

SERFF Tracking Number: AMMB-126852286 State: Arkansas
 Filing Company: Amica Life Insurance Company State Tracking Number: 48946
 Company Tracking Number: SIMPLIFIED LIFE POLICY
 TOI: L04I Individual Life - Term Sub-TOI: L04I.213 Specified Age or Duration -
 Fixed/Indeterminate Premium - Single Life
 Product Name: (10/15/20) Year Amica Simplified Life Policy
 Project Name/Number: Simplified Life/ SILT01-01

Filing at a Glance

Company: Amica Life Insurance Company

Product Name: (10/15/20) Year Amica
 Simplified Life Policy

TOI: L04I Individual Life - Term

Sub-TOI: L04I.213 Specified Age or Duration -
 Fixed/Indeterminate Premium - Single Life

Filing Type: Form

SERFF Tr Num: AMMB-126852286 State: Arkansas

SERFF Status: Closed-Approved- State Tr Num: 48946
 Closed

Co Tr Num: SIMPLIFIED LIFE
 POLICY

State Status: Approved-Closed

Reviewer(s): Linda Bird

Author: Marlene Kumar

Disposition Date: 06/13/2011

Date Submitted: 06/01/2011

Disposition Status: Approved-
 Closed

Implementation Date Requested: On Approval

Implementation Date:

State Filing Description:

General Information

Project Name: Simplified Life

Project Number: SILT01-01

Requested Filing Mode: Review & Approval

Status of Filing in Domicile: Authorized

Date Approved in Domicile:

Domicile Status Comments: Rhode Island is part of the Interstate Compact. The compact approved these forms on January 26, 2011. ICC11 L101-1 (standard version) is pending with the Compact.

Explanation for Combination/Other:

Market Type: Individual

Submission Type: New Submission

Individual Market Type:

Overall Rate Impact:

Filing Status Changed: 06/13/2011

State Status Changed: 06/13/2011

Deemer Date:

Created By: Marlene Kumar

Submitted By: Laurie Clark

Corresponding Filing Tracking Number:

Filing Description:

Attached is a copy of our new level-term (10/15/20) Year Amica Simplified Life Policy, Form No. SILT01-01, and the product-specific Applications, Form No. L100-1 AR and L101-1 AR. The only difference between the two applications are the addition of spaces for the Proposed Insured to indicate their Social Security Number and Driver's License

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Number, which is necessary for those Proposed Insured's for whom we do not already have such information in our files.

The premiums for this policy are fully guaranteed. The minimum issue age for this new product is 25 years old. The maximum issue age for this policy is 55 years old (50 for the 20 year version).

The face amount will remain level for the life of the contract. This plan is available for face amounts of \$50,000; \$100,000; \$150,000; or \$200,000 only. We will solicit sales of this product primarily from our existing insureds and those of our parent, Amica Mutual Insurance Company; however, we may offer this product to those outside our current policyholder base a later time.

Our company's individual life portfolio is sex-distinct. Please be assured that this policy will not be subject to Norris and/or Title VII of the Civil Rights Act of 1964.

Premium rates are based on the sex and age of the insured, and are differentiated by two rate classes only -- Preferred and Standard. There will be no substandard ratings on this policy since it is a simplified-issue product.

This policy form contains a conversion privilege. The Conversion Expiry Date – clearly stated in the Schedule of Benefits and Premiums found on Page 1 of the policy – is equal to the earlier of the policy anniversary immediately following the insured's 65th birthday, or the policy anniversary immediately following completion of 80% of the coverage period. For example, if the period selected is 10 years, the conversion privilege expires on the 8th policy anniversary; if the period selected is 15 years, such conversion privilege expires on the 12th policy anniversary; and if the period selected is 20 years, such conversion privilege expires on the 16th policy anniversary – but in any case, no later than the policy anniversary immediately following the insured attaining age 65.

Please note that except for the front and back "jacket" pages, the policy itself will be completely system-generated; the bracketed data found on policy Page 1 are "variable" only in the sense that such data will be customized based on the specific policy issue information. The first page of the scanned policy is actually a "cover flap". The size of the "cover flap" measures 8 ½ x 5 ½ inches. This page allows the pertinent information to be readily viewed by the policyowner.

At this time, there are no optional benefits available to be added to this plan. However we may offer Accidental Death Benefit (Form No. AD01-01 AR) which was approved on November 4, 1996 (filing number was not available) at some time in the future.

This product will be direct-marketed by Amica Life and will not utilize the services or involvement of our licensed, full-time employee representatives. All such policies will be issued directly to the policy owners from our Corporate Offices, again with no agent involvement whatsoever in the solicitation/sales, application, issue and delivery processes.

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Since the premium rates are fully guaranteed, this product is not subject to the requirements and restrictions imposed by the NAIC Life Insurance Illustrations Model Regulation. We will provide a copy of the Statement of Policy Cost and Benefit Information at issue -- or sooner, if it is requested by the applicant.

Company and Contact

Filing Contact Information

Laurie A. Clark, Compliance Supervisor lclark@amica.com
 10 Amica Center Boulevard 800-234-5433 [Phone] 29729 [Ext]
 Lincoln, RI 02861 401-334-5146 [FAX]

Filing Company Information

Amica Life Insurance Company CoCode: 72222 State of Domicile: Rhode Island
 100 Amica Way Group Code: 28 Company Type: Life
 Lincoln, RI 02865 Group Name: 72222 State ID Number:
 (800) 234-5433 ext. 29729[Phone] FEIN Number: 05-0340166

Filing Fees

Fee Required? Yes
 Fee Amount: \$150.00
 Retaliatory? No
 Fee Explanation: Filing fee is \$50.00 per form. We are filing three forms. Therefore, the fee is \$150.00
 Per Company: No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Amica Life Insurance Company	\$150.00	06/01/2011	48212389

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Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved- Closed	Linda Bird	06/13/2011	06/13/2011

Objection Letters and Response Letters

Objection Letters				Response Letters		
Status	Created By	Created On	Date Submitted	Responded By	Created On	Date Submitted
Pending Industry Response	Linda Bird	06/09/2011	06/09/2011	Marlene Kumar	06/10/2011	06/10/2011

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Disposition

Disposition Date: 06/13/2011

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 (revised)	Flesch Certification		Yes
Supporting Document	Flesch Certification		Yes
Supporting Document	Application		No
Supporting Document	Life & Annuity - Actuarial Memo		No
Supporting Document	Statement of Variability		Yes
Form	(10/15/20) Year Amica Simplified Life Policy		Yes
Form	Amica Simplified Life Policy Application		Yes
Form	Amica Simplified Life Policy Application		Yes

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Objection Letter

Objection Letter Status Pending Industry Response
Objection Letter Date 06/09/2011
Submitted Date 06/09/2011
Respond By Date 07/11/2011

Dear Laurie A. Clark,

This will acknowledge receipt of the captioned filing.

