

<i>SERFF Tracking Number:</i>	<i>METF-127318429</i>	<i>State:</i>	<i>Arkansas</i>
<i>Filing Company:</i>	<i>Texas Life Insurance Company</i>	<i>State Tracking Number:</i>	<i>49353</i>
<i>Company Tracking Number:</i>	<i>11M009</i>		
<i>TOI:</i>	<i>L071 Individual Life - Whole</i>	<i>Sub-TOI:</i>	<i>L071.101 Fixed/Indeterminate Premium - Single Life</i>
<i>Product Name:</i>	<i>Application</i>		
<i>Project Name/Number:</i>	<i>/11M009</i>		

Filing at a Glance

Company: Texas Life Insurance Company

Product Name: Application

TOI: L071 Individual Life - Whole

Sub-TOI: L071.101 Fixed/Indeterminate
Premium - Single Life

Filing Type: Form

SERFF Tr Num: METF-127318429 State: Arkansas

SERFF Status: Closed-Approved-
Closed State Tr Num: 49353

Co Tr Num: 11M009

State Status: Approved-Closed

Author: Jan Spoede

Date Submitted: 07/20/2011

Reviewer(s): Linda Bird

Disposition Date: 07/22/2011

Disposition Status: Approved-
Closed

Implementation Date Requested: On Approval

State Filing Description:

Implementation Date:

General Information

Project Name:

Project Number: 11M009

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: 06/14/2011

Domicile Status Comments:

Market Type: Individual

Individual Market Type:

Filing Status Changed: 07/22/2011

State Status Changed: 07/22/2011

Created By: Jan Spoede

Corresponding Filing Tracking Number:

Deemer Date:

Submitted By: Jan Spoede

Filing Description:

11M009, Application

11M010, Supplement to Applicaton

We made revision to the application and supplement to the application. They were previously approved on March 24, 2011 under SERF Filing # METF-127047555.

The revisions to the application are:

SERFF Tracking Number: METF-127318429 State: Arkansas
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 Product Name: Application
 Project Name/Number: /11M009

we changed the word "past" to "last" in the to bacco question.

we changed the lead-in question to Tier 2

The revision to the supplement to application is:

we changed question 1. b.

Company and Contact

Filing Contact Information

Jan Spoede, Senior Associate, Product Development
 P.O. Box 830 Waco, TX 76703
 jspoede@texaslife.com
 800-283-9233 [Phone] 6371 [Ext]
 254-745-6389 [FAX]

Filing Company Information

Texas Life Insurance Company P.O. Box 830 Waco, TX 76703
 (800) 283-9233 ext. [Phone]
 CoCode: 69396
 Group Code:
 Group Name:
 FEIN Number: 74-0940890
 State of Domicile: Texas
 Company Type: Life
 State ID Number:

Filing Fees

Fee Required? Yes
 Fee Amount: \$100.00
 Retaliatory? No
 Fee Explanation: AR requires a fee of \$50.00 per form.
 Per Company: No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Texas Life Insurance Company	\$100.00	07/20/2011	49937925

SERFF Tracking Number: METF-127318429 State: Arkansas
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Product Name: Application
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Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Linda Bird	07/22/2011	07/22/2011

SERFF Tracking Number: *METF-127318429* *State:* *Arkansas*
Filing Company: *Texas Life Insurance Company* *State Tracking Number:* *49353*
Company Tracking Number: *11M009*
TOI: *L071 Individual Life - Whole* *Sub-TOI:* *L071.101 Fixed/Indeterminate Premium - Single*
Product Name: *Application* *Life*
Project Name/Number: */11M009*

Disposition

Disposition Date: 07/22/2011

Implementation Date:

Status: Approved-Closed

Comment:

Rate data does NOT apply to filing.

SERFF Tracking Number: METF-127318429 State: Arkansas
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 Product Name: Application
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Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification		Yes
Supporting Document	Application		Yes
Supporting Document	Life & Annuity - Actuarial Memo		No
Supporting Document	Red-lined Forms		Yes
Form	Application		Yes
Form	Supplement to Application		Yes

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 Product Name: Application
 Project Name/Number: /11M009

Form Schedule

Lead Form Number: 11M009

Schedule Item Status	Form Number	Form Type Form Name	Action	Action Specific Data	Readability	Attachment
	11M009	Application/ Application Enrollment Form	Initial		56.600	11M009 6-16-11.pdf
	11M010	Application/ Supplement to Enrollment Application Form	Initial		56.600	11M010 Suppl to App 6-16-11.pdf

