

SERFF Tracking Number: ONLI-127243430 State: Arkansas  
Filing Company: Ozark National Life Insurance Company State Tracking Number: 49176  
Company Tracking Number:  
TOI: L04I Individual Life - Term Sub-TOI: L04I.213 Specified Age or Duration -  
Fixed/Indeterminate Premium - Single Life  
Product Name: 697  
Project Name/Number: /

## Filing at a Glance

Company: Ozark National Life Insurance Company

Product Name: 697

SERFF Tr Num: ONLI-127243430 State: Arkansas

TOI: L04I Individual Life - Term

SERFF Status: Closed-Approved-  
Closed State Tr Num: 49176

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

Co Tr Num:

State Status: Approved-Closed

Filing Type: Form

Author: Jodi Coen

Reviewer(s): Linda Bird

Date Submitted: 06/29/2011

Disposition Date: 07/05/2011

Disposition Status: Approved-  
Closed

Implementation Date Requested: On Approval

Implementation Date:

State Filing Description:

## General Information

Project Name:

Status of Filing in Domicile: Pending

Project Number:

Date Approved in Domicile:

Requested Filing Mode: Review & Approval

Domicile Status Comments:

Explanation for Combination/Other:

Market Type: Individual

Submission Type: New Submission

Individual Market Type:

Overall Rate Impact:

Filing Status Changed: 07/05/2011

State Status Changed: 07/05/2011

Deemer Date:

Created By: Jodi Coen

Submitted By: Jodi Coen

Corresponding Filing Tracking Number:

Filing Description:

This rider form is a portfolio of term products. The product types currently available are:

§ 10 Year Level Premium Term (premiums level for 10 years followed by annually increasing premiums)

§ 20 Year Level Premium Term (premiums level for 20 years or until age 80, whichever occurs first, followed by annually increasing premiums)

The scheduled premiums are level for the specified duration and then increase annually thereafter. Gross premiums are

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fully guaranteed for all durations.

The product will be sold to males and females. The range of issue ages is:

10 Year Level Premium Term 15-69

20 Year Level Premium Term 15-75

The premiums are fully guaranteed. Premiums vary by issue age, duration, gender, underwriting risk class and product. There is no rider/policy fee. This product is nonparticipating.

There is a conversion privilege allowing the insured to switch to any form of whole life or endowment policy then offered by the company. The amount converted is subject to a) a maximum of the amount in force on the term rider at time of conversion and b) the minimum policy requirement of the company at the time of conversion.

A table of premium rates per \$1,000 of insurance is included as Appendix A. Cash Values are calculated as Minimum according to the Standard Nonforfeiture Law. For all issue ages, durations, underwriting classes and products Minimum values are less than \$25 per \$1,000 of insurance and thus exempt from providing cash values.

## Company and Contact

### Filing Contact Information

Jodi Coen, Paralegal

500 E 9th St.

Kansas City, MO 64106-2627

jodi.coen@ozark-national.com

816-842-6300 [Phone] 222 [Ext]

816-842-7482 [FAX]

### Filing Company Information

Ozark National Life Insurance Company

500 E 9th St

Kansas City, MO 64106-2627

(816) 842-6300 ext. [Phone]

CoCode: 67393

Group Code:

Group Name:

FEIN Number: 43-0812448

State of Domicile: Missouri

Company Type: life insurer

State ID Number:

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## Filing Fees

Fee Required? Yes

Fee Amount: \$50.00

Retaliatory? No

Fee Explanation: 697 SERFF FEE

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Per Company: No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Ozark National Life Insurance Company	\$50.00	06/29/2011	49246397

SERFF Tracking Number: ONLI-127243430

State: Arkansas

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Fixed/Indeterminate Premium - Single Life

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## Correspondence Summary

### Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Linda Bird	07/05/2011	07/05/2011

SERFF Tracking Number: ONLI-127243430

State: Arkansas

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Fixed/Indeterminate Premium - Single Life

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## Disposition

Disposition Date: 07/05/2011

Implementation Date:

Status: Approved-Closed

Comment:

Rate data does NOT apply to filing.

