

SERFF Tracking Number: PNAL-127363212 State: Arkansas  
Filing Company: Pan-American Assurance Company State Tracking Number: 49520  
Company Tracking Number: SJL-527  
TOI: L08 Life - Other Sub-TOI: L08.000 Life - Other  
Product Name: SIT 210/30  
Project Name/Number: /SJL-527

## Filing at a Glance

Company: Pan-American Assurance Company

Product Name: SIT 210/30

TOI: L08 Life - Other

Sub-TOI: L08.000 Life - Other

Filing Type: Form

SERFF Tr Num: PNAL-127363212 State: Arkansas

SERFF Status: Closed-Approved-  
Closed State Tr Num: 49520

Co Tr Num: SJL-527

State Status: Approved-Closed

Author: San Llull

Reviewer(s): Linda Bird

Date Submitted: 08/10/2011

Disposition Date: 08/17/2011

Disposition Status: Approved-  
Closed

Implementation Date Requested: On Approval

Implementation Date:

State Filing Description:

## General Information

Project Name:

Project Number: SJL-527

Requested Filing Mode:

Explanation for Combination/Other:

Submission Type: New Submission

Overall Rate Impact:

Status of Filing in Domicile: Authorized

Date Approved in Domicile: 04/30/2011

Domicile Status Comments: Approved

Market Type: Individual

Individual Market Type:

Filing Status Changed: 08/17/2011

State Status Changed: 08/17/2011

Created By: San Llull

Corresponding Filing Tracking Number:

Deemer Date:

Submitted By: San Llull

Filing Description:

Simplified Issue Term policy for 20 and 30 years.

Simplified Issue Term application B-1545.

Global Repatriation Benefit Rider 33ADB

## Company and Contact

### Filing Contact Information

San Llull, Senior Compliance and Policy

slull@panamericanlife.com

Analyst

601 Poydras Street

504-566-3449 [Phone]

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28th Floor      504-566-3600 [FAX]  
 New Orleans, LA 70130

**Filing Company Information**

Pan-American Assurance Company	CoCode: 93459	State of Domicile: Louisiana
601 Poydras Street	Group Code:	Company Type:
28th Floor	Group Name:	State ID Number:
New Orleans, LA 70130	FEIN Number: 72-0917222	
(504) 566-3449 ext. [Phone]		

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**Filing Fees**

Fee Required?	Yes
Fee Amount:	\$75.00
Retaliatory?	No
Fee Explanation:	
Per Company:	No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Pan-American Assurance Company	\$75.00	08/10/2011	50524522
Pan-American Assurance Company	\$75.00	08/11/2011	50538787

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## Correspondence Summary

### Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Linda Bird	08/17/2011	08/17/2011

### 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	08/12/2011	08/12/2011	San Llull	08/16/2011	08/16/2011
Pending Industry Response	Linda Bird	08/10/2011	08/10/2011	San Llull	08/11/2011	08/11/2011

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## Disposition

Disposition Date: 08/17/2011

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	Actuarial Memorandum		No
Supporting Document	SIT 20/30 Cover letter		Yes
Supporting Document	Guaranty Association disclosure		Yes
Supporting Document	Important Information Bulletin (15-2009)		Yes
Form	Simplified Issue Term 20/30		Yes
Form	Global Repatriation Rider		Yes
Form	SIT Application		Yes

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## Objection Letter

Objection Letter Status Pending Industry Response  
Objection Letter Date 08/12/2011  
Submitted Date 08/12/2011  
Respond By Date 09/12/2011

Dear San Llull,

This will acknowledge receipt of the captioned filing.

Objection 1

Comment: Ark. Code Ann. 23-79-138 requires that certain information accompany every policy. Bulletin 15-2009 further address this issue.

Regulation 19s10B requires that all new or revised filings submitted must contain a certification that the submission meets the provisions of this rule as well as all applicable requirements of this Department.

Please feel free to contact me if you have questions.

Sincerely,  
Linda Bird

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Project Name/Number: /SJL-527

## Response Letter

Response Letter Status Submitted to State  
Response Letter Date 08/16/2011  
Submitted Date 08/16/2011

Dear Linda Bird,

### Comments:

We have a form A-2562 (Rev 5/10).

### Response 1

Comments: We have a form A-2562 (Rev 5/10). This form is always attached to our policies when delivered. Sorry I forgot to attach with my original filing.

### Related Objection 1

Comment:

Ark. Code Ann. 23-79-138 requires that certain information accompany every policy. Bulletin 15-2009 further address this issue.

Regulation 19s10B requires that all new or revised filings submitted must contain a certification that the submission meets the provisions of this rule as well as all applicable requirements of this Department.

### Changed Items:

#### Supporting Document Schedule Item Changes

Satisfied -Name: Important Information Bulletin (15-2009)

Comment: We have had this "Important Information" with our policies. Unfortunately, I forgot to attach to my original filing. See attached A-2562 form

Thank you

No Form Schedule items changed.

No Rate/Rule Schedule items changed.

I have attached form A-2562 (Rev 5/10) to clear this objection.

Thank you

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San Llull

Sincerely,  
San Llull

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## Objection Letter

Objection Letter Status Pending Industry Response  
Objection Letter Date 08/10/2011  
Submitted Date 08/10/2011  
Respond By Date 09/12/2011

Dear San Llull,

This will acknowledge receipt of the captioned filing.

### Objection 1

Comment: Regulation 57 was revised effective January 2010, the filing fee is now \$50.00 per form. We will hold your filing in a pending status until the additional \$75.00 is received.

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 08/11/2011  
Submitted Date 08/11/2011

Dear Linda Bird,

### Comments:

Sorry for my oversight. I just added \$75.00

### Response 1

Comments: Sorry for my oversight. I just added \$75.00 more to the EFT.

Thank you for handling my filing so quick. (my Marketing Group is overanxious to get it approved) Please let me know if you have any questions,  
San Llull

### Related Objection 1

Comment:

Regulation 57 was revised effective January 2010, the filing fee is now \$50.00 per form. We will hold your filing in a pending status until the additional \$75.00 is received.

### Changed Items:

No Supporting Documents changed.

No Form Schedule items changed.

No Rate/Rule Schedule items changed.

I just added \$75.00 to the EFT. New Total \$ 150.00

Sincerely,  
San Llull

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## Form Schedule

### Lead Form Number: 38AD(AR)

Schedule Item Status	Form Number	Form Type Form Name	Action	Action Specific Data	Readability	Attachment
	38AD(AR)	Policy/Cont Simplified Issue ract/Fratern Term 20/30 al Certificate	Initial		53.550	38AD(AR).pdf
	33ADB	Certificate Global Repatriation Amendmen Rider t, Insert Page, Endorseme nt or Rider	Initial		53.550	33ADB.pdf
	B-1545	Application/SIT Application Enrollment Form	Initial		53.550	B-1545.pdf



# PAN AMERICAN

ASSURANCE COMPANY

Pan-American Assurance Company  
601 Poydras Street  
Pan-American Life Center  
New Orleans, Louisiana 70130

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**ADJUSTABLE PREMIUM LEVEL TERM  
INSURANCE TO AGE 95**

Sum Insured Payable at Death of Insured Prior to the Expiration Date  
Premiums Payable to Expiration Date or Until Prior Death,  
And Change as Shown in the Schedule of Premiums for  
Periods After the Initial Premium Guarantee Period  
**NON-PARTICIPATING**

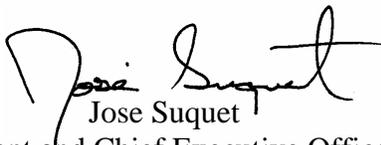
---

**WE AGREE TO PAY**

the benefits provided in this policy subject to its terms  
and conditions.