Objection 1

Comment: The Certificate of Compliance has not been completed.

Please feel free to contact me if you have questions.

Sincerely,

Linda Bird

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Response Letter

Response Letter Status Submitted to State
Response Letter Date 06/10/2011
Submitted Date 06/10/2011

Dear Linda Bird,

Comments:

This is in reference to your objection letter dated June 9, 2011.

Response 1

Comments: As requested, we have completed the Certificate of Compliance.

We apologize for the oversight.

Related Objection 1

Comment:

The Certificate of Compliance has not been completed.

Changed Items:

Supporting Document Schedule Item Changes

Satisfied -Name: Flesch Certification

Comment: Attached is the revised Certificate of Compliance.

No Form Schedule items changed.

No Rate/Rule Schedule items changed.

Thank you for your help.

Sincerely,

Marlene Kumar

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Form Schedule

Lead Form Number:

Schedule Item Status	Form Number	Form Type Form Name	Action	Action Specific Data	Readability	Attachment
	SILT01-01	Policy/Cont (10/15/20) Year ract/Fratern Amica Simplified Life al Policy Certificate	Initial		60.450	Arkansas Policy.pdf
	L100-1 AR	Application/ Amica Simplified Life Enrollment Policy Application Form	Initial		50.490	L100-1 AR.pdf
	L101-1 AR	Application/ Amica Simplified Life Enrollment Policy Application Form	Initial		50.490	L101-1 AR.pdf



Amica Life Insurance Company

Amica Life Insurance Company (a stock company) agrees to pay the Death Benefit to the Beneficiary when We receive due proof that the Insured died while this policy was in force, subject to the terms of this policy.

We have issued this policy in consideration of the attached Application and the payment of premiums as provided in this policy. The provisions on the following pages are an essential part of this contract. PLEASE READ YOUR POLICY CAREFULLY.

Signed for the Company at the Corporate Office, [Lincoln, Rhode Island,] on the Date of Issue.

[*Rares B. St. Jean*]
Senior Vice President

[*Robert K. MacKenzie*]
Secretary

[*Robert A. J. Muccio*]
President

1. SCHEDULE OF BENEFITS AND PREMIUMS

THE PREMIUMS FOR THIS POLICY ARE PAYABLE FOR THE YEARS SHOWN (STARTING WITH THE DATE OF ISSUE) OR UNTIL THE DEATH OF THE INSURED, IF EARLIER.

BENEFIT	ANNUAL PREMIUM	POLICY YEARS PAYABLE
[10] YEAR AMICA SIMPLIFIED LIFE POLICY	[\$190.50]	1-[10]

TOTAL [ANNUAL] PREMIUM: [\$190.50]

[10] YEAR AMICA SIMPLIFIED LIFE POLICY. Provides a level-term Death Benefit payable in the event of the Insured's death prior to the Coverage Expiry Date. RENEWABLE to the Coverage Expiry Date, provided premiums are paid prior to expiration of the Grace Period. CONVERTIBLE prior to the Conversion Expiry Date, subject to the terms contained herein. Premiums are payable as stated herein. This policy is NONPARTICIPATING; it will not share in the Company's earnings through the payment of dividends.

You may return this policy at any time within 31 days after receipt by delivering or mailing it to Our Corporate Offices at [100 Amica Way, LINCOLN, RI 02865 (P.O. Box 6008, Providence, RI 02940-6008)] or to the agent through whom it was purchased. Immediately upon such delivery or mailing, We will deem this policy void and will refund to You any premiums paid. If You have any questions or need to obtain information about Your coverage, or if You need assistance in resolving a complaint with Our Company, please contact Us at www.amica.com or by calling Us at [1-800-234-LIFE.] You may also contact Your local state insurance department at [1-800-282-9134.]

INSURED: [JOHN DOE]	POLICY NUMBER: [1-099100331]
DATE OF ISSUE: [FEBRUARY 11, 2011]	FACE AMOUNT: [\$50,000]
OWNER: [JOHN DOE]	SEX AND AGE OF INSURED: [MALE] [35]
COVERAGE EXPIRY DATE: [FEBRUARY 11, 2021]	POLICY CLASS: [PREFERRED]
CONVERSION EXPIRY DATE: [FEBRUARY 11, 2019]	
BENEFICIARY: AS STATED IN APPLICATION UNLESS CHANGED AS PROVIDED HEREIN.	

AMICA LIFE INSURANCE COMPANY

TABLE OF CONTENTS

1. Schedule of Benefits and Premiums.....1

2. Definitions3

3. Payment of Premiums4

4. Grace Period.....4

5. Termination.....4

6. Reinstatement4

7. Owner and Beneficiary Provisions5

8. Assignment.....5

9. General Provisions6

10. Conversion Privilege7

11. Settlement Provisions.....8

2. DEFINITIONS

- (a) Amica Life, Company, Our, Us, We - refers to the Amica Life Insurance Company.
- (b) Application - includes the application form itself and any required addendums, copies of which are attached to this policy or otherwise furnished to You.
- (c) Coverage Expiry Date - the latest date on which all coverage under this policy will terminate, as shown on Page 1.
- (d) Death Benefit - the total amount We will pay upon the Insured's death, subject to the terms of this policy. Such amount includes the Face Amount; plus all additional or supplementary payments as provided herein, if any; less any unpaid premiums then due and payable.

Such payment will be made within 30 days of receipt of due proof that the death of the Insured occurred before the Coverage Expiry Date of this policy.

Amica Life shall add to the Death Benefit payment a refund of the pro rata portion of premium paid for any period beyond the end of the policy month in which death occurred if the death of the Insured occurs during a period in which the premium has been paid.