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Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification		Yes
Supporting Document	Application		Yes
Supporting Document	Life & Annuity - Acturial Memo		No
Form	697		Yes

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## Form Schedule

### Lead Form Number:

Schedule Item Status	Form Number	Form Type Form Name	Action	Action Specific Data	Readability	Attachment
		Policy/Cont 697 ract/Fraternal Certificate: Amendment, Insert Page, Endorsement or Rider	Initial			AR697 Rider 6.29.11.pdf 697-10.pdf 697-20.pdf

## LIFE OF THE OZARKS

### Insured's Additional Limit Term Rider

Providing Additional Death Benefit for Insured

The following provisions are part of the Policy to which this Rider is attached, provided a premium for this benefit is shown on the Schedule Page of the Policy.

**WE WILL PAY** the Benefit Amount shown for this Rider in the Rider Schedule of the Policy to the Beneficiary, in addition to the amount otherwise payable under the Policy, upon receipt of due proof of the Insured's Spouse's death, if such death occurs while this Rider and the Policy are in force.

**DEFINITION OF INSURED SPOUSE.** The person who is the Insured's spouse on the Application Date and who is designated as Insured spouse on the Application.

**BENEFICIARY.** The Beneficiary for insurance under this Rider is the Insured. The Policy sets forth procedures for change in Beneficiary.

**CONVERSION PRIVILEGE.** You may elect to convert this Rider, without evidence of insurability, to a new whole life or endowment policy, subject to the following:

- (1) Proper written application for conversion must be submitted to Us, with payment of the first premium, while this Rider is in force. The Conversion Date and date of the new policy will be the date of such application.
- (2) The face amount of the new policy may not exceed the Face Amount of this Rider immediately before the Conversion Date. It may be less, however, subject to Our minimum amount requirements for the new policy.
- (3) The new policy will be issued at the Insured's attained age as of the Conversion Date. The premium will be based on the rates then in use by Us.
- (4) A rider providing benefits in the event of total and permanent disability or additional benefits in event of accidental death will be included in the new policy without evidence of insurability only if such a rider is in force under this Rider at the Date of Conversion, and only if We, on the Date of Conversion, customarily issue such riders with new policies at the then attained age of the Insured at last birthday. The new policy may include any additional riders only with Our consent subject to evidence of insurability as We may require.

- (5) If, under the provisions of a disability rider, We are waiving payment of premium because of the Insured's total disability, or if the conversion is requested after the commencement of or during the Insured's Total Disability, then the conversion privilege cannot be used.

**REINSTATEMENT.** This Rider may be reinstated at the same time the Policy is reinstated, subject to the following:

- (1) The Insured under the reinstated Rider must be insurable. We may ask questions about the health and habits of the Insured; and
- (2) All past due premiums on the Policy and this Rider are paid with interest at the Annual Interest Rate of 6%.

We shall have no liability for a death that occurs after the end of the grace period for a premium in default and before reinstatement.

**MISSTATEMENT OF AGE.** If the age of the Insured has been misstated, the Termination Date of this Rider shall be those dates according to the correct age.

**OWNERSHIP.** The Owner of the Policy has control of this Rider.

**INCONTESTABILITY.** After this Rider has been in force during the lifetime of the Insured for two years from the Issue Date, or reinstatement, if later, We cannot contest it except for nonpayment of premium. This paragraph does not apply to any benefits payable under any Disability or Accidental Death Rider.

**SUICIDE EXCLUSION.** If the Insured dies by suicide before the end of the two years\* after the Policy Date, the benefits payable to the Beneficiary shall then be only the amount of premiums paid before the date of the suicide. This is true whether the Insured is sane or insane at the time of suicide.

\*This exclusion is limited to one year for any policy issued or delivered in the States of Missouri, Colorado and North Dakota.

**TERMINATION.** This Rider terminates if any of the following occurs:

- (1) Expiration of the grace period allowed for any premium in default under the Policy or under this Rider.
- (2) Surrender of the Policy or the operation of any Nonforfeiture Option.
- (3) The end of the premium paying period of the Policy.
- (4) The Policy Anniversary on or after the Insured's ninetieth (90th) birthday.

