.82	3.43	4.11	4.02	2.81	3.08	3.62
49	3.24	3.14	2.63	2.88	3.56	4.21	4.09	2.86	3.16	3.71
50	3.38	3.21	2.79	3.05	3.69	4.32	4.17	3.01	3.37	3.80
51	3.61	3.45	3.05	3.27	3.97	4.64	4.36	3.23	3.58	4.01
52	3.87	3.77	3.34	3.53	4.28	4.98	4.56	3.48	3.81	4.24
53	4.15	4.13	3.67	3.80	4.62	5.37	4.78	3.76	4.07	4.50
54	4.48	4.55	4.04	4.12	5.00	5.81	5.01	4.07	4.34	4.78
55	4.85	5.02	4.45	4.48	5.43	6.31	5.25	4.41	4.66	5.10
56	5.40	5.39	4.81	4.74	5.42	6.99	5.51	4.70	4.82	5.07
57	6.04	5.83	5.22	5.04	5.45	7.78	5.79	5.03	5.00	5.08
58	6.81	6.40	5.76	5.38	5.48	8.71	6.09	5.39	5.20	5.09
59	7.73	7.06	6.38	5.78	5.56	9.80	6.41	5.82	5.45	5.14
60	8.83	7.86	7.15	6.27	5.68	11.12	6.93	6.31	5.73	5.21

Smoker: Multiply by 120%

Auto-Owners Life Insurance Company
 3% Cost of Living Increase Rider
 Rider Form # 61746

Benefit Period 5 Years
 Occupation Class B
 Non-Smoker

Annual Premiums per \$100 Monthly Base and CAI Rider Benefit, by Gender and Elimination Period in days

Issue Age	Male 30	Male 60	Male 90	Male 180	Male 365	Female 30	Female 60	Female 90	Female 180	Female 365
18-25	1.66	1.72	1.16	1.23	1.35	1.96	1.93	1.20	1.28	1.37
26	1.68	1.73	1.17	1.26	1.37	1.98	1.97	1.22	1.31	1.41
27	1.70	1.74	1.18	1.28	1.40	2.01	2.01	1.24	1.35	1.46
28	1.72	1.76	1.19	1.30	1.43	2.03	2.04	1.26	1.38	1.51
29	1.74	1.77	1.20	1.32	1.46	2.05	2.08	1.28	1.41	1.56
30	1.76	1.78	1.21	1.34	1.49	2.08	2.12	1.30	1.45	1.61
31	1.88	1.88	1.30	1.43	1.58	2.23	2.25	1.40	1.55	1.73
32	2.01	1.98	1.41	1.52	1.68	2.39	2.39	1.50	1.67	1.85
33	2.16	2.10	1.52	1.63	1.78	2.57	2.54	1.61	1.79	1.99
34	2.31	2.21	1.64	1.73	1.89	2.76	2.70	1.72	1.92	2.13
35	2.47	2.34	1.77	1.85	2.00	2.96	2.87	1.84	2.06	2.28
36	2.46	2.36	1.79	1.89	2.06	3.00	2.92	1.88	2.13	2.36
37	2.45	2.39	1.82	1.92	2.12	3.05	2.97	1.92	2.20	2.43
38	2.43	2.41	1.84	1.96	2.19	3.09	3.01	1.96	2.26	2.51
39	2.42	2.44	1.87	2.00	2.25	3.13	3.06	2.00	2.34	2.59
40	2.41	2.46	1.90	2.04	2.32	3.18	3.11	2.04	2.41	2.68
41	2.63	2.64	2.06	2.22	2.51	3.35	3.26	2.16	2.54	2.83
42	2.88	2.84	2.24	2.43	2.72	3.53	3.40	2.29	2.67	2.99
43	3.15	3.05	2.44	2.64	2.94	3.72	3.56	2.42	2.82	3.16
44	3.45	3.28	2.65	2.88	3.19	3.92	3.72	2.56	2.97	3.34
45	3.77	3.53	2.88	3.15	3.45	4.13	3.89	2.71	3.12	3.54
46	3.85	3.62	2.96	3.23	3.56	4.24	3.97	2.74	3.18	3.61
47	3.92	3.72	3.03	3.32	3.68	4.35	4.05	2.77	3.23	3.68
48	4.00	3.82	3.11	3.41	3.80	4.47	4.13	2.80	3.29	3.76
49	4.08	3.93	3.19	3.51	3.92	4.58	4.22	2.83	3.34	3.84
50	4.17	4.04	3.27	3.61	4.05	4.70	4.30	2.86	3.40	3.92
51	4.42	4.27	3.60	3.94	4.35	5.04	4.50	2.99	3.50	4.06
52	4.68	4.54	3.96	4.30	4.68	5.41	4.71	3.13	3.61	4.22
53	5.00	4.82	4.37	4.72	5.05	5.82	4.93	3.29	3.74	4.40
54	5.34	5.15	4.85	5.20	5.47	6.30	5.17	3.47	3.87	4.60
55	5.74	5.53	5.40	5.74	5.95	6.82	5.42	3.67	4.03	4.81
56	6.44	6.03	5.83	5.98	5.96	7.68	5.80	4.15	4.38	5.00
57	7.25	6.60	6.34	6.24	6.00	8.67	6.20	4.70	4.79	5.22
58	8.23	7.26	6.93	6.56	6.07	9.85	6.64	5.35	5.25	5.48
59	9.40	8.06	7.63	6.94	6.19	11.24	7.13	6.13	5.78	5.78
60	10.84	9.02	8.50	7.39	6.33	12.93	7.67	7.05	6.40	6.11

Smoker: Multiply by 120%

Auto-Owners Life Insurance Company
 3% Cost of Living Increase Rider
 Rider Form # 61746

Benefit Period To Age 67
 Occupation Class AAAA
 Non-Smoker

Annual Premiums per \$100 Monthly Base and CAI Rider Benefit, by Gender and Elimination Period in days

Issue Age	Male 30	Male 60	Male 90	Male 180	Male 365	Female 30	Female 60	Female 90	Female 180	Female 365
18-25	5.93	6.22	3.03	2.86	2.83	7.11	7.06	4.60	4.43	4.49
26	6.25	6.48	3.12	2.94	2.88	7.60	7.44	4.77	4.63	4.67
27	6.59	6.74	3.22	3.02	2.94	8.13	7.85	4.95	4.84	4.86
28	6.95	7.02	3.32	3.10	3.00	8.69	8.28	5.14	5.07	5.05
29	7.33	7.31	3.43	3.18	3.06	9.29	8.73	5.34	5.30	5.26
30	7.73	7.61	3.53	3.27	3.12	9.94	9.20	5.54	5.54	5.47
31	8.09	7.84	3.69	3.38	3.24	11.07	9.97	5.82	5.86	5.75
32	8.46	8.08	3.86	3.50	3.35	12.33	10.79	6.12	6.20	6.05
33	8.85	8.32	4.04	3.63	3.47	13.73	11.69	6.43	6.57	6.37
34	9.27	8.57	4.22	3.76	3.60	15.29	12.66	6.75	6.95	6.70
35	9.70	8.83	4.41	3.89	3.73	17.03	13.71	7.09	7.35	7.05
36	9.86	8.90	4.55	4.01	3.85	18.20	14.27	7.40	7.54	7.17
37	10.03	8.97	4.70	4.14	3.98	19.44	14.86	7.73	7.74	7.30
38	10.20	9.04	4.85	4.27	4.11	20.77	15.47	8.07	7.94	7.43
39	10.37	9.11	5.00	4.41	4.24	22.19	16.10	8.42	8.15	7.56
40	10.54	9.18	5.16	4.55	4.38	23.71	16.77	8.79	8.36	7.70
41	10.50	9.06	5.25	4.61	4.47	23.27	16.22	8.83	8.31	7.65
42	10.45	8.93	5.35	4.67	4.55	22.84	15.69	8.87	8.26	7.61
43	10.41	8.81	5.44	4.73	4.64	22.42	15.18	8.90	8.21	7.56
44	10.36	8.69	5.54	4.79	4.73	22.01	14.69	8.94	8.16	7.52
45	10.32	8.57	5.64	4.86	4.82	21.60	14.21	8.98	8.11	7.47
46	10.38	8.55	5.60	4.82	4.81	20.32	13.27	8.99	8.12	7.48
47	10.43	8.52	5.56	4.79	4.80	19.12	12.39	9.00	8.12	7.49
48	10.49	8.50	5.52	4.76	4.79	17.98	11.57	9.01	8.13	7.50
49	10.54	8.47	5.48	4.72	4.77	16.92	10.80	9.02	8.14	7.50
50	10.60	8.45	5.44	4.69	4.76	15.92	10.09	9.03	8.15	7.51
51	9.99	7.88	5.29	4.56	4.65	15.93	10.10	9.03	8.16	7.52
52	9.42	7.34	5.15	4.44	4.54	15.95	10.11	9.04	8.16	7.53
53	8.88	6.84	5.00	4.33	4.43	15.97	10.12	9.05	8.17	7.53
54	8.37	6.38	4.87	4.21	4.33	15.98	10.13	9.06	8.18	7.54
55	7.89	5.95	4.74	4.10	4.22	16.00	10.14	9.07	8.19	7.55
56	7.15	5.84	4.27	3.66	3.87	14.72	9.34	8.61	7.79	7.21
57	6.48	5.72	3.85	3.27	3.53	13.42	8.54	8.14	7.39	6.87
58	5.88	5.60	3.47	2.93	3.17	12.10	7.73	7.67	6.98	6.52
59	5.33	5.48	3.12	2.62	2.82	10.77	6.91	7.19	6.56	6.17
60	4.83	5.36	2.81	2.34	2.46	9.43	6.08	6.71	6.14	5.81

Smoker: Multiply by 120%

Auto-Owners Life Insurance Company
 3% Cost of Living Increase Rider
 Rider Form # 61746

Benefit Period To Age 67
 Occupation Class AAA
 Non-Smoker

Annual Premiums per \$100 Monthly Base and CAI Rider Benefit, by Gender and Elimination Period in days

Issue Age	Male 30	Male 60	Male 90	Male 180	Male 365	Female 30	Female 60	Female 90	Female 180	Female 365
18-25	7.13	7.52	3.55	3.45	3.43	8.51	8.65	6.19	5.82	5.37
26	7.51	7.85	3.68	3.52	3.49	9.14	9.16	6.39	6.02	5.62
27	7.91	8.19	3.82	3.60	3.56	9.82	9.70	6.60	6.22	5.88
28	8.34	8.54	3.97	3.68	3.62	10.54	10.27	6.82	6.43	6.16
29	8.78	8.91	4.12	3.76	3.69	11.32	10.87	7.03	6.64	6.45
30	9.25	9.30	4.27	3.84	3.76	12.16	11.51	7.25	6.81	6.75
31	9.75	9.60	4.48	4.00	3.90	13.61	12.50	7.57	7.21	7.09
32	10.28	9.90	4.70	4.17	4.05	15.25	13.58	7.90	7.64	7.45
33	10.83	10.22	4.93	4.34	4.20	17.07	14.75	8.24	8.10	7.83
34	11.42	10.55	5.17	4.53	4.35	19.12	16.03	8.59	8.58	8.23
35	12.04	10.88	5.43	4.72	4.51	21.41	17.41	8.92	9.09	8.65
36	12.28	10.91	5.60	4.86	4.67	22.68	17.99	9.30	9.33	8.81
37	12.52	10.93	5.78	5.01	4.83	24.03	18.58	9.69	9.58	8.97
38	12.77	10.95	5.97	5.16	4.99	25.46	19.19	10.11	9.84	9.14
39	13.02	10.97	6.16	5.31	5.17	26.97	19.83	10.54	10.11	9.31
40	13.28	10.99	6.36	5.47	5.34	28.57	20.48	10.99	10.38	9.48
41	13.20	10.91	6.47	5.57	5.46	28.60	20.50	10.98	10.39	9.40
42	13.13	10.82	6.58	5.67	5.59	28.63	20.52	10.97	10.40	9.32
43	13.06	10.74	6.70	5.77	5.71	28.66	20.54	10.96	10.41	9.24
44	12.99	10.66	6.81	5.87	5.84	28.69	20.56	10.95	10.42	9.16
45	12.92	10.58	6.93	5.97	5.97	28.72	20.58	10.94	10.43	9.08
46	13.02	10.52	6.87	5.94	5.97	28.75	20.60	10.42	10.44	8.72
47	13.12	10.46	6.80	5.90	5.97	28.78	20.62	9.93	10.45	8.36
48	13.22	10.40	6.74	5.87	5.97	28.80	20.64	9.47	10.46	8.02
49	13.33	10.35	6.68	5.84	5.98	28.83	20.66	9.02	10.47	7.69
50	13.43	10.29	6.62	5.81	5.98	28.86	20.68	8.60	10.48	7.38
51	12.61	9.65	6.43	5.65	5.82	27.51	19.84	8.61	10.01	7.39
52	11.84	9.05	6.25	5.50	5.67	26.16	18.98	8.62	9.54	7.40
53	11.11	8.48	6.07	5.35	5.52	24.79	18.12	8.62	9.06	7.40
54	10.43	7.95	5.90	5.21	5.38	23.40	17.25	8.63	8.58	7.41
55	9.79	7.46	5.73	5.07	5.24	21.99	16.37	8.64	8.09	7.42
56	8.86	7.36	5.18	4.51	4.82	20.58	15.47	8.06	7.59	6.99
57	8.02	7.25	4.67	4.02	4.39	19.14	14.57	7.47	7.09	6.56
58	7.26	7.15	4.22	3.57	3.97	17.69	13.66	6.88	6.59	6.12
59	6.57	7.05	3.81	3.18	3.54	16.22	12.74	6.28	6.08	5.68
60	5.95	6.95	3.44	2.83	3.11	14.74	11.80	5.68	5.56	5.23

Smoker: Multiply by 120%

Auto-Owners Life Insurance Company
 3% Cost of Living Increase Rider
 Rider Form # 61746