Signed for the Company at its Home Office in  
New Orleans, Louisiana

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Jose Suquet

President and Chief Executive Officer



Patrick C. Fraizer

Corporate Secretary and General Counsel

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**RIGHT TO EXAMINE POLICY**

Within 20 days after this policy is first received, it may be canceled for any reason by delivering or mailing it to our Home Office in New Orleans, Louisiana, or to the agent through whom it was purchased.

Upon Cancellation we will return any premium paid.

This is a legal contract between you and us.

**PLEASE READ YOUR POLICY AND APPLICATION CAREFULLY**

**FOR INFORMATION, OR TO MAKE A COMPLAINT, CALL 1-800-999-0514**

*We, our and us refer to Pan-American Assurance Company.*

*You and your refer to the Owner of this policy.*

*In Force means that the insurance under the policy is being continued for the Death Benefit.*

	<b>Page</b>		<b>Page</b>
<b>ALPHABETICAL GUIDE</b>			
Additional Interest .....	9	Incontestability.....	9
Adjustment at Death .....	6	Interest Before Settlement.....	10
Age and Gender .....	3, 10	Minimum Amount .....	9
Assignment .....	5	Non-Payment of Premium .....	6
Change of Beneficiary .....	5	Payee .....	9
Change of Premiums.....	6	Payment of Premiums .....	6
Claim of Creditors.....	10	Policy Date.....	3, 9
Contract.....	9	Proceeds .....	6
Control of Policy.....	5	Reinstatement.....	6
Death of a Beneficiary .....	5	Settlement Options.....	7
Designation .....	5	Suicide.....	10
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## **POLICY PROVISIONS**

Policy Schedule.....	3	Change of Premiums.....	6
Schedule of Premiums for Periods		Payment of Proceeds.....	6
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Life Insurance Benefit.....	5		
Ownership .....	5		
Beneficiary .....	5		
Premiums and Reinstatement.....	6		

## POLICY SCHEDULE

**Insured:** [Insured Name] **Policy Number:** [Policy Number]  
**Issue Age:** [Issue Age] **Policy Date:** [Policy Date]  
**Gender:** [Gender] **Expiration Date:** [Expiration Date]  
**Rate Class:** [Rate Class] **Mode:** [Sum Insured]  
**Owner:** As stated in the application unless subsequently changed in accordance with the provisions of the policy.

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### Benefits & Riders

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<b>Benefit</b>	<b>Amount</b>	<b>Annualized Premiums Payable (Guaranteed)</b>	<b>Years Payable</b>
Adjustable Premium Level Term Insurance To Age 95	[Sum Insured]	[\$1,816.56]	[30]
Global Repatriation Benefit Rider	NA	[\$6.24]	[30]

Death benefit payable upon receipt of proof that the death of the insured occurred prior to the Expiration Date and while the policy is In Force.

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### Premiums

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Total Initial Premiums	Annual [\$1,746.00]	Semi-Annual [\$907.92]	Monthly [\$151.90]
------------------------	------------------------	---------------------------	-----------------------

**First Premium Payment:** [\$151.90] **Frequency of Premium Payments:** [Monthly]  
**Initial Premium Guarantee Period:** [30] years

See page 4 for the Schedule of Premiums for Periods After the Initial Guarantee Period.

**SCHEDULE OF PREMIUMS FOR PERIODS AFTER THE INITIAL PREMIUM GUARANTEE PERIOD**

<b>Insured:</b>	[Insured Name]	<b>Policy Number:</b>	[Policy Number]
<b>Issue Age:</b>	[Issue Age]	<b>Policy Date:</b>	[Policy Date]
<b>Gender:</b>	[Gender]	<b>Expiration Date:</b>	[Expiration Date]
<b>Rate Class:</b>	[Rate Class]	<b>Mode:</b>	[Mode]

<b>POLICY YEAR</b>	<b>ATTAINED AGE OF INSURED</b>	<b>ANNUALIZED PREMIUMS</b>
31	80	\$21,060.60
32	81	\$23,661.24
33	82	\$26,448.72
34	83	\$29,525.40
35	84	\$32,973.72
36	85	\$36,842.76
37	86	\$41,069.88
38	87	\$45,678.12
39	88	\$50,624.64
40	89	\$55,866.48
41	90	\$61,161.72
42	91	\$66,452.64
43	92	\$72,047.52
44	93	\$77,994.12
45	94	\$84,312.36

## **LIFE INSURANCE BENEFIT**

We will pay the life insurance proceeds upon proof that the Insured died prior to the Expiration Date and while the policy was In Force. The proceeds will be paid to the Beneficiary. All proceeds or payments are subject to the terms of this policy.

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## **OWNERSHIP**

**Control of Policy** – The Owner shall be as shown in the application or any attached written endorsement. All rights, options, and privileges belong to:

- You, if living; otherwise
- Any contingent Owner or Owners, if living; otherwise
- The estate of the last Owner to die; subject to the rights of any irrevocable Beneficiary and any assignee of record with us.

We reserve the right to require this policy for endorsement of any assignment, change of Beneficiary or ownership designation, surrender, amendment, or modification.

Consistent with the terms of the Beneficiary designation and any assignment during the Insured's lifetime, you may:

- Assign or surrender this policy;
- Amend or modify this policy with our consent;
- Exercise any right, receive any benefit, and enjoy any privilege contained in this policy.

**Assignment** – An assignment shall be accepted by us only if it is made in writing and filed with us at our Home Office. We will not be responsible for the validity of any assignment. Payment of any benefits shall be subject to the rights of any assignee of record at our Home Office. A collateral assignment is not a change of ownership, and an assignee cannot change the Owner or Beneficiary, or elect or change an optional method of payment.

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## **BENEFICIARY**

**Designation** – The application contains the Beneficiary(ies) and their designated class. Any payments made to the Beneficiary(ies) will be made according to their class. When there is more than one Beneficiary of the same class, payments will be shared equally among them unless otherwise stated.

**Death of a Beneficiary** – If a Beneficiary dies before the Insured, the payments will be made to:

- Any surviving Beneficiary(ies) of that class; otherwise
- Any Beneficiary(ies) of the next class; otherwise
- The Owner; otherwise
- The estate of the Owner.

If a Beneficiary dies within 15 days after the Insured, but before proof of the Insured's death is received by us, payments will be made as though the Beneficiary had died before the Insured.

**Change of Beneficiary** – You may change any Beneficiary at any time during the Insured's lifetime unless otherwise provided in the previous designation. The new designation must be made by a signed notice in satisfactory form to our Home Office. The change will take effect on the date the notice was signed subject to any action taken by us before recording the change.

## **PREMIUMS AND REINSTATEMENT**

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**Payment of Premiums** – Premiums must be paid in advance at our Home Office.

Premiums may be paid at the published rates in use by us as mentioned in the Change of Premiums section. The collection method and frequency of payment will determine the premium. Premium payments must be at least \$15.00. We may approve other frequencies or methods of payment. Receipts, signed by one of our officers, will be furnished on request.

**Grace Period** – A 31 day grace period beyond the due date is allowed for payment of each premium after the first premium. The policy will continue in force during this period.

**Non-Payment of Premium** – This policy will lapse if a premium is not paid before the end of the grace period.

Upon lapse, our liability will be according to the Reinstatement Provision.

**Adjustment at Death** – If death occurs within the grace period, a monthly premium will be deducted from the proceeds. Any premium paid beyond the month of the Insured's death will be included in the proceeds.