(5) The Date this Rider is converted.

(6) Cancellation by You.

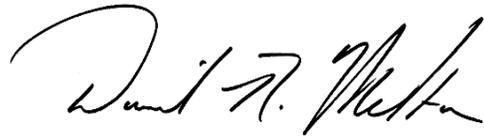
**CONSIDERATION.** This Rider is issued based on the information in the Application and in consideration of the payment of the premium specified for this Rider in the Schedule. Upon termination of this Rider, the premium shall no longer be payable. We will refund any premium paid for any period after termination.

**GENERAL PROVISIONS.** This Rider is subject to all provisions and conditions of the Policy which are not inconsistent with this Rider. This Rider will not increase the Loan or Nonforfeiture Values provided by the Policy.

**IN WITNESS WHEREOF,** We have caused this Rider to be issued as of the Issue Date set forth on the Schedule page of the Policy, unless a different date is shown here.



Chairman and CEO



Secretary

PLAN 697-10

RIDER SCHEDULE

INSURED:	SAM SAMPLE	POLICY NUMBER:	1067351
AGE:	35	POLICY DATE:	06-27-2011
OWNER:	Sam Sample	SEX:	MALE
BENEFICIARY:	AS SHOWN ON THE APPLICATION	PREMIUM CLASS:	NON-TOBACCO

FACE AMOUNT/ DEATH BENEFIT	CURRENT ANNUAL PREMIUMS	PERIOD PAYABLE
20,000	19.40	01-10
20,000	112.20	11
20,000	122.80	12
20,000	131.60	13
20,000	138.40	14
20,000	147.20	15
20,000	158.80	16
20,000	173.40	17
20,000	191.40	18
20,000	212.00	19
20,000	238.20	20
20,000	267.80	21
20,000	298.00	22
20,000	327.60	23
20,000	357.00	24
20,000	391.40	25
20,000	433.40	26
20,000	484.40	27
20,000	543.80	28
20,000	608.60	29
20,000	676.20	30
20,000	746.60	31
20,000	817.80	32
20,000	892.40	33
20,000	971.00	34
20,000	1,059.40	35
20,000	1,162.40	36
20,000	1,287.60	37
20,000	1,433.80	38
20,000	1,588.00	39
20,000	1,753.60	40
20,000	1,933.80	41
20,000	2,137.20	42
20,000	2,373.60	43
20,000	2,648.20	44
20,000	2,956.00	45
20,000	3,299.20	46
20,000	3,672.20	47
20,000	4,067.40	48
20,000	4,498.80	49
20,000	4,978.60	50
20,000	5,512.20	51
20,000	6,099.20	52
20,000	6,733.40	53
20,000	7,407.80	54
20,000	8,115.40	55

CONTINUED (OVER)

PLAN 697-10

RIDER SCHEDULE

INSURED:	SAM SAMPLE	POLICY NUMBER:	1067351
AGE:	35	POLICY DATE:	06-27-2011
OWNER:	Sam Sample	SEX:	MALE
BENEFICIARY:	AS SHOWN ON THE APPLICATION	PREMIUM CLASS:	NON-TOBACCO

WAIVER OF PREMIUM

3.00

25 YEARS

PLAN 697-20

RIDER SCHEDULE

INSURED:	SAM SAMPLE	POLICY NUMBER:	1067351
AGE:	35	POLICY DATE:	06-27-2011
OWNER:	SAM SAMPLE	SEX:	MALE
BENEFICIARY:	AS SHOWN ON THE APPLICATION	PREMIUM CLASS:	NON-TOBACCO