1st Deduction Date: _____ Employer: _____ Policy Number: _____

Proposed Insured Personal Information

Last Name	<input type="text"/>	SSN	<input type="text"/>
First Name	<input type="text"/>	Birth Date	<input type="text"/> Age ⁽¹⁾ <input type="text"/>
MI	<input type="text"/>	Sex	<input type="text"/>
		Hire Date	<input type="text"/>

Tier 1 **Within the last 12 months have you used tobacco in any form?** Yes No
Are you at work on a full-time basis, performing your usual duties? Yes No

Street/PO Box City State Zip

Phone: Day Evening Email

Beneficiary Name: Relationship:

Will proposed coverage replace or change any existing insurance or annuity policy? Yes No
 (if "Yes" identify and complete replacement form.) Company Policy Number

Do you have existing insurance or annuities (including coverage with Texas Life)? Yes No If "Yes" complete the Existing Insurance Form *even if replacement is not contemplated.*

Coverage Information

Face Amount ⁽²⁾	<input type="text"/>	Plan of Insurance: _____
Premium	<input type="text"/>	Select Riders to be Added: <input type="checkbox"/> Family Term Rider <input type="checkbox"/> Accidental Death ⁽³⁾ <input type="checkbox"/> Waiver Premium ⁽³⁾ [<input type="checkbox"/> Rider] [<input type="checkbox"/> Rider]
Rider Premium	<input type="text"/>	Payroll is per: <input type="checkbox"/> Weekly <input type="checkbox"/> Bi-Weekly <input type="checkbox"/> Semi-Monthly <input type="checkbox"/> Monthly <input type="checkbox"/> Skip _____
Total Premium	<input type="text"/>	<input type="checkbox"/> I elect the Automatic Contract Loan provision to pay a premium overdue 30 days or more, if my policy has sufficient cash value.

Tier 2 Questions

(If answered "Yes" no coverage is offered, except as available under Tier 1 questions.)

During the last 24 months have you sought treatment or been treated for, been prescribed medication for, or been diagnosed by a member of the medical profession as having, any of the following:	Yes No
a. Cancer (excluding non-melanoma skin cancer)?	<input type="checkbox"/> <input type="checkbox"/>
b. Heart attack, coronary artery or valve disease, heart failure or cardiomyopathy?	<input type="checkbox"/> <input type="checkbox"/>
c. Alcohol or drug abuse?	<input type="checkbox"/> <input type="checkbox"/>
d. Diabetes for which the recommended treatment is insulin?	<input type="checkbox"/> <input type="checkbox"/>
e. Chronic obstructive pulmonary disease (COPD), emphysema or other chronic lung disease (excluding asthma)?	<input type="checkbox"/> <input type="checkbox"/>
f. Stroke or transient ischemic attack (TIA)?	<input type="checkbox"/> <input type="checkbox"/>
g. Chronic kidney disease or kidney failure (excluding kidney stones)?	<input type="checkbox"/> <input type="checkbox"/>
h. Parkinson's disease or paralysis?	<input type="checkbox"/> <input type="checkbox"/>
i. Cirrhosis of the liver or hepatitis (excluding Hepatitis A)?	<input type="checkbox"/> <input type="checkbox"/>
j. Acquired Immune Deficiency Syndrome or tested positive for the Human Immunodeficiency Virus (HIV) or its antibodies?	<input type="checkbox"/> <input type="checkbox"/>

Secondary Addressee — Available and valid only for residents of Florida

Under state law, I understand that I have the right to designate a secondary addressee or third party to receive notification of a possible lapse of my policy if I fail to pay premiums. I hereby designate:

Name Relationship Phone
 Street/PO Box City State Zip

(1) Age on Issue Date (2) or Face Amount purchased by premium shown, if less (3) Proposed insured (employee) issue ages 17-59

Additional Statements

For residents of [AL, DC, IN, and OR]: I received a summary description of the accelerated death benefit and Important Notice regarding Accelerated Death Benefit.

For residents of Arkansas: Any person who knowingly and with intent to defraud any insurance company or other person files an application containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime.

For residents of Washington, DC: WARNING: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment, and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.

For residents of Florida: Any person who knowingly and with intent to injure, defraud or deceive any insurer files a statement of claim or an application containing any false, incomplete or misleading information is guilty of a felony of the third degree.

REPRESENTATIONS: I represent to the best of my knowledge and belief that all statements and answers in this application are complete, true and correctly recorded, and are made as a consideration for the insurance applied for. I understand that Texas Life Insurance Company will rely on my statements and answers as being true and complete in deciding whether to issue insurance on the proposed insured. Insurance is effective under the policy only when it is delivered to the owner, if the full first premium is paid in cash and all of the statements in this application remain correct and complete.