**Reinstatement** – If this policy lapses, as provided in the Non-Payment of Premium section, it may be reinstated at any time within six months after the date of lapse and prior to the Expiration Date. The reinstatement is subject to:

- Receipt of evidence of insurability of the Insured satisfactory to us to reinstate the basic policy; and
- Receipt of evidence of insurability of any person covered by any rider to reinstate the rider to the policy; and
- Payment of all past due premiums with interest of 6% per year.

Evidence of insurability is not required if the reinstatement payment is received by us within 31 days after the end of the grace period. The Insured must be living when the payment is received.

## **CHANGE OF PREMIUMS**

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**Change of Premiums** – The guaranteed premiums, the number of years for which they are payable, and the frequency of payment are shown on Page 3 of the policy. The guaranteed premiums for periods after the Initial Premium Guarantee Period are shown on Page 4 of the policy.

## **PAYMENT OF PROCEEDS**

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**Proceeds** – The life insurance proceeds will be paid if the Insured dies while the policy is In Force.

Except for payment of a lump sum, a payment contract will be issued when the proceeds are due. It will contain the terms of payment of the proceeds.

The contract's effective date is the date the proceeds become due.

The life insurance proceeds will be the sum of:

- The Sum Insured In Force as shown on Page 3; plus
- Any additional benefits; plus
- Any premiums paid beyond the month of the Insured's death; less
- Any premium due and unpaid that applied to time before Insured's death.

Any amounts due in settlement are payable at our Home Office. Any amount of the proceeds due an assignee who is not a Beneficiary will be paid in one sum. The remainder of the proceeds may be settled by an elected settlement option.

**Settlement Options** – The life proceeds will be paid in one sum unless otherwise elected. The following settlement options are available:

1. *Proceeds Left at Interest* – The life proceeds may be held by us. Interest will be paid at a guaranteed rate of 2.5% compounded annually; it will be payable at the end of every month, 3 months, 6 months, or 12 months as elected. The proceeds will be held during the longer of the Payee's lifetime or 30 years. Withdrawals of \$100 or more may be made from the proceeds as often as every month. When the proceeds become less than \$5,000, it will be paid in one sum.
2. *Payments for a Fixed Period* – Equal monthly payments will be made for the number of years elected, up to 30 years. Interest will be paid at a guaranteed rate of 2.5% compounded annually.

<b>OPTION 2 - PAYMENTS FOR A FIXED PERIOD</b>					
<b>Monthly Payments Per \$1,000 Of Proceeds</b>					
No. of Years	Payments	No of Years	Payments	No. of Years	Payments
1	\$84.45	11	\$8.66	21	\$5.09
2	\$42.75	12	\$8.03	22	\$4.91
3	\$28.85	13	\$7.50	23	\$4.75
4	\$21.90	14	\$7.05	24	\$4.61
5	\$17.73	15	\$6.65	25	\$4.47
6	\$14.96	16	\$6.31	26	\$4.35
7	\$12.98	17	\$6.01	27	\$4.23
8	\$11.49	18	\$5.74	28	\$4.13
9	\$10.34	19	\$5.50	29	\$4.03
10	\$9.41	20	\$5.29	30	\$3.94

3. *Payments of a Fixed Amount* – Equal payments may be made every month, 3 months, 6 months, or 12 months as elected. The total paid each year must be at least 5% of the proceeds settled. Interest on the balance will be credited each year at a guaranteed rate of 2.5% compounded annually. Payments will be made until the proceeds with interest have been paid.

4. *Single Life Income Payments* – Equal monthly payments may be made as elected:

- *Straight Life* – Payments will be made during the Payee's lifetime.
- *Guaranteed Period* – Payments will be guaranteed for 10 or 20 years, as elected. The payments will continue after the guaranteed period for the Payee's lifetime.
- *Installment Refund* – Payments will be made during the Payee's lifetime. The payments will continue until the total amount paid equals the life proceeds under this option even if beyond the Payee's lifetime.

Excess interest will be paid only during the guaranteed period as declared by us.

Life income option amounts are based on the Annuity 2000 Mortality Table with interest at a guaranteed rate of 2.5% compounded annually.

<b>OPTION 4 - SINGLE LIFE INCOME PAYMENTS</b> <b>MONTHLY PAYMENTS PER \$1,000 OF LIFE PROCEEDS</b> <i>The age will be the Payee's age last birthday on the first payment date.</i>								
Age of Payee	Life Only		Life w/10 Years		Life w/20 Year		Installment Refunds	
	Male	Female	Male	Female	Male	Female	Male	Female
50	\$3.83	\$3.57	\$3.80	\$3.56	\$3.70	\$3.51	\$3.66	\$3.47
51	3.90	3.63	3.87	3.62	3.76	3.56	3.71	3.52
52	3.97	3.70	3.94	3.68	3.81	3.61	3.77	3.58
53	4.05	3.76	4.01	3.74	3.87	3.67	3.84	3.63
54	4.14	3.84	4.09	3.81	3.94	3.73	3.90	3.69
55	4.22	3.91	4.17	3.89	4.00	3.79	3.97	3.75
56	4.32	3.99	4.26	3.96	4.06	3.85	4.04	3.82
57	4.42	4.08	4.35	4.04	4.13	3.92	4.12	3.89
58	4.52	4.17	4.45	4.13	4.19	3.98	4.20	3.96
59	4.64	4.26	4.55	4.22	4.26	4.05	4.28	4.04
60	4.75	4.36	4.66	4.31	4.33	4.12	4.37	4.12
61	4.88	4.47	4.77	4.41	4.40	4.20	4.46	4.20
62	5.02	4.58	4.89	4.51	4.46	4.27	4.56	4.29
63	5.16	4.70	5.02	4.63	4.53	4.34	4.66	4.38
64	5.32	4.83	5.15	4.74	4.60	4.42	4.76	4.48
65	5.49	4.97	5.28	4.87	4.66	4.49	4.87	4.58
66	5.66	5.12	5.42	5.00	4.72	4.56	4.99	4.69
67	5.85	5.28	5.57	5.14	4.78	4.63	5.11	4.80
68	6.05	5.45	5.72	5.28	4.84	4.70	5.24	4.92
69	6.27	5.63	5.88	5.43	4.89	4.77	5.38	5.05
70	6.50	5.83	6.05	5.59	4.94	4.83	5.52	5.19
71	6.74	6.04	6.21	5.76	4.99	4.89	5.67	5.33
72	7.00	6.28	6.38	5.94	5.03	4.95	5.82	5.48
73	7.27	6.52	6.56	6.12	5.07	5.00	5.99	5.64
74	7.57	6.79	6.73	6.31	5.10	5.05	6.16	5.81
75	7.89	7.09	6.91	6.51	5.13	5.09	6.34	5.99
76	8.22	7.40	7.09	6.71	5.16	5.12	6.53	6.18
77	8.58	7.74	7.27	6.91	5.18	5.15	6.73	6.38
78	8.97	8.11	7.44	7.11	5.20	5.18	6.94	6.59
79	9.39	8.51	7.61	7.31	5.22	5.20	7.16	6.82
80	9.83	8.94	7.78	7.51	5.23	5.22	7.39	7.06
81	10.30	9.41	7.95	7.71	5.24	5.23	7.64	7.31
82	10.80	9.92	8.10	7.89	5.25	5.24	7.89	7.57
83	11.34	10.47	8.25	8.07	5.26	5.25	8.16	7.85
84	11.91	11.07	8.39	8.24	5.26	5.26	8.44	8.14
85	12.52	11.71	8.51	8.39	5.27	5.26	8.73	8.45

The proceeds may be paid in any other manner approved by us.