If the Death Benefit payment (including premium refund, if any) is not tendered within said 30-day period, the final settlement shall include interest from the date of the Insured's death until date of settlement. Interest shall be paid at the rate of 8% per annum.

- (e) Due Proof of Death - a certified copy of the Insured's death certificate, or other lawful evidence providing equivalent information, and proof of the appropriate payee's legal entitlement to such payment.
- (f) Face Amount - the basic amount We will pay upon the Insured's death, as shown on Page 1 of this policy.
- (g) Insured - the person on whose life this policy is issued; the Insured may or may not be the Owner.
- (h) Interval - the period of time for which the premium required to be paid will provide coverage under this policy.
- (i) Owner, You, Your - refers to this policy's Owner, unless changed in writing and filed with and recorded by the Company.
- (j) Policy Anniversary - the same day and month of each year as of this policy's Date of Issue.
- (k) Written Notice - unless otherwise stated, a Written Notice filed at Our Corporate Office in Lincoln, Rhode Island, or at one of Our authorized offices.

3. PAYMENT OF PREMIUMS

Premiums are payable as shown on Page 1. The first premium must be paid before this policy can be issued and made effective. Each premium is due and payable in advance by the first day of the payment Interval You have selected. You may pay premiums on either an annual or a monthly basis as allowed by the Company, with Our prior approval.

Premiums are payable to Us at Our Corporate Office in Lincoln, Rhode Island, or to one of Our agents authorized to receive such payment. We will give You a receipt in exchange for a premium payment, if You request it. Our receipt will be valid only if signed by the President or Secretary, and countersigned by the person receiving the payment.

4. GRACE PERIOD

If You fail to pay a premium (other than the first premium) on or before its due date, You will be granted a Grace Period of thirty-one (31) days for the payment of such premium. This Grace Period will begin on the due date of such unpaid premium. During this period the policy will remain in force. If the Insured dies during the Grace Period, We will deduct any premium due and payable from the Death Benefit. Any premium sent to Us by the U.S. Postal Service and postmarked during the Grace Period will be considered to have been paid within such Grace Period.

If any premium due and payable is not paid during the Grace Period, this policy will terminate immediately without further value. We will notify You, at Your last known address, that this policy has terminated.

5. TERMINATION

This policy will terminate and all insurance under this policy will stop:

- (a) when You request it, by Your sending to Us and Our receiving Written Notice of Your request; or,
- (b) on the Date of Issue of a permanent life insurance policy issued under the Conversion Privilege section of this policy; or,
- (c) when We do not receive by the end of the Grace Period any premium then due and payable; or,
- (d) when the Insured dies; or,
- (e) on the Coverage Expiry Date as shown on Page 1.

6. REINSTATEMENT

If this policy terminates for nonpayment of premium, within five (5) years from the due date of such unpaid premium You may reinstate this policy provided:

- (a) You submit to Us an Application for reinstatement prior to this policy's Coverage Expiry Date; and,
- (b) You furnish to Us satisfactory evidence of the Insured's continued insurability; and,
- (c) You pay to Us all prior unpaid premiums with interest at the rate of 6% per year compounded annually.

6. REINSTATEMENT (continued)

The effective date of the reinstated policy will be the date on which all of the above-noted conditions are satisfied.

For statements made in the original Application, the Incontestability provision will apply as of this policy's Date of Issue.

For statements made in the reinstatement Application, We will not contest this policy after it has been in force during the lifetime of the Insured for two (2) years from the date all conditions for reinstatement as stated above have been satisfied.

Upon reinstatement, the Suicide Exclusion provision will apply as of this policy's Date of Issue.

7. OWNER AND BENEFICIARY PROVISIONS

General

The Owner and Beneficiary named in the original Application will remain in effect unless You change them in writing.

You have the sole power to exercise all rights and privileges without the consent of any other person; unless, however, You have provided otherwise by Written Notice filed with and recorded by Amica Life; or, unless You have named an irrevocable Beneficiary and filed such designation with Us.

If You are not the Insured, at Your death the Insured will become the Owner of this policy. All of Your rights and privileges will transfer to the Insured; unless, however, You have provided otherwise in writing to Us.

The Beneficiary at the Insured's death will be as provided in the Beneficiary designation then in effect. If no Beneficiary designation is then in effect, or if no designated Beneficiary is alive, You will be the Beneficiary. If You are also the Insured, Your estate will be the Beneficiary.

Change of Owner or Beneficiary

You may change the named Owner or Beneficiary during the lifetime of the Insured by Written Notice to Us; however, an irrevocable Beneficiary must consent in writing to any such change. Any such change is effective on the date the notice is signed, whether or not You or the Insured is alive at the time of such acknowledgment. Any such change is subject to the rights of any current assignee. Such change will not affect any payment We make or action We take before We know of such change. We are not responsible for the validity or sufficiency of any change of Beneficiary or Owner You may make.

8. ASSIGNMENT

You must file all assignments of this policy in writing at Our Corporate Office. Any assignment will take effect on the date You sign the notice of assignment, unless You specify another date in such notice; however, an assignment will not affect any payment We make or action We take before We know of such assignment. We are not responsible for the validity or sufficiency of any assignment. Your interest, or the interest of any Beneficiary, and the election of a settlement option will be subordinate to the interest of any assignee. Other than an absolute assignee, an assignee cannot change the Owner or Beneficiary designations. A settlement option may not be elected by an assignee, other than by an absolute assignee.

8. ASSIGNMENT (continued)

An assignment, other than an absolute assignment, is not a change of Owner; and an assignee, other than an absolute assignee, is not a new Owner.

9. GENERAL PROVISIONS

Entire Contract

This policy and the Application constitute the entire contract between You and Amica Life. Statements made in the Application shall be considered representations and not warranties. We will not use any such statement in defense of a claim under this policy unless that statement is contained in the Application and We attach to this policy or furnish You with a copy of that Application when We issue, reinstate or amend this policy.

No condition or provision of this policy may be waived or modified in any way except by an endorsement signed by Our President, Vice President or Secretary.

Incontestability

We will not contest the validity of this policy after it has been in force during the lifetime of the Insured for two (2) years from the Date of Issue. Only statements made in an Application which are material to the risk accepted may be used to contest such validity. This provision will not apply to any provisions for accidental death benefits.