Proposed Insured
(Owner) Signature _____ Date _____ City _____ State _____

Agent Only: To the best of my knowledge the insurance applied for is is not to replace existing insurance or annuity.

I have delivered to the Proposed Insured the applicable forms and information described in Additional Statements above.

Enroller
Signature _____ Print
Enroller Name _____ Agent # _____

Florida Sales Only: Agent's Florida License Number _____

Interim Insurance

Interim insurance will be in force on the application date if these conditions are met: (1) the insurance is purchased through payroll deduction or through your membership in a union or association; (2) you sign a Salary Deduction Authorization or Bank Draft Authorization Form (union and association members only); and, (3) you are insurable at standard rates under Our rules and usual practice. Interim insurance remains in effect until the earlier of: (a) the Policy Date; (b) the date We decline the application; (c) the date We notify you that you are ineligible for interim insurance; or, (d) the 180th day after the application date.

Supplement to Application from (Employee): _____
 Employee Social Security: _____ Application Date: _____

1. Within the past five years, have you: a. Consulted a physician, been observed at a hospital or clinic, or been advised to have a surgical operation? b. Had an X-ray, EKG, lab test, blood test, or any other medical test or study, except those related to the Human Immunodeficiency Virus (AIDS virus)? c. Used heroin, cocaine, marijuana, PCP, or any other narcotic, hallucinogenic, sedative or legally controlled substance, except as prescribed by a physician? d. Been diagnosed or treated by a member of the medical profession as having AIDS (Acquired Immune Deficiency Syndrome) or the HIV (Human Immunodeficiency Virus) infection?	Yes	No
	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/>	<input type="checkbox"/>
2. Within the past ten years, have you been diagnosed with or been treated for: a. Alcohol or drug abuse, or disorder of the stomach, liver, intestines, or kidneys? b. Cancer, tumor, diabetes, or disorder of the blood? c. Asthma, lung disease, seizure, depression, or mental, psychiatric, or neurologic disorder? d. Heart or circulatory disease or abnormality, chest pain, shortness of breath, murmur, stroke, or high blood pressure?	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/>	<input type="checkbox"/>
3. Are you taking any prescribed medication at regular intervals? If "Yes", indicate name of medication in Details below.	<input type="checkbox"/>	<input type="checkbox"/>

4. What is your height, weight, and birth state?	Hgt. Wgt.	Birth State
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5. Your personal physician (if none, enter "None")

Physician Name: _____

Address: _____ City: _____ State: _____

6. Details, including date, diagnosis, type of treatment, and current condition		Name, address and phone # of physician(s)
Ques No.	Details	

REPRESENTATIONS: I represent to the best of my knowledge and belief that all statements and answers in this application are complete, true and correctly recorded, and are made as a consideration for the insurance applied for. I understand that Texas Life Insurance Company will rely on my statements and answers as being true and complete in deciding whether to issue insurance on the proposed insured. Insurance is effective under the policy only when it is delivered to the owner, if the full first premium is paid in cash and all of the statements in this application remain correct and complete.

X _____
 Proposed Insured (Owner) Signature

X _____
 Enroller/Agent Signature Print Enroller/Agent Name Agt No. Date City State

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<i>Product Name:</i>	<i>Application</i>		
<i>Project Name/Number:</i>	<i>/11M009</i>		

Supporting Document Schedules

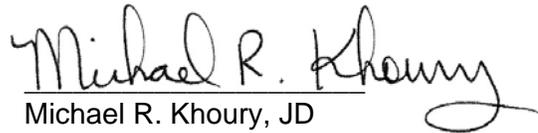
	Item Status:	Status Date:
<p>Satisfied - Item: Flesch Certification</p> <p>Comments: Regulation 34 does not apply.</p> <p>Attachments: WLSTO-NI-11 & apps_Read_Cert.pdf AR Cert of Bull 11-83 for apps.pdf AR Cert of Bull 11-83.pdf</p>		
<p>Satisfied - Item: Application</p> <p>Comments: This is a filing for a revision to an application</p>		
<p>Bypassed - Item: Life & Annuity - Acturial Memo</p> <p>Bypass Reason: N/A only an application filing.</p> <p>Comments:</p>		
<p>Satisfied - Item: Red-lined Forms</p> <p>Comments:</p> <p>Attachments: 11M010 Suppl to App 6-16-11 RED LINED.pdf 11M009 6-16-11 Red-Lined.pdf</p>		

TEXASLIFE

INSURANCE COMPANY

CERTIFICATION OF READABILITY
FORM: WLSTO-NI-11, 11M009 & 11M010

This is to certify that Texas Life Insurance Company Form WLSTO-NI-11, 11M009 & 11M010 has achieved a Flesch Reading Ease Score of 56.60.