**Election of Settlement Options** – The settlement option may be elected as follows:

By You – During the Insured’s lifetime, you may elect a settlement option. The option may be changed if you have reserved that right.

By Beneficiary – If no election is In Force at death of the Insured, the Beneficiary may elect a settlement option within 3 months from when the proceeds become payable.

An election or change must be in writing to us. A change in Beneficiary revokes any previous payment election. Once payment has begun, the settlement option cannot be changed.

When an option is elected by a person other than a Payee, the Payee may not advance or assign payments, receive payments in a single sum, or make any other change unless the person making the election has so directed in writing.

**Payee** – The Payee must be the Insured, Owner, or a Beneficiary. The Payee must receive payments in his own right and not as an assignee. If any payments remain at the death of a Payee, payments will be made by the terms of the payment contract.

**Minimum Amount** – The minimum amount of life proceeds applied under a Settlement Option is \$5,000. Each payment must be at least \$50.00. If a payment becomes less than \$50.00, payments will be made less often so that the amount of each payment is at least \$50.00.

**Additional Interest** – Any additional interest will be paid on the payment due on each anniversary of the payment contract. The rate will be declared each calendar year by us.

## **GENERAL PROVISIONS**

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**Contract** – This policy, the attached application and any riders, amendments or endorsements make up the entire contract. It is based on the application and the payment of the premium amount. In the absence of fraud, all statements made by the Insured in the application are representations and not warranties. Statements may be used to contest a claim or the validity of the policy only if they are contained in the application for the policy or the application for reinstatement of the policy and a copy of such application is attached to the policy when issued or made a part of the policy when reinstated.

Only the President, Vice-President, Secretary or Assistant Secretary can modify this policy. Any changes must be made in writing. No agent has the authority to alter or modify any of the terms, conditions or agreements of this policy, or to waive any of its provisions.

**Policy Date** – This policy will be effective on the Policy Date if:

- The first premium is paid and the policy is delivered during the Insured’s lifetime; and
- The Insured’s risk class has not changed since the application.

Policy years, months and anniversaries will be computed from the Policy Date.

**Incontestability** – This policy shall, in the absence of fraud, be incontestable after it has been In Force for two years during the lifetime of the Insured except for non-payment of premiums.

Any addition of a rider effective after the Policy Date shall, in the absence of fraud, be incontestable only after such addition has been In Force during the lifetime of the Insured for two years from the effective date of such addition.

Any reinstatement shall, in the absence of fraud, be incontestable only after having been In Force during the lifetime of the Insured for two years after the effective date of the reinstatement.

Any contest of a reinstatement will be based on material misrepresentations in the application for reinstatement.

**Age and Gender** – The Insured's age is his or her age last birthday on the Policy Date. If the Insured's age or gender has been misstated, the proceeds will be the amount that the sum of all premiums paid would have purchased had those premiums been paid from issue at the correct age and gender.

**Suicide** – Suicide of the Insured, while sane or insane, within two years from the Policy Date is not covered by this policy. Our liability would be limited to the sum of the premiums received.

**Claim of Creditors** – To the extent permitted by law, any proceeds of this policy are exempt from the claims of creditors.

**Interest Before Settlement** – If the proceeds are not paid in one sum or under an Optional Method of Settlement within 30 days after they become payable or, the time provided by law, whichever is less, we will pay interest on the unpaid proceeds. Interest will accrue from the date proof is accepted to the date of payment, but not for more than one year, at a yearly rate of 2.5 percent, or the rate and time provided by law, whichever is greater.

**Computation of Reserves** –A detailed method of computing reserves has been filed with the Insurance Department of the state where this policy is delivered. All reserves are at least equal to those required by the laws of such state.

If you have any questions concerning this Policy  
or if anyone suggests that you change or replace  
this Policy, please contact your Pan-American Life agent or our Home Office.

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**Pan-American Assurance Company**

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601 Poydras Street

New Orleans, Louisiana 70130

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**ADJUSTABLE PREMIUM LEVEL TERM  
INSURANCE TO AGE 95**

Sum Insured Payable at Death of Insured Prior to the Expiration Date.  
Premiums Payable to Expiration Date or Until Prior Death,  
And Change as Shown in the Schedule of Premiums for  
Periods After the Initial Premium Guarantee Period

**NON-PARTICIPATING**

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Pan-American Assurance Company  
601 Poydras Street  
Pan-American Life Center  
New Orleans, Louisiana 70130

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## GLOBAL REPATRIATION BENEFIT RIDER

This rider is attached to and made part of policy number: 12345678

Effective date of this rider: JANUARY 1, 2010

This rider is subject to all the provisions of the policy except where noted herein.

**BENEFITS** – When an Insured dies as a result of a covered accident or illness while at least 100 miles away from his permanent residence and while this rider is in force, we will provide benefits for the following covered expenses for the preparation and return of the Insured's remains to his or her place of residence or to the place of his or her burial. Benefits are subject to a maximum benefit amount of \$20,000.

Covered expenses include:

1. Expenses for embalming the body or cremation of the Insured's body;
2. The least costly coffin or receptacle adequate for transporting the Insured's remains; and
3. Transportation of the Insured's remains to his or her place of residence or to the place of his or her burial.

All transportation must be according to the most direct and economical route and conveyance possible and may not exceed the usual and customary charges for similar transportation in the locality where the expense is incurred.

All arrangements for preparation and repatriation of remains must be made through us or by a company approved by us.

**LIMITATIONS AND EXCLUSIONS** – Loss caused by, or resulting from, the following are excluded:

1. Intentionally self-inflicted injury;
2. Suicide or attempted suicide;
3. War or any act of war, whether declared or not;
4. A covered accident that occurs while the Insured is on active duty service in the military, naval or air force of any country or international organization. Upon our receipt of proof of service, we will refund any premium paid for this time. Reserve or National Guard active duty training is not excluded unless it extends beyond 31 days;
5. Piloting or serving as a crewmember in any aircraft;
6. Commission of, or attempt to commit, a felony;
7. Death while incarcerated in a jail or holding facility when confined because of the commission of, or attempt to commit a felony;
8. Pregnancy, childbirth, except for complications of pregnancy;
9. Mental or nervous disorders unless hospitalized; and
10. Participation in or practice for professional sports.

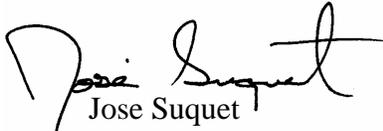
This rider does not apply to the extent that trade or economic sanctions or regulations prohibit us from providing the benefits and services covered by this rider.

**TERMINATION** – This rider will terminate:

1. when the benefit it provides is paid; or
2. when a premium for the policy or this rider has not been paid before the end of the grace period; or
3. upon death of the Insured; or
4. when the policy to which it is attached terminates.

**CONSIDERATION** – This rider is issued in consideration of the application, a copy of which is attached, and the payment of the premiums shown for this rider on the Policy Schedule.