Benefit Period To Age 67
 Occupation Class AA
 Non-Smoker

Annual Premiums per \$100 Monthly Base and CAI Rider Benefit, by Gender and Elimination Period in days

Issue Age	Male 30	Male 60	Male 90	Male 180	Male 365	Female 30	Female 60	Female 90	Female 180	Female 365
18-25	8.08	8.56	5.76	6.17	5.86	13.29	11.12	6.14	6.19	6.34
26	8.51	8.85	6.01	6.37	6.03	14.08	11.68	6.43	6.49	6.64
27	8.96	9.15	6.26	6.57	6.20	14.91	12.27	6.74	6.80	6.96
28	9.42	9.46	6.53	6.77	6.38	15.79	12.89	7.07	7.13	7.29
29	9.91	9.78	6.80	6.98	6.56	16.73	13.54	7.41	7.47	7.65
30	10.44	10.11	7.09	7.20	6.75	17.72	14.23	7.76	7.83	8.01
31	10.98	10.52	7.39	7.48	6.99	19.13	15.10	8.25	8.32	8.52
32	11.54	10.95	7.71	7.76	7.24	20.65	16.04	8.77	8.85	9.07
33	12.14	11.39	8.04	8.06	7.50	22.30	17.01	9.31	9.40	9.64
34	12.76	11.84	8.38	8.37	7.76	24.07	18.07	9.90	9.99	10.26
35	13.42	12.32	8.73	8.69	8.04	25.99	19.18	10.52	10.61	10.91
36	13.75	12.52	9.05	8.95	8.35	27.47	19.91	11.11	11.25	11.37
37	14.08	12.74	9.38	9.22	8.67	29.04	20.68	11.74	11.93	11.84
38	14.42	12.95	9.73	9.50	9.01	30.69	21.47	12.40	12.64	12.34
39	14.91	13.18	10.08	9.79	9.36	32.45	22.80	13.10	13.40	12.85
40	15.43	13.39	10.45	10.09	9.72	34.30	24.25	13.85	14.21	13.39
41	15.99	13.53	10.77	10.40	10.03	33.78	24.27	14.14	14.41	13.57
42	16.57	13.80	11.10	10.71	10.34	33.28	24.30	14.44	14.62	13.74
43	17.16	14.07	11.43	11.03	10.66	32.77	24.32	14.74	14.83	13.92
44	17.78	14.35	11.78	11.37	11.00	32.27	24.35	15.05	15.05	14.10
45	18.43	14.63	12.14	11.71	11.34	31.79	24.37	15.37	15.26	14.28
46	18.38	14.69	12.35	11.96	11.60	30.46	24.40	14.89	14.76	13.93
47	18.34	14.75	12.58	12.21	11.86	29.19	24.42	14.43	14.27	13.59
48	18.30	14.81	12.80	12.47	12.12	27.96	24.44	13.99	13.79	13.25
49	18.26	14.88	13.04	12.73	12.39	26.80	24.47	13.56	13.33	12.92
50	18.22	14.94	13.27	13.00	12.67	25.68	24.63	13.35	12.89	12.60
51	18.24	14.95	12.60	12.34	12.12	25.71	24.66	13.39	12.90	12.61
52	18.26	15.17	11.96	11.71	11.58	25.73	24.68	13.46	12.94	12.63
53	18.27	15.42	11.36	11.12	11.08	25.76	24.71	13.55	13.00	12.64
54	18.29	15.69	10.78	10.55	10.59	25.78	24.73	13.64	13.06	12.65
55	18.31	15.95	10.24	10.01	10.13	25.81	24.76	13.74	13.12	12.66
56	17.08	14.87	9.25	9.12	9.33	24.62	24.40	12.86	12.32	11.93
57	15.84	13.79	8.26	8.23	8.53	22.90	23.39	11.96	11.50	11.19
58	14.58	12.70	7.27	7.32	7.71	21.17	22.37	11.07	10.69	10.45
59	13.31	11.59	6.49	6.40	6.89	19.42	21.34	10.15	9.86	9.70
60	12.02	10.47	5.79	5.47	6.05	17.65	20.30	9.23	9.02	8.95

Smoker: Multiply by 120%

Auto-Owners Life Insurance Company
Spousal Catastrophic Disability Rider
Rider Form # 61743

Non-Smoker

Annual Premiums per \$100 Monthly Rider Benefit

Issue <u>Age</u>	Male	Female
18-25	1.54	2.60
26	1.56	2.63
27	1.59	2.67
28	1.61	2.71
29	1.64	2.75
30	1.66	2.80
31	1.69	2.84
32	1.72	2.89
33	1.75	2.92
34	1.77	2.97
35	1.79	3.02
36	1.84	3.08
37	1.88	3.15
38	1.92	3.21
39	1.97	3.28
40	2.01	3.36
41	2.07	3.46
42	2.13	3.58
43	2.20	3.69
44	2.27	3.81
45	2.34	3.93
46	2.43	4.09
47	2.54	4.26
48	2.64	4.43
49	2.75	4.60
50	2.87	4.80
51	3.03	5.03
52	3.19	5.28
53	3.38	5.55
54	3.56	5.82
55	3.76	6.11
56	4.11	6.60
57	4.50	7.13
58	4.91	7.70
59	5.38	8.32
60	5.88	8.98

Smoker: Multiply by 120%
Gender and Smoker Status apply to Spouse

Auto-Owners Life Insurance Company
 First Day Hospital Confined Rider
 Rider Form # 61744

Occupation Class AAAA
 Non-Smoker

Annual Premiums per \$100 Monthly Base and CAI Rider Benefit, by Gender and Elimination Period in days

Issue Age	Male 30	Male 60	Male 90	Male 180	Male 365	Female 30	Female 60	Female 90	Female 180	Female 365
18-25	2.01	2.11	2.22	2.44	2.68	3.88	4.07	4.27	4.70	5.17
26	2.07	2.17	2.29	2.51	2.76	3.89	4.09	4.29	4.72	5.19
27	2.13	2.24	2.35	2.59	2.84	3.91	4.10	4.30	4.74	5.21
28	2.19	2.31	2.42	2.66	2.93	3.92	4.12	4.32	4.75	5.23
29	2.26	2.38	2.49	2.74	3.02	3.94	4.13	4.34	4.77	5.25
30	2.33	2.45	2.57	2.83	3.11	3.95	4.15	4.35	4.79	5.27
31	2.46	2.58	2.71	2.98	3.28	3.98	4.18	4.38	4.82	5.31
32	2.59	2.72	2.86	3.15	3.46	4.00	4.20	4.41	4.85	5.34
33	2.74	2.87	3.02	3.32	3.65	4.03	4.23	4.44	4.89	5.38
34	2.89	3.03	3.18	3.51	3.86	4.05	4.26	4.47	4.92	5.41
35	3.04	3.20	3.36	3.70	4.07	4.08	4.29	4.50	4.95	5.45
36	3.12	3.28	3.44	3.79	4.17	4.10	4.31	4.52	4.97	5.48
37	3.19	3.35	3.52	3.88	4.27	4.12	4.33	4.54	5.00	5.50
38	3.27	3.44	3.61	3.97	4.37	4.14	4.35	4.56	5.02	5.53
39	3.35	3.52	3.69	4.06	4.47	4.16	4.37	4.59	5.05	5.55
40	3.43	3.60	3.78	4.16	4.58	4.18	4.39	4.61	5.07	5.58
41	3.58	3.76	3.95	4.34	4.78	4.21	4.42	4.65	5.11	5.62
42	3.74	3.93	4.12	4.53	4.99	4.25	4.46	4.68	5.15	5.67
43	3.90	4.10	4.30	4.73	5.21	4.28	4.50	4.72	5.19	5.72
44	4.07	4.28	4.49	4.94	5.44	4.32	4.53	4.76	5.24	5.76
45	4.25	4.47	4.69	5.16	5.68	4.35	4.57	4.80	5.28	5.81
46	4.35	4.57	4.79	5.27	5.80	4.43	4.65	4.88	5.37	5.91
47	4.44	4.67	4.90	5.39	5.93	4.51	4.73	4.97	5.47	6.02
48	4.54	4.77	5.00	5.51	6.06	4.59	4.82	5.06	5.56	6.12
49	4.64	4.87	5.11	5.63	6.19	4.67	4.90	5.15	5.66	6.23
50	4.74	4.98	5.23	5.75	6.32	4.75	4.99	5.24	5.76	6.34
51	5.00	5.25	5.52	6.07	6.68	4.93	5.18	5.44	5.98	6.58
52	5.28	5.54	5.82	6.41	7.05	5.12	5.38	5.65	6.21	6.84
53	5.57	5.85	6.15	6.76	7.44	5.32	5.59	5.87	6.45	7.10
54	5.88	6.18	6.49	7.14	7.85	5.53	5.81	6.09	6.70	7.37
55	6.21	6.52	6.85	7.54	8.29	5.74	6.03	6.33	6.96	7.66
56	6.28	6.60	6.93	7.63	8.39	5.82	6.12	6.42	7.06	7.77
57	6.36	6.68	7.01	7.72	8.49	5.91	6.21	6.51	7.16	7.88
58	6.43	6.76	7.10	7.81	8.59	5.99	6.30	6.61	7.27	8.00
59	6.51	6.84	7.18	7.90	8.69	6.08	6.39	6.71	7.38	8.11
60	6.59	6.92	7.27	7.99	8.79	6.17	6.48	6.80	7.48	8.23

Smoker: Multiply by 120%

Auto-Owners Life Insurance Company
 First Day Hospital Confined Rider
 Rider Form # 61744

Occupation Class AAA
 Non-Smoker

Annual Premiums per \$100 Monthly Base and CAI Rider Benefit, by Gender and Elimination Period in days

Issue Age	Male 30	Male 60	Male 90	Male 180	Male 365	Female 30	Female 60	Female 90	Female 180	Female 365
18-25	2.01	2.11	2.22	2.44	2.68	3.88	4.07	4.27	4.70	5.17
26	2.07	2.17	2.29	2.51	2.76	3.89	4.09	4.29	4.72	5.19
27	2.13	2.24	2.35	2.59	2.84	3.91	4.10	4.30	4.74	5.21
28	2.19	2.31	2.42	2.66	2.93	3.92	4.12	4.32	4.75	5.23
29	2.26	2.38	2.49	2.74	3.02	3.94	4.13	4.34	4.77	5.25
30	2.33	2.45	2.57	2.83	3.11	3.95	4.15	4.35	4.79	5.27
31	2.46	2.58	2.71	2.98	3.28	3.98	4.18	4.38	4.82	5.31
32	2.59	2.72	2.86	3.15	3.46	4.00	4.20	4.41	4.85	5.34
33	2.74	2.87	3.02	3.32	3.65	4.03	4.23	4.44	4.89	5.38
34	2.89	3.03	3.18	3.51	3.86	4.05	4.26	4.47	4.92	5.41
35	3.04	3.20	3.36	3.70	4.07	4.08	4.29	4.50	4.95	5.45
36	3.12	3.28	3.44	3.79	4.17	4.10	4.31	4.52	4.97	5.48
37	3.19	3.35	3.52	3.88	4.27	4.12	4.33	4.54	5.00	5.50
38	3.27	3.44	3.61	3.97	4.37	4.14	4.35	4.56	5.02	5.53
39	3.35	3.52	3.69	4.06	4.47	4.16	4.37	4.59	5.05	5.55
40	3.43	3.60	3.78	4.16	4.58	4.18	4.39	4.61	5.07	5.58
41	3.58	3.76	3.95	4.34	4.78	4.21	4.42	4.65	5.11	5.62
42	3.74	3.93	4.12	4.53	4.99	4.25	4.46	4.68	5.15	5.67
43	3.90	4.10	4.30	4.73	5.21	4.28	4.50	4.72	5.19	5.72
44	4.07	4.28	4.49	4.94	5.44	4.32	4.53	4.76	5.24	5.76
45	4.25	4.47	4.69	5.16	5.68	4.35	4.57	4.80	5.28	5.81
46	4.35	4.57	4.79	5.27	5.80	4.43	4.65	4.88	5.37	5.91
47	4.44	4.67	4.90	5.39	5.93	4.51	4.73	4.97	5.47	6.02
48	4.54	4.77	5.00	5.51	6.06	4.59	4.82	5.06	5.56	6.12
49	4.64	4.87	5.11	5.63	6.19	4.67	4.90	5.15	5.66	6.23
50	4.74	4.98	5.23	5.75	6.32	4.75	4.99	5.24	5.76	6.34
51	5.00	5.25	5.52	6.07	6.68	4.93	5.18	5.44	5.98	6.58
52	5.28	5.54	5.82	6.41	7.05	5.12	5.38	5.65	6.21	6.84
53	5.57	5.85	6.15	6.76	7.44	5.32	5.59	5.87	6.45	7.10
54	5.88	6.18	6.49	7.14	7.85	5.53	5.81	6.09	6.70	7.37
55	6.21	6.52	6.85	7.54	8.29	5.74	6.03	6.33	6.96	7.66
56	6.28	6.60	6.93	7.63	8.39	5.82	6.12	6.42	7.06	7.77
57	6.36	6.68	7.01	7.72	8.49	5.91	6.21	6.51	7.16	7.88
58	6.43	6.76	7.10	7.81	8.59	5.99	6.30	6.61	7.27	8.00
59	6.51	6.84	7.18	7.90	8.69	6.08	6.39	6.71	7.38	8.11
60	6.59	6.92	7.27	7.99	8.79	6.17	6.48	6.80	7.48	8.23

Smoker: Multiply by 120%

Auto-Owners Life Insurance Company
 First Day Hospital Confined Rider
 Rider Form # 61744

Occupation Class AA
 Non-Smoker

Annual Premiums per \$100 Monthly Base and CAI Rider Benefit, by Gender and Elimination Period in days