FACE AMOUNT/ DEATH BENEFIT	CURRENT ANNUAL PREMIUMS	PERIOD PAYABLE
20,000	25.60	01-20
20,000	267.80	21
20,000	298.00	22
20,000	327.60	23
20,000	357.00	24
20,000	391.40	25
20,000	433.40	26
20,000	484.40	27
20,000	543.80	28
20,000	608.60	29
20,000	676.20	30
20,000	746.60	31
20,000	817.80	32
20,000	892.40	33
20,000	971.00	34
20,000	1,059.40	35
20,000	1,162.40	36
20,000	1,287.60	37
20,000	1,433.80	38
20,000	1,588.00	39
20,000	1,753.60	40
20,000	1,933.80	41
20,000	2,137.20	42
20,000	2,373.60	43
20,000	2,648.20	44
20,000	2,956.00	45
20,000	3,299.20	46
20,000	3,672.20	47
20,000	4,067.40	48
20,000	4,498.80	49
20,000	4,978.60	50
20,000	5,512.20	51
20,000	6,099.20	52
20,000	6,733.40	53
20,000	7,407.80	54
20,000	8,115.40	55
WAIVER OF PREMIUM	3.00	25 YEARS

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## Supporting Document Schedules

	Item Status:	Status Date:
<b>Satisfied - Item:</b> Flesch Certification <b>Comments:</b> <b>Attachment:</b> AR697 Flesch Score Certification.pdf		

	Item Status:	Status Date:
<b>Satisfied - Item:</b> Application <b>Comments:</b> <b>Attachment:</b> 540 IR 08-AR.pdf		

	Item Status:	Status Date:
<b>Satisfied - Item:</b> Life & Annuity - Acturial Memo <b>Comments:</b> <b>Attachment:</b> AR697 Term Statement of Basis signed AR.pdf		

## **CERTIFICATE OF COMPLIANCE**

Re: Policy Form No. 697

I have carefully reviewed the above listed form submitted with this Certificate, and, to the best of my knowledge, information and belief, hereby certify the following:

1. The captioned form complies with the applicable statutory and regulatory laws in the state to which this filing is submitted.
2. The captioned form meets or exceeds the legibility and readability requirements in the stats to which this filing is submitted.
3. That the Company complies with Rule and Regulation 19 by providing the consumer with a Life and Health Guaranty Association notice.
4. The captioned forms contain no unusual or controversial provisions.

### **LIFE OF THE OZARKS**



By: \_\_\_\_\_  
David R. Melton, Vice President & General Counsel

Date: \_\_\_\_\_  
June 24, 2011



**LIFE OF THE OZARKS**

P.O. Box 219541 Kansas City, MO 64121-9541 (816) 842-6300

For Insurance On Life Of Proposed Insured Named Below

**POLICY NUMBER**

**INSURED**

**USE BLACK INK ONLY - PLEASE PRINT**

1. Full name of proposed insured. (Legal name)

First Middle Last

2. Residence Address

Street

City State Zip

3. Insured's Previous Address

Street

City State Zip

4. Driver's License # State Issued

6. a. Proposed Insured's Occupation How Long?

b. Duties Performed

State of Birth Birth date (mm/dd/yyyy) Age Sex:  Male  Female

Marital Status:  Single  Married  Widowed  Divorced  Separated

Social Security # [ ][ ]-[ ][ ]-[ ][ ][ ][ ]

Are you a U.S. Citizen?  Yes  No

Height Weight

Home Phone ( )

Bus/Cell Phone ( )

Email Address:

5. Existing Fund Account Numbers

Employer

Location

**PLAN INFORMATION**

7. Total Annual Premium Mode Premium Pay Mode Pay Code  A  S  ET  DB  SS  Q  M  GR  FB  PY

8. Plan # of Insurance Rider I Rider II Rider III Base Plan Volume  Tobacco Use  Non-Tobacco GR / FB #  WP  AD  GI  PDD (See #16)

9. Special Requests: 10. Special Draft Date

11. Automatic Premium Loan Clause to be operative?  Yes  No 12. Replacement / Conversion  Yes  No

Prior Policy #

**OWNER**

13. Proposed ownership designation - Legal name(s)

Same as above insured

Primary Owner

[ ][ ]-[ ][ ]-[ ][ ][ ][ ] Owner's Soc. Sec. # Birth Date Relationship

Owner's Mailing Address

City State Zip

Contingent Owner

[ ][ ]-[ ][ ]-[ ][ ][ ][ ] Contingent Owner's Soc. Sec. # Birth Date Relationship