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Jose Suquet  
President and Chief Executive Officer



Patrick C. Fraizer  
Corporate Secretary and General Counsel

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# Pan-American Assurance Company

## Simplified Issue Term Application for Insurance

601 Poydras Street  
 New Orleans, LA 70130  
 Toll Free (877) 939-4551

1. Full Name of Proposed Insured: First				M.I.	Last		
2. Residence Address: Street Address			City		State	Zip Code	Phone Number
3. a) Social Security Number	b) Date of Birth	c) Age	d) State of Birth		e) <input type="checkbox"/> Male <input type="checkbox"/> Female		f) Occupation
4. a) Owner's name (if other than insured)				b) Relationship to Insured			
c) Owner's Address				d) Social Security Number or Tax ID Number			
5. a) Name of Primary Beneficiary				b) Relationship to Insured			
c) Name of Contingent Beneficiary				d) Relationship to Insured			
6. Face Amount \$			7. Term Plan <input type="checkbox"/> 20 years <input type="checkbox"/> 30 years <input type="checkbox"/> Other				
8. Riders: <input type="checkbox"/> Repatriation of Remains (ROR) <input type="checkbox"/> Other							
9. Premium Mode: <input type="checkbox"/> Automatic Monthly Draft (PAC) <input type="checkbox"/> ACH <input type="checkbox"/> Credit Card <input type="checkbox"/> Monthly <input type="checkbox"/> Annual <input type="checkbox"/> Semi-Annual							
10. Do you intend to replace any existing life insurance or annuity contract? <input type="checkbox"/> Yes <input type="checkbox"/> No If YES, give details below							
Company		Policy #		Amount of Coverage \$			
11. a) Current Height	b) Current Weight	c) Driver License #		d) D.L. State			
Ft. _____ in. _____	Lbs _____						
12. Is the Proposed Insured currently taking any medications? If yes, please list:							
13. In the past 12 (twelve) months has the Proposed Insured used any form of tobacco or nicotine replacement products? .....					<input type="checkbox"/> YES	<input type="checkbox"/> NO	
14. In the past 5 (five) years has the Proposed Insured charged with driving under the influence of alcohol or drugs (DUI/DWI)? .....					<input type="checkbox"/> YES	<input type="checkbox"/> NO	
15. Has the Proposed Insured been medically diagnosed as having a life expectancy of 12 months or less? .....					<input type="checkbox"/> YES	<input type="checkbox"/> NO	
16. Has a member of the medical profession ever diagnosed or treated the Proposed Insured for Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC) or has the Proposed Insured ever tested positive for Human Immunodeficiency Virus (HIV)? ...					<input type="checkbox"/> YES	<input type="checkbox"/> NO	
17. Has the Proposed Insured ever received or been advised to receive an organ or tissue transplant? .....					<input type="checkbox"/> YES	<input type="checkbox"/> NO	
18. Has the Proposed Insured ever been medically diagnosed as having or been treated for Alzheimer's Disease or dementia? .....					<input type="checkbox"/> YES	<input type="checkbox"/> NO	
19. In the past 5 (five) years, has the Proposed Insured had or been treated for internal cancer, malignant melanoma or leukemia? .....					<input type="checkbox"/> YES	<input type="checkbox"/> NO	
20. In the past 18 (eighteen) months, has the Proposed Insured had heart surgery, heart attack, stroke, aneurysm, Angina (chest pain), congestive heart failure, cardiomyopathy, kidney dialysis, or used oxygen to assist in breathing? .....					<input type="checkbox"/> YES	<input type="checkbox"/> NO	
21. In the past 18 (eighteen) months, has the Proposed Insured had a drug or alcohol dependency/habit or had treatment for alcoholism or drug addiction? .....					<input type="checkbox"/> YES	<input type="checkbox"/> NO	
22. In the past 18 (eighteen) months, has the Proposed Insured had amputation due to disease? .....					<input type="checkbox"/> YES	<input type="checkbox"/> NO	
23. In the past 10 (ten) years has the Proposed Insured had, been treated for or taken medication for any of the following conditions? (if "yes", check the applicable condition) <input type="checkbox"/> emphysema <input type="checkbox"/> chronic lung disease (COPD) <input type="checkbox"/> Parkinson's Disease <input type="checkbox"/> kidney disease <input type="checkbox"/> kidney failure <input type="checkbox"/> cirrhosis <input type="checkbox"/> other liver disease <input type="checkbox"/> sickle cell anemia							
24. In the past 2 (two) years, has the Proposed Insured been treated for or taken medication for any of the following conditions (if "yes", check the applicable condition) <input type="checkbox"/> brain tumor <input type="checkbox"/> pacemaker <input type="checkbox"/> angina (chest pain) <input type="checkbox"/> heart attack <input type="checkbox"/> congestive heart failure?							
The Proposed Insured and Owner, if other than Proposed Insured, represents to the best of his or her knowledge, information and belief that the answers and statements made in this application and medical examination (if required by the Company) are complete and true. The undersigned agrees that (1) No waiver or modification of a contract provision or of any of the Company's rights or requirements shall be binding upon the Company unless made in writing and approved by the Company; (2) if, within 60 days from the date of application, no policy is received or I am not notified of approval or rejection, this application shall be deemed declined. There will be no life insurance until (a) a policy is delivered; (b) the first full premium is received by the Company during the Insured's lifetime, and (c) no change in the Insured's health has occurred that would place the Insured in a higher risk class than at time of application for this policy.							
Signed at _____ on the _____ day of _____, 20____							
(city/state)				(month)			
Signature of Proposed Insured				Signature of Owner (if other than Proposed Insured). If Corporation, Officer, other than Proposed Insured must sign.			
X _____				X _____			
I hereby certify that I have truly and accurately recorded on this application the information supplied by the applicant. To the best of my knowledge and belief the policy applied for <input type="checkbox"/> does <input type="checkbox"/> does not involve replacement of existing life insurance or annuity contract.							
Signature of Soliciting Agent		Name of Agent, Personal Code - Participating %		Signature of Soliciting Agent		Name of Agent, Personal Code - Participating %	
X _____		_____		X _____		_____	

**HIPAA AUTHORIZATION FOR THE USE  
AND/OR DISCLOSURE OF PROTECTED HEALTH INFORMATION**

I authorize the use and/or disclosure of the protected health information of \_\_\_\_\_ as described below:

1. This authorization applies to the information described below. Only this information may be used and/or disclosed pursuant to this authorization:  
All medical records and other protected health information concerning the above named individual.
  
2. I authorize the following persons (or class of persons) to disclose the protected health information:  
Any health plan, physician, health care professional, hospital, clinic, laboratory, pharmacy, benefit manager, medical facility, insurance company, insurance support organization or other health care provider that has provided payment, treatment or services to or on behalf of the above named individual.
  
3. I authorize the following persons (or class of persons) to receive the protected health information:  
Pan-American Life Insurance Company and/or Pan-American Assurance Company and/or \_\_\_\_\_
  
4. I understand that, if the protected health information is disclosed to someone who is not required to comply with the federal privacy regulations, then such information may be re-disclosed and would no longer be protected.
  
5. I understand that I have a right to revoke this authorization at any time. My revocation must be in writing to Pan-American Life Insurance Company, HIPAA Compliance Officer, 601 Poydras Street, New Orleans, LA 70130. I am aware that my revocation is not effective to the extent that the persons I have authorized to use and/or disclose the protected health information have acted in reliance upon this authorization.
  
6. This authorization expires upon six months after the date of signature below.
  
7. I understand that I do not have to sign this authorization. However, I understand that my claim for benefits or my application for insurance coverage may not be processed until all of the necessary information needed to complete the claims and/or underwriting process has been received by Pan-American.
  
8. The protected health information will be used or disclosed upon request for the following purposes:  
To furnish the insurer with information necessary to complete the processing of an application for life, health and/or disability insurance, and/or to furnish the insurer with information necessary to complete processing of a life and/or disability claim.
  
9. I understand that I have a right to inspect and copy the protected health information to be used or disclosed in accordance with the requirements of the federal privacy protection regulations.

I certify that I have received a copy of this authorization.