Issue Age	Male 30	Male 60	Male 90	Male 180	Male 365	Female 30	Female 60	Female 90	Female 180	Female 365
18-25	2.21	2.32	2.44	2.68	2.95	4.32	4.54	4.77	5.25	5.78
26	2.28	2.39	2.52	2.76	3.04	4.34	4.55	4.78	5.26	5.80
27	2.35	2.47	2.59	2.85	3.14	4.35	4.57	4.80	5.28	5.81
28	2.43	2.55	2.68	2.94	3.24	4.36	4.58	4.81	5.29	5.83
29	2.50	2.63	2.76	3.03	3.34	4.38	4.60	4.83	5.31	5.84
30	2.58	2.71	2.84	3.13	3.44	4.39	4.61	4.84	5.32	5.86
31	2.72	2.86	3.00	3.30	3.63	4.42	4.64	4.87	5.36	5.89
32	2.87	3.01	3.17	3.48	3.83	4.45	4.67	4.90	5.39	5.93
33	3.03	3.18	3.34	3.67	4.04	4.47	4.70	4.94	5.43	5.97
34	3.19	3.36	3.53	3.88	4.27	4.50	4.73	4.97	5.46	6.01
35	3.37	3.54	3.72	4.09	4.50	4.53	4.76	5.00	5.50	6.05
36	3.45	3.63	3.81	4.19	4.61	4.55	4.78	5.02	5.53	6.08
37	3.54	3.72	3.91	4.29	4.72	4.57	4.80	5.05	5.55	6.11
38	3.63	3.81	4.00	4.40	4.84	4.60	4.83	5.07	5.58	6.13
39	3.72	3.90	4.10	4.51	4.96	4.62	4.85	5.09	5.60	6.16
40	3.81	4.00	4.20	4.62	5.08	4.64	4.87	5.12	5.63	6.19
41	3.97	4.17	4.38	4.82	5.30	4.67	4.90	5.15	5.66	6.23
42	4.13	4.34	4.56	5.02	5.52	4.70	4.93	5.18	5.70	6.27
43	4.31	4.52	4.75	5.23	5.75	4.73	4.97	5.21	5.74	6.31
44	4.48	4.71	4.95	5.45	6.00	4.76	5.00	5.25	5.77	6.35
45	4.67	4.91	5.16	5.68	6.25	4.79	5.03	5.28	5.81	6.39
46	4.78	5.02	5.28	5.81	6.39	4.88	5.12	5.38	5.92	6.51
47	4.89	5.14	5.40	5.95	6.54	4.97	5.22	5.48	6.03	6.63
48	5.01	5.26	5.53	6.08	6.69	5.06	5.31	5.58	6.14	6.75
49	5.13	5.39	5.66	6.22	6.85	5.15	5.41	5.68	6.25	6.88
50	5.25	5.51	5.79	6.37	7.00	5.25	5.51	5.79	6.37	7.00
51	5.54	5.81	6.11	6.72	7.39	5.45	5.72	6.01	6.61	7.27
52	5.84	6.13	6.44	7.09	7.79	5.66	5.94	6.24	6.86	7.55
53	6.16	6.47	6.79	7.48	8.22	5.87	6.17	6.48	7.13	7.84
54	6.50	6.83	7.17	7.89	8.67	6.10	6.41	6.72	7.40	8.14
55	6.86	7.20	7.56	8.32	9.15	6.33	6.65	6.98	7.68	8.45
56	6.96	7.31	7.67	8.44	9.28	6.44	6.76	7.10	7.81	8.59
57	7.06	7.41	7.79	8.57	9.42	6.55	6.88	7.22	7.94	8.74
58	7.17	7.52	7.90	8.69	9.56	6.66	6.99	7.34	8.08	8.89
59	7.27	7.64	8.02	8.82	9.70	6.77	7.11	7.47	8.22	9.04
60	7.38	7.75	8.14	8.95	9.85	6.89	7.23	7.60	8.36	9.19

Smoker: Multiply by 120%

Auto-Owners Life Insurance Company
 First Day Hospital Confined Rider
 Rider Form # 61744

Occupation Class A
 Non-Smoker

Annual Premiums per \$100 Monthly Base and CAI Rider Benefit, by Gender and Elimination Period in days

Issue Age	Male 30	Male 60	Male 90	Male 180	Male 365	Female 30	Female 60	Female 90	Female 180	Female 365
18-25	2.42	2.54	2.67	2.94	3.23	4.72	4.96	5.21	5.73	6.30
26	2.49	2.62	2.75	3.03	3.33	4.73	4.97	5.22	5.75	6.32
27	2.57	2.70	2.84	3.12	3.43	4.75	4.99	5.24	5.76	6.34
28	2.65	2.78	2.93	3.22	3.54	4.76	5.00	5.25	5.78	6.35
29	2.73	2.87	3.02	3.32	3.65	4.78	5.02	5.27	5.79	6.37
30	2.82	2.96	3.11	3.42	3.76	4.79	5.03	5.28	5.81	6.39
31	2.98	3.13	3.29	3.61	3.98	4.82	5.07	5.32	5.85	6.44
32	3.15	3.31	3.47	3.82	4.20	4.86	5.10	5.36	5.89	6.48
33	3.33	3.49	3.67	4.04	4.44	4.89	5.14	5.39	5.93	6.53
34	3.51	3.69	3.88	4.27	4.69	4.92	5.17	5.43	5.98	6.57
35	3.71	3.90	4.10	4.51	4.96	4.96	5.21	5.47	6.02	6.62
36	3.80	3.99	4.19	4.61	5.07	4.98	5.23	5.50	6.05	6.65
37	3.89	4.08	4.29	4.72	5.19	5.01	5.26	5.52	6.08	6.68
38	3.98	4.17	4.39	4.82	5.31	5.03	5.28	5.55	6.10	6.71
39	4.07	4.27	4.48	4.93	5.43	5.06	5.31	5.57	6.13	6.75
40	4.16	4.37	4.59	5.05	5.55	5.08	5.33	5.60	6.16	6.78
41	4.34	4.55	4.78	5.26	5.78	5.12	5.37	5.64	6.20	6.82
42	4.52	4.74	4.98	5.48	6.03	5.15	5.41	5.68	6.25	6.87
43	4.71	4.94	5.19	5.71	6.28	5.19	5.44	5.72	6.29	6.92
44	4.91	5.15	5.41	5.95	6.54	5.22	5.48	5.76	6.34	6.97
45	5.12	5.37	5.64	6.20	6.82	5.26	5.52	5.80	6.38	7.02
46	5.24	5.50	5.78	6.35	6.99	5.36	5.63	5.91	6.50	7.15
47	5.37	5.64	5.92	6.51	7.16	5.46	5.73	6.02	6.62	7.29
48	5.50	5.78	6.07	6.67	7.34	5.57	5.84	6.14	6.75	7.43
49	5.64	5.92	6.22	6.84	7.52	5.67	5.95	6.25	6.88	7.57
50	5.78	6.07	6.37	7.01	7.71	5.78	6.07	6.37	7.01	7.71
51	6.09	6.40	6.72	7.39	8.13	6.00	6.30	6.62	7.28	8.01
52	6.42	6.74	7.08	7.79	8.57	6.23	6.55	6.87	7.56	8.32
53	6.77	7.11	7.47	8.21	9.03	6.47	6.80	7.14	7.85	8.64
54	7.14	7.49	7.87	8.66	9.52	6.72	7.06	7.41	8.16	8.97
55	7.52	7.90	8.30	9.13	10.04	6.98	7.33	7.70	8.47	9.32
56	7.61	7.99	8.40	9.23	10.16	7.09	7.45	7.82	8.60	9.47
57	7.70	8.08	8.49	9.34	10.27	7.20	7.56	7.94	8.74	9.61
58	7.79	8.18	8.59	9.45	10.39	7.32	7.68	8.07	8.88	9.76
59	7.88	8.27	8.69	9.56	10.51	7.43	7.80	8.20	9.01	9.92
60	7.97	8.37	8.79	9.67	10.63	7.55	7.93	8.32	9.16	10.07

Smoker: Multiply by 120%

Auto-Owners Life Insurance Company
 First Day Hospital Confined Rider
 Rider Form # 61744

Occupation Class B
 Non-Smoker

Annual Premiums per \$100 Monthly Base and CAI Rider Benefit, by Gender and Elimination Period in days

Issue Age	Male 30	Male 60	Male 90	Male 180	Male 365	Female 30	Female 60	Female 90	Female 180	Female 365
18-25	2.42	2.54	2.67	2.94	3.23	4.72	4.96	5.21	5.73	6.30
26	2.49	2.62	2.75	3.03	3.33	4.73	4.97	5.22	5.75	6.32
27	2.57	2.70	2.84	3.12	3.43	4.75	4.99	5.24	5.76	6.34
28	2.65	2.78	2.93	3.22	3.54	4.76	5.00	5.25	5.78	6.35
29	2.73	2.87	3.02	3.32	3.65	4.78	5.02	5.27	5.79	6.37
30	2.82	2.96	3.11	3.42	3.76	4.79	5.03	5.28	5.81	6.39
31	2.98	3.13	3.29	3.61	3.98	4.82	5.07	5.32	5.85	6.44
32	3.15	3.31	3.47	3.82	4.20	4.86	5.10	5.36	5.89	6.48
33	3.33	3.49	3.67	4.04	4.44	4.89	5.14	5.39	5.93	6.53
34	3.51	3.69	3.88	4.27	4.69	4.92	5.17	5.43	5.98	6.57
35	3.71	3.90	4.10	4.51	4.96	4.96	5.21	5.47	6.02	6.62
36	3.80	3.99	4.19	4.61	5.07	4.98	5.23	5.50	6.05	6.65
37	3.89	4.08	4.29	4.72	5.19	5.01	5.26	5.52	6.08	6.68
38	3.98	4.17	4.39	4.82	5.31	5.03	5.28	5.55	6.10	6.71
39	4.07	4.27	4.48	4.93	5.43	5.06	5.31	5.57	6.13	6.75
40	4.16	4.37	4.59	5.05	5.55	5.08	5.33	5.60	6.16	6.78
41	4.34	4.55	4.78	5.26	5.78	5.12	5.37	5.64	6.20	6.82
42	4.52	4.74	4.98	5.48	6.03	5.15	5.41	5.68	6.25	6.87
43	4.71	4.94	5.19	5.71	6.28	5.19	5.44	5.72	6.29	6.92
44	4.91	5.15	5.41	5.95	6.54	5.22	5.48	5.76	6.34	6.97
45	5.12	5.37	5.64	6.20	6.82	5.26	5.52	5.80	6.38	7.02
46	5.24	5.50	5.78	6.35	6.99	5.36	5.63	5.91	6.50	7.15
47	5.37	5.64	5.92	6.51	7.16	5.46	5.73	6.02	6.62	7.29
48	5.50	5.78	6.07	6.67	7.34	5.57	5.84	6.14	6.75	7.43
49	5.64	5.92	6.22	6.84	7.52	5.67	5.95	6.25	6.88	7.57
50	5.78	6.07	6.37	7.01	7.71	5.78	6.07	6.37	7.01	7.71
51	6.09	6.40	6.72	7.39	8.13	6.00	6.30	6.62	7.28	8.01
52	6.42	6.74	7.08	7.79	8.57	6.23	6.55	6.87	7.56	8.32
53	6.77	7.11	7.47	8.21	9.03	6.47	6.80	7.14	7.85	8.64
54	7.14	7.49	7.87	8.66	9.52	6.72	7.06	7.41	8.16	8.97
55	7.52	7.90	8.30	9.13	10.04	6.98	7.33	7.70	8.47	9.32
56	7.61	7.99	8.40	9.23	10.16	7.09	7.45	7.82	8.60	9.47
57	7.70	8.08	8.49	9.34	10.27	7.20	7.56	7.94	8.74	9.61
58	7.79	8.18	8.59	9.45	10.39	7.32	7.68	8.07	8.88	9.76
59	7.88	8.27	8.69	9.56	10.51	7.43	7.80	8.20	9.01	9.92
60	7.97	8.37	8.79	9.67	10.63	7.55	7.93	8.32	9.16	10.07

Smoker: Multiply by 120%

Auto-Owners Life Insurance Company
 Business Overhead Expense Rider
 Rider Form # 61745

Benefit Period 12 Months
 Occupation Class AAAA
 Non-Smoker

Annual Premiums per \$100 Monthly Rider Benefit, by Gender and Elimination Period in days

Issue Age	Male 30	Male 60	Female 30	Female 60
18-25	10.27	8.94	13.97	11.49
26	10.57	9.18	14.52	11.94
27	10.89	9.43	15.09	12.40
28	11.22	9.68	15.69	12.88
29	11.55	9.95	16.31	13.38
30	11.90	10.22	16.96	13.90
31	12.36	10.56	17.79	14.49
32	12.83	10.91	18.66	15.11
33	13.32	11.26	19.58	15.75
34	13.83	11.64	20.54	16.42
35	14.36	12.02	21.54	17.12
36	14.83	12.38	22.23	17.58
37	15.31	12.75	22.94	18.05
38	15.80	13.14	23.68	18.54
39	16.32	13.54	24.44	19.03
40	16.84	13.95	25.23	19.54
41	17.36	14.36	25.65	19.78
42	17.89	14.77	26.07	20.03
43	18.44	15.21	26.50	20.28
44	19.00	15.66	26.94	20.53
45	19.58	16.11	27.38	20.79
46	20.45	16.79	27.90	21.09
47	21.37	17.49	28.43	21.39
48	22.33	18.22	28.96	21.70
49	23.32	18.98	29.51	22.01
50	24.37	19.78	30.07	22.33
51	25.58	20.72	30.76	22.78
52	26.84	21.71	31.46	23.25
53	28.17	22.74	32.18	23.72
54	29.56	23.82	32.92	24.20
55	31.03	24.95	33.67	24.69
56	32.32	25.96	35.32	25.38
57	33.74	27.07	37.21	26.11
58	35.30	28.26	39.42	26.92
59	37.03	29.56	42.04	27.82
60	38.98	30.97	45.20	28.81

Smoker: Multiply by 120%

Auto-Owners Life Insurance Company
 Business Overhead Expense Rider
 Rider Form # 61745

Benefit Period 12 Months
 Occupation Class AAA
 Non-Smoker

Annual Premiums per \$100 Monthly Rider Benefit, by Gender and Elimination Period in days

Issue Age	Male 30	Male 60	Female 30	Female 60
18-25	11.70	10.20	16.41	13.48
26	12.08	10.50	17.12	14.05
27	12.47	10.80	17.86	14.64
28	12.88	11.10	18.62	15.25
29	13.29	11.43	19.42	15.88
30	13.72	11.75	20.26	16.55
31	14.26	12.16	21.32	17.31
32	14.82	12.58	22.44	18.11
33	15.40	13.02	23.62	18.94
34	16.01	13.47	24.85	19.82
35	16.63	13.94	26.15	20.73
36	17.21	14.39	27.05	21.31
37	17.81	14.85	27.97	21.92
38	18.43	15.33	28.92	22.53
39	19.07	15.83	29.90	23.16
40	19.74	16.34	30.93	23.82
41	20.39	16.84	31.46	24.15
42	21.07	17.35	32.00	24.49
43	21.76	17.88	32.56	24.82
44	22.48	18.43	33.13	25.18
45	23.23	19.00	33.70	25.52
46	24.33	19.85	34.36	25.89
47	25.48	20.74	35.03	26.28
48	26.68	21.67	35.72	26.66
49	27.95	22.65	36.42	27.05
50	29.27	23.67	37.13	27.45
51	30.80	24.85	38.00	28.03
52	32.39	26.09	38.90	28.62
53	34.07	27.38	39.81	29.24
54	35.84	28.74	40.75	29.86
55	37.70	30.17	41.70	30.49
56	39.32	31.44	43.03	31.38
57	41.11	32.82	44.52	32.33
58	43.08	34.31	46.20	33.36
59	45.29	35.94	48.10	34.47
60	47.76	37.72	50.29	35.71

Smoker: Multiply by 120%

Auto-Owners Life Insurance Company
 Business Overhead Expense Rider
 Rider Form # 61745

Benefit Period 12 Months
 Occupation Class AA
 Non-Smoker

Annual Premiums per \$100 Monthly Rider Benefit, by Gender and Elimination Period in days

Issue Age	Male 30	Male 60	Female 30	Female 60
18-25	14.11	11.38	21.85	16.84
26	14.38	11.58	22.44	17.28
27	14.65	11.79	23.05	17.73
28	14.93	12.03	23.67	18.19
29	15.22	12.37	24.32	18.67
30	15.50	12.73	24.98	19.16
31	15.91	13.17	25.70	19.68
32	16.33	13.63	26.44	20.21
33	16.77	14.11	27.20	20.76
34	17.34	14.60	27.98	21.47
35	18.02	15.10	28.79	22.46
36	18.65	15.59	29.53	23.09
37	19.30	16.09	30.30	23.74
38	19.97	16.61	31.33	24.40
39	20.66	17.15	32.39	25.10
40	21.38	17.69	33.50	25.80
41	22.09	18.24	34.08	26.16
42	22.82	18.79	34.67	26.52
43	23.58	19.36	35.27	26.89
44	24.36	19.97	35.89	27.38
45	25.16	20.58	36.51	27.99
46	26.35	21.51	37.33	28.69
47	27.60	22.47	38.24	29.40
48	28.90	23.48	39.18	30.13
49	30.28	24.54	40.14	30.89
50	31.71	25.64	41.12	31.66
51	33.36	26.91	42.04	32.45
52	35.65	29.28	42.99	33.26
53	38.52	31.87	43.96	34.09
54	41.61	34.69	44.95	34.94
55	44.95	37.77	45.95	35.81
56	46.73	39.28	48.04	37.01
57	48.74	40.97	50.40	38.29
58	51.06	42.92	53.09	39.66
59	53.75	45.17	56.19	41.12
60	56.95	47.84	59.82	42.70

Smoker: Multiply by 120%

Auto-Owners Life Insurance Company
 Business Overhead Expense Rider
 Rider Form # 61745

Benefit Period 12 Months
 Occupation Class A
 Non-Smoker

Annual Premiums per \$100 Monthly Rider Benefit, by Gender and Elimination Period in days

Issue Age	Male 30	Male 60	Female 30	Female 60
18-25	20.49	14.71	28.92	20.05
26	20.92	15.02	30.03	20.80
27	21.35	15.34	31.17	21.57
28	21.79	15.67	32.37	22.37
29	22.25	16.00	33.60	23.21
30	22.71	16.34	34.89	24.07
31	23.31	16.77	36.06	24.87
32	23.92	17.21	37.28	25.69
33	24.55	17.66	38.53	26.54
34	25.19	18.12	39.83	27.41
35	25.85	18.60	41.17	28.32
36	26.72	19.25	42.29	29.12
37	27.63	19.93	43.44	29.94
38	28.56	20.63	44.63	30.78
39	29.53	21.35	45.84	31.65
40	30.53	22.10	47.09	32.54
41	31.88	23.04	48.38	33.45
42	33.28	24.02	49.71	34.38
43	34.75	25.04	51.07	35.34
44	36.29	26.10	52.47	36.33
45	37.89	27.21	53.91	37.34
46	39.70	28.53	55.16	38.25
47	41.60	29.92	56.43	39.17
48	43.59	31.37	57.74	40.12
49	45.51	32.70	59.32	41.24
50	47.85	34.49	60.44	42.09
51	49.85	35.99	61.39	42.93
52	51.94	37.56	62.35	43.78
53	54.11	39.20	63.33	44.65
54	56.38	40.91	64.33	45.54
55	58.74	42.69	65.34	46.44
56	61.25	44.64	67.25	47.89
57	63.86	46.68	69.21	49.39
58	66.59	48.81	71.23	50.93
59	69.43	51.04	73.30	52.52
60	72.39	53.37	75.44	54.16

Smoker: Multiply by 120%

Auto-Owners Life Insurance Company
 Business Overhead Expense Rider
 Rider Form # 61745

Benefit Period 12 Months
 Occupation Class B
 Non-Smoker

Annual Premiums per \$100 Monthly Rider Benefit, by Gender and Elimination Period in days

Issue Age	Male 30	Male 60	Female 30	Female 60
18-25	27.10	20.95	34.46	26.74
26	27.65	21.39	35.75	27.67
27	28.20	21.83	37.09	28.63
28	28.77	22.28	38.48	29.62
29	29.35	22.75	39.92	30.65
30	29.94	23.22	41.41	31.71
31	30.70	23.80	42.82	32.77
32	31.48	24.40	44.28	33.87
33	32.28	25.00	45.79	35.01
34	33.10	25.63	47.35	36.19
35	33.94	26.27	48.97	37.40
36	35.07	27.14	50.38	38.44
37	36.25	28.04	51.84	39.51
38	37.46	28.97	53.34	40.60
39	38.71	29.93	54.88	41.73
40	40.00	30.92	56.46	42.89
41	41.81	32.30	58.11	44.14
42	43.71	33.74	59.80	45.43
43	45.69	35.24	61.54	46.75
44	47.76	36.81	63.33	48.12
45	49.93	38.45	65.18	49.52
46	52.40	40.37	66.91	50.74
47	54.99	42.38	68.69	52.00
48	57.72	44.49	70.51	53.28
49	60.57	46.71	72.38	54.60
50	63.57	49.04	74.30	55.95
51	66.23	51.13	75.67	57.12
52	68.99	53.32	77.06	58.31
53	71.88	55.59	78.48	59.53
54	74.88	57.97	79.92	60.78
55	78.01	60.44	81.39	62.05
56	80.52	63.15	83.88	64.07
57	83.68	65.97	86.45	66.15
58	87.34	68.93	89.09	68.30
59	91.58	72.02	91.82	70.53
60	96.60	75.24	94.63	72.82

Smoker: Multiply by 120%

Auto-Owners Life Insurance Company
 Business Overhead Expense Rider
 Rider Form # 61745

Benefit Period 18 Months
 Occupation Class AAAA
 Non-Smoker

Annual Premiums per \$100 Monthly Rider Benefit, by Gender and Elimination Period in days

Issue Age	Male 30	Male 60	Female 30	Female 60
18-25	11.81	10.28	16.06	13.21
26	12.16	10.56	16.69	13.73
27	12.52	10.85	17.36	14.26
28	12.90	11.13	18.05	14.81
29	13.28	11.44	18.76	15.39
30	13.69	11.76	19.50	15.99
31	14.21	12.14	20.46	16.67
32	14.75	12.54	21.46	17.38
33	15.32	12.95	22.51	18.12
34	15.91	13.38	23.62	18.89
35	16.52	13.82	24.77	19.69
36	17.05	14.24	25.56	20.22
37	17.60	14.67	26.39	20.76
38	18.17	15.11	27.23	21.32
39	18.76	15.57	28.11	21.88
40	19.37	16.04	29.02	22.47
41	19.96	16.51	29.50	22.75
42	20.57	16.99	29.98	23.03
43	21.20	17.49	30.48	23.32
44	21.85	18.00	30.98	23.61
45	22.51	18.53	31.49	23.90
46	23.52	19.31	32.08	24.25
47	24.58	20.11	32.70	24.60
48	25.68	20.95	33.31	24.95
49	26.82	21.82	33.94	25.31
50	28.03	22.74	34.58	25.68
51	29.42	23.83	35.37	26.20
52	30.87	24.96	36.18	26.74
53	32.40	26.15	37.01	27.28
54	34.00	27.39	37.85	27.83
55	35.69	28.69	38.72	28.40
56	37.17	29.86	40.61	29.18
57	38.80	31.13	42.79	30.03
58	40.60	32.50	45.33	30.96
59	42.59	33.99	48.35	31.99
60	44.83	35.62	51.99	33.13

Smoker: Multiply by 120%

Auto-Owners Life Insurance Company
 Business Overhead Expense Rider
 Rider Form # 61745

Benefit Period 18 Months
 Occupation Class AAA
 Non-Smoker

Annual Premiums per \$100 Monthly Rider Benefit, by Gender and Elimination Period in days

Issue Age	Male 30	Male 60	Female 30	Female 60
18-25	13.37	11.66	18.76	15.41
26	13.81	12.00	19.56	16.06
27	14.25	12.34	20.41	16.73
28	14.72	12.69	21.28	17.43
29	15.19	13.06	22.19	18.15
30	15.68	13.43	23.15	18.91
31	16.30	13.90	24.37	19.79
32	16.94	14.38	25.64	20.70
33	17.60	14.88	26.99	21.65
34	18.29	15.40	28.41	22.65
35	19.01	15.93	29.89	23.69
36	19.67	16.45	30.91	24.36
37	20.36	16.97	31.96	25.05
38	21.06	17.52	33.05	25.75
39	21.80	18.09	34.17	26.47
40	22.56	18.67	35.34	27.23
41	23.30	19.25	35.96	27.60
42	24.08	19.83	36.58	27.99
43	24.87	20.43	37.21	28.37
44	25.70	21.06	37.86	28.77
45	26.54	21.71	38.52	29.17
46	27.80	22.69	39.27	29.59
47	29.12	23.70	40.04	30.03
48	30.49	24.77	40.82	30.47
49	31.94	25.89	41.62	30.91
50	33.46	27.05	42.43	31.37
51	35.20	28.40	43.43	32.03
52	37.02	29.81	44.45	32.71
53	38.94	31.29	45.50	33.41
54	40.96	32.84	46.57	34.12
55	43.09	34.48	47.66	34.85
56	44.94	35.93	49.18	35.86
57	46.98	37.51	50.88	36.94
58	49.23	39.22	52.80	38.12
59	51.76	41.07	54.97	39.40
60	54.58	43.11	57.47	40.81

Smoker: Multiply by 120%

Auto-Owners Life Insurance Company
 Business Overhead Expense Rider
 Rider Form # 61745

Benefit Period 18 Months
 Occupation Class AA
 Non-Smoker

Annual Premiums per \$100 Monthly Rider Benefit, by Gender and Elimination Period in days

Issue Age	Male 30	Male 60	Female 30	Female 60
18-25	16.23	13.08	25.13	19.37
26	16.54	13.32	25.81	19.87
27	16.85	13.56	26.51	20.39
28	17.17	13.84	27.23	20.92
29	17.50	14.23	27.97	21.47
30	17.83	14.64	28.73	22.03
31	18.30	15.15	29.56	22.63
32	18.78	15.67	30.41	23.24
33	19.29	16.22	31.28	23.87
34	19.94	16.79	32.18	24.69
35	20.72	17.37	33.11	25.83
36	21.45	17.93	33.96	26.55
37	22.19	18.50	34.85	27.30
38	22.96	19.10	36.03	28.06
39	23.76	19.72	37.25	28.86
40	24.59	20.35	38.53	29.67
41	25.40	20.98	39.19	30.08
42	26.25	21.61	39.87	30.50
43	27.11	22.27	40.56	30.92
44	28.01	22.96	41.27	31.48
45	28.93	23.67	41.99	32.19
46	30.30	24.73	42.93	32.99
47	31.74	25.84	43.98	33.82
48	33.24	27.00	45.05	34.65
49	34.82	28.22	46.16	35.52
50	36.47	29.49	47.29	36.41
51	38.36	30.95	48.35	37.32
52	41.00	33.67	49.44	38.25
53	44.29	36.65	50.55	39.20
54	47.85	39.90	51.69	40.18
55	51.70	43.44	52.84	41.18
56	53.74	45.17	55.25	42.56
57	56.05	47.12	57.95	44.03
58	58.72	49.35	61.06	45.61
59	61.82	51.95	64.62	47.28
60	65.49	55.02	68.79	49.10

Smoker: Multiply by 120%

Auto-Owners Life Insurance Company
 Business Overhead Expense Rider
 Rider Form # 61745

Benefit Period 24 Months
 Occupation Class AAAA
 Non-Smoker

Annual Premiums per \$100 Monthly Rider Benefit, by Gender and Elimination Period in days

Issue Age	Male 30	Male 60	Female 30	Female 60
18-25	12.83	11.17	17.46	14.36
26	13.21	11.48	18.15	14.92
27	13.61	11.79	18.87	15.50
28	14.02	12.10	19.62	16.10
29	14.44	12.44	20.39	16.73
30	14.88	12.78	21.19	17.38
31	15.45	13.20	22.24	18.12
32	16.04	13.63	23.32	18.89
33	16.65	14.08	24.47	19.69
34	17.29	14.54	25.67	20.53
35	17.96	15.02	26.92	21.40
36	18.53	15.48	27.79	21.97
37	19.13	15.94	28.68	22.56
38	19.75	16.43	29.60	23.17
39	20.40	16.92	30.55	23.79
40	21.05	17.43	31.54	24.42
41	21.70	17.95	32.06	24.73
42	22.36	18.47	32.59	25.03
43	23.05	19.01	33.13	25.35
44	23.75	19.57	33.68	25.66
45	24.47	20.14	34.23	25.98
46	25.56	20.99	34.87	26.36
47	26.71	21.86	35.54	26.74
48	27.91	22.77	36.20	27.12
49	29.16	23.72	36.89	27.51
50	30.47	24.72	37.59	27.91
51	31.98	25.90	38.45	28.48
52	33.55	27.13	39.33	29.06
53	35.22	28.42	40.22	29.65
54	36.96	29.77	41.14	30.25
55	38.79	31.19	42.09	30.87
56	40.40	32.45	44.15	31.72
57	42.17	33.84	46.51	32.64
58	44.13	35.32	49.28	33.65
59	46.29	36.95	52.55	34.77
60	48.73	38.71	56.51	36.01

Smoker: Multiply by 120%

Auto-Owners Life Insurance Company
 Business Overhead Expense Rider
 Rider Form # 61745

Benefit Period 24 Months
 Occupation Class AAA
 Non-Smoker

Annual Premiums per \$100 Monthly Rider Benefit, by Gender and Elimination Period in days

Issue Age	Male 30	Male 60	Female 30	Female 60
18-25	14.54	12.67	20.39	16.75
26	15.01	13.04	21.26	17.45
27	15.49	13.41	22.18	18.18
28	16.00	13.79	23.13	18.94
29	16.51	14.19	24.12	19.73
30	17.04	14.60	25.17	20.56
31	17.72	15.11	26.49	21.51
32	18.41	15.63	27.87	22.50
33	19.13	16.18	29.34	23.53
34	19.88	16.74	30.88	24.62
35	20.66	17.32	32.49	25.75
36	21.38	17.88	33.60	26.48
37	22.13	18.45	34.74	27.23
38	22.90	19.05	35.93	27.99
39	23.69	19.67	37.15	28.78
40	24.52	20.29	38.42	29.59
41	25.33	20.92	39.08	30.00
42	26.17	21.56	39.76	30.42
43	27.04	22.21	40.45	30.84
44	27.93	22.90	41.15	31.27
45	28.85	23.60	41.87	31.70
46	30.22	24.66	42.68	32.17
47	31.65	25.76	43.52	32.64
48	33.15	26.92	44.37	33.12
49	34.72	28.14	45.24	33.60
50	36.37	29.40	46.12	34.10
51	38.26	30.87	47.21	34.82
52	40.24	32.40	48.32	35.56
53	42.32	34.01	49.46	36.32
54	44.53	35.70	50.62	37.09
55	46.84	37.48	51.80	37.88
56	48.85	39.05	53.46	38.98
57	51.06	40.77	55.31	40.16
58	53.51	42.63	57.39	41.44
59	56.26	44.64	59.76	42.83
60	59.33	46.85	62.47	44.36

Smoker: Multiply by 120%

Auto-Owners Life Insurance Company
 Business Overhead Expense Rider
 Rider Form # 61745

Benefit Period 24 Months
 Occupation Class AA
 Non-Smoker

Annual Premiums per \$100 Monthly Rider Benefit, by Gender and Elimination Period in days

Issue Age	Male 30	Male 60	Female 30	Female 60
18-25	17.64	14.22	27.31	21.05
26	17.97	14.48	28.05	21.60
27	18.32	14.73	28.81	22.16
28	18.67	15.04	29.59	22.74
29	19.02	15.47	30.40	23.34
30	19.38	15.91	31.23	23.95
31	19.89	16.46	32.13	24.60
32	20.42	17.03	33.05	25.26
33	20.97	17.63	34.00	25.94
34	21.67	18.25	34.98	26.84
35	22.52	18.88	35.99	28.07
36	23.31	19.48	36.92	28.86
37	24.12	20.11	37.88	29.68
38	24.96	20.76	39.16	30.50
39	25.82	21.43	40.49	31.37
40	26.72	22.12	41.88	32.25
41	27.61	22.80	42.60	32.70
42	28.53	23.49	43.34	33.16
43	29.47	24.21	44.09	33.61
44	30.45	24.96	44.86	34.22
45	31.45	25.73	45.64	34.99
46	32.94	26.89	46.66	35.86
47	34.50	28.08	47.80	36.76
48	36.13	29.35	48.97	37.67
49	37.85	30.68	50.18	38.61
50	39.64	32.05	51.40	39.58
51	41.70	33.64	52.55	40.57
52	44.56	36.59	53.74	41.57
53	48.15	39.83	54.95	42.61
54	52.01	43.37	56.18	43.67
55	56.19	47.22	57.44	44.76
56	58.42	49.10	60.05	46.27
57	60.92	51.21	62.99	47.86
58	63.82	53.65	66.37	49.57
59	67.19	56.47	70.24	51.40
60	71.18	59.80	74.77	53.37

Smoker: Multiply by 120%

Auto-Owners Life Insurance Company
 Individual Disability Income Insurance Policy
 Other Riders

Premiums for the following riders are equal to the factor shown times the sum of the premium for the Base Policy (excluding policy fee), the Coordinating Additional Insurance Rider, and the 3% Cost of Living Increase Rider:

Own Occupation Five Year Rider, Form # 61748:
 8%

Own Occupation To Age 67 Rider, Form # 61749:

Issue Age	
<56	20%
56	19%
57	18%
58	17%
59	16%
60	15%

Residual Disability Rider, Form # 61747
 15%

Business Owner Return-to-Work Rider, Form # 61729

Elim Period	Benefit Period		
	<u>2 year</u>	<u>5 year</u>	<u>To Age 67</u>
30	7%	5%	2%
60	7%	5%	2%
90	4%	3%	1%
180	4%	3%	1%
365	4%	3%	1%

Guaranteed Insurability Rider, Form # 61728

The premium for the Guaranteed Insurability Rider is equal to 10% times the sum of the premium for the Base Policy (excluding policy fee), plus the base-related components of the premium for the 3% Cost of Living Increase Rider, the First Day Hospital Confined Rider, the Own Occupation Five Year Rider, the Own Occupation To Age 67 Rider, the Residual Disability Rider, and the Business Owner Return-to-Work Rider.

SERFF Tracking Number: AOIC-126829993 State: Arkansas
 Filing Company: Auto-Owners Life Insurance Company State Tracking Number: 48630
 Company Tracking Number:
 TOI: H111 Individual Health - Disability Income Sub-TOI: H111.003 Long Term - Unrelated to marketing
 with employer or association groups
 Product Name: Disability Income
 Project Name/Number: /

Supporting Document Schedules

	Item Status:	Status Date:
Satisfied - Item: Flesch Certification	Approved-Closed	05/03/2011
Comments: Attached is the Certificate of Readability.		
Attachment: Certificate of Readability_AR.pdf		

	Item Status:	Status Date:
Satisfied - Item: Application	Approved-Closed	05/03/2011
Comments: Attached you will find our 3 applications that were previously approved by your state on 9/10/08 with SERFF #125575189:		

1002 (1-08) Joint Life and/or Disability Application
 61446 (1-08) App-Celerator Application - replaced by 61011 (9-10)
 61447 (1-08) App-Celerator Addendum
Attachments:
 61011 APP-CELERATOR john doe.pdf
 Arkansas addendum 61447 (9-10).pdf
 1002 (11-10) john doe.pdf

	Item Status:	Status Date:
Satisfied - Item: Outline of Coverage	Approved-Closed	05/03/2011
Comments: Attached is the Outline of Coverage.		
Attachment: 61763 (9-10) Outline of Coverage john doe.pdf		

	Item Status:	Status
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SERFF Tracking Number: AOIC-126829993 State: Arkansas
Filing Company: Auto-Owners Life Insurance Company State Tracking Number: 48630
Company Tracking Number:
TOI: H111 Individual Health - Disability Income Sub-TOI: H111.003 Long Term - Unrelated to marketing
with employer or association groups
Product Name: Disability Income
Project Name/Number: /

Satisfied - Item: Statement of Variability

Approved-Closed

Date:
05/03/2011

Comments:

Attached is the Statement of Variability

Attachment:

Statement of Variability_OOC.pdf

AUTO-OWNERS LIFE INSURANCE COMPANY
P.O. Box 30325
Lansing, MI 48909

CERTIFICATION OF READABILITY

I hereby certify, to the best of my knowledge and belief, that the following forms have the respective Flesch Scores, which meet the readability requirements of the ARKANSAS Department of Insurance.



Gayle A. Fisher
Assistant Vice President, Life Operations

FORM 61739 (5-10) – Policy Front Jacket
FLESCH SCORE = 56.9

FORM 61740 (5-10) – Policy Pages
FLESCH SCORE = 47.8

FORM 61744 (5-10) – First Day Hospital Confined Rider
FLESCH SCORE = 46.1

FORM 61746 (5-10) – Cost of Living Increase Rider
FLESCH SCORE = 51.7

FORM 61748 (5-10) – Own Occupation Five Year Rider
FLESCH SCORE = 57.1

FORM 61729 (4-10) – Business Owner Return-To-Work Rider
FLESCH SCORE = 45.2

FORM 61745 (5-10) – Business Overhead Expense Rider
FLESCH SCORE = 49.9

FORM 61732 (5-10) – Coordinating Additional Insurance Rider
FLESCH SCORE = 47.2

FORM 61728 (4-10) – Guaranteed Insurability Rider
FLESCH SCORE = 49.2

Page two, Certification of Readability

FORM 61743 – Spousal Catastrophic Disability Rider
FLESCH SCORE = 45

FORM 61747 (5-10) – Residual Disability Rider
FLESCH SCORE = 56.9

FORM 61749 (5-10) – Own Occupation to Age 67 Rider
FLESCH SCORE = 56.1

FORM 1059 (8-85) – Aviation Exclusion Provision
FLESCH SCORE = 63

FORM 1002 (11-10) – Joint Life and/or Disability Application
FLESCH SCORE = 49.4

FORM 61011 (9-10) – APP-CELERATOR Application
FLESCH SCORE = 48.9

FORM 61762 (9-10) – Business Overhead Expense Rider Addendum
FLESCH SCORE = 50.6

FORM 61781 (9-10) – Spousal Catastrophic Disability Rider Addendum
FLESCH SCORE = 52.9

FORM 61763 (9-10) – Outline of Coverage
FLESCH SCORE = 60.8

FORM 61447 (9-10) – APP-CELERATOR Addendum
Exempt because this is *read to the applicant* by ExamOne.

A. ALL APPLICATIONS - Proposed Insured (print full name) John Doe				Height 5'10"	Weight 180
Social Security No. 555-55-5555		Birth Date 05/05/1980	Gender Male	Driver's License Number D555-555-555-555	
Telephone No. (555) 555-5555	Alternate No. ()	Best Time to Call after 5pm	Email Address doe_john@emailaddress		
Place of Birth (State/Country) Anywhere USA		Are you a US Citizen? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No (if no, submit a copy of valid permanent resident card)			
Home Street Address 55 Any Street		Purpose of Insurance Personal			
Hours Worked/Week 40	Occupation (briefly describe job duties) Any occupation	Gross Income \$ 40,000	Net Income \$ 50,000	Net Worth \$ 200,000	
Have you smoked one or more cigarettes in the last 12 months?		<input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No		
Have you used tobacco in any form within the past 24 months?		<input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No		
Do you have other life insurance with Auto-Owners? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, _____ and _____ <small>face amount policy number</small>					
Beneficiary* (print full name)		Relationship	Premium with Application \$ <u>248.00</u>		
a. Primary: Primary Beneficiary		wife	Bill: <input type="checkbox"/> Annually <input type="checkbox"/> Semi-Ann. <input type="checkbox"/> Quarterly <input type="checkbox"/> Monthly (PT2/PT3 only) <input type="checkbox"/> Annual EFT <input checked="" type="checkbox"/> Semi-Ann. EFT <input type="checkbox"/> Quarterly EFT <input type="checkbox"/> Monthly EFT Planned Payment (PT2/PT3) \$ _____		
b. Contingent: Contingent Beneficiary		son	Home Office Endorsement/Special Requests:		
* Will be paid to surviving beneficiaries equally unless specified otherwise					

Will there be an Owner/Payor on the policy other than the Proposed Insured? If so, complete Owner/Payor information.

B. Policyowner and/or Payor	
Name of Owner and Relationship _____	Name of Premium Payor _____
Social Security No. of Owner _____	Social Security No. of Payor _____
Owner's Address _____	Annual Net Income of Payor \$ _____
_____	Billing Address _____
_____	_____

Which product do you want?

C. LIFE INSURANCE

Amount \$ _____ Plan _____ Item No. _____

Do you want to be considered for Premier Rates? (24 months tobacco-free) Yes No Decreasing Term Period _____

Additional Benefits

- Disability Premium Waiver (WL, UL, Level & Decreasing Term)
- Accidental Death Benefit (WL, UL, Level & Decreasing Term). . . . \$ _____
- Guaranteed Purchase Option (WL, UL) \$ _____
- Guaranteed Renewability Benefit (10, 20 Year Level Term)
- Premium Waiver for Death or Disability of Payor (WL, UL)
- Cost of Living Increase (UL)
- Automatic Premium Loan (WL)
- Disability Income Benefit-complete below (WL, UL, Level & Decreasing Term)

Monthly Benefit Amount \$ _____ Elimination Period is 60 Days Occupational Class _____ Benefit Period _____ Years

Other Income \$ _____ (Explain) _____

D. DISABILITY - Complete for Disability Income Policy

Benefit Period: 2 Years 5 Years To age 67 Elimination Period 60 Days Prior Year's Taxable Income \$ 50,000
Occupational Class AA Monthly Benefit Amount \$ 2,000

Additional Benefits:

- 3% Cost of Living Increase Rider
- Business Owner Return-to-Work Rider
- Business Overhead Expense Rider \$ _____ monthly benefit amount (complete Business Overhead Expense Addendum)
- Coordinating Additional Insurance Rider \$ _____ monthly benefit amount
- First Day Hospital Confined Rider
- Guaranteed Insurability Rider
- Own Occupation Five Year Rider
- Own Occupation to Age 67 Rider
- Residual Disability Rider
- Spousal Catastrophic Disability Rider (complete Spousal Catastrophic Disability Rider Addendum)

E. ALL APPLICATIONS - Please answer the following questions in every case and provide details:

ONLY COLLECT MONEY AND ISSUE BINDING RECEIPT WHEN ANSWERS TO QUESTIONS 1-4 ARE NO

1. Do you have or during the past 10 years have you been diagnosed or treated by any physician or other practitioner for:
 - a. Heart disease or disorder, angina, stroke or cancer? Yes No
 - b. Acquired Immunodeficiency Syndrome (AIDS) or Human Immunodeficiency Virus (HIV)? Yes No
2. Are you currently unemployed, retired, laid off or collecting disability? Yes No
3. During the past 5 years have you been absent from work due to accident or sickness for more than 10 days at a time? Yes No
4. During the past 90 days have you been admitted to or been advised to be admitted to a hospital or medical facility by any physician or other practitioner? Yes No
5. Do you have any existing life insurance or annuity policies? If yes, _____ amount Yes No
If yes, is the policy applied for replacing or likely to replace any existing plan? Yes No
6. Do you have any Disability Income insurance in force? (including salary continuation from employer, union, group DI, or State sick pay plan). Yes No
If yes, is the policy applied for replacing or likely to replace any existing Disability Income insurance? Yes No

Prior Carrier Name: _____ Prior Carrier Policy Number: _____

Please provide details to all questions answered yes: _____

Auto-Owners Life Insurance Company

IT IS UNDERSTOOD AND AGREED: (1) That all answers to the questions on **this application** which shall include any related addendum ("application") are complete and true to the best of my knowledge and/or belief. (2) That all answers to such questions, together with this agreement, shall form the basis and become a part of any policy issued. (3) In consideration of the application and premium payment, insurance benefits applied for shall take effect on the date of the application subject to terms and limitations of the Binding Receipt; otherwise, benefits shall not take effect until the policy is delivered to the owner and the first premium paid during the lifetime and continued insurability, as stated in the application, of the person to be insured. (4) That acceptance of any policy issued on this application will constitute a ratification of any correction in or addition to this application made by the Company and noted in the space for Home Office Endorsement, provided, however, no change shall be made as to amount, classification, plan of insurance or benefits, unless agreed to in writing. (5) Only the President, Vice President or Secretary of the Company can make, modify, alter or discharge contracts or waive any of the Company's rights or requirements. (6) That the Company may obtain answers to the questions on the **APP-CELERATOR®** Addendum by using a designated third party and that the truthfulness of such answers may be acknowledged verbally by voice signature or any other lawful means.

HIPAA COMPLIANT AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

I **authorize** any health plan, physician, health care professional, hospital, clinic, laboratory, pharmacy or pharmacy benefit manager, insurance company, medical facility, the MIB, Inc., the Veterans Administration or other health care provider that has provided payment, treatment or services to me or on my behalf within the past 10 years ("My Providers") to disclose to Auto-Owners Life Insurance Company, its reinsurer(s) or insurance supporting organizations and their representatives, my entire medical record, prescription history, medications prescribed and any other protected health information concerning me. This includes information on the diagnosis or treatment of Human Immunodeficiency Virus (HIV) infection and sexually transmitted diseases. This also includes information on the diagnosis and treatment of mental illness and the use of alcohol, drugs and tobacco, but excludes psychotherapy notes.

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

This protected health information is to be disclosed under this Authorization so that Auto-Owners Life Insurance Company may: 1) underwrite my application for coverage, make eligibility, risk rating, policy issuance and enrollment determinations; 2) obtain reinsurance; 3) administer claims and determine or fulfill responsibility for coverage and provision of benefits; 4) administer coverage; and 5) conduct other legally permissible activities that relate to any coverage I have or have applied for with Auto-Owners Life Insurance Company.

This Authorization shall remain in force for 24 months following the date of my signature below, and a copy of this Authorization is as valid as the original. I understand that I have the right to revoke this Authorization in writing, at any time, by providing written notification to Auto-Owners Life Insurance Company. I understand that a revocation is not effective to the extent that any of My Providers have already replied on this Authorization to disclose information about me or to the extent that Auto-Owners Life Insurance Company has a legal right to contest a claim under an insurance policy or to contest the policy itself. I understand that any information disclosed pursuant to this Authorization is no longer covered by federal rules governing privacy and confidentiality of health information, but it will not be redisclosed by Auto-Owners Life Insurance Company except as authorized by me or as required by law.

I understand that My Providers may not refuse to provide treatment or payment for health care services if I refuse to sign this Authorization. I further understand that if I refuse to sign this Authorization to release my complete medical record, Auto-Owners Life Insurance Company may not be able to process my application, or if coverage has been issued, may not be able to make any benefit payments. I understand that any authorized representative or I will receive a copy of this Authorization upon request.

I **AUTHORIZE** my employer, any consumer reporting agency, other organization, institution or person having any records or knowledge of me or my health to release any financial or personal details to Auto-Owners, its reinsurer(s) or insurance support organizations and their representatives. This information may be used by underwriters, Company Officers and medical personnel to evaluate claims. They may also use it to consider Life and/or Disability insurance and/or benefits applied for by me. I understand this authorization is valid for 24 months from the date it is signed. A copy of it is also valid. I acknowledge having received a copy. I understand that I have the right to revoke this at any time. I also received a copy of NOTICE OF INSURANCE INFORMATION PRACTICES. I acknowledge possession of the binding receipt for Life and/or Disability Income insurance bearing the same date as this application and certify that I have read it, and its terms, conditions and limitations, to which I agree, have been explained to me fully.

THE AGENT AND I CERTIFY that I have read, or the agent has read to me, the completed application. I realize that any false statement or misrepresentation in my application may result in the loss of coverage under the policy (subject to the incontestability provision, time limit on certain defenses and legal proceedings).

I received the Outline of Coverage. (for Disability Income insurance)

I wish to have an interview if an investigative consumer report is made for this application.

For the Agent: To the best of your knowledge, does the applicant have any existing life insurance, annuity or disability income policies? Yes No
Will the insurance applied for replace any existing insurance? Yes No
If yes, is this a 1035 Exchange? Yes No
Does the Proposed Insured have other Auto-Owners policies in force? Yes No
Did you see the Proposed Insured? Yes No

How long have you known the Proposed Insured? 11 years Agent Name, Agency Code and Phone Agency Y, 01-01-01, 555-555-5551

Signed in the State of Any State this 11 day of November, 2010

I certify information supplied by the applicant has been accurately recorded on the application.

John Doe
(Signature of Proposed Insured)

Joe Agent
(Agent's Signature)

Agency Y, 01-01-01
(Agency & Producer code)

(Signature of Owner/Applicant - If Other Than Proposed Insured)

Joe Agent
(Agent's Name - Please Print)

Must be submitted with application to Auto-Owners Life Insurance Company

John Doe

APP-CELERATOR® Addendum

PART F Complete if Self Employed, Owner of a Business, Contract Employee or Reporting 1099 Income.

1. Average monthly expenses \$ 2,500
2. Net worth of Business \$ 2,000,000
3. Net Earned Income after business expenses as reported for federal income tax purposes:
a. Average monthly income for current tax year \$ 4,000
b. Actual annual income for prior tax year \$ 50,000
c. Actual annual income for tax year 2 years ago \$ 47,500
d. Other Income \$
(explain)
4. Is firm: [X] Sole Proprietorship [] C Corporation [] S Corporation [] Partnership [] Other
5. If application is for Business Insurance: Purpose of Application:
[] Keyman [] Fund a Buy-Sell Agreement [] Split Dollar [] Stock Redemption [] Deferred Compensation [] Other
6. If Partnership, list names of partners
7. Amount of insurance in force or contemplated on other members of firm \$
8. Financial Details of Business:
CURRENT FISCAL YEAR TO DATE 1/10 through 10/10 PREVIOUS FISCAL YEAR
a. Total Assets \$ 3,000,000 \$ 2,500,000
b. Total Liabilities \$ 1,000,000 \$ 1,450,000
c. Gross Sales or Revenue \$ 300,000 \$ 500,000
9. Percentage of ownership by Proposed Insured 100 %

PART G Occupation/Volunteer

1. Percentage of time spent performing:
a. Professional, managerial or administrative duties 75 %
b. Trade, service or labor 25 %
c. Other % (explain)
2. Do you have any additional occupations? Yes [] No [X]
3. Do you participate in any volunteer activities? (e.g. volunteer firefighter) Yes [] No [X]
a. What type of volunteer activities do you participate in?
b. How many hours do you participate in these activities?
c. Are you paid for these activities? Yes [] No []
If yes, annual amount \$ (explain)
4. Do you work from an office in your home? Yes [] No [X]
a. How many hours do you work each week in your home office?
b. How many hours each week do you leave your home office to conduct business?
c. Does your office have a separate entrance, distinct from the main residential entrance? Yes [] No []
d. What duties of your occupation are performed away from your office?

PART H Activities/Health Habits

1. During the past 5 years, have you:
a. Been refused, rejected, rated or postponed for Life and/or Disability Insurance? Yes [] No [X]
b. Been a member of any armed forces or military or have plans to in the future? Yes [] No [X]
c. Made or contemplated making flights as pilot, student pilot or crew member? Yes [] No [X]
d. Participated in any hazardous avocation such as skydiving, scuba diving, hang gliding, any type of organized motor vehicle racing, mountain or rock climbing, or rodeo? Yes [] No [X]
e. Been convicted of driving while impaired or intoxicated, reckless driving, or 3 or more speeding violations? Yes [] No [X]
f. Been convicted of or are awaiting trial for any crime other than a misdemeanor, including currently being on parole or probation? (if yes, please explain and provide date and location) Yes [] No [X]
g. Made a claim for benefits to any insurance company or to the Veterans Administration because of an illness or injury? Yes [] No [X]
h. Traveled, lived or worked outside of the US or Canada or have plans to in the future? (if yes, please explain) Yes [] No [X]
2. Is any other Life and/or Disability application pending with any company? Yes [] No [X]
3. Have you smoked one or more cigarettes within the last 12 months? Yes [] No [X]
a. Have you used tobacco in any form within the last 24 months? (if so, explain) Yes [] No [X]

4. DETAILS to yes answers H1-3 (indicate question number)

A. ALL APPLICATIONS

Proposed Insured (print full name) John Doe		Height 5'10"	Weight 180
Social Security No. 555-55-5555		Birth Date 05/05/1981	Gender Male
Driver's License No. D555-555-555-555	Telephone No. (555) 555-5555	Alternate No. ()	
Best Time to Call after 5 pm	E-mail Address doe_john@emailaddress		
Place of Birth (State/Country) Any state, USA	Are you a US Citizen? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If no, please provide valid resident card		
Home Street Address 55 Any Street, Any City, Any State, Any Zip			
Purpose of Insurance Personal			
Employer's Name and Address self, 5 Any Street, Any City, Any State		Type of Business retail	
Hours Worked/Week 40	Change in Employment Contemplated? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No (If yes, explain)		
Occupation (briefly describe job duties) run tackle shop		How Long? (yrs / mths) 6 / 6	
Gross Income \$ 40,000	Net Income \$ 50,000	Net Worth \$ 200,000	
Beneficiary* (print full name)		Relationship	
Primary Beneficiary a. Primary:		wife	
Contingent Beneficiary b. Contingent:		son	

* Will be paid equally to surviving beneficiaries unless specified otherwise

Policyowner and/or Payor (If other than Proposed Insured)

Name of Owner and Relationship _____
 Social Security No. of Owner _____
 Owner's Address: _____

 Name of Premium Payor _____
 Social Security No. of Payor _____
 Annual Net Income of Payor \$ _____
 Billing Address _____

 Premium With Application \$ 248.00
 Bill: Annual Semi-Annual Quarterly Monthly (PT2/PT3 only)
 Annual EFT Semi-Annual EFT Quarterly EFT Monthly EFT
 Planned Payment (PT2/PT3) \$ _____

Home Office Endorsement/Special Requests:

B. ADDITIONAL ADULT INSURED

<input type="checkbox"/> Secondary (print full name)	<input type="checkbox"/> Adult under Spouse and Children's Term Insurance	
Height	Weight	
Social Security No.	Birth Date	Gender
Driver's License No.	Telephone No. ()	Alternate No. ()
Best Time to Call	E-mail Address	
Place of Birth (State/Country)	Are you a US Citizen? <input type="checkbox"/> Yes <input type="checkbox"/> No If no, please provide valid resident card	
Home Street Address		
Purpose of Insurance		
Employer's Name and Address		Type of Business
Hours Worked/Week	Change in Employment Contemplated? <input type="checkbox"/> Yes <input type="checkbox"/> No (If yes, explain)	
Occupation (briefly describe job duties)		How Long? (yrs / mths) /
Gross Income \$	Net Income \$	Net Worth \$
Beneficiary* (print full name)		Relationship
a. Primary:		
b. Contingent:		

* Will be paid equally to surviving beneficiaries unless specified otherwise

C. ALL APPLICATIONS

Complete if Self Employed, Owner of a Business, Contract Employee or Reporting 1099 Income.