Michael R. Khoury, JD
Director
Compliance

Texas Life Insurance Company
Waco, Texas

Date: 6 July 2011



CERTIFICATION

The undersigned, an officer of Texas Life Insurance Company, does hereby certify that he has personally reviewed the guidelines of Arkansas Bulletin Number 11-83, and does further certify that form 11M009 and 11M010 do comply with the guidelines of such Bulletin.

A handwritten signature in black ink that reads "Michael Khoury". The signature is written in a cursive style and is positioned above a horizontal line.

Michael Khoury, JD
Director
Product Development, Claims and Records

Date: 12 July 2011



CERTIFICATION

The undersigned, an officer of Texas Life Insurance Company, does hereby certify that he has personally reviewed the guidelines of Arkansas Bulletin Number 11-83, and does further certify that form WLSTO-NI-11 does comply with the guidelines of such Bulletin.

A handwritten signature in black ink that reads "Michael Khoury". The signature is written in a cursive style and is positioned above a horizontal line.

Michael Khoury, JD
Director
Product Development, Claims and Records

Date: 21 March 2011

Supplement to Application from (Employee): _____
 Employee Social Security: _____ Application Date: _____

<p>1. Within the past five years, have you:</p> <p>a. Consulted a physician, been observed at a hospital or clinic, or been advised to have a surgical operation?</p> <p>b. Had an X-ray, EKG, lab test, blood test, or any other medical test or study, except those related to the Human Immunodeficiency Virus (AIDS virus)?</p> <p>c. Used heroin, cocaine, marijuana, PCP, or any other narcotic, hallucinogenic, sedative or legally controlled substance, except as prescribed by a physician?</p> <p>d. Been diagnosed or treated by a member of the medical profession as having AIDS (Acquired Immune Deficiency Syndrome) or the HIV (Human Immunodeficiency Virus) infection?</p>	Yes	No
	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/>	<input type="checkbox"/>
<p>2. Within the past ten years, have you been diagnosed with or been treated for:</p> <p>a. Alcohol or drug abuse, or disorder of the stomach, liver, intestines, or kidneys?</p> <p>b. Cancer, tumor, diabetes, or disorder of the blood?</p> <p>c. Asthma, lung disease, seizure, depression, or mental, psychiatric, or neurologic disorder?</p> <p>d. Heart or circulatory disease or abnormality, chest pain, shortness of breath, murmur, stroke, or high blood pressure?</p>	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/>	<input type="checkbox"/>
<p>3. Are you taking any prescribed medication at regular intervals? If "Yes", indicate name of medication in Details below.</p>	<input type="checkbox"/>	<input type="checkbox"/>

4. What is your height, weight, and birth state?	Hgt. Wgt.	Birth State
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5. Your personal physician (if none, enter "None")

Physician Name: _____

Address: _____ City: _____ State: _____

6. Details, including date, diagnosis, type of treatment, and current condition		Name, address and phone # of physician(s)
Ques No.	Details	

REPRESENTATIONS: I represent to the best of my knowledge and belief that all statements and answers in this application are complete, true and correctly recorded, and are made as a consideration for the insurance applied for. I understand that Texas Life Insurance Company will rely on my statements and answers as being true and complete in deciding whether to issue insurance on the proposed insured. Insurance is effective under the policy only when it is delivered to the owner, if the full first premium is paid in cash and all of the statements in this application remain correct and complete.

X _____
 Proposed Insured (Owner) Signature

X _____
 Enroller/Agent Signature Print Enroller/Agent Name Agt No. Date City State

1st Deduction Date: _____ Employer: _____ Policy Number: _____

Proposed Insured Personal Information

Last Name	<input type="text"/>	SSN	<input type="text"/>
First Name	<input type="text"/>	Birth Date	<input type="text"/> Age ⁽¹⁾ <input type="text"/>
MI	<input type="text"/>	Sex	<input type="text"/>
		Hire Date	<input type="text"/>

Tier 1 **Within the last 12 months have you used tobacco in any form?** Yes No
Are you at work on a full-time basis, performing your usual duties? Yes No

Street/PO Box City State Zip

Phone: Day Evening Email

Beneficiary Name: Relationship:

Will proposed coverage replace or change any existing insurance or annuity policy? Yes No
 (if "Yes" identify and complete replacement form.) Company Policy Number

Do you have existing insurance or annuities (including coverage with Texas Life)? Yes No If "Yes" complete the Existing Insurance Form *even if replacement is not contemplated.*

Coverage Information

Face Amount ⁽²⁾	<input type="text"/>	Plan of Insurance: _____
Premium	<input type="text"/>	Select Riders to be Added: <input type="checkbox"/> Family Term Rider <input type="checkbox"/> Accidental Death ⁽³⁾ <input type="checkbox"/> Waiver Premium ⁽³⁾ [<input type="checkbox"/> Rider] [<input type="checkbox"/> Rider]
Rider Premium	<input type="text"/>	Payroll is per: <input type="checkbox"/> Weekly <input type="checkbox"/> Bi-Weekly <input type="checkbox"/> Semi-Monthly <input type="checkbox"/> Monthly <input type="checkbox"/> Skip _____
Total Premium	<input type="text"/>	<input type="checkbox"/> I elect the Automatic Contract Loan provision to pay a premium overdue 30 days or more, if my policy has sufficient cash value.

Tier 2 Questions

(If answered "Yes" no coverage is offered, except as available under Tier 1 questions.)

<u>During the last 24 months have you sought treatment or been treated for, been prescribed medication for, or been diagnosed by a member of the medical profession as having, any of the following:</u>		Yes	No
a. Cancer (excluding non-melanoma skin cancer)?	f. Stroke or transient ischemic attack (TIA)?	<input type="checkbox"/>	<input type="checkbox"/>
b. Heart attack, coronary artery or valve disease, heart failure or cardiomyopathy?	g. Chronic kidney disease or kidney failure (excluding kidney stones)?		
c. Alcohol or drug abuse?	h. Parkinson's disease or paralysis?		
d. Diabetes for which the recommended treatment is insulin?	i. Cirrhosis of the liver or hepatitis (excluding Hepatitis A)?		
e. Chronic obstructive pulmonary disease (COPD), emphysema or other chronic lung disease (excluding asthma)?	j. Acquired Immune Deficiency Syndrome or tested positive for the Human Immunodeficiency Virus (HIV) or its antibodies?		

Secondary Addressee — Available and valid only for residents of Florida

Under state law, I understand that I have the right to designate a secondary addressee or third party to receive notification of a possible lapse of my policy if I fail to pay premiums. I hereby designate:

Name Relationship Phone
 Street/PO Box City State Zip

(1) Age on Issue Date (2) or Face Amount purchased by premium shown, if less (3) Proposed insured (employee) issue ages 17-59

Additional Statements

For residents of [AL, DC, IN, and OR]: I received a summary description of the accelerated death benefit and Important Notice regarding Accelerated Death Benefit.

For residents of Arkansas: Any person who knowingly and with intent to defraud any insurance company or other person files an application containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime.

For residents of Washington, DC: WARNING: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment, and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.

For residents of Florida: Any person who knowingly and with intent to injure, defraud or deceive any insurer files a statement of claim or an application containing any false, incomplete or misleading information is guilty of a felony of the third degree.

REPRESENTATIONS: I represent to the best of my knowledge and belief that all statements and answers in this application are complete, true and correctly recorded, and are made as a consideration for the insurance applied for. I understand that Texas Life Insurance Company will rely on my statements and answers as being true and complete in deciding whether to issue insurance on the proposed insured. Insurance is effective under the policy only when it is delivered to the owner, if the full first premium is paid in cash and all of the statements in this application remain correct and complete.

Proposed Insured (Owner) Signature _____ Date _____ City _____ State _____

Agent Only: To the best of my knowledge the insurance applied for is is not to replace existing insurance or annuity. I have delivered to the Proposed Insured the applicable forms and information described in Additional Statements above.

Enroller Signature _____ Print Enroller Name _____ Agent # _____

Florida Sales Only: Agent's Florida License Number _____

Interim Insurance

Interim insurance will be in force on the application date if these conditions are met: (1) the insurance is purchased through payroll deduction or through your membership in a union or association; (2) you sign a Salary Deduction Authorization or Bank Draft Authorization Form (union and association members only); and, (3) you are insurable at standard rates under Our rules and usual practice. Interim insurance remains in effect until the earlier of: (a) the Policy Date; (b) the date We decline the application; (c) the date We notify you that you are ineligible for interim insurance; or, (d) the 180th day after the application date.