**MEDICAL INFORMATION BUREAU AUTHORIZATION**

I hereby authorize any licensed physician, medical practitioner, hospital, clinic or other medical or medically related facility, insurance company, the MIB, Inc. ("MIB"), consumer reporting agency or other organization, institution or person that has any records or knowledge of me or my minor child or my health or my minor child's health to give to the Pan-American Life Insurance Company or its reinsurers any such information in order to evaluate my application for life or disability insurance.

I agree that this authorization shall be valid for 30 months from the date signed.

I know that I may request a copy of this authorization.

I agree that a photographic copy of this authorization shall be as valid as the original.

The Undersigned acknowledges receipt of the Notice Concerning the Medical Information Bureau, the Fair Credit Reporting Act Disclosure, and the Abbreviated Notice of Insurance Information Practices.

I understand that I may be interviewed if an investigative consumer report is prepared in connection with this application.

Signature of Proposed Insured	Name of Proposed Insured	Date
<b>X</b>		

## CONDITIONAL RECEIPT

Received from \_\_\_\_\_  
for Life Insurance applied for with the application bearing the same date as this receipt:

- A payment of \$ \_\_\_\_\_  Check  Other  
 Authorization for Electronic Funds Transfer

**IMPORTANT:** The insurance applied for will take effect on the later of the completion of the application process or the completion of any medical examination or tests required by the Company, only if the following conditions are met.

1. All persons to be covered must be insurable as standard risks for the kind and amount of insurance applied for according to the Company's rules on the date the insurance takes effect.
2. Any check or draft given in payment of the initial premium must be honored when first presented.
3. The premium paid or authorized in the application must be sufficient to provide one month of the coverage applied for.
4. The total amount of life insurance provided under this receipt is limited to the amount applied for.

The conditional receipt expires at the earliest of:

1. 45 days after the application is signed.
2. Issue date of the policy.
3. The date the application is declined.

The agent and medical examiner cannot accept risks or waive any of the Company's rights or requirements. This receipt is not valid unless it is signed by an agent of the Company, the Proposed Insured and the Owner. All premium checks shall be made payable to the Company. **DO NOT MAKE CHECKS PAYABLE TO THE AGENT OR LEAVE THE PAYEE BLANK.**

**I have received and read this conditional receipt. It has been explained to me by the agent. I understand and agree to all the conditions and limitations.**

Proposed Insured's signature  <b>X</b> _____	Owner's signature <i>(if different than Proposed Insured)</i>  <b>X</b> _____
Agent's signature  <b>X</b> _____	Date signed
Agent's name	Agent's Code

If you do not hear from the Company regarding the proposed insurance within 45 days, notify the Administrative Offices of the Company at 601 Poydras Street, New Orleans, LA 70130. Give your name, the agent's name, date and amount paid.

**INSURANCE, IF ANY, PROVIDED UNDER THIS RECEIPT IS CONDITIONAL. IF ANY OF THE ABOVE CONDITIONS ARE NOT MET, OR IF THE APPLICATION PROCESS IS NOT COMPLETE, THIS RECEIPT CONFERS NO INSURANCE AND THE PREMIUM PAID WILL BE RETURNED TO YOU.**

**THIS NOTICE MUST BE DELIVERED TO THE PROPOSED INSURED  
WHEN APPLICATION IS COMPLETED**

**NOTICE CONCERNING THE MEDICAL INFORMATION BUREAU**

Information regarding your insurability will be treated as confidential. Pan-American Assurance Company or its reinsurers may, however, make a brief report thereon to the MIB, Inc., formerly known as Medical Information Bureau, a not-for-profit membership organization of insurance companies, which operates an information exchange on behalf of its Members. If you apply to another MIB Member company for life insurance 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. 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 Fair Credit Reporting Act. The address of MIB's information office is 50 Braintree Hill Park, Suite 400, Braintree, Massachusetts 02184-8734, telephone (866) 692-6901 (TTY 866-346-3642).

Pan-American Assurance Company or its reinsurers may also release information in its file to other insurance companies to whom you may apply for life or health insurance, or to whom a claim for benefits may be submitted. Information for consumers about MIB may be obtained on its website at [www.mib.com](http://www.mib.com).

**FAIR CREDIT REPORTING ACT DISCLOSURE**

In making this application, it is understood that an investigative consumer report may be prepared whereby information is obtained through personal interviews with your neighbors, friends, or others with whom you are acquainted. This inquiry includes information as to your character, general reputation, personal characteristics and mode of living. You have the right to make a written request within a reasonable period of time to receive additional, detailed information about the nature and scope of this investigation and a written summary of your rights under the Fair Credit Reporting Act.

**ABBREVIATED NOTICE OF INSURANCE INFORMATION PRACTICES**

To issue an insurance policy we need to obtain information about you. Some of that information will come from you and some will come from other sources. The information collected by us may in certain circumstances be disclosed to third parties without your specific authorization.

You have a right of access and correction with respect to the information collected except information which relates to a claim or civil or criminal proceeding.

If you wish to have a more detailed explanation of our information practices, please write to the Underwriting Department, Pan-American Assurance Company, P.O.Box 60219, New Orleans, Louisiana. 70160.



SERFF Tracking Number: PNAL-127363212 State: Arkansas  
Filing Company: Pan-American Assurance Company State Tracking Number: 49520  
Company Tracking Number: SJL-527  
TOI: L08 Life - Other Sub-TOI: L08.000 Life - Other  
Product Name: SIT 210/30  
Project Name/Number: /SJL-527

**Item Status:** **Status Date:**

**Satisfied - Item:** Guaranty Association disclosure

**Comments:**

**Attachment:**

A2908.pdf

**Item Status:** **Status Date:**

**Satisfied - Item:** Important Information Bulletin (15-2009)

**Comments:**

We have had this "Important Information" with our policies. Unfortunately, I forgot to attach to my original filing. See attached A-2562 form

Thank you

**Attachment:**

A2562 (Rev 5-10).pdf

## **CERTIFICATE OF READABILITY**

PAN-AMERICAN ASSURANCE COMPANY hereby certifies that:

The policy form submitted herein meets the minimum required score or more on the Flesch Reading Ease Test. That the combined score for the forms listed below is :

<b><u>Form Number</u></b>	<b><u>Description</u></b>	<b><u>Combined Score</u></b>
38AD	SIMPLIFIED ISSUE TERM	53.55
33ADB	GLOBAL REPATRIATION BENEFIT RIDER “	
B-1545	SIT APPLICATION FOR INSURANCE “	