- Average monthly expenses \$ 2,500
- Net worth of Business \$ 2,000,000
- Net Earned Income after business expenses as reported for federal income tax purposes:
 - Average monthly income for current tax year \$ 4,000
 - Actual annual income for prior tax year \$ 50,000
 - Actual annual income for tax year 2 years ago \$ 47,500
 - Other Income \$ _____
(explain) _____
- Is firm: Sole Proprietorship C Corporation S Corporation
 Partnership Other
- If application is for Business Insurance: Purpose of Application:
 Keyman Fund a Buy-Sell Agreement Split Dollar
 Stock Redemption Deferred Compensation Other
- If Partnership, list names of partners _____
- Amount of insurance in force or contemplated on other members of firm \$ _____
- Financial Details of Business: CURRENT FISCAL YEAR TO DATE PREVIOUS FISCAL YEAR

	1/10 through 10/10	
a. Total Assets	\$ <u>3,000,000</u>	\$ <u>2,500,000</u>
b. Total Liabilities	\$ <u>1,000,000</u>	\$ <u>1,450,000</u>
c. Gross Sales or Revenue	\$ <u>300,000</u>	\$ <u>500,000</u>
- Percentage of ownership by Proposed Insured 100 %

D. LIFE

Complete when **CHILDREN** are proposed for Secondary or Children's or Spouse and Children's Term Coverage

Print Child's Name	Social Security No.	Birth Date	Gender	Amount	Height		Weight	Relationship to Applicant
					Ft.	In.		

Beneficiary (print full name) Will be paid equally to surviving beneficiaries unless specified otherwise

Relationship

a. Primary:

b. Contingent:

E. LIFE

Name of Plan _____ Item Number _____

Amount \$ _____ (Primary) \$ _____ (Secondary) Decreasing Term Period _____ Years

Do you want to be considered for Premier Rates? (24 months tobacco-free) Yes No

Additional Benefits:

- Disability Premium Waiver (WL, UL, Level & Decreasing Term)
- Guaranteed Renewability Benefit (10, 20 Year Level Term)
- Premium Waiver for Death or Disability of Payor (WL, UL)
- Cost of Living Increase (UL)
- Automatic Premium Loan (WL)
- Accidental Death Benefit (WL, UL, Level & Decreasing Term) \$ _____ amount
- Spouse and Children's Term Insurance (WL, UL, Level & Decreasing Term) . . . _____ units
- Children's Term Life Insurance (WL, UL, Level & Decreasing Term) _____ units
- Guaranteed Purchase Option (WL, UL) \$ _____ amount
- Disability Income Benefit Rider - complete below (WL, UL, Level & Decreasing Term)

Monthly Benefit Amount \$ _____ Elimination Period is 60 Days Occupational Class _____ Benefit Period _____ Years

Other Income \$ _____ (explain) _____

F. DISABILITY

Benefit Period: 2 Years 5 Years To age 67 Elimination Period 60 Days Prior Year's Taxable Income \$ 50,000

Occupational Class AA Monthly Benefit Amount \$ 2,000

1. Percentage of time spent performing:
 - a. Professional, managerial or administrative duties 75 %
 - b. Trade, services or labor 25 %
 - c. Other _____% (explain) _____
2. Do you have any additional occupations? Yes No
3. Do you participate in any volunteer activities? (e.g., volunteer firefighter) Yes No
 - a. What type of volunteer activities do you participate in? _____
 - b. How many hours do you participate in these activities? _____
 - c. Are you paid for these activities? Yes No
If yes, annual amount \$ _____ (explain) _____
4. Do you work from an office in your home? Yes No
 - a. How many hours do you work each week in your home office? _____
 - b. How many hours each week do you leave your home office to conduct business? _____
 - c. Does your office have a separate entrance, distinct from the main residential entrance? Yes No
 - d. What duties of your occupation are performed away from your office? _____

Additional Benefits:

- 3% Cost of Living Increase Rider
- Business Owner Return-to-Work Rider
- Business Overhead Expense Rider \$ _____ monthly benefit amount
(complete Business Overhead Expense Addendum)
- Coordinating Additional Insurance Rider . . . \$ _____ monthly benefit amount
- First Day Hospital Confined Rider
- Guaranteed Insurability Rider
- Own Occupation 5 Year Rider
- Own Occupation to Age 67 Rider
- Residual Disability Rider
- Spousal Catastrophic Disability Rider (complete Spousal Catastrophic Disability Rider Addendum)

G. ALL APPLICATIONS

Please answer the following questions for each Proposed Insured
Give details to yes answers for questions G1, 3, 4 in H6

	Proposed Insured		Additional Adult Insured		Children		
	Yes	No	Yes	No	Yes	No	
ONLY COLLECT MONEY AND ISSUE BINDING RECEIPT WHEN ALL ANSWERS TO QUESTIONS 1-4 ARE NO							
1. Do you have or during the past 10 years, have you been diagnosed or treated by any physician or other practitioner for:							
a. Heart disease or disorder, angina, stroke or cancer?	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
b. Acquired Immunodeficiency Syndrome (AIDS) or Human Immunodeficiency Virus (HIV)?	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
2. Are you currently unemployed, retired, laid off or collecting Disability? (explain _____)	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
3. During the past 5 years, have you been absent from work due to accident or sickness for more than 10 days at a time? . . .	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
4. During the past 90 days, have you been admitted to or been advised to be admitted to a hospital or medical facility by any physician or other practitioner?	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
5. Do you have any existing life insurance or annuity policies? (provide details in G7)	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
If yes, is the policy applied for replacing or likely to replace any existing life insurance or annuity policies?	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
6. Do you have any Disability Income insurance in force? (provide details in G7).	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
(include salary continuation from employer, union, group DI or State sick pay plan)							
If yes, is the policy applied for replacing or likely to replace any existing Disability Income insurance?	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
7. Insured's Name	Company	Issue Date	Life Amount	Accidental Death	Disability Income	Benefit Years	Elimination Period

H. ALL APPLICATIONS

Completion of H1-5 is optional for persons who will be medically examined

	Yes		No		Yes		No	
	Yes	No	Yes	No	Yes	No	Yes	No
1. Are you currently taking medication, receiving treatment or under consultation for any disease, ailment or condition? . . .	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>					
2. Do you have or during the past 10 years, have you been treated for:								
a. Disease or disorder of the eyes, ears, nose, throat or mouth?	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>					
b. Chest pain, high blood pressure, circulatory system disorder, vascular disease or rheumatic fever?	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>					
c. Diabetes, gout, Lupus or thyroid disorder?	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>					
d. Epilepsy, seizure, headaches, dizziness, paralysis, multiple sclerosis, Alzheimer's, brain or nervous system disorder?	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>					
e. Asthma, sleep apnea, emphysema, chronic obstructive pulmonary disease (COPD) or other lung disorder?	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>					
f. Disease or disorder of the kidneys, bladder, genital organs or any part of the urinary tract?	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>					
g. Disease or disorder of the stomach, gallbladder, liver, intestines, rectum, or for Crohn's or ulcerative colitis?	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>					
h. Arthritis, back trouble, or any disorder of the spine, muscles, joints or bones?	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>					
i. Depression, stress, anxiety, nervousness, fatigue, or other mental or emotional disorder?	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>					
j. Cancer, tumor, cyst, growth, or disease or disorder of the skin or lymph nodes?	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>					
k. Complications from pregnancy or are you currently pregnant?	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>					
l. Any other disease, disorder or physical illness?	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>					
3. Have you had any other illness, operation or condition not shown above which in the past 10 years:								
a. Caused you to consult any physician or other practitioner (including all specialists such as a cardiologist, psychologist, chiropractor, etc.)	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>					
b. Required home care or confined you to a hospital, sanitarium, clinic, adult day care, assisted living facility or nursing home?	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>					
c. Required an x-ray, electrocardiogram, stress test, medical test, laboratory test or study?	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>					
d. Been advised by any physician or other practitioner to have any additional diagnostic testing, hospitalization or surgery which was not completed or do you have any results pending?	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>					

H. ALL APPLICATIONS

4. During the past 10 years, have you:	Yes	No	Yes	No	Yes	No
a. Used cocaine, heroin, LSD, marijuana, PCP or any other hallucinogenic or narcotic drug?	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. Received treatment for alcohol or drug abuse or addiction or been advised by any physician or other practitioner to limit the use?	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. Used illegal drugs or do you currently?	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Is there any family history of Alzheimer's, diabetes, cancer, heart, Huntington's, kidney or other hereditary diseases? ... (if yes, list age at diagnosis of father, mother, brothers, sisters)	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

6. DETAILS to yes answers for questions G1, 3, 4 and H1-5

Ques. No.	Name	Condition	Date	Medication (name & dose)	Surgery (type & date)	Results	Attending Physician and/or Hospital Name Address

7. For each Proposed Insured please provide:

	Individual Insured	Additional Insured	Children
Name and Address of Personal Physician			
Date and reason last seen			
Medications			

I. ALL APPLICATIONS

Please answer the following questions for each Proposed Insured.

1. During the past 5 years, have you:	Yes	No	Yes	No	Yes	No
a. Been refused, rejected, rated or postponed for Life and/or Disability Insurance?	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. Been a member of any armed forces or military or have plans to in the future?	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. Made or contemplated making flights as pilot, student pilot or crew member? (If yes, complete Section K)	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d. Participated in any hazardous avocation such as sky diving, scuba diving, hang gliding, any type of organized motor vehicle racing, mountain or rock climbing, or rodeo?	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e. Been convicted of driving while impaired or intoxicated, reckless driving, or 3 or more speeding violations? ...	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
f. Been convicted of or are awaiting trial for any crime other than a misdemeanor, including currently being on parole or probation? (if yes, please explain and provide date and location)	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
g. Made a claim for benefits to any insurance company or to the Veterans Administration because of an illness or injury?	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
h. Traveled, lived or worked outside the US or Canada or have plans to in the future? (if yes, please explain)	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Is any other Life and/or Disability application pending with any company?	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Have you smoked one or more cigarettes within the last 12 months?	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
a. Have you used tobacco in any form within the last 24 months?	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
(If yes, explain) _____						

4. DETAILS to yes answers for questions I1 - 3 (Indicate Question No. and Identify Person)

J. ALL APPLICATIONS

IT IS UNDERSTOOD AND AGREED: (1) That all answers to the questions on **this application** are complete and true to the best of my (our) knowledge and/or belief. (2) That all answers to such questions, together with this agreement, shall form the basis and become a part of any policy issued. (3) In consideration of the application and premium payment, insurance benefits applied for shall take effect on the date of the application subject to terms and limitations of the Binding Receipt; otherwise, benefits shall not take effect until the policy is delivered to the owner and the first premium paid during the lifetime and continued insurability, as stated in the application, of the person(s) to be insured. (4) That acceptance of any policy issued on this application will constitute a ratification of any correction in or addition to this application made by the Company and noted in the space for Home Office Endorsement, provided, however, no change shall be made as to amount, classification, plan of insurance or benefits, unless agreed to in writing. (5) Only the President, Vice President or Secretary of the Company can make, modify, alter or discharge contracts or waive any of the Company's rights or requirements.

HIPAA COMPLIANT AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

I authorize any health plan, physician, health care professional, hospital, clinic, laboratory, pharmacy or pharmacy benefit manager, insurance company, medical facility, the MIB, Inc., the Veterans Administration or other health care provider that has provided payment, treatment or services to me or on my behalf within the past 10 years ("My Providers") to disclose to Auto-Owners Life Insurance Company, its reinsurer(s) or insurance supporting organizations and their representatives, my entire medical record, prescription history, medications prescribed and any other protected health information concerning me. This includes information on the diagnosis or treatment of Human Immunodeficiency Virus (HIV) infection and sexually transmitted diseases. This also includes information on the diagnosis and treatment of mental illness and the use of alcohol, drugs and tobacco, but excludes psychotherapy notes.

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

This protected health information is to be disclosed under this Authorization so that Auto-Owners Life Insurance Company may: 1) underwrite my application for coverage, make eligibility, risk rating, policy issuance and enrollment determinations; 2) obtain reinsurance; 3) administer claims and determine or fulfill responsibility for coverage and provision of benefits; 4) administer coverage; and 5) conduct other legally permissible activities that relate to any coverage I have or have applied for with Auto-Owners Life Insurance Company.

This Authorization shall remain in force for 24 months following the date of my signature below, and a copy of this Authorization is as valid as the original. I understand that I have the right to revoke this Authorization in writing, at any time, by providing written notification to Auto-Owners Life Insurance Company. I understand that a revocation is not effective to the extent that any of My Providers have already replied on this Authorization to disclose information about me or to the extent that Auto-Owners Life Insurance Company has a legal right to contest a claim under an insurance policy or to contest the policy itself. I understand that any information disclosed pursuant to this Authorization is no longer covered by federal rules governing privacy and confidentiality of health information, but it will not be redisclosed by Auto-Owners Life Insurance Company except as authorized by me or as required by law.

I understand that My Providers may not refuse to provide treatment or payment for health care services if I refuse to sign this Authorization. I further understand that if I refuse to sign this Authorization to release my complete medical record, Auto-Owners Life Insurance Company may not be able to process my application, or if coverage has been issued, may not be able to make any benefit payments. I understand that any authorized representative or I will receive a copy of this Authorization upon request.

I AUTHORIZE my employer, any consumer reporting agency, other organization, institution or person having any records or knowledge of me or my health to release any financial or personal details to Auto-Owners, its reinsurer(s) or insurance support organizations and their representatives. This information may be used by underwriters, Company Officers and medical personnel to evaluate claims. They may also use it to consider Life and/or Disability insurance and/or benefits applied for by me. I understand this Authorization is valid for 24 months from the date it is signed. A copy of it is also valid. I acknowledge having received a copy. I understand that I have the right to revoke this at any time. I also received a copy of NOTICE OF INSURANCE INFORMATION PRACTICES. I acknowledge possession of the binding receipt for Life and/or Disability Income insurance bearing the same date as this application and certify that I have read it, and its terms, conditions and limitations, to which I agree, have been explained to me fully.

THE AGENT AND I CERTIFY that I have read, or the agent has read to me, the completed application. I realize that any false statement or misrepresentation in my application may result in loss of coverage under the policy (subject to the incontestability provision, time limit on certain defenses and legal proceedings).

- I received the Outline of Coverage. (For Disability Income insurance)
- I wish to have an interview if an investigative consumer report is made for this application.

