

SERFF Tracking Number: AMEQ-127211679 State: Arkansas
Filing Company: American Equity Investment Life Insurance Company State Tracking Number: 49048
Company Tracking Number: 5001
TOI: L08 Life - Other Sub-TOI: L08.000 Life - Other
Product Name: 5001
Project Name/Number: 5001/5001

Filing at a Glance

Company: American Equity Investment Life Insurance Company

Product Name: 5001

TOI: L08 Life - Other

Sub-TOI: L08.000 Life - Other

Filing Type: Form

SERFF Tr Num: AMEQ-127211679 State: Arkansas

SERFF Status: Closed-Accepted State Tr Num: 49048

For Informational Purposes

Co Tr Num: 5001

State Status: Filed-Closed

Reviewer(s): Linda Bird

Authors: Terri Parker, Kathleen

Disposition Date: 06/20/2011

Underwood, Cheryl Parker, Tiffany

Meuer, Dave Milligan, Troy

Christensen, Janine Plettner-Glodt

Date Submitted: 06/13/2011

Disposition Status: Accepted For Informational Purposes

Implementation Date:

Implementation Date Requested: 06/13/2011

State Filing Description:

General Information

Project Name: 5001

Project Number: 5001

Requested Filing Mode: Informational

Explanation for Combination/Other:

Submission Type: New Submission

Overall Rate Impact:

Status of Filing in Domicile: Authorized

Date Approved in Domicile: 03/12/1997

Domicile Status Comments:

Market Type: Individual

Individual Market Type:

Filing Status Changed: 06/20/2011

State Status Changed: 06/20/2011

Created By: Cheryl Parker

Corresponding Filing Tracking Number:

Deemer Date:

Submitted By: Cheryl Parker

Filing Description:

INFORMATIONAL ONLY

This informational only filing is to provide your department with our updated simplified underwriting Life Insurance Application 5001. Your state approved the original filing of this application on December 26, 1997.

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We have updated the following information on this application: Home office fax number, mailing address and name change for Medical Information Bureau to MIB, Inc.

Company and Contact

Filing Contact Information

Terri Parker, Senior Compliance Analyst terriparker@american-equity.com
 6000 Westown Parkway 515-457-1724 [Phone]
 West Des Moines, IA 50266 515-273-3620 [FAX]

Filing Company Information

American Equity Investment Life Insurance CoCode: 92738 State of Domicile: Iowa
 Company
 6000 Westown Pkwy Group Code: 2658 Company Type:
 West Des Moines, IA 50266 Group Name: State ID Number:
 (515) 221-0002 ext. [Phone] FEIN Number: 42-1153896

Filing Fees

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

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
American Equity Investment Life Insurance Company	\$50.00	06/13/2011	48653559

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Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Accepted For Informational Purposes	Linda Bird	06/20/2011	06/20/2011

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Disposition

Disposition Date: 06/20/2011

Implementation Date:

Status: Accepted For Informational Purposes

Comment:

Rate data does NOT apply to filing.

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Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification	No	No
Supporting Document	Application	No	No
Form	Life Insurance Application	Yes	Yes

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Form Schedule

Lead Form Number: 5001

Schedule Item Status	Form Number	Form Type Form Name	Action	Action Specific Data	Readability	Attachment
	5001B	Application/Life Insurance Enrollment Application Form	Initial			5001B-M-Rplc_0611_.pdf



Home Office:
P.O. Box 71335
Des Moines, IA 50325-0335
Phone 888-221-1234
Fax 515-457-1839
www.american-equity.com

Life Insurance Application
American Equity Investment Life Insurance Company
Life Division: 20 Cropwell Drive, Ste. 100
Pell City, AL 35128
Phone 877-508-9888
Fax 205-884-7928

APPLICANT

Name _____ Sex _____
Birth date ___/___/___ Soc. Sec. No. _____
Birth Place _____ Height _____ Weight _____
Address _____ Phone _____
City _____ State _____ Zip _____

SPOUSE

Name _____ Sex _____
Birth date ___/___/___ Soc. Sec. No. _____
Birth Place _____ Height _____ Weight _____

CHILDREN

Date Of Birth Of Oldest Child Under 18 (or age) _____

BENEFICIARY - The applicant is the beneficiary and owner of the spouse policy and any children's rider(s), unless endorsed otherwise.

Name _____ Relationship: _____
Name _____ Relationship: _____

Policy form: _____ Premiums: _____ Monthly Bi-Weekly Other _____
Face Amount: Self \$ _____ Spouse \$ _____ Dependent Children \$ _____
If available, I request the automatic premium loan provision on the above policy(ies) Yes No

IN THE PAST THREE YEARS HAS ANY PROPOSED INSURED HAD ANY, BEEN DIAGNOSED AS HAVING, OR RECEIVED MEDICAL OR SURGICAL TREATMENT FOR ANY OF THE FOLLOWING?