Suicide Exclusion

Suicide of the Insured, while sane or insane, within two (2) years from the Date of Issue is not covered under this policy. In such event, We will pay to the Beneficiary an amount equal to the premiums paid on this policy.

Misstatement of Age or Sex

If the age or sex of the Insured is misstated, We will change the Face Amount of insurance to that which the premiums paid would have purchased for the correct age and sex. If the corrected age is outside the allowable issue age limits for this policy, We will extrapolate a premium and benefit based on the nearest age allowed under such limits.

Conformity to State Laws

This policy is subject to the laws of the state as of the date the original Application was signed. If part of this policy as written does not conform to the laws of such state, We will automatically treat that part of the policy as if it does conform.

9. GENERAL PROVISIONS (continued)

Nonparticipating

This policy is Nonparticipating. It will not share in the Company's earnings through the payment of dividends.

10. CONVERSION PRIVILEGE

You may convert this policy to a new policy on any permanent life plan (minimum Face Amount of \$25,000) that We are then offering, subject to Our normal issue rules. As part of the new policy, You may continue any supplementary benefits in force under this policy on the date the conversion takes place; such benefits are subject to Our normal issue limits and rules. You do not have to furnish evidence of the Insured's insurability for any such conversion, provided:

- (a) the Face Amount of the new policy is not larger than the Face Amount of this policy in force on the date the conversion takes place; and,
- (b) this policy is in force; and,
- (c) Your request for conversion is made in writing and accompanied by this policy no later than the Conversion Expiry Date stated on Page 1; and,
- (d) You pay to Us the premium then due and payable for the new policy.

We will issue the new policy at the Insured's then current age, and in the same (or most comparable) Policy Class as this policy. We will use the premium rates and policy forms in effect on the date We approve the conversion. The Date of Issue of the new policy and any supplementary benefits will be the date We approve the conversion.

The Incontestability provision for the new policy and any supplementary benefits will apply:

- (a) as of this policy's Date of Issue for statements made in the original Application; and,
- (b) as of the effective date of reinstatement for statements made in the reinstatement Application, if applicable.

The Suicide Exclusion provision for the new policy and any supplementary benefits will apply as of this policy's Date of Issue.

If a supplementary benefit has a signing or effective date which is later than this policy's Date of Issue, the Incontestability and Suicide provisions for that benefit will apply as of its signing or effective date.

11. SETTLEMENT PROVISIONS

We will pay the benefits under this policy either in one sum or under any optional method of settlement You elect by prior written request, or by written request of the Beneficiary, and agreed to by Us.

If an amount of \$5,000 or more becomes payable, it may be left with the Company by electing one of the following options:

Option A - Interest Income

Interest will be paid on proceeds held on deposit with the Company.

Option B - Income of a Specified Amount

Payments will be made each year totaling at least 12% of the proceeds until the proceeds, with interest, are fully paid.

Option C - Income for a Fixed Period

Payments shown in the Table for Option C will be made for the period selected.

Option D - Life Income with Payments for a Guaranteed Period

Payments will be made for the life of the Payee for an amount determined from the Table for Option D. If the payee dies within the guaranteed period, the income payments for the remainder of this period will be discounted using 3% interest, compounded annually, and paid as a final payment.

The guaranteed interest rate for all options is based on the Annuity 2000 ALB Table at 3% per year, compounded annually. Payments made under Options C or D, at the time of their commencement, will not be less than those that would be provided if the proceeds were applied to purchase a single-consideration immediate annuity at purchase rates offered by Us at the time such payments begin. Under any option, excess interest may be paid or credited from time to time at Our sole discretion.

AMOUNT OF EACH MONTHLY PAYMENT PER \$1,000 OF PROCEEDS - OPTION C

Period (Years)	Monthly Payment						
1	\$84.47	9	\$10.53	16	\$6.53	23	\$4.99
2	\$42.86	10	\$9.61	17	\$6.23	24	\$4.84
3	\$28.99	11	\$8.86	18	\$5.96	25	\$4.71
4	\$22.06	12	\$8.24	19	\$5.73	26	\$4.59
5	\$17.91	13	\$7.71	20	\$5.51	27	\$4.47
6	\$15.14	14	\$7.26	21	\$5.32	28	\$4.37
7	\$13.16	15	\$6.87	22	\$5.15	29	\$4.27
8	\$11.68					30	\$4.18

AMOUNT OF EACH MONTHLY PAYMENT PER \$1,000 OF PROCEEDS - OPTION D

(Based on the payee's age last birthday on the date the proceeds are settled under the option)													
PERIOD CERTAIN							PERIOD CERTAIN						
Age	10 Years		15 Years		20 Years		Age	10 Years		15 Years		20 Years	
	Male	Female	Male	Female	Male	Female		Male	Female	Male	Female	Male	Female
10*	\$2.85	\$2.79	\$2.84	\$2.79	\$2.84	\$2.79	46	\$3.84	\$3.63	\$3.81	\$3.62	\$3.77	\$3.60
11	2.86	2.80	2.86	2.80	2.85	2.80	47	3.90	3.68	3.87	3.67	3.82	3.64
12	2.87	2.81	2.87	2.81	2.87	2.81	48	3.95	3.73	3.92	3.71	3.87	3.69
13	2.88	2.82	2.88	2.82	2.88	2.82	49	4.02	3.78	3.98	3.77	3.92	3.74
14	2.90	2.83	2.90	2.83	2.89	2.83	50	4.08	3.84	4.04	3.82	3.98	3.78
15	2.91	2.85	2.91	2.85	2.91	2.84	51	4.15	3.90	4.10	3.87	4.03	3.84
16	2.93	2.86	2.92	2.86	2.92	2.86	52	4.22	3.96	4.17	3.93	4.09	3.89
17	2.94	2.87	2.94	2.87	2.94	2.87	53	4.29	4.02	4.23	3.99	4.15	3.94
18	2.96	2.89	2.96	2.89	2.95	2.88	54	4.37	4.09	4.30	4.06	4.21	4.00
19	2.98	2.90	2.97	2.90	2.97	2.90	55	4.45	4.16	4.38	4.12	4.27	4.06
20	2.99	2.92	2.99	2.91	2.99	2.91	56	4.54	4.24	4.46	4.19	4.33	4.12
21	3.01	2.93	3.01	2.93	3.00	2.93	57	4.63	4.32	4.54	4.27	4.39	4.19
22	3.03	2.95	3.03	2.95	3.02	2.94	58	4.73	4.40	4.62	4.34	4.46	4.25
23	3.05	2.96	3.05	2.96	3.04	2.96	59	4.83	4.49	4.70	4.42	4.52	4.32
24	3.07	2.98	3.07	2.98	3.06	2.98	60	4.93	4.58	4.79	4.51	4.59	4.39
25	3.09	3.00	3.09	3.00	3.08	3.00	61	5.05	4.68	4.88	4.59	4.66	4.46
26	3.11	3.02	3.11	3.02	3.10	3.01	62	5.16	4.79	4.98	4.68	4.72	4.53
27	3.13	3.04	3.13	3.04	3.13	3.03	63	5.29	4.90	5.08	4.78	4.79	4.60
28	3.16	3.06	3.15	3.06	3.15	3.05	64	5.42	5.01	5.17	4.88	4.85	4.67
29	3.18	3.08	3.18	3.08	3.17	3.07	65	5.55	5.14	5.27	4.98	4.91	4.75
30	3.21	3.10	3.21	3.10	3.20	3.10	66	5.69	5.26	5.38	5.08	4.97	4.82
31	3.24	3.13	3.23	3.12	3.22	3.12	67	5.84	5.40	5.48	5.19	5.03	4.89
32	3.27	3.15	3.26	3.15	3.25	3.14	68	5.99	5.55	5.58	5.30	5.09	4.95
33	3.30	3.18	3.29	3.17	3.28	3.17	69	6.15	5.70	5.68	5.41	5.14	5.02
34	3.33	3.20	3.32	3.20	3.31	3.19	70	6.31	5.86	5.78	5.53	5.19	5.08
35	3.36	3.23	3.35	3.23	3.34	3.22	71	6.47	6.02	5.88	5.64	5.23	5.14
36	3.39	3.26	3.39	3.25	3.37	3.25	72	6.64	6.20	5.97	5.75	5.27	5.19
37	3.43	3.29	3.42	3.28	3.41	3.28	73	6.81	6.38	6.07	5.86	5.31	5.24
38	3.47	3.32	3.46	3.32	3.44	3.31	74	6.99	6.57	6.15	5.97	5.34	5.29
39	3.51	3.35	3.50	3.35	3.48	3.34	75	7.16	6.76	6.24	6.08	5.37	5.33
40	3.55	3.39	3.54	3.38	3.52	3.37	76	7.34	6.96	6.32	6.17	5.40	5.36
41	3.59	3.42	3.58	3.42	3.55	3.41	77	7.52	7.16	6.39	6.27	5.42	5.39
42	3.64	3.46	3.62	3.45	3.59	3.44	78	7.69	7.36	6.46	6.35	5.44	5.42
43	3.69	3.50	3.67	3.49	3.64	3.48	79	7.86	7.56	6.52	6.43	5.46	5.44
44	3.73	3.54	3.71	3.53	3.68	3.52	80**	8.03	7.76	6.57	6.50	5.47	5.45
45	3.79	3.59	3.76	3.58	3.73	3.56							

*Ages 10 and under

**Ages 80 and over



Amica Life Insurance Company

INDIVIDUAL LIFE INSURANCE
APPLICATION DEADLINE: MONTH 00, 2011

9. In the past 2 years, have you participated in mountain or rock climbing, bungee jumping, sky diving, scuba diving, flying a plane, or racing of powered air, water, or land vehicles?
 YES NO
10. In the past year, have you experienced unintentional weight loss?
 YES NO

NOTE: Please review your answers to these questions to be sure you have answered them fully and truthfully. A misrepresentation on these questions could void your coverage.

Beneficiary Designation Note: All beneficiaries in a class share equally unless otherwise noted.

▶	PRIMARY Beneficiary Full Name	Relationship	
▶	Contingent Beneficiary Full Name	Relationship	%
▶	Contingent Beneficiary Full Name	Relationship	%

3. Acknowledgements and Signature Please read and sign.

1. Do you have any existing life insurance policies or annuity contracts in force?
 YES NO
2. If so, is the insurance applied for intended to replace or change any existing life insurance or annuity contracts in force with an insurance company?
 YES NO

Please supply company name and policy number being replaced if answered "Yes."

Company _____ Policy Number _____

I acknowledge: that I have read this application and all the statements and answers contained herein; and that they are complete and true to the best of my knowledge and belief. I understand that such statements and answers will be used by Amica Life to determine eligibility for insurance; and that no additional information regarding such statements and answers will be considered to have been given to Amica Life unless such information is stated in this application.

I understand: that no policy is effective until this application has been approved; a policy has been issued by Amica Life and accepted by the Owner; and the entire amount of the first modal premium has been received and accepted by Amica Life while the Insured is alive. I also understand that a sales representative does not have authorization to: accept risk; rule on insurability; or make, void, waive or change any conditions or provisions of this application or of any receipt or policy issued by Amica Life.

I acknowledge that I have read and received "How Your Amica Life Application is Processed to Protect Your Rights," required by the Federal Fair Credit Reporting Act and the Medical Information Bureau (MIB). I authorize any: physician; medical professional; hospital, clinic or other medical care institution; the MIB; insurer consumer reporting agency; other insurance company; pharmacy benefits manager; or any other organization, institution or person that has any records or knowledge of me or my health; to provide information to Amica Life Insurance Company, its representative, or any consumer reporting agency acting on Amica Life's behalf. To facilitate rapid submission of such information, I authorize all said sources, except MIB, to give such records or knowledge to any agency employed by Amica Life to collect and transmit such information. I also authorize Amica Mutual Insurance Company to provide personal information to Amica Life Insurance Company to assist Amica Life Insurance Company in obtaining information and reports necessary to process this application.

I understand that a photographic copy or facsimile (or transmission by other electronic means) of this statement shall be as valid as the original. I know that my authorized representative or I have the right to receive a copy of this statement upon request.

INDIVIDUAL LIFE INSURANCE
APPLICATION DEADLINE: MONTH 00, 2011

I agree this authorization is valid for two and one-half (2½) years from the date signed. A consumer report may be obtained; if such a report is obtained, I know that my authorized representative or I have the right to receive a copy of this statement upon request.

I (check one) do do not request to be interviewed if such a consumer report is obtained.

ANY PERSON WHO KNOWINGLY PRESENTS A FALSE OR FRAUDULENT CLAIM FOR PAYMENT OF A LOSS OR BENEFIT, OR KNOWINGLY PRESENTS FALSE INFORMATION IN AN APPLICATION FOR INSURANCE, IS GUILTY OF A CRIME AND MAY BE SUBJECT TO FINES AND CONFINEMENT IN PRISON.

Signed in: _____ on _____
City, State Month, Day, Year

X _____ X _____
Signature of Proposed Insured Signature of Owner and/or Payor
(if different than Proposed Insured)

Policyowner Information (Required ONLY if owner is different than the proposed insured.)

Full Name (First, Middle, Last) _____ Relationship to Proposed Insured _____
Street Address (Include street number and/or apt. #) _____
City, State _____ Zipcode _____ Telephone Number (with area code) _____

4. Payment Options You can find your premium in the personalized chart enclosed in this package.

Payment Frequency

- Annual (One payment equal to 12 monthly payments.)
 Monthly (You must make your first payment by check or credit card. Then, recurring monthly payments must be made by electronic funds transfer from your checking account or by charges to your credit card. Complete Automatic Payment Plan Agreement in section 5 or the Credit Card Authorization enclosed.)

First Payment

Check enclosed (Make check payable to Amica Life.)

Amount \$ _____ Check # _____

Credit Card (Complete the Credit Card Authorization on the enclosed form.)

5. Automatic Payment Plan Agreement

Complete only if you chose the monthly payment frequency in section 4 for which premiums will be paid by electronic funds transfer from your checking account. Do NOT complete if paying premiums by check or credit card.

I request and authorize Amica Life Insurance Company to make monthly withdrawals against the account specified on the attached check or any account named by me, and such bank to process these withdrawals as if I had signed them, for the purpose of collecting premiums under this plan.

Bank Name _____ Bank Account Number _____

Amount Authorized _____

Important: Attach voided personal check (It is used to verify bank account and routing numbers only.)

Name(s) on Account (Please Print) _____

Signature(s) _____ Date _____

Return in enclosed postage-paid envelope with your first payment

If you are paying your premium(s) by credit card, you must complete the Credit Card Authorization enclosed.

INDIVIDUAL LIFE INSURANCE
APPLICATION DEADLINE: MONTH 00, 2011

9. In the past 2 years, have you participated in mountain or rock climbing, bungee jumping, sky diving, scuba diving, flying a plane, or racing of powered air, water, or land vehicles?
 YES NO

10. In the past year, have you experienced unintentional weight loss?
 YES NO

NOTE: Please review your answers to these questions to be sure you have answered them fully and truthfully. A misrepresentation on these questions could void your coverage.

Beneficiary Designation Note: All beneficiaries in a class share equally unless otherwise noted.

▶
PRIMARY Beneficiary Full Name Relationship

▶
Contingent Beneficiary Full Name Relationship %

▶
Contingent Beneficiary Full Name Relationship %

3. Acknowledgements and Signature Please read and sign.

1. Do you have any existing life insurance policies or annuity contracts in force?
 YES NO
2. If so, is the insurance applied for intended to replace or change any existing life insurance or annuity contracts in force with an insurance company?
 YES NO

Please supply company name and policy number being replaced if answered "Yes."

Company _____ Policy Number _____

I acknowledge: that I have read this application and all the statements and answers contained herein; and that they are complete and true to the best of my knowledge and belief. I understand that such statements and answers will be used by Amica Life to determine eligibility for insurance; and that no additional information regarding such statements and answers will be considered to have been given to Amica Life unless such information is stated in this application.

I understand: that no policy is effective until this application has been approved; a policy has been issued by Amica Life and accepted by the Owner; and the entire amount of the first modal premium has been received and accepted by Amica Life while the Insured is alive. I also understand that a sales representative does not have authorization to: accept risk; rule on insurability; or make, void, waive or change any conditions or provisions of this application or of any receipt or policy issued by Amica Life.

I acknowledge that I have read and received "How Your Amica Life Application is Processed to Protect Your Rights," required by the Federal Fair Credit Reporting Act and the Medical Information Bureau (MIB). I authorize any: physician; medical professional; hospital, clinic or other medical care institution; the MIB; insurer consumer reporting agency; other insurance company; pharmacy benefits manager; or any other organization, institution or person that has any records or knowledge of me or my health; to provide information to Amica Life Insurance Company, its representative, or any consumer reporting agency acting on Amica Life's behalf. To facilitate rapid submission of such information, I authorize all said sources, except MIB, to give such records or knowledge to any agency employed by Amica Life to collect and transmit such information. I also authorize Amica Mutual Insurance Company to provide personal information to Amica Life Insurance Company to assist Amica Life Insurance Company in obtaining information and reports necessary to process this application.

I understand that a photographic copy or facsimile (or transmission by other electronic means) of this statement shall be as valid as the original. I know that my authorized representative or I have the right to receive a copy of

INDIVIDUAL LIFE INSURANCE
APPLICATION DEADLINE: MONTH 00, 2011

this statement upon request.

I agree this authorization is valid for two and one-half (2½) years from the date signed. A consumer report may be obtained; if such a report is obtained, I know that my authorized representative or I have the right to receive a copy of this statement upon request.

I (check one) do do not request to be interviewed if such a consumer report is obtained.

ANY PERSON WHO KNOWINGLY PRESENTS A FALSE OR FRAUDULENT CLAIM FOR PAYMENT OF A LOSS OR BENEFIT, OR KNOWINGLY PRESENTS FALSE INFORMATION IN AN APPLICATION FOR INSURANCE, IS GUILTY OF A CRIME AND MAY BE SUBJECT TO FINES AND CONFINEMENT IN PRISON.

Signed in: _____ on _____
City, State Month, Day, Year

X _____ X _____
Signature of Proposed Insured Signature of Owner and/or Payor
(if different than Proposed Insured)

Policyowner Information (Required ONLY if owner is different than the proposed insured.)

Full Name (First, Middle, Last) _____ Relationship to Proposed Insured _____
Street Address (Include street number and/or apt. #) _____
City, State _____ Zipcode _____ Telephone Number (with area code) _____

4. Payment Options You can find your premium in the personalized chart enclosed in this package.

Payment Frequency

- Annual (One payment equal to 12 monthly payments.)
- Monthly (You must make your first payment by check or credit card. Then, recurring monthly payments must be made by electronic funds transfer from your checking account or by charges to your credit card. Complete Automatic Payment Plan Agreement in section 5 or the Credit Card Authorization enclosed.)

First Payment

Check enclosed (Make check payable to Amica Life.)

Amount \$ _____ Check # _____

Credit Card (Complete the Credit Card Authorization on the enclosed form.)

5. Automatic Payment Plan Agreement

Complete only if you chose the monthly payment frequency in section 4 for which premiums will be paid by electronic funds transfer from your checking account. Do NOT complete if paying premiums by check or credit card.

I request and authorize Amica Life Insurance Company to make monthly withdrawals against the account specified on the attached check or any account named by me, and such bank to process these withdrawals as if I had signed them, for the purpose of collecting premiums under this plan.

Bank Name _____ Bank Account Number _____

Amount Authorized _____

Important: Attach voided personal check (It is used to verify bank account and routing numbers only.)

Name(s) on Account (Please Print) _____

Signature(s) _____ Date _____

Return in enclosed postage-paid envelope with your first payment

If you are paying your premium(s) by credit card, you must complete the Credit Card Authorization enclosed.

SERFF Tracking Number: AMMB-126852286 State: Arkansas
 Filing Company: Amica Life Insurance Company State Tracking Number: 48946
 Company Tracking Number: SIMPLIFIED LIFE POLICY
 TOI: L041 Individual Life - Term Sub-TOI: L041.213 Specified Age or Duration - Fixed/Indeterminate Premium - Single Life
 Product Name: (10/15/20) Year Amica Simplified Life Policy
 Project Name/Number: Simplified Life/ SILT01-01

Supporting Document Schedules

	Item Status:	Status Date:
Satisfied - Item: Flesch Certification		
Comments: Attached is the revised Certificate of Compliance.		
Attachment: AR - Cert of Compliance - SILT.pdf		

	Item Status:	Status Date:
Bypassed - Item: Application		
Bypass Reason: The application that we will be using with this policy is new. It is attached in the Form Schedule section.		
Comments:		

	Item Status:	Status Date:
Satisfied - Item: Life & Annuity - Actuarial Memo		
Comments:		
Attachment: Actuarial Memorandum - SILT Non Compact version.pdf		

	Item Status:	Status Date:
Satisfied - Item: Statement of Variability		
Comments:		
Attachment: Statement of Variability (SILT01-01).pdf		

STATE OF ARKANSAS
CERTIFICATION OF COMPLIANCE

Form Number (s): SILT01-01
 L100-1 AR
 L101-1 AR

As an officer of Amica Life Insurance Company, I hereby certify that:

1. The above-referenced policy form complies in all respects with the provisions, requirements and restrictions of Regulation 19 – Section 10(B). To the best of my knowledge, information and belief, it also complies with all applicable requirements of the Insurance Department.

2. We do comply with Regulation 49. The attached Life and Health Insurance Guaranty Association form is sent out with every policy issue package.

3. In order to comply with ACA 23-80-206, a copy of a Flesch Certificate is attached.

4. Form No. SN01-01 AR (previously approved March 8, 2004) is included with every policy issue package in order to comply with ACA23-79-138 (copy attached to filing).



James R. Ruegg
Senior Assistant Vice President

June 9, 2011

**STATEMENT OF VARIABILITY
FOR FORM SILT01-01**

<u>FIELD</u>	<u>EXPLANATION OF VARIABILITY</u>
<i>ADDRESSES ON COVER JACKET AND ON SCHEDULE OF BENEFITS & PREMIUMS PAGE</i>	WILL CHANGE AS ADDRESSES CHANGE
<i>COVER JACKET (OFFICER SIGNATURES AND TITLES)</i>	WILL CHANGE AS OFFICERS/TITLES CHANGE
<i>ANNUAL PREMIUM</i>	A DOLLAR AMOUNT
<i>POLICY YEARS PAYABLE</i>	[10] OR [15] OR [20]
<i>TOTAL PREMIUM</i>	EITHER [ANNUAL] or [MONTHLY]
<i>INSURED</i>	A NAME
<i>OWNER</i>	A NAME
<i>DATE OF ISSUE</i>	A DATE
<i>FACE AMOUNT</i>	EITHER [50,000] OR [100,000] OR [150,000] OR [200,000]
<i>COVERAGE EXPIRY DATE</i>	A DATE - POLICY ANNIVERSARY IMMEDIATELY FOLLOWING YEAR [10] OR [15] OR [20]
<i>POLICY NUMBER</i>	A NUMBER
<i>SEX AND AGE OF INSURED</i>	EITHER [MALE] or [FEMALE] and AN AGE BETWEEN 25 - 55
<i>POLICY CLASS</i>	EITHER [PREFERRED] or [STANDARD]
<i>CONVERSION EXPIRY DATE</i>	A DATE (POLICY ANNIVERSARY DATE FOLLOWING POLICY YEAR [8] OR [12] OR [16] OR AGE 65, WHICHEVER IS EARLIER.
<i>AMICA LIFE TELEPHONE NUMBER</i>	WILL CHANGE AS TELEPHONE NUMBER CHANGES
<i>STATE INSURANCE DEPARTMENT TELEPHONE NUMBER</i>	WILL CHANGE AS TELEPHONE NUMBER CHANGES

<i>SERFF Tracking Number:</i>	AMMB-126852286	<i>State:</i>	Arkansas
<i>Filing Company:</i>	Amica Life Insurance Company	<i>State Tracking Number:</i>	48946
<i>Company Tracking Number:</i>	SIMPLIFIED LIFE POLICY		
<i>TOI:</i>	L04I Individual Life - Term	<i>Sub-TOI:</i>	L04I.213 Specified Age or Duration - Fixed/Indeterminate Premium - Single Life
<i>Product Name:</i>	(10/15/20) Year Amica Simplified Life Policy		
<i>Project Name/Number:</i>	Simplified Life/ SILT01-01		

Superseded Schedule Items

Please note that all items on the following pages are items, which have been replaced by a newer version. The newest version is located with the appropriate schedule on previous pages. These items are in date order with most recent first.