Patrick C. Fraizer  
Corporate Secretary and General Counsel  
January 14, 2011

# Pan-American Assurance Company

## Simplified Issue Term Application for Insurance

601 Poydras Street  
 New Orleans, LA 70130  
 Toll Free (877) 939-4551

1. Full Name of Proposed Insured: First				M.I.	Last		
2. Residence Address: Street Address			City		State	Zip Code	Phone Number
3. a) Social Security Number	b) Date of Birth	c) Age	d) State of Birth		e) <input type="checkbox"/> Male <input type="checkbox"/> Female		f) Occupation
4. a) Owner's name (if other than insured)				b) Relationship to Insured			
c) Owner's Address				d) Social Security Number or Tax ID Number			
5. a) Name of Primary Beneficiary				b) Relationship to Insured			
c) Name of Contingent Beneficiary				d) Relationship to Insured			
6. Face Amount \$			7. Term Plan <input type="checkbox"/> 20 years <input type="checkbox"/> 30 years <input type="checkbox"/> Other				
8. Riders: <input type="checkbox"/> Repatriation of Remains (ROR) <input type="checkbox"/> Other							
9. Premium Mode: <input type="checkbox"/> Automatic Monthly Draft (PAC) <input type="checkbox"/> ACH <input type="checkbox"/> Credit Card <input type="checkbox"/> Monthly <input type="checkbox"/> Annual <input type="checkbox"/> Semi-Annual							
10. Do you intend to replace any existing life insurance or annuity contract? <input type="checkbox"/> Yes <input type="checkbox"/> No If YES, give details below							
Company		Policy #		Amount of Coverage \$			
11. a) Current Height	b) Current Weight	c) Driver License #		d) D.L. State			
Ft. in.	Lbs						
12. Is the Proposed Insured currently taking any medications? If yes, please list:							
13. In the past 12 (twelve) months has the Proposed Insured used any form of tobacco or nicotine replacement products? .....					<input type="checkbox"/> YES	<input type="checkbox"/> NO	
14. In the past 5 (five) years has the Proposed Insured charged with driving under the influence of alcohol or drugs (DUI/DWI)? .....					<input type="checkbox"/> YES	<input type="checkbox"/> NO	
15. Has the Proposed Insured been medically diagnosed as having a life expectancy of 12 months or less? .....					<input type="checkbox"/> YES	<input type="checkbox"/> NO	
16. Has a member of the medical profession ever diagnosed or treated the Proposed Insured for Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC) or has the Proposed Insured ever tested positive for Human Immunodeficiency Virus (HIV)? ...					<input type="checkbox"/> YES	<input type="checkbox"/> NO	
17. Has the Proposed Insured ever received or been advised to receive an organ or tissue transplant? .....					<input type="checkbox"/> YES	<input type="checkbox"/> NO	
18. Has the Proposed Insured ever been medically diagnosed as having or been treated for Alzheimer's Disease or dementia? .....					<input type="checkbox"/> YES	<input type="checkbox"/> NO	
19. In the past 5 (five) years, has the Proposed Insured had or been treated for internal cancer, malignant melanoma or leukemia? .....					<input type="checkbox"/> YES	<input type="checkbox"/> NO	
20. In the past 18 (eighteen) months, has the Proposed Insured had heart surgery, heart attack, stroke, aneurysm, Angina (chest pain), congestive heart failure, cardiomyopathy, kidney dialysis, or used oxygen to assist in breathing? .....					<input type="checkbox"/> YES	<input type="checkbox"/> NO	
21. In the past 18 (eighteen) months, has the Proposed Insured had a drug or alcohol dependency/habit or had treatment for alcoholism or drug addiction? .....					<input type="checkbox"/> YES	<input type="checkbox"/> NO	
22. In the past 18 (eighteen) months, has the Proposed Insured had amputation due to disease? .....					<input type="checkbox"/> YES	<input type="checkbox"/> NO	
23. In the past 10 (ten) years has the Proposed Insured had, been treated for or taken medication for any of the following conditions? (if "yes", check the applicable condition) <input type="checkbox"/> emphysema <input type="checkbox"/> chronic lung disease (COPD) <input type="checkbox"/> Parkinson's Disease <input type="checkbox"/> kidney disease <input type="checkbox"/> kidney failure <input type="checkbox"/> cirrhosis <input type="checkbox"/> other liver disease <input type="checkbox"/> sickle cell anemia							
24. In the past 2 (two) years, has the Proposed Insured been treated for or taken medication for any of the following conditions (if "yes", check the applicable condition) <input type="checkbox"/> brain tumor <input type="checkbox"/> pacemaker <input type="checkbox"/> angina (chest pain) <input type="checkbox"/> heart attack <input type="checkbox"/> congestive heart failure?							
The Proposed Insured and Owner, if other than Proposed Insured, represents to the best of his or her knowledge, information and belief that the answers and statements made in this application and medical examination (if required by the Company) are complete and true. The undersigned agrees that (1) No waiver or modification of a contract provision or of any of the Company's rights or requirements shall be binding upon the Company unless made in writing and approved by the Company; (2) if, within 60 days from the date of application, no policy is received or I am not notified of approval or rejection, this application shall be deemed declined. There will be no life insurance until (a) a policy is delivered; (b) the first full premium is received by the Company during the Insured's lifetime, and (c) no change in the Insured's health has occurred that would place the Insured in a higher risk class than at time of application for this policy.							
Signed at _____ on the _____ day of _____, 20____							
(city/state)				(month)			
Signature of Proposed Insured				Signature of Owner (if other than Proposed Insured). If Corporation, Officer, other than Proposed Insured must sign.			
X _____				X _____			
I hereby certify that I have truly and accurately recorded on this application the information supplied by the applicant. To the best of my knowledge and belief the policy applied for <input type="checkbox"/> does <input type="checkbox"/> does not involve replacement of existing life insurance or annuity contract.							
Signature of Soliciting Agent		Name of Agent, Personal Code - Participating %		Signature of Soliciting Agent		Name of Agent, Personal Code - Participating %	
X _____		_____		X _____		_____	

**HIPAA AUTHORIZATION FOR THE USE  
AND/OR DISCLOSURE OF PROTECTED HEALTH INFORMATION**

I authorize the use and/or disclosure of the protected health information of \_\_\_\_\_ as described below:

1. This authorization applies to the information described below. Only this information may be used and/or disclosed pursuant to this authorization:  
All medical records and other protected health information concerning the above named individual.
  
2. I authorize the following persons (or class of persons) to disclose the protected health information:  
Any health plan, physician, health care professional, hospital, clinic, laboratory, pharmacy, benefit manager, medical facility, insurance company, insurance support organization or other health care provider that has provided payment, treatment or services to or on behalf of the above named individual.
  
3. I authorize the following persons (or class of persons) to receive the protected health information:  
Pan-American Life Insurance Company and/or Pan-American Assurance Company and/or \_\_\_\_\_
  
4. I understand that, if the protected health information is disclosed to someone who is not required to comply with the federal privacy regulations, then such information may be re-disclosed and would no longer be protected.
  
5. I understand that I have a right to revoke this authorization at any time. My revocation must be in writing to Pan-American Life Insurance Company, HIPAA Compliance Officer, 601 Poydras Street, New Orleans, LA 70130. I am aware that my revocation is not effective to the extent that the persons I have authorized to use and/or disclose the protected health information have acted in reliance upon this authorization.
  
6. This authorization expires upon six months after the date of signature below.
  
7. I understand that I do not have to sign this authorization. However, I understand that my claim for benefits or my application for insurance coverage may not be processed until all of the necessary information needed to complete the claims and/or underwriting process has been received by Pan-American.
  
8. The protected health information will be used or disclosed upon request for the following purposes:  
To furnish the insurer with information necessary to complete the processing of an application for life, health and/or disability insurance, and/or to furnish the insurer with information necessary to complete processing of a life and/or disability claim.
  
9. I understand that I have a right to inspect and copy the protected health information to be used or disclosed in accordance with the requirements of the federal privacy protection regulations.

I certify that I have received a copy of this authorization.

**MEDICAL INFORMATION BUREAU AUTHORIZATION**

I hereby authorize any licensed physician, medical practitioner, hospital, clinic or other medical or medically related facility, insurance company, the MIB, Inc. ("MIB"), consumer reporting agency or other organization, institution or person that has any records or knowledge of me or my minor child or my health or my minor child's health to give to the Pan-American Life Insurance Company or its reinsurers any such information in order to evaluate my application for life or disability insurance.

I agree that this authorization shall be valid for 30 months from the date signed.

I know that I may request a copy of this authorization.

I agree that a photographic copy of this authorization shall be as valid as the original.

The Undersigned acknowledges receipt of the Notice Concerning the Medical Information Bureau, the Fair Credit Reporting Act Disclosure, and the Abbreviated Notice of Insurance Information Practices.