Contingent Owner's Address

City State Zip

Agent No. 1 Agent # Agent No. 2 Agent #

**PRIMARY BENEFICIARIES**

14. Primary Beneficiary(ies)	Share % Leave blank for Equal distribution	Social Security	Birth Date	Relationship
_____	_____ %	□□□-□□-□□□□	_____	_____
_____	_____ %	□□□-□□-□□□□	_____	_____
_____	_____ %	□□□-□□-□□□□	_____	_____
_____	_____ %	□□□-□□-□□□□	_____	_____
_____	_____ %	□□□-□□-□□□□	_____	_____

Additional Primary Beneficiaries Continued on another sheet

**CONTINGENT BENEFICIARIES**

15. Contingent Beneficiary(ies)	Share % Leave blank for Equal distribution	Social Security	Birth Date	Relationship
_____	_____ %	□□□-□□-□□□□	_____	_____
_____	_____ %	□□□-□□-□□□□	_____	_____
_____	_____ %	□□□-□□-□□□□	_____	_____
_____	_____ %	□□□-□□-□□□□	_____	_____

Additional Contingent Beneficiaries Continued on another sheet

**COMPLETE FOR SPOUSE, CPR, PAYOR DEATH / DISABILITY COVERAGE**

16. No. of CPR Units \_\_\_\_\_ Spouse Volume \_\_\_\_\_  Tobacco Use  Non-Tobacco

**PDD**  Yes  No

Proposed Insured	Relationship to Applicant	Date of Birth mm/dd/yyyy	Birthplace (State)	Age	Sex	Height	Weight	Amount of Insurance Now Inforce

Spouse's / Payor's occupation (duties performed, name of employer): \_\_\_\_\_ Spouse's Driver's License #: \_\_\_\_\_ Social Security No. □□□-□□-□□□□

**ADDITIONAL INSURANCE**

17. Life Insurance in force on Proposed Insured:

Year Issued	Name of Company	Amount	Amount of Accidental Death
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

**FAMILY HISTORY**

18. Family History	Age if Living	Age at Death	State of Health or Cause of Death
Father	_____	_____	_____
Mother	_____	_____	_____
Siblings	No. Living	_____	_____
	No. Dead	_____	_____

**MEDICAL HISTORY**  
**IF ANSWERED YES, GIVE FULL DETAILS - NAMES, AILMENTS, DATES, PHYSICIANS' NAMES, ADDRESSES, ETC.**  
**Identify questions and proposed insured to which details apply**

Applicant's Name				Primary Insured		Other Insured	
	First	Middle	Last	Yes	No	Yes	No
19.	Has any proposed insured <b>ever</b> been diagnosed, treated, or tested for any of the following:						
	a. Disorder of eyes or ears? .....			<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
	b. Mental, depression or anxiety disorder? .....			<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
	c. Seizure disorder, multiple sclerosis, muscular dystrophy, Parkinson's disease, ALS, Alzheimer's disease or other neurological disorder? .....			<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
	d. Asthma, bronchitis, emphysema, COPD or other chronic respiratory disorder? .....			<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
	e. High blood pressure, stroke, aneurysm, blood clot, heart murmur, chest pain, heart attack or heart surgery? Other disease or disorder of heart or blood vessels? .....			<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
	f. Diabetes, tumor, cancer or skin disorder? .....			<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
	g. Disorder of stomach, intestines, liver, kidney, bladder, prostate or reproductive organs? .....			<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
	h. Arthritis, disease or disorder of the muscles, bones or back? .....			<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
	i. Deformity, limited mobility, amputation or paralysis? .....			<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
	j. Anemia or other disease or disorder of the blood? .....			<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
	k. Other disease or disorder not listed above? .....			<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
	l. Is this insurance intended to change or replace any existing life insurance or annuities in any company? (Details below) .....			<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
20.	Any weight change by more than ten pounds in the last <b>six months</b> ? .....			<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
	If Yes, amount and cause _____						
21.	Is any person proposed for insurance:						
	a. Now under treatment or observation? .....			<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
	b. List all current medications. _____						
22.	In the past <b>five years</b> , has any person proposed for insurance:						
	a. received treatment or counseling for the use of alcohol or drugs (prescribed or non-prescribed)? . . . .			<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
	b. been advised to receive treatment or counseling for the use of alcohol or drugs (prescribed or non-prescribed)? .....			<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
23.	In the past <b>twelve months</b> , have you used any form of tobacco or tobacco cessation products? .....			<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
24.	In the past <b>ten years</b> has any person proposed for insurance:						
	a. Been told that they had Acquired Immune Deficiency Syndrome (AIDS), or "AIDS" Related Complex (ARC), or "AIDS" related condition? .....			<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
	b. Been advised to obtain tests or treatment in connection with any of these things mentioned in (a) above? .....			<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
	c. Tested positive for anti-bodies to the "AIDS" (Human T-Cell Lymphotropic, Type III, TLV-III) virus or Lymphadenopathy Associated Virus (LAV)? .....			<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
25.	Has any person proposed for insurance ever been disabled or ever requested payment or received a payment for Worker's Compensation, Social Security or other disability income payment? .....			<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
	Is this person currently disabled or claiming to be disabled? .....			<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
26.	Within the past <b>five years</b> has any proposed insured:						
	a. Been treated by a health care provider or at a health care facility? If YES, provide details. ....			<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
	_____						
	b. Had any test, procedure or treatment? If YES, provide details. ....			<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
	_____						
	c. Been advised to have any diagnostic test, hospitalization, treatment or surgery which was not completed? .....			<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
	_____						





**CERTIFICATION**

Each of the undersigned declares they have read the questions and answers above and certifies the answers are complete and true to the best of their knowledge and belief. The following agreements are offered to the Company as a consideration for the insurance. It is agreed that: (1) The Company shall incur no liability under this application until it has been received and approved, a policy has been issued and delivered, and the full first premium specified in the policy has been actually paid to and accepted by the Company while health, habits and occupation of the proposed insureds remain as described in this application, in which case the policy shall be deemed to have taken effect as of the date on which the policy was signed. However, if the full first premium specified in the application on the policy applied for is paid on the date of this application and the Company's receipt is issued to the applicant, then the liability of the Company shall be stated in the receipt and the policy form for which application is made. (2) Only the President, a Vice-President, Secretary, or an Assistant Secretary of the Company can make, modify or discharge contracts or waive any of the Company's rights or requirements and then only in writing. (3) The Company is authorized to amend this application in the space entitled "Home Office Additions or Corrections" and acceptance by the applicant of any policy issued on this application shall constitute a ratification of any such amendments, except no change in the amount of insurance or the amount of the premium or classification of kind of insurance or benefits unless agreed to in writing by the applicant.

**FRAUD WARNING**

**"Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or a statement of claim 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 and subjects such person to criminal and civil penalties."**

**ACKNOWLEDGMENT AND AUTHORIZATION**

We acknowledge receipt of a statement describing the underwriting procedures and were furnished the notice required by the Fair Credit Reporting Act. We hereby authorize any physician, medical practitioner, hospital, clinic or other medical or medically related facility, insurance company, the Medical Information Bureau, or any other organization, institution or person that has any record or knowledge of the persons whose signatures appear below (or their children) or their health to give such record or information to the Life of the Ozarks or its reinsurers. A reproduced copy of this Acknowledgment and Authorization shall be as valid as the original. This Authorization shall be valid for 24 months from the date signed.

Monies Received with Application \$ \_\_\_\_\_ For \_\_\_\_\_ Premium \_\_\_\_\_

Date and signed at \_\_\_\_\_ (City) \_\_\_\_\_ (State) on \_\_\_\_\_ (Date)

Signature of Spouse (if coverage or **Conversion** applied for) \_\_\_\_\_ Signature of Applicant \_\_\_\_\_

Signature of Owner if other than proposed Insured (Give official capacity if signed on behalf of a corporation) \_\_\_\_\_

Witness or Agent \_\_\_\_\_ Code No. \_\_\_\_\_ Agent \_\_\_\_\_ Code No. \_\_\_\_\_

**Home Office Additions or Corrections**

\_\_\_\_\_

\* A A R O S \*

**CONDITIONAL RECEIPT (DO NOT DETACH UNLESS FULL FIRST PREMIUM IS PAID WITH APPLICATION)**

**ALL PREMIUM CHECKS MUST BE MADE PAYABLE TO THE INSURANCE COMPANY - DO NOT MAKE CHECK PAYABLE TO THE AGENT OR LEAVE THE PAYEE BLANK.**

Received from \_\_\_\_\_ the sum of \_\_\_\_\_ (\$ \_\_\_\_\_) Dollars for the full first premium specified in the application for insurance in Life of the Ozarks which bears the same date as this receipt. The insurance under the policy for which application is made shall be effective on the date of this receipt or the date of completion of the medical examination (if, and when required by the Company), whichever is the later date, if in the opinion of the authorized officers of the Company at its Home Office in Kansas City, Missouri, the Proposed Insured is insurable and acceptable for insurance under the rules and practices of the plan of insurance, for the amount of insurance, and at the premium rate set forth in the application exclusive of any amendments in the space for "Home Office Additions or Corrections." Coverage under this receipt shall expire the earlier of: (i) issuance and delivery of the policy, (ii) rejection of any counter-offer, or (iii) ninety (90) days from the date of this receipt. However, even if the Proposed Insured is so insurable and acceptable, the maximum liability of the Company under this receipt and other insurance in force in this company shall be \$100,000 or the amount of said other insurance, whichever is greater. If the Proposed Insured is not so insurable and acceptable, the Company has no liability under this receipt, and the above payment will be returned by the Company's check, upon surrender of this receipt. This receipt shall be void if given for check or draft which is not honored on presentation.

Agent \_\_\_\_\_ Date \_\_\_\_\_

**Agents Report and Special Instructions  
THIS SECTION MUST BE COMPLETED WHERE APPLICABLE**

- |  | YES                   | NO                    |
|--|-----------------------|-----------------------|
| 28. <b>STATEMENT OF AGENT REGARDING REPLACEMENT</b><br>Do you have knowledge or reason to believe that replacement of existing insurance or annuities may be involved?<br>If Yes, refer to special instructions for your state. If no special instructions, give details here. _____ | <input type="radio"/> | <input type="radio"/> |
| <hr/>  |                       |                       |
| 29. <b>UNDERWRITING REQUIREMENTS</b><br>Was the "Your Insurance Application and How it is Handled" form given to applicant? .....  | <input type="radio"/> | <input type="radio"/> |
| 30. <b>If NON-MEDICAL</b> , these questions <b>MUST</b> be answered before the application can be processed.<br>a. Did you see the proposed insured at time of making application? .....   | <input type="radio"/> | <input type="radio"/> |
| (If not, need examination)   |                       |                       |
| b. Do you know of any condition which the proposed insured did not indicate under Medical History? .....   | <input type="radio"/> | <input type="radio"/> |
| 31. <b>SETTLEMENT</b><br>a. Was full premium for mode collected and submitted with the application? .....  | <input type="radio"/> | <input type="radio"/> |
| b. If so, was Conditional Receipt given to applicant? .....  | <input type="radio"/> | <input type="radio"/> |
| c. Were terms of receipt explained to the applicant? .....   | <input type="radio"/> | <input type="radio"/> |
| 32. <b>ALL APPLICANTS</b><br>a. Previous names and dates of name changes? _____  |                       |                       |
| <hr/>  |                       |                       |
| b. If married, how much insurance does spouse carry? _____   |                       |                       |
| <hr/>  |                       |                       |
| 33. <b>CHILD APPLICANTS (under age 15)</b><br>a. Amount of insurance on      Father _____      Mother _____  |                       |                       |
| b. Amount of insurance on brothers and sisters under age 15. _____   |                       |                       |

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**OTHER SPECIAL REQUESTS**



Date \_\_\_\_\_ Agent's Signature \_\_\_\_\_

**MEDICAL INFORMATION BUREAU DISCLOSURE NOTICE**

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

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

Life of the Ozarks, or its reinsurers, may also release information in its file to other insurance companies to whom you may apply for life or health insurance, or to whom a claim for benefits may be submitted.