Creation Date:	Schedule	Schedule Item Name	Replacement Creation Date	Attached Document(s)
10/08/2010	Supporting	Flesch Certification Document	06/09/2011	AR - Contact Notice.pdf (Superseded) AR - Guaranty Association Form.pdf (Superseded) AR - Certification of Compliance.pdf (Superseded) Flesch Cert - Policy (Non ICC version).pdf (Superseded) AR Flesch Cert - SIILT App (Non ICC).pdf (Superseded)

AMICA LIFE INSURANCE COMPANY

Thank you for entrusting Amica Life Insurance Company with your insurance needs!

If you ever need to contact us, please write to us at:

*Amica Life Insurance Company
Life Customer Services
100 Amica Way
Lincoln, RI 02865*

We may be reached by telephone, toll-free, at (800) 234-5433, ext. 3400.

*You may also communicate with us by visiting our Web site at www.amica.com/life.
Once there, please point your cursor to the "Contact Us" menu selection near the top
of the main screen, and click on the "How Are We Doing?" link provided.*

*If we at Amica Life Insurance Company fail to provide you with reasonable and
adequate services, you should feel free to contact us:*

*Arkansas Department of Insurance
1200 West 3rd Street
Little Rock, AR 72201-1904
800-852-5494
or
501-371-2640*

Again, thank you! We look forward to serving you now and in the future.

AMICA LIFE INSURANCE COMPANY

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

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

DISCLAIMER

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

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

Insurance companies or their agents are required by law to provide you with this notice.

**The Arkansas Life and Disability
Insurance Guaranty Association
1023 West Capitol, Suite 2
Little Rock, AR 72201**

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

(Continued on next page)

The state law that provides for this safety-net coverage is called the Arkansas Life and Health Insurance Guaranty Association Act ("Act").

Below is a brief summary of the Act's coverages, exclusions and limits. This summary does not cover all provisions of the Act; nor does it in any way change anyone's rights or obligations under the Act or the rights or obligations of the Guaranty Association.

COVERAGE

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

EXCLUSIONS FROM COVERAGE

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

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

The Guaranty Association also does **NOT** provide coverage for:

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

(Continued on next page)

LIMITS ON AMOUNT OF COVERAGE

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

STATE OF ARKANSAS
CERTIFICATION OF COMPLIANCE

Form Number (s):

As an officer of Amica Life Insurance Company, I hereby certify that the above-referenced policy form complies in all respects with the provisions, requirements and restrictions of Regulation 19 – Section 10(B). To the best of my knowledge, information and belief, it also complies with all applicable requirements of the Insurance Department

James R. Ruegg
Senior Assistant Vice President

Date

AMICA LIFE INSURANCE COMPANY

This is to certify that each form listed below is in compliance with the insurance policy form language simplification rules and readability standards of your state in accordance with the following test procedures:

A. Option Selected

1. The form(s) submitted with this filing and any related forms have been scored as one unit for the Flesch reading ease test. The combined score is _____.
2. Each form has been scored separately for the Flesch reading ease test. Scores for each form submitted with this filing are:

<u>Form Number</u>	<u>Title</u>	<u>Sentences</u>	<u>Words</u>	<u>Syllables</u>	<u>Flesch Score</u>
SILT01-01	(10/15/20) Year Simplified Life Policy	117	1,825	2,804	60.45

B. Test Option Selected

1. The test was applied to each entire form.
2. The test was applied on a sample basis since the form(s) contain(s) more than 10,000 words. A copy of the form(s) indicating the word samples tested is enclosed.

C. Standards for Certification

A checked line indicates the standard has been achieved:

1. The form text achieves a minimum score of 40 on the Flesch reading ease test in accordance with the option selected in Section A above.
2. Each form is printed in not less than 10-point type, 1-point leaded. (This does not apply to specification pages, schedules and tables.)
3. The layout and spacing of each form separate the paragraphs from each other and from the border of the paper.
4. The section titles are captioned in boldface type or otherwise stand out significantly from the text.
5. Unnecessarily long, complicated or obscure words, sentences, paragraphs or constructions are not used in any form.
6. The style, arrangement and overall appearance of each form give no undue prominence to any portion of any form submitted with this filing or to any related form.
7. A table of contents or index of the principal sections is included in the policy. (This applies only to a policy having more than 3,000 words or consisting of more than 3 pages.)



James R. Ruegg, FLMI/M, CLU, AIRC, CCP
Sr. Assistant Vice President
Name and Title of Company Officer

June 1, 2011

AMICA LIFE INSURANCE COMPANY

This is to certify that each form listed below is in compliance with the insurance policy form language simplification rules and readability standards of your state in accordance with the following test procedures:

A. Option Selected

1. The form(s) submitted with this filing and any related forms have been scored as one unit for the Flesch reading ease test. The combined score is _____.
2. Each form has been scored separately for the Flesch reading ease test. Scores for each form submitted with this filing are:

<u>Form Number</u>	<u>Title</u>	<u>Sentences</u>	<u>Words</u>	<u>Syllables</u>	<u>Flesch Score</u>
L100-1 AR	Simplified Life Policy Application	26	395	658	50.49
L101-1 AR	Simplified Life Policy Application	26	395	658	50.49

B. Test Option Selected

1. The test was applied to each entire form.
2. The test was applied on a sample basis since the form(s) contain(s) more than 10,000 words. A copy of the form(s) indicating the word samples tested is enclosed.

C. Standards for Certification

A checked line indicates the standard has been achieved:

1. The form text achieves a minimum score of 40 on the Flesch reading ease test in accordance with the option selected in Section A above.
2. Each form is printed in not less than 10-point type, 1-point leaded. (This does not apply to specification pages, schedules and tables.)
3. The layout and spacing of each form separate the paragraphs from each other and from the border of the paper.
4. The section titles are captioned in boldface type or otherwise stand out significantly from the text.
5. Unnecessarily long, complicated or obscure words, sentences, paragraphs or constructions are not used in any form.
6. The style, arrangement and overall appearance of each form give no undue prominence to any portion of any form submitted with this filing or to any related form.
7. A table of contents or index of the principal sections is included in the policy. (This applies only to a policy having more than 3,000 words or consisting of more than 3 pages.)



James R. Ruegg, FLMI/M, CLU, AIRC, CCP
Sr. Assistant Vice President
Name and Title of Company Officer

June 1, 2011