Signed in the state of Any State this 12 day of December, 2010

John Doe
(Signature of Proposed Insured)

(Signature of Additional Adult Insured Over Age 15)

(Signature of Owner/Applicant — If Other Than Proposed Insured)

(Social Security Number / FEIN)

(Policyowner Name, Address, and Relationship — Please Print)

I certify information supplied by the applicant has been accurately recorded on the application.

Joe Agent
(Agent's Signature)

Joe Agent
(Agent's Name — Please Print)

Agency Y, 01-01-01
(Agency & Producer Codes)

Auto-Owners Life Insurance Company

P.O. Box 30325
Lansing, MI 48909-7825

[NOTICE: Read this outline of coverage carefully. It is not identical to the outline of coverage provided upon application, and the coverage originally applied for has *not* been issued.]

**INDIVIDUAL DISABILITY INCOME PROTECTION INSURANCE POLICY
REQUIRED OUTLINE OF COVERAGE
FOR POLICY FORM 61739**

READ YOUR POLICY CAREFULLY – This outline of coverage provides a very brief description of the important features of Your policy. This is not the insurance contract and only the actual policy provisions will control. The policy itself sets forth in detail the rights and obligations of both You and Your insurance company (herein called "We", "Us", "Our"). It is, therefore, important that You **READ YOUR POLICY CAREFULLY!**

Caution: The issuance of the policy will be based on Your responses to the questions in Your application. A copy of Your application will be made part of the policy. If Your answers are incorrect or untrue, We may have the right to deny benefits or rescind Your policy. The best time to clear up any questions is now, before a claim arises! If, for any reason, any of Your answers are incorrect, contact Us at the address shown above.

DISABILITY INCOME PROTECTION COVERAGE – Policies of this category are designed to provide, to persons insured, coverage for disabilities resulting from a covered injury or sickness. Benefits are subject to any limitations set forth in the policy. Coverage is *not* provided for basic hospital or medical or surgical expenses, or for major medical expenses.

BENEFITS

Total Disability Benefit..... Included
Premium: \$ [248.00] Per [semi-ann]
If an Injury or a Sickness causes You to be Totally Disabled, a benefit of \$ [2,000] per month will be paid to You. Payments start after the [60] day Elimination Period is satisfied. Benefits will be paid up to the [2 year] Maximum Benefit Period.

Partial Disability Benefit..... Included
If You are Partially Disabled due to the Injury or Sickness that caused Your Total Disability, immediately after You receive benefit(s) for Total Disability, then a Monthly Benefit Amount of one half the Total Monthly Disability Benefit will be paid. Benefits will be paid for up to 6 months, but not after the date on which the number of Total Disability and Partial Disability benefits paid equals the number of months in the Maximum Benefit Period.

Transplant Benefit..... Included
If You donate one of Your organs, or bone marrow, or other body part that can be transplanted, for transfer to another person, then the physical condition that results from the transfer will be deemed a Sickness. If You become Totally Disabled as a result, then Total Disability Benefits will be payable as for any other Disability. Your policy must have been in force for at least 6 months before Your donation, for benefits to be payable for this reason.

Premium Waiver Benefit..... Included
After You have been Disabled for 90 days in a row, We will waive the payment of premiums that become due for the policy and any riders attached to it. We will continue to waive them for as long as Your Disability continues. All premiums paid that were due during that 90 day period will be returned to You. When You are no longer Disabled, this waiver of premium ends, and You must resume premium payments as of the next premium due date to continue Your coverage under the policy and its riders.

Optional 3% Cost of Living Increase Rider, Form 61746 Included Not Included
Premium: \$ _____ Per _____

This rider provides an increase in monthly benefits for Disability under the policy after You have been Disabled for 12 months in a row. While You remain Disabled, Your benefit amount is increased each year by 3% compounded annually, until the benefit doubles.

This rider also applies to:

- the Total Disability Monthly Benefit increases purchased under the Guaranteed Insurability Rider; and
 - the Monthly Benefit Amount for the Coordinating Additional Insurance Rider;
- if included with Your policy.

Optional Business Overhead Expense Rider, Form 61745 Included Not Included
Premium: \$ _____ Per _____

This rider provides benefits if You incur Covered Business Owner Expenses while You are Totally Disabled and while this rider is in force. The monthly benefit is the lesser of the actual amount of Covered Business Overhead Expenses incurred in that month, and \$_____. This benefit has an Elimination Period of _____ days of Total Disability. This benefit has a Maximum Benefit Period during Your lifetime of _____ months.

Optional Business Owner Return-To-Work Rider, Form 61729 Included Not Included
Premium: \$ _____ Per _____

This rider provides a limited extension of Your Total Disability Benefits, if You recover from Your Total Disability before benefits are paid for the Maximum Benefit Period. To qualify, You must return to Actively at Work status in Your Regular Occupation within 30 days after the last day of a period of Total Disability for which a Total Disability Benefit was paid. Benefits will then be extended, from 1 to 3 months, based on the number of Total Disability Benefits You had received before Your Recovery. The extended benefit amount under this rider equals 50% of the Total Disability Benefit above. The Maximum Benefit Period applies to the total number of Total Disability Benefit payments under Your policy plus any extended payments under this rider.

This rider also applies to:

- the Monthly Benefit Amount for the Coordinating Additional Insurance Rider; and
 - the 3% Cost of Living Increase Rider; and
 - the Total Disability Monthly Benefit increases purchased under the Guaranteed Insurability Rider;
- if included with Your policy.

Optional Coordinating Additional Insurance Rider, Form 61732 Included Not Included
Premium: \$ _____ Per _____

This rider provides a monthly benefit in addition to the Total Disability Benefit or Partial Disability Benefit above. The amount of this monthly benefit equals \$_____, less the amount of any benefits from Other Benefit Programs that are payable to You or Your Family Member, or for which You or Your Family Member are eligible, for the same month.

Other Benefit Programs include:

- Social Security disability benefits; and
- Worker's Compensation disability benefits; and
- federal, state or local retirement and disability fund benefits.

This monthly benefit will be paid while Your Disability continues, but not after the date that Total Disability benefits or Partial Disability benefits under the policy end.

Optional First Day Hospital Confined Rider, Form 61744 Included Not Included
Premium: \$ _____ Per _____

This rider provides for payment of Total Disability Benefit amounts, during the Elimination Period, if You are Confined in a Hospital because of Your Total Disability. We will pay a pro rata portion of the Total Disability Benefit amount for each day of such Confinement during the Elimination Period while You remain Totally Disabled.

This rider also applies to:

- the Total Disability Monthly Benefit increases purchased under the Guaranteed Insurability Rider; and
 - the Monthly Benefit Amount for the Coordinating Additional Insurance Rider; and
 - the Business Overhead Expense Rider;
- if included with Your policy.

Optional Guaranteed Insurability Rider, Form 61728 Included Not Included
Premium: \$ _____ Per _____

This rider allows You to increase Your Total Disability Benefit amount prior to Your 58th birthday. Your health status will not be considered, other than proof that You are not Disabled. An increase can only take effect on an anniversary of Your Policy Date, and only after Your policy has been in force for at least 2 years. Increases must be at least 2 years apart. Increases are subject to Our underwriting requirements. The amount of any increase is subject to a minimum of \$100.00, and a maximum of 50% of Your Total Disability Benefit amount on Your Policy Date. The maximum amount for all increases is 2 times Your Total Disability Benefit amount on Your Policy Date.

Optional Own Occupation Five Year Rider, Form 61748 Included Not Included
Premium: \$ _____ Per _____

This rider lengthens the time period described in the policy definition of Own Occupation Period. This time period is increased from 24 months to 60 months.

Optional Own Occupation To Age 67 Rider, Form 61749 Included Not Included
Premium: \$ _____ Per _____

This rider lengthens the time period described in the policy definition of Own Occupation Period. This time period is increased, from 24 months, to the number of months from the completion of the Elimination Period to the date You attain age 67.

Optional Residual Disability Rider, Form 61747 Included Not Included
Premium: \$ _____ Per _____

This rider provides a monthly benefit if You return to Your Regular Occupation while Residually Disabled. If this return follows immediately after You receive a Total Disability Benefit, and You suffer a loss of 15% or more of Your Pre-Disability Income, then We will pay a Residual Disability benefit. Your benefit is based on the percent of income lost as a result of Your Disability. We will pay this benefit while Your Residual Disability continues, but not after the date on which the number of Total Disability and Residual Disability benefits paid equals the number of months in the Maximum Benefit Period.

Optional Spousal Catastrophic Disability Rider, Form 61743 Included Not Included
Premium: \$ _____ Per _____

This rider provides a monthly benefit to You of \$ _____, if Your Spouse suffers a Catastrophic Disability while this rider is in force. Your Spouse must be unable to perform 2 or more Activities of Daily Living without Hands-On Assistance, or must require Substantial Supervision due to a Severe Cognitive Impairment, in order to qualify. Your Spouse must be Catastrophically Disabled for 60 days in a row. Benefits can then be paid while the Catastrophic Disability continues. A maximum of 24 months of benefits will be paid during the Spouse's lifetime.

EXCLUSIONS AND LIMITATIONS

Exclusions – Benefits will not be paid under Your policy or any attached riders, for:

- any Disability caused by war or any act of war, whether declared or undeclared, or by any other armed conflict; or
- any Disability caused or contributed to by Your intentionally self-inflicted injury or sickness, except that this does not include a voluntary donation described in the Transplant Benefit; or
- any Disability due to normal pregnancy, childbirth or elective abortion, except that this does not include Complications of Pregnancy; or
- any Disability caused by Your active participation in a riot or insurrection; or
- any Disability that results from Your military service of any country or authority, except during active duty for training of less than 60 days; or

Statement of Variability

Policy Form 61739 (5-10)

The following fields on the Policy Front Jacket are indicated in the filing as variable. These fields will vary based on individual policy characteristic and choice:

Insured (*name of insured*)
Number (*policy number*)

The following fields on the Policy Data page 3 (61737) are indicated in the filing as variable. These fields will vary based on the individual policy characteristic and choice:

Insured (*name of Insured*)
Policy Owners (*name of owner*)
Gender (*gender of Insured, male or female*)
Issue Age (*age of Insured*)
Policy Number
Policy Date
Premium Class (*Smoker, Non-Smoker*)
Occupational Class (*4A, 3A, 2A, A, B*)
Birth Date (*birth date of Insured*)
Initial Premium Mode (*premium amount: Annual, Semi-Annual, Quarterly, Monthly*)

Coverage:

Total Base Policy Disability Benefit – Non-Coordinated (*premium amount*)
Total Disability Monthly Benefit (*monthly benefit amount*)
Elimination Period (*period of Total Disability before monthly benefits are Payable*)
Maximum Benefit Period (*the longest period of time we will pay benefits under this Policy for any one period of continuous disability*)

(Additional Benefits:

3% Cost of Living Increase Rider (*premium amount*)
Business Owner Return-To-Work Rider (*premium amount*)
Business Overhead Expense Rider (*premium amount*)
Maximum Monthly Benefit Amount (*maximum benefit that will be paid for each month of Total Disability*)
Elimination Period (*number of days of Total Disability before benefits become payable*)
Maximum Benefit Period (*the longest period of time we will pay benefits under this Policy during the lifetime of the insured*)
Coordinating Additional Insurance Rider (*premium amount*)
Monthly Benefit Amount (*maximum benefit that will be paid for each month of disability*)
First Day Hospital Confined Rider (*premium amount*)
Guaranteed Insurability Rider (*premium amount*)

Own Occupation Five Year Rider (*premium amount*)
Own Occupation to Age 67 Rider (*premium amount*)
Residual Disability Rider (*premium amount*)
Spousal Catastrophic Disability Rider (*premium amount*)
Monthly Benefit Amount (*maximum monthly benefit payable after insured's spouse is Catastrophically Disabled for 60 consecutive days*)

Total Annual Premium: (*total annual premium amount for base Policy and riders*)

Premium Mode Options

(Monthly (*total premium on a monthly basis*))
(Quarterly (*total premium on a quarterly basis*))
(Semi-Annual (*total premium on a semi-annual basis*))
(Annual (*total premium on an annual basis*))

The following statement will print if any Additional Benefits** are selected:
(**See Rider Provisions for Coverage Details.*)

The following fields on the Individual Disability Income Protection Insurance Policy Outline of Coverage (61763) are indicated in the filing as variable by parentheses. These fields will vary based on the individual policy characteristic and choice:

Notice Options: Will display if the policy is issued other than applied for and delivered at time of policy: [*Notice: Read this outline of coverage carefully. It is not identical to the outline of coverage provided upon application, and the coverage originally applied for has not been issued.*]

Premium: \$(*Premium amount*) Per (*payment mode*)

Total Disability Benefit

If an Injury or a Sickness causes You to be Totally Disabled, a benefit of \$ (*\$500.00-\$10,000.00*) per month will be paid to You. Payments start after the (*30, 60, 90, 180, 365*) day Elimination Period is satisfied. Benefits will be paid up to the (*2 year, 5 year, To Age 67*) Maximum Benefit Period

Optional Business Overhead Expense Rider, Form 61745

If an Injury or a Sickness causes You to be Totally Disabled, a benefit of \$ (*monthly benefit selected*) per month will be paid to You. Payments start after the (*30, 60, 90, 180, 365*) day Elimination Period is satisfied. Benefits will be paid up to the (*2 year, 5 year, To Age 67*) Maximum Benefit Period

Optional Coordinating Additional Insurance Rider, Form 61732

The amount of this monthly benefit equals \$ (*\$100.00-\$2000.00*) less the amount of any benefits from Other Benefit Programs that are payable to You or Your Family Member, or for which You or Your Family Member are eligible, for the same month.

Optional Spousal Catastrophic Disability Rider, Form 61745

This rider provides a monthly benefit to You of \$(250.00-2,000.00), if Your Spouse suffers a Catastrophic Disability while this rider is in force.

Total Premium: \$ *(Total Premium for the Total Disability Benefit and all included riders)*
Per *(payment mode)*