

SERFF Tracking Number: AHLI-127627912 State: Arkansas
 Filing Company: The American Home Life Insurance Company State Tracking Number: 49824
 Company Tracking Number:
 TOI: L07I Individual Life - Whole Sub-TOI: L07I.101 Fixed/Indeterminate Premium - Single Life
 Product Name: 2011 Final Expense Applications
 Project Name/Number: /

Filing at a Glance

Company: The American Home Life Insurance Company

Product Name: 2011 Final Expense Applications SERFF Tr Num: AHLI-127627912 State: Arkansas

TOI: L07I Individual Life - Whole SERFF Status: Closed-Approved-Closed State Tr Num: 49824

Sub-TOI: L07I.101 Fixed/Indeterminate Premium - Single Life Co Tr Num: State Status: Approved-Closed

Filing Type: Form

Reviewer(s): Linda Bird
 Author: Juell Moulden Disposition Date: 09/21/2011
 Date Submitted: 09/19/2011 Disposition Status: Approved-Closed

Implementation Date Requested: On Approval
 State Filing Description:

Implementation Date:

General Information

Project Name:
 Project Number:
 Requested Filing Mode: Review & Approval
 Explanation for Combination/Other:
 Submission Type: New Submission
 Overall Rate Impact:

Status of Filing in Domicile: Pending

Date Approved in Domicile:

Domicile Status Comments:

Market Type: Individual

Individual Market Type:

Filing Status Changed: 09/21/2011

State Status Changed: 09/21/2011

Deemer Date:

Created By: Juell Moulden

Submitted By: Juell Moulden

Corresponding Filing Tracking Number:

Filing Description:

Application Form 2011 FEPA-AR is the application form American Home Life will be using exclusively with policy forms 06 FEPL-AR, 06 FSPL-AR, and 06 FEPG-AR, which were previously approved. The following changes have been made to the present application, Form 2007 FEPA-AR, previously approved by your state:

1. All of the medical questions (page 2) have been updated for clarity purposes. Additional medical questions are also now included.
2. The MIB notice has been updated.

SERFF Tracking Number: AHLL-127627912 State: Arkansas
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 Product Name: 2011 Final Expense Applications
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American Home Life uses the Final Expense (Guidestar®) Insurance Telephone Script as a part of the underwriting process in addition to the Form 2011 FEPA-AR. The proposed insured is asked the medical questions and to confirm their personal information over the telephone as set forth in the script by an American Home Life representative. In addition, we confirm all of the information provided by the agents in the Form 2011 FEPA-AR. This form was previously approved as 2010 FEITS and the following changes have been made:

1. Simplified the information obtained.
2. Mirrored the medical questions to that of the Form 2011 FEPA-AR.

The 2011 TSFE is a Telesales Phone Interview which is used by an American Home Life representative when the Form 2011 FEPA-AR is taken over the telephone (in lieu of the completed application being mailed or faxed to our company). Our representative completes the Form 2011 FEPA-AR as they follow the 2011 TSFE script obtaining the information from the agent and proposed insured.

Company and Contact

Filing Contact Information

Juell Nebergall, Legal Correspondent jnebergall@amhomelife.com
 400 S Kansas Ave 785-235-6276 [Phone] 344 [Ext]
 P.O. Box 1497 785-235-1037 [FAX]
 Topeka, KS 66601

Filing Company Information

The American Home Life Insurance Company	CoCode: 60542	State of Domicile: Kansas
400 S Kansas Ave	Group Code:	Company Type: Life Insurance & Annuities
P.O. Box 1497	Group Name:	State ID Number:
Topeka, KS 66601	FEIN Number: 48-0119710	
(785) 235-6276 ext. [Phone]		

Filing Fees

Fee Required?	Yes
Fee Amount:	\$150.00
Retaliatory?	No
Fee Explanation:	3 Applications @ \$50 each
Per Company:	No

SERFF Tracking Number: AHLL-127627912 State: Arkansas
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TOI: L071 Individual Life - Whole Sub-TOI: L071.101 Fixed/Indeterminate Premium - Single Life
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COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
The American Home Life Insurance Company	\$150.00	09/19/2011	51742393

SERFF Tracking Number: AHLL-127627912 State: Arkansas
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TOI: L071 Individual Life - Whole Sub-TOI: L071.101 Fixed/Indeterminate Premium - Single Life
Product Name: 2011 Final Expense Applications
Project Name/Number: /

Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Linda Bird	09/21/2011	09/21/2011

SERFF Tracking Number: *AHLI-127627912* *State:* *Arkansas*
Filing Company: *The American Home Life Insurance Company* *State Tracking Number:* *49824*
Company Tracking Number:
TOI: *L071 Individual Life - Whole* *Sub-TOI:* *L071.101 Fixed/Indeterminate Premium - Single*
Product Name: *2011 Final Expense Applications*
Project Name/Number: */*
Life

Disposition

Disposition Date: 09/21/2011

Implementation Date:

Status: Approved-Closed

Comment:

Rate data does NOT apply to filing.

SERFF Tracking Number: AHLL-127627912 State: Arkansas
 Filing Company: The American Home Life Insurance Company State Tracking Number: 49824
 Company Tracking Number:
 TOI: L071 Individual Life - Whole Sub-TOI: L071.101 Fixed/Indeterminate Premium - Single Life
 Product Name: 2011 Final Expense Applications
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Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification		Yes
Supporting Document	Application		No
Supporting Document	Life & Annuity - Acturial Memo		No
Form	Final Expense Application		Yes
Form	Guidestar Insurance Telephone Script		Yes
Form	Telesales Phone Interview		Yes

SERFF Tracking Number: AHLL-127627912 State: Arkansas
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 TOI: L071 Individual Life - Whole Sub-TOI: L071.101 Fixed/Indeterminate Premium - Single Life
 Product Name: 2011 Final Expense Applications
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Form Schedule

Lead Form Number: Form 2011 FEPA-AR

Schedule Item Status	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
	Form 2011 FEPA-AR	Application/ Enrollment Form	Final Expense Enrollment Application	Initial		49.500	AR.pdf
	2011 FEITS	Application/ Enrollment Form	Guidestar Insurance Telephone Script	Initial		63.400	2011 FEITS.pdf
	2011 TSFE	Application/ Enrollment Form	Telesales Phone Interview	Initial		43.600	2011 TSFE.pdf

HEALTH INFORMATION**Yes No****If any part of questions 1-5 is answered "YES" do not submit the application.**

- | | | |
|--|--------------------------|--------------------------|
| 1. Are you hospitalized, bedridden or confined to a nursing home, hospice or long-term care facility? | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Have you been diagnosed by or received treatment from a medical professional for any of the following: | | |
| A. A terminal illness, ALS, Alzheimer's or dementia? | <input type="checkbox"/> | <input type="checkbox"/> |
| B. Diabetes accompanied by heart disease (excluding hypertension), kidney disease, peripheral arterial disease (PAD, poor circulation), Transient Ischemic Attack (TIA) or stroke? | <input type="checkbox"/> | <input type="checkbox"/> |
| C. Cirrhosis or liver failure? | <input type="checkbox"/> | <input type="checkbox"/> |
| D. Kidney failure requiring dialysis? | <input type="checkbox"/> | <input type="checkbox"/> |
| E. Used or been advised to use oxygen to assist breathing? | <input type="checkbox"/> | <input type="checkbox"/> |
| F. Leukemia or organ transplant? | <input type="checkbox"/> | <input type="checkbox"/> |
| G. Coronary artery disease (CAD) accompanied by (1) congestive heart failure or (2) cardiomyopathy? | <input type="checkbox"/> | <input type="checkbox"/> |
| H. Implantation of a defibrillator? | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. To the best of your knowledge, have you been diagnosed or treated by a medical professional for an immune deficiency disorder, HIV, AIDS, or AIDS related complex (ARC), or tested positive on an AIDS related blood test? | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Have you, within the past 12 months , been advised to have a diagnostic test, surgery, dialysis, home health care, nursing home, hospice or long-term care facility confinement or hospitalization which has not yet been started, completed or for which results are not known? | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. In the last 36 months , have you been convicted of a felony or of operating a vehicle while intoxicated or impaired or are you presently incarcerated, on probation or parole? | <input type="checkbox"/> | <input type="checkbox"/> |

If two or less of the following questions (6-9) are answered "yes", Proposed Insured will only be eligible for Graded Benefit. If more than two questions (6-9) are answered yes, do not submit the application.**Yes No**

- | | | |
|--|--------------------------|--------------------------|
| 6. Do you have diabetes diagnosed by a medical professional (a) with duration of 10 years or more, or (b) requiring insulin, or (c) diagnosed at any age and that is not controlled? | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. Do you need ongoing assistance with activities of daily living (help with eating, bathing, dressing, transferring, use of the toilet or the taking of medications) either provided by a family member or third party? | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. In the last 24 months have you been diagnosed by or received treatment from a medical professional for any of the following: | | |
| A. Heart disease (excluding hypertension) or any procedure to improve circulation to the heart including coronary artery bypass or stents? | <input type="checkbox"/> | <input type="checkbox"/> |
| B. Stroke or Transient Ischemic Attack (TIA) or a procedure to improve circulation to the brain? | <input type="checkbox"/> | <input type="checkbox"/> |
| C. Peripheral arterial disease (PAD, poor circulation) or any procedure to improve circulation to the extremities? | <input type="checkbox"/> | <input type="checkbox"/> |
| D. Counseling or treatment for alcohol or substance abuse? | <input type="checkbox"/> | <input type="checkbox"/> |
| E. Kidney or liver disease? | <input type="checkbox"/> | <input type="checkbox"/> |
| F. Any chronic lung disorder excluding intermittent asthma attacks? | <input type="checkbox"/> | <input type="checkbox"/> |
| 9. In the last 36 months have you been diagnosed by or received treatment from a medical professional for internal cancer, melanoma or disorder of the blood (this excludes squamous cell and basal cell skin cancers)? | <input type="checkbox"/> | <input type="checkbox"/> |

Have you smoked cigarettes in the past 12 months?

 PHYSICIAN INFORMATION (U.S. physician required)

Primary Physician's Name

Address

Phone Number

DECLARATIONS AND AUTHORIZATION DECLARATIONS

I have read and received the Pre-Notices attached to this application. I agree that: 1) all statements and answers are true and complete; 2) this application will be a part of the policy; 3) temporary insurance coverage starts and remains in effect only as provided in the "Conditional Receipt". I certify, under penalty of perjury that the social security numbers shown on the application are correct. I understand that the agent is not authorized to accept risks or pass on insurability, to make or modify contracts, or waive the Company's rights including the requirement that the adult proposed insured personally sign this application in the agent's presence.

If the Company does not issue a policy from this application, the application will be canceled and a refund will be made. By accepting a policy issued from this application, the owner agrees to any changes made by the Company.

I understand that I may attend any and all meetings of the policyholders of the Company. If I do not attend, the Executive Committee of the Board of Directors will act as my lawful proxy, until that proxy is revoked by me, in writing. The annual meeting of policyholders shall be held at 10:00 a.m. on the second Tuesday in March, each year.

I permit the Company to give information about me and any proposed insured except HIV test results to MIB, any reinsurer, and other insurer(s) from which benefits have been claimed or insurance purchased. I acknowledge receipt of the Notice Regarding MIB, Notice Regarding Fair Credit Reporting Act and Notice of Information Practices before signing this form. I understand that I may request in writing to be interviewed. If any investigative consumer report is prepared in connection with this application, upon written request, I am entitled to receive a copy. I understand that there is no benefit paid for suicide for the first two policy years (for residents of Colorado, Missouri and North Dakota, one policy year).

AUTHORIZATION TO OBTAIN INFORMATION

By this form, I authorize any licensed physician, medical practitioner, clinic, hospital, other medical or medically-related facility, the Veterans Administration, MIB, an employer, consumer reporting agency, any person, organization, other institution or other insurance companies that have records or knowledge about me or any children to be insured (if applicable) to release this information to The American Home Life Insurance Company of Kansas. This information may be about: (a) employment; (b) occupation; (c) avocations; (d) other insurance coverage; (e) driving record; (f) age; (g) prescription drug usage; (h) any medical history, condition, care or advice relative to the proposed insured's physical or mental health; and (i) other personal characteristics. This AUTHORIZATION extends to information on the use of alcohol, drugs and tobacco; and the diagnosis or treatment of HIV (the virus that causes AIDS) infection or other sexually transmitted disease. I understand that this information will be used by The American Home Life Insurance Company of Kansas, its representatives or reinsurers in the evaluation of this application to determine eligibility for insurance and/or to investigate claims. The American Home Life Insurance Company of Kansas or its representatives may release information covered by this AUTHORIZATION to the American Home Agent(s) listed in my application for insurance, to its subsidiaries, reinsurers, the MIB, or other insurance companies. The American Home Life Insurance Company of Kansas may also release this information to others who I authorize in writing or as allowed by law.

This AUTHORIZATION may be used for a period of 24 months from the date signed below unless sooner revoked. I may revoke this AUTHORIZATION at any time by notifying The American Home Life Insurance Company of Kansas in writing at Underwriting Department, The American Home Life Insurance Company, P.O. Box 1497, Topeka, KS 66601. My revocation will not be effective to the extent The American Home Life Insurance Company, its reinsurers, or any other person already has disclosed or collected information or taken other action in reliance on the AUTHORIZATION. I understand that my application for insurance will not be considered unless this AUTHORIZATION is signed and dated. The information The American Home Life Insurance Company of Kansas or its reinsurers obtains through this AUTHORIZATION may become subject to further disclosure, as required by law. I understand that any information that is disclosed pursuant to this AUTHORIZATION is no longer covered by federal rules governing privacy and confidentiality of health information, but it will not be redisclosed except as authorized by me or as required by law. I agree that a photocopy of this AUTHORIZATION is as valid as the original. I understand that I have the right to receive a copy of this AUTHORIZATION upon request.

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

NOTICE: I have reviewed all answers and responses contained in this application. I certify that all answers and responses contained in this application are true and correct to the best of my knowledge. I UNDERSTAND THAT ANY INCORRECT STATEMENTS, OMISSIONS, OR MISREPRESENTATIONS IN THE APPLICATION WHICH AFFECT THE ACCEPTANCE OF THE RISK OR HAZARD ASSUMED BY THE COMPANY MAY RESULT IN THE LOSS OF COVERAGE AND NONPAYMENT OF DEATH BENEFITS SUBJECT TO THE "INCONTESTABILITY" PROVISION OF THE POLICY.

Signed at _____
Date _____
Agent _____

Proposed Insured _____
Applicant/Owner _____
Agent Name (Printed) _____

Mail Policy To: Agent Insured Owner

AGENT'S CERTIFICATION

I hereby certify that, to the best of my knowledge, there is is not existing life insurance and/or annuity contract(s) on the life of the insured. If there is, I have presented and read the applicant a notice regarding replacement, if required by applicable state law. If there is existing coverage, I certify that the insurance hereby applied for will will not replace any existing life insurance or annuity contract. I further certify that: 1) the above answers are full, complete and true to the best of my knowledge; 2) that I know of no factors affecting the insurability of any proposed insured except as stated on the application; 3) that the above signatures are those they are represented to be; and 4) that the application was signed by all proposed insureds in my presence.

Signed at _____
Date _____
Remarks _____

Licensed Agent _____
Agent Number _____

AGENT'S REMARKS

Telephone Interview Completed: Yes No

Best Time to Call: ____AM ____PM

Premium Notices To: Insured Owner

Mail Policy To: Agent Insured Owner

Remarks/Requests: _____

COMPANY'S COPY OF THE CONDITIONAL RECEIPT

All Premium Checks Must Be Payable to American Home Life Insurance Company; Do Not Make Checks Payable To The Agent Or Leave The Payee Blank.

Received \$ _____ from _____ in connection with the application for life insurance, including any riders for which application has been made.

1. **NO INSURANCE WILL BECOME EFFECTIVE PRIOR TO DELIVERY OF THE POLICY UNLESS AND UNTIL EACH AND EVERY ONE OF THE FOLLOWING CONDITIONS HAVE BEEN FULFILLED EXACTLY:**
 - (a) **If the proposed insured(s) is/are a tobacco user**, the amount of payment taken with the application must be at least equal to the amount of the full first premium at tobacco premium rates for the mode of payment selected in the application and for the amount of insurance which may become effective prior to delivery of the policy;
 - (b) **If the proposed insured(s) is/are NOT a tobacco user**, the amount of payment taken with the application must be at least equal to the amount of the full first premium at non-tobacco premium rates for the mode of payment selected in the application and for the amount of insurance which may become effective prior to delivery of the policy;
 - (c) all medical examinations, tests, x-rays, and electrocardiograms required by the Company must be completed and received at its Home Office within 60 days from the date of completion of the application;
 - (d) on the Effective Date, as defined below, the Company at its Home Office must be satisfied that each person proposed for insurance in this application is a risk insurable by the company at no greater than standard tobacco or standard non-tobacco premium rates under its rules, limits, and standards for the plan and the amount applied for without any modification either as to plan, amount riders, or supplemental agreements; and
 - (e) on the Effective Date the state of health and all factors, including tobacco usage, affecting the insurability of each person proposed for insurance must be as stated in the application.
2. Subject to the conditions of paragraph 1, insurance, as provided by the terms and conditions of the policy applied for and in use on the Effective Date, but for an amount not exceeding that specified in paragraph 2, will become effective as of the Effective Date. "Effective Date", as used herein, is the latest of (a) the date of completion of the application questions, or (b) the date of completion of all medical examinations, prescription checks, tests, x-rays, and electrocardiograms required by the Company, or (c) the date of issue, if any, requested in the application.
3. **The total amount of insurance which may become effective on any person proposed for insurance shall not exceed \$35,000 of life insurance.**
4. If one or more of the conditions of paragraph 1 have not been fulfilled exactly, there shall be no liability on the part of the Company except to return the applicable payment in exchange for this Receipt.
5. **NO AGENT OR ANY OTHER PERSON IS AUTHORIZED BY THE COMPANY TO WAIVE OR MODIFY IN ANY WAY ANY OF THE PROVISIONS OF THIS CONDITIONAL RECEIPT.**

Date at _____

Signature of Agent

this _____ day of _____ Year _____

I acknowledge possession of this receipt and I certify that I have read it and the agreement in the application. The terms and conditions of this receipt, to which I agree, and the agreement in the application have been explained to me fully by the agent and I understand them.

Signature of the Owner

OWNER'S COPY OF THE CONDITIONAL RECEIPT

All Premium Checks Must Be Payable to American Home Life Insurance Company; Do Not Make Checks Payable To The Agent Or Leave The Payee Blank.

1. **NO INSURANCE WILL BECOME EFFECTIVE PRIOR TO DELIVERY OF THE POLICY UNLESS AND UNTIL EACH AND EVERY ONE OF THE FOLLOWING CONDITIONS HAVE BEEN FULFILLED EXACTLY:**
 - (a) **If the proposed insured(s) is/are a tobacco user**, the amount of payment taken with the application must be at least equal to the amount of the full first premium at tobacco premium rates for the mode of payment selected in the application and for the amount of insurance which may become effective prior to delivery of the policy;
 - (b) **If the proposed insured(s) is/are NOT a tobacco user**, the amount of payment taken with the application must be at least equal to the amount of the full first premium at non-tobacco premium rates for the mode of payment selected in the application and for the amount of insurance which may become effective prior to delivery of the policy;
 - (c) all medical examinations, tests, x-rays, and electrocardiograms required by the Company must be completed and received at its Home Office within 60 days from the date of completion of the application;
 - (d) on the Effective Date, as defined below, the Company at its Home Office must be satisfied that each person proposed for insurance in this application is a risk insurable by the company at no greater than standard tobacco or standard non-tobacco premium rates under its rules, limits, and standards for the plan and the amount applied for without any modification either as to plan, amount riders, or supplemental agreements; and
 - (e) on the Effective Date the state of health and all factors, including tobacco usage, affecting the insurability of each person proposed for insurance must be as stated in the application.
2. Subject to the conditions of paragraph 1, insurance, as provided by the terms and conditions of the policy applied for and in use on the Effective Date, but for an amount not exceeding that specified in paragraph 2, will become effective as of the Effective Date. "Effective Date", as used herein, is the latest of (a) the date of completion of the application questions, or (b) the date of completion of all medical examinations, prescription checks, tests, x-rays, and electrocardiograms required by the Company, or (c) the date of issue, if any, requested in the application.
3. **The total amount of insurance which may become effective on any person proposed for insurance shall not exceed \$35,000 of life insurance.**
4. If one or more of the conditions of paragraph 1 have not been fulfilled exactly, there shall be no liability on the part of the Company except to return the applicable payment in exchange for this Receipt.
5. **NO AGENT OR ANY OTHER PERSON IS AUTHORIZED BY THE COMPANY TO WAIVE OR MODIFY IN ANY WAY ANY OF THE PROVISIONS OF THIS CONDITIONAL RECEIPT.**

OWNER'S COPY OF THE AUTHORIZATION TO OBTAIN INFORMATION

By this form, I **authorize** any licensed physician, medical practitioner, clinic, hospital, other medical or medically-related facility, the Veterans Administration, MIB, an employer, consumer reporting agency, any person, organization, other institution or other insurance companies that have records or knowledge about me or any children to be insured (if applicable) to release this information to The American Home Life Insurance Company of Kansas. This information may be about: (a) employment; (b) occupation; (c) avocations; (d) other insurance coverage; (e) driving record; (f) age; (g) prescription drug usage; (h) any medical history, condition, care or advice relative to the proposed insured's physical or mental health; and (i) other personal characteristics. This AUTHORIZATION extends to information on the use of alcohol, drugs and tobacco; and the diagnosis or treatment of HIV (the virus that causes AIDS) infection or other sexually transmitted disease. I understand that this information will be used by The American Home Life Insurance Company of Kansas, its representatives or reinsurers in the evaluation of this application to determine eligibility for insurance and/or to investigate claims. The American Home Life Insurance Company of Kansas or its representatives may release information covered by this AUTHORIZATION to the American Home Agent(s) listed in my application for insurance, to its subsidiaries, reinsurers, the MIB, or other insurance companies. The American Home Life Insurance Company of Kansas may also release this information to others who I authorize in writing or as allowed by law.

This AUTHORIZATION may be used for a period of 24 months from the date signed below unless sooner revoked. I may revoke this AUTHORIZATION at any time by notifying The American Home Life Insurance Company of Kansas in writing at Underwriting Department, The American Home Life Insurance Company, P.O. Box 1497, Topeka, KS 66601. My revocation will not be effective to the extent The American Home Life Insurance Company, its reinsurers, or any other person already has disclosed or collected information or taken other action in reliance on the AUTHORIZATION. I understand that my application for insurance will not be considered unless this AUTHORIZATION is signed and dated. The information The American Home Life Insurance Company of Kansas or its reinsurers obtains through this AUTHORIZATION may become subject to further disclosure, as required by law. I understand that any information that is disclosed pursuant to this AUTHORIZATION is no longer covered by federal rules governing privacy and confidentiality of health information, but it will not be redisclosed except as authorized by me or as required by law. I agree that a photocopy of this AUTHORIZATION is as valid as the original. I understand that I have the right to receive a copy of this AUTHORIZATION upon request.

NOTICE REGARDING MIB

Information regarding your insurability will be treated as confidential. The American Home Life Insurance Company of Kansas 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 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 about you in its file.

Upon receipt of a request from you, MIB will arrange disclosure of any information in your file. Please contact MIB at 866-692-6901 (TTY 866 346-3642). If you question the accuracy of the 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.

The American Home Life Insurance Company of Kansas, or its reinsurers, may also release information from 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.

NOTICE REGARDING FAIR CREDIT REPORTING ACT

You are entitled to know that, as a part of our regular procedures, we may request an investigative consumer report concerning the insurability of each person proposed for coverage. This report would include information as to character, general reputation, personal characteristics and mode of living, except as may be related directly or indirectly to your sexual orientation, obtained through personal interviews with friends, neighbors, and associates of the Proposed Insured(s).

Upon receipt of written request to our Home Office, we will inform you whether an investigative consumer report has, in fact, been obtained and the name and address of the consumer reporting agency from whom the report was requested. Copies of the report may be obtained from the consumer reporting agency.

NOTICE OF INFORMATION PRACTICES

To properly underwrite and administer your life insurance coverage, American Home Life must collect certain information. The primary source of information is your application and any supporting amendments, questionnaires, etc. However, it may be necessary to obtain more information from sources such as medical professionals and institutions which have provided care to you or members of your family who have applied for coverage. We may contact your employers, business associates, friends and neighbors, public records, and other insurance companies to which you may have applied. Information from these sources may be obtained by correspondence, phone, or personal contact. In some cases, we may ask an insurance support organization to complete an investigative consumer report for us. This information may be disclosed as follows:

1. To other persons or organizations who perform business, professional or insurance services for us, and whose proper performance for us requires that we disclose certain information to them.
2. To another insurance company to which you have applied for coverage or benefits.
3. To your AHL agent to assist in providing proper service to you.
4. To insurance support organizations formed to prevent or detect fraud in insurance transactions.
5. To our reinsurers if we ask them to accept a portion of the risk under your policy.
6. To a medical care institution or medical professional to verify that you have coverage with us. Also, if a medical examination for insurance purposes reveals a condition or problem unknown to the individual, we may inform the individual's personal medical professional.
7. To state regulatory authorities who conduct examinations and audits of company operations,
8. To law enforcement agencies to assist in the prevention or prosecution of fraud, or to alert them to the possibilities of illegal conduct.

You have certain rights concerning access to information about you that we have collected and retained in our files. To maintain security of that information, access will be permitted only after proper identification has been submitted to us.

If you would like access to this information you must send a signed, written request to the Underwriting Department, The American Home Life Insurance Company, P.O. Box 1497, Topeka, Kansas 66601. The request must include full name, address, telephone number and policy number. Within 30 business days after receiving your request we will tell you the nature and substance of the information in our files. If you wish to see and copy the records in person, we will advise you of the location of the records. There may be a charge for each copy made.

Also we will tell you to whom we have disclosed information about you within the last two years or to whom such information normally would have been disclosed.

There are limitations of access. We will identify sources of information which comes from institutions such as hospitals, clinics, doctors or insurance support organizations, but we will not identify sources of information which was obtained from individuals such as friends or neighbors. Also, we are not obligated to provide access to information obtained in connection with or in anticipation of a claim for policy benefits or a civil or criminal proceeding.

Medical information will be provided only through a doctor or some other medical professional, designated by you, who is licensed to provide medical care relevant to the nature of the information.

If you believe, after reviewing information in our files, that it is incorrect, you may request, in writing, that we correct, amend or delete any item of information. Requests should be directed to the Underwriting Department, The American Home Life Insurance Company, P.O. Box 1497, Topeka, Kansas 66601. We will respond within thirty business days of receipt of your written request.

If we agree that certain changes should be made, we will notify any person to whom we may have disclosed the original information during the preceding two years. We will also notify any insurance support organization to whom we have disclosed the information or who may have furnished the original information.

If we do not agree to change our records, you may file with us a brief written statement setting forth what you believe to be the correct, relevant or fair information and why you disagree with our decision not to change the original information. Your statement will become a permanent part of our file and will be disclosed in the future with the original information. Also, copies of your statement will be sent to any person or insurance support organization to whom the original information was furnished.

ACCELERATED BENEFIT RIDER

Summary and Acknowledgement

BRIEF DESCRIPTION: This rider enables the Owner to claim a portion of the policy's death benefit prior to the actual death of the Insured, when the Insured is diagnosed as having a Qualifying Event. The benefit, when paid, is treated as an advance against the death benefit, reducing the policy's death benefit, accordingly. Descriptions of major provisions are given below.

AVAILABILITY: Automatically provided in any new American Home Life final expense policy at issue.

MINIMUM BENEFIT: \$1,000.

MAXIMUM BENEFIT: 100% of the policy's Eligible Proceeds which, in no event shall exceed the lesser of the policy's death benefit or \$35,000. Eligible Proceeds are that portion of the policy's death benefit that can be paid out as an Accelerated Benefit. Additional death benefits provided by rider or endorsement are not a part of the policy's Eligible Proceeds. The Accelerated Benefit amount is subject to the following adjustments and deductions: (1) An actuarial discount, (2) repayment of a portion of any outstanding policy loan, (3) payment of any premium due within the policy's grace period and unpaid at the time the Accelerated Benefit is approved for payment, (4) an Administrative Expense Fee of \$150 for each Accelerated Benefit claim.

BENEFIT QUALIFICATION: To make a claim for the Accelerated Benefit, the Insured must be diagnosed as having a Qualifying Event, which means (1) a non-correctable medical condition that, with reasonable medical certainty, will result in the death of the Insured within 12 months from the date on which this benefit is requested or (2) permanent and continuous confinement to a nursing home licensed and operated for nursing home care pursuant to the laws of the state in which it is located, and providing nursing care as its primary function. The Company will require a physician's statement certifying the Insured's life expectancy in the event of a terminal illness or certification of permanent confinement as outlined in the rider.

BENEFIT PAYMENT: The Accelerated Benefit may be paid in a lump sum. It may also be paid in installments of not less than \$250. The amount of each installment payment will be based on the following: (1) The lump sum amount; (2) the frequency of payment; (3) the number of installment payments to be made; and (4) a minimum interest rate of 3%.

BENEFITS AND ADJUSTMENTS: The following sample illustration shows how the amount available for payment as an Accelerated Benefit is calculated:

Base Policy:	\$10,000	Cash Value:	\$1,000
Eligible Death Benefit:	\$10,000	Policy Loan:	\$ 500
Maximum Gross Accelerated Benefit:			\$10,000
Requested Accelerated Benefit:			\$ 5,000

Adjustments:	Actuarial Discount	Loan Repayment	Premiums Due	Admin Fee	Total Adjustments
	\$5,000	\$500			
X	.05*	.50			
	<u>\$250</u>	<u>\$250</u>	<u>\$50</u>	<u>\$150</u>	<u>\$700</u>
	+	+	+	=	

*Discount rate is variable; 5% used as example only.

Maximum Net Accelerated Benefit: \$ 4,300 (\$5,000 - \$700 = \$4,300)

EFFECT ON POLICY VALUES: This shows how the benefits of the policy are altered after an Accelerated Benefit is paid:

Base Policy:	\$ 5,000	(\$10,000 X .5	= \$5,000)
Benefit at Death:	\$ 5,000		
Cash Value:	\$ 500	(\$1,000 X .5	= \$500)
Policy Loan:	<u> - 250</u>	(\$ 500 X .5	= \$250)
Remaining Cash Value:	\$ 250	(\$ 500 - \$250	= \$250)

Premium Before Benefit: \$ 600 per year

Premium After Benefit: \$ 300 per year (\$ 600 X .5 = \$300)

TAX CONSEQUENCES: Acceleration of life insurance benefits under this rider may or may not qualify for favorable tax treatment under the Internal Revenue Code of 1986, section 101 (g). Qualification for favorable tax treatment will depend on factors such as the Insured's life expectancy at the time benefits are accelerated or use of benefits for necessary long-term care expenses, such as nursing home care. If the acceleration of life insurance benefits qualifies for favorable tax treatment, the benefits will be excludable from the Owner's income and not subject to federal taxation. Tax laws relating to acceleration of life insurance benefits are complex. Consult a qualified tax advisor to assess the tax consequences of accelerated benefits.

ACCELERATED BENEFITS AND PUBLIC ASSISTANCE PROGRAMS: Receipt of accelerated benefits may affect eligibility for public assistance programs such as medical assistance (Medicaid), Aid to Families with Dependent Children (AFDC), supplementary social security income (SSI) and drug assistance programs. Consult a qualified tax advisor and social service agencies concerning how receipt of accelerated benefits will affect eligibility for public assistance.

I hereby acknowledge receipt of the Summary and Acknowledgement form. I also acknowledge that I have reviewed the "Benefits and Adjustments" and "Effect on Policy Values".

Signature of Agent

Date

Signature of Owner

Date

ACCELERATED BENEFIT RIDER

Summary and Acknowledgement

BRIEF DESCRIPTION: This rider enables the Owner to claim a portion of the policy's death benefit prior to the actual death of the Insured, when the Insured is diagnosed as having a Qualifying Event. The benefit, when paid, is treated as an advance against the death benefit, reducing the policy's death benefit, accordingly. Descriptions of major provisions are given below.

AVAILABILITY: Automatically provided in any new American Home Life final expense policy at issue.

MINIMUM BENEFIT: \$1,000.

MAXIMUM BENEFIT: 100% of the policy's Eligible Proceeds which, in no event shall exceed the lesser of the policy's death benefit or \$35,000. Eligible Proceeds are that portion of the policy's death benefit that can be paid out as an Accelerated Benefit. Additional death benefits provided by rider or endorsement are not a part of the policy's Eligible Proceeds. The Accelerated Benefit amount is subject to the following adjustments and deductions: (1) An actuarial discount, (2) repayment of a portion of any outstanding policy loan, (3) payment of any premium due within the policy's grace period and unpaid at the time the Accelerated Benefit is approved for payment, (4) an Administrative Expense Fee of \$150 for each Accelerated Benefit claim.

BENEFIT QUALIFICATION: To make a claim for the Accelerated Benefit, the Insured must be diagnosed as having a Qualifying Event, which means (1) a non-correctable medical condition that, with reasonable medical certainty, will result in the death of the Insured within 12 months from the date on which this benefit is requested or (2) permanent and continuous confinement to a nursing home licensed and operated for nursing home care pursuant to the laws of the state in which it is located, and providing nursing care as its primary function. The Company will require a physician's statement certifying the Insured's life expectancy in the event of a terminal illness or certification of permanent confinement as outlined in the rider.

BENEFIT PAYMENT: The Accelerated Benefit may be paid in a lump sum. It may also be paid in installments of not less than \$250. The amount of each installment payment will be based on the following: (1) The lump sum amount; (2) the frequency of payment; (3) the number of installment payments to be made; and (4) a minimum interest rate of 3%.

BENEFITS AND ADJUSTMENTS: The following sample illustration shows how the amount available for payment as an Accelerated Benefit is calculated:

Base Policy:	\$10,000	Cash Value:	\$1,000
Eligible Death Benefit:	\$10,000	Policy Loan:	\$ 500
Maximum Gross Accelerated Benefit:			\$10,000
Requested Accelerated Benefit:			\$ 5,000

Adjustments:	Actuarial Discount	Loan Repayment	Premiums Due	Admin Fee	Total Adjustments
	\$5,000	\$500			
X	.05*	.50			
	<u>\$250</u>	<u>\$250</u>	<u>\$50</u>	<u>\$150</u>	<u>\$700</u>
	+	+	+	=	

*Discount rate is variable; 5% used as example only.

Maximum Net Accelerated Benefit: \$ 4,300 (\$5,000 - \$700 = \$4,300)

EFFECT ON POLICY VALUES: This shows how the benefits of the policy are altered after an Accelerated Benefit is paid:

Base Policy:	\$ 5,000	(\$10,000 X .5 = \$5,000)
Benefit at Death:	\$ 5,000	

Cash Value:	\$ 500	(\$1,000 X .5 = \$500)
Policy Loan:	<u>- 250</u>	(\$ 500 X .5 = \$250)
Remaining Cash Value:	\$ 250	(\$ 500 - \$250 = \$250)

Premium Before Benefit: \$ 600 per year

Premium After Benefit: \$ 300 per year (\$ 600 X .5 = \$300)

TAX CONSEQUENCES: Acceleration of life insurance benefits under this rider may or may not qualify for favorable tax treatment under the Internal Revenue Code of 1986, section 101 (g). Qualification for favorable tax treatment will depend on factors such as the Insured's life expectancy at the time benefits are accelerated or use of benefits for necessary long-term care expenses, such as nursing home care. If the acceleration of life insurance benefits qualifies for favorable tax treatment, the benefits will be excludable from the Owner's income and not subject to federal taxation. Tax laws relating to acceleration of life insurance benefits are complex. Consult a qualified tax advisor to assess the tax consequences of accelerated benefits.

ACCELERATED BENEFITS AND PUBLIC ASSISTANCE PROGRAMS: Receipt of accelerated benefits may affect eligibility for public assistance programs such as medical assistance (Medicaid), Aid to Families with Dependent Children (AFDC), supplementary social security income (SSI) and drug assistance programs. Consult a qualified tax advisor and social service agencies concerning how receipt of accelerated benefits will affect eligibility for public assistance.

I hereby acknowledge receipt of the Summary and Acknowledgement form. I also acknowledge that I have reviewed the "Benefits and Adjustments" and "Effect on Policy Values".

Signature of Agent

Date

Signature of Owner

Date

Guidestar® Insurance Telephone Script

INFO FROM AGENT:

Client Name: _____ Amount: _____
Agent Name: _____ Level: _____ Limited: _____
Address, City, St, Zip: _____ Telephone #: _____
SS#: _____ Date of Birth: _____ State of Birth: _____
Any prescription medications? (name and what for): _____

Current Family Doctor or Clinic: _____

Phone Number or City/State: _____

Did the Proposed Insured read the Declarations and Authorizations related to the
Guidestar Product? YES NO

INFO FROM CLIENT:

1. To complete this interview over the phone, we need to record this call and accept your signature electronically through voice recording. Is this OK? YES NO

Verify social security number and date of birth.

Also, please make sure to answer all questions accurately. Inaccurate or incomplete answers could affect the payment of policy benefits. Are these terms agreeable to you? YES NO

Have you read the Declarations and Authorizations allowing MIB or any other person or organization to release records regarding your medical and prescription drug history? YES NO

By stating yes, you are signing the notice and authorizations electronically and are authorizing American Home Life to immediately obtain this information regarding your medical and prescription drug history? Is that OK? YES NO

RUN MIB AND SCRIPT CHECK

Place electronic signature below:

Guidestar® Insurance Telephone Script

Height: _____ Weight: _____

Please verify that the medications your agent provided are correct. YES NO

*** For Indiana residents only, questions #3 &4 must be limited to the last 10 years and thus must begin... “In the last 10 years...”**

**** For Nebraska residents only, if a medical question does not contain a time limitation, please limit responses to the last 10 years.**

- | | | |
|--|-----|----|
| 2. Are you hospitalized, bedridden or confined to a nursing home, hospice or long-term care facility? | YES | NO |
| 3. Have you been diagnosed by or received treatment from a medical professional for any of the following: | | |
| A. A terminal illness, ALS, Alzheimer’s or dementia? | YES | NO |
| B. Diabetes accompanied by heart disease (excluding hypertension), kidney disease, peripheral arterial disease (PAD, poor circulation), Transient Ischemic Attack (TIA) or stroke? | YES | NO |
| C. Cirrhosis or liver failure? | YES | NO |
| D. Kidney failure requiring dialysis? | YES | NO |
| E. Used or been advised to use oxygen to assist breathing? | YES | NO |
| F. Leukemia or organ transplant? | YES | NO |
| G. Coronary artery disease (CAD) accompanied by (1) congestive heart failure or (2) cardiomyopathy? | YES | NO |
| H. Implantation of a defibrillator? | YES | NO |
| 4. To the best of your knowledge, have you been diagnosed or treated by a medical professional, for an immune deficiency disorder, HIV, AIDS, or AIDS related complex (ARC), or tested positive on an AIDS related blood test? | YES | NO |

***** Read for residents of Wisconsin only: Tests received at anonymous counseling and testing sites and the results of home test kits need not be revealed.**

- | | | |
|--|-----|----|
| 5. Have you, within the past 12 months, been advised to have a diagnostic test, surgery, dialysis, home health care, nursing home, hospice or long-term care facility confinement or hospitalization which has not yet been started, completed or for which results are not known? | YES | NO |
| 6. In the last 36 months, have you been convicted of a felony or of operating a vehicle while intoxicated or impaired or are you presently incarcerated, on probation or parole? | YES | NO |
| 7. Do you have diabetes diagnosed by a medical professional? | YES | NO |
| † If “Yes” ask Questions 7A-7D. If “No” go to Question #8. | | |
| A. Does your diabetes have a duration of 10 years or more? | YES | NO |
| B. Does your diabetes require insulin? | YES | NO |
| C. Was your diabetes diagnosed at any age and not presently controlled? | YES | NO |