I understand that I may be interviewed if an investigative consumer report is prepared in connection with this application.

Signature of Proposed Insured  <b>X</b>	Name of Proposed Insured	Date
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## CONDITIONAL RECEIPT

Received from \_\_\_\_\_  
for Life Insurance applied for with the application bearing the same date as this receipt:

- A payment of \$ \_\_\_\_\_  Check  Other  
 Authorization for Electronic Funds Transfer

**IMPORTANT:** The insurance applied for will take effect on the later of the completion of the application process or the completion of any medical examination or tests required by the Company, only if the following conditions are met.

1. All persons to be covered must be insurable as standard risks for the kind and amount of insurance applied for according to the Company's rules on the date the insurance takes effect.
2. Any check or draft given in payment of the initial premium must be honored when first presented.
3. The premium paid or authorized in the application must be sufficient to provide one month of the coverage applied for.
4. The total amount of life insurance provided under this receipt is limited to the amount applied for.

The conditional receipt expires at the earliest of:

1. 45 days after the application is signed.
2. Issue date of the policy.
3. The date the application is declined.

The agent and medical examiner cannot accept risks or waive any of the Company's rights or requirements. This receipt is not valid unless it is signed by an agent of the Company, the Proposed Insured and the Owner. All premium checks shall be made payable to the Company. **DO NOT MAKE CHECKS PAYABLE TO THE AGENT OR LEAVE THE PAYEE BLANK.**

**I have received and read this conditional receipt. It has been explained to me by the agent. I understand and agree to all the conditions and limitations.**

Proposed Insured's signature  <b>X</b> _____	Owner's signature <i>(if different than Proposed Insured)</i>  <b>X</b> _____
Agent's signature  <b>X</b> _____	Date signed
Agent's name	Agent's Code

If you do not hear from the Company regarding the proposed insurance within 45 days, notify the Administrative Offices of the Company at 601 Poydras Street, New Orleans, LA 70130. Give your name, the agent's name, date and amount paid.

**INSURANCE, IF ANY, PROVIDED UNDER THIS RECEIPT IS CONDITIONAL. IF ANY OF THE ABOVE CONDITIONS ARE NOT MET, OR IF THE APPLICATION PROCESS IS NOT COMPLETE, THIS RECEIPT CONFERS NO INSURANCE AND THE PREMIUM PAID WILL BE RETURNED TO YOU.**

**THIS NOTICE MUST BE DELIVERED TO THE PROPOSED INSURED  
WHEN APPLICATION IS COMPLETED**

**NOTICE CONCERNING THE MEDICAL INFORMATION BUREAU**

Information regarding your insurability will be treated as confidential. Pan-American Assurance Company or its reinsurers may, however, make a brief report thereon to the MIB, Inc., formerly known as Medical Information Bureau, a not-for-profit membership organization of insurance companies, which operates an information exchange on behalf of its Members. If you apply to another MIB Member company for life insurance 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. 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 Fair Credit Reporting Act. The address of MIB's information office is 50 Braintree Hill Park, Suite 400, Braintree, Massachusetts 02184-8734, telephone (866) 692-6901 (TTY 866-346-3642).

Pan-American Assurance Company or its reinsurers may also release information in its file to other insurance companies to whom you may apply for life or health insurance, or to whom a claim for benefits may be submitted. Information for consumers about MIB may be obtained on its website at [www.mib.com](http://www.mib.com).

**FAIR CREDIT REPORTING ACT DISCLOSURE**

In making this application, it is understood that an investigative consumer report may be prepared whereby information is obtained through personal interviews with your neighbors, friends, or others with whom you are acquainted. This inquiry includes information as to your character, general reputation, personal characteristics and mode of living. You have the right to make a written request within a reasonable period of time to receive additional, detailed information about the nature and scope of this investigation and a written summary of your rights under the Fair Credit Reporting Act.

**ABBREVIATED NOTICE OF INSURANCE INFORMATION PRACTICES**

To issue an insurance policy we need to obtain information about you. Some of that information will come from you and some will come from other sources. The information collected by us may in certain circumstances be disclosed to third parties without your specific authorization.

You have a right of access and correction with respect to the information collected except information which relates to a claim or civil or criminal proceeding.

If you wish to have a more detailed explanation of our information practices, please write to the Underwriting Department, Pan-American Assurance Company, P.O.Box 60219, New Orleans, Louisiana. 70160.

**PAN-AMERICAN LIFE INSURANCE COMPANY**  
**PAN-AMERICAN ASSURANCE COMPANY**  
P.O. BOX 60219, NEW ORLEANS, LOUISIANA 70160

**INSURANCE FRAUD WARNING**  
(Required by Law)

Arkansas law requires us to include the following language on all applications.

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 of fines and confinement in prison.



**San J. Llull**  
Senior Compliance and Policy Analyst  
601 Poydras Street  
New Orleans, LA 70130  
E-mail: slull@panamericanlife.com  
(504-566-3449)

August 10, 2011

NAIC # 93459  
FEIN # 72-0917222

Mr. Dan Honey  
State of Arkansas  
Dept of Insurance  
1200 W. Third Street  
Little Rock, AR 72201

**RE: ADJUSTABLE PREMIUM LEVEL TERM**

Dear Mr. Honey:

Enclosed for your review is policy form 38AD(AR), Adjustable Premium Level Term Insurance to Age 95. This is an original form and does not replace any previously approved form. This product will be marketed for individual sales through various channels, including telemarketing, broker dealers, and banks. It will be sold without an illustration. The client chooses the term option of 20 or 30 years and the benefit amount. This product will be offered to clients between the ages of 18 and 60 for the 20-year option and up to age 50 for the 30-year option.

The application form B-1545 will be used to issue this policy. This application will be taken by licensed agents through both telemarketing and direct sales. For telemarketing, the agent will fill out the application using a predefined script.

A new rider form 33ADB, Global Repatriation Benefit Rider will be available with this product. This rider is optional and designed to provide the payments for the preparation and return of the covered insured's body to their place of residence or place of burial.

Included in this filing are the following items:

1. Policy Form 38AD(AR)
2. Application B-1545 with Form B-1542 for Fraud Warning disclosure.
3. Rider 33ADB
4. Readability Certification
5. Actuarial Memorandum

If you need further information, you may contact me at 504-566-3449. Thank you for your time and consideration.

Sincerely,

San J. Llull  
Senior Compliance and Policy Analyst

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

Residents of this state who purchase life insurance, annuities or disability 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 policy owners 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 the 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. However, insurance companies and their agents are prohibited by law from using the existence of the Guaranty Association to induce you to purchase any kind of insurance policy.**

**The Arkansas Life and Health Insurance Guaranty Association  
c/o The Liquidation Division  
1023 West Capitol  
Little Rock, Arkansas 72201**

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

The state law that provides for this safety-net coverage is called the Arkansas Life and Health Insurance Guaranty Association Act ("Act"). On the back of this page 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 insurance 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 owning 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 contractholders, 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).

## **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 net 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 owner 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.

# IMPORTANT INFORMATION

- PAN-AMERICAN LIFE INSURANCE COMPANY
- PAN-AMERICAN ASSURANCE COMPANY

POLICY OWNER SERVICE  
PAN-AMERICAN LIFE CENTER  
NEW ORLEANS, LOUISIANA 70130  
(504) 566-1300

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AGENT \_\_\_\_\_  
ADDRESS \_\_\_\_\_  
TELEPHONE \_\_\_\_\_

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**For more information contact:**  
Arkansas Insurance Department  
1200 West Third Street  
Little Rock, AR 72201  
(501) 371-2640 or 1-800-852-5494