1. Have any impairments in health or physical condition?* Yes No
2. Had any illness or injuries?* Yes No
3. Cancer, Diabetes, Disease of the Heart, Lungs, Stomach, Kidney, Liver; Brain or any other disease?* Yes No
4. Have or had Alcoholism, Drug addiction, Substance abuse? Yes No
5. Mental or Nervous Disorder? Yes No
6. Currently take Prescription Drugs? Yes No

* AIDS, ARC or HIV must be diagnosed by a member of the medical profession, doctor or a physician.

Ever been refused, postponed or rated up by an insurance company? Yes No

IF THE ANSWER FOR ANY POTENTIAL INSURED IS YES TO ANY OF THE ABOVE QUESTIONS, COMPLETE REVERSE SIDE OF THIS FORM.

I AUTHORIZE any physician, medical practitioner, hospital, clinic, other medical or medically related facility, insurance or reinsuring company, the MIB, Inc., consumer reporting agency, or employer having available information about diagnosis, treatment and/or prognosis of me or of any member of my family pertaining to any physical or mental condition, including alcoholism and/or use of drugs, and any other non-medical information about me or my family to give the Company or it's reinsurers any and all such information.

5001B

NOTE: Make all Checks payable to American Equity Investment Life Insurance Company

M-Rplc(6/11)

IF THE ANSWER FOR ANY POTENTIAL INSURED IS YES TO ANY OF THE QUESTIONS ON THE FACE OF THIS FORM, INDICATE BELOW, WHICH INSURED, THE NATURE, DURATION AND SEVERITY OF THE ILLNESS OR INJURY. GIVE DATES AND DETAILS, PROVIDE THE NAME AND ADDRESS OF THE PHYSICIAN. THE DATE AND NAME OF THE INSURANCE COMPANY AND REASON FOR REFUSAL, POSTPONEMENT OR RATING.

Do you have any existing life insurance or annuities with this or any other company? Yes No
(If "Yes", please complete replacement forms.)

Insured _____ Company _____ Plan _____
Amount _____ Reason _____

Each person who signs below acknowledges that he/she has read and understands this Application and has read and understands the Information Practices outlined on the back of this form.

Do you have knowledge or reason to believe that applicant has any existing life insurance or annuities? Yes No
If "Yes", complete required replacement forms:

Agent's Name/Number (Please Print)

Agent's Signature/Phone Number

Resident's Agent's Countersignature/Phone Number
(where required)

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.
To the best of my knowledge and belief, the statements above are true and complete.
Signed at _____ on ____/____/____
City/State Date

Applicant's Signature

Other Proposed Insured(s) Signature

5001B M-Rplc(06/11)

DETACH AND LEAVE WITH APPLICANT

INFORMATION PRACTICES

FAIR CREDIT REPORTING ACT NOTICE

I (We) understand, as part of the normal procedure of processing an application, The Company may obtain an investigative consumer report concerning such information as character, general reputation, personal characteristics such as health, finances, job, through personal interviews with friends, neighbors, and associates. We may request further information on the nature and scope of any such report, by requesting it in writing from The Company.

APPLICANT'S PRE-NOTICE

The Company treats information regarding your insurability as confidential. The Company or its reinsurers may, however, make a brief report based on this information to the MIB, Inc., a non-profit membership organization of life insurance companies, which operates an information exchange on behalf of its members. If you apply to another MIB, Inc. member company for life or health insurance coverage, or a claim for benefits is submitted to such company, MIB, Inc., upon request, will supply such company with the information in its file. Upon receipt of a request from you, MIB, Inc. will arrange disclosure of any information it may have in your file. If you question the accuracy of information in MIB, Inc.'s file, you may contact MIB, Inc. and seek a correction in accordance with the procedures set forth in the Federal Fair Credit Reporting Act. The MIB, Inc.'s information office address is 50 Braintree Hill Park, Suite 400, Braintree, MA 02184-8734, telephone number (866) 692-6901, (TTY) (866) 346-3642). The Company or its reinsurers may also release information in its file to other life insurance companies to whom you may apply for life or health insurance, or to whom a claim for benefits may be submitted. 09/15/09

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Supporting Document Schedules

Item Status: **Status**
Date:

Bypassed - Item: Flesch Certification
Bypass Reason: N/A Informational filing of a previously approved application.
Comments:

Item Status: **Status**
Date:

Bypassed - Item: Application
Bypass Reason: Informational filing of a previously approved application.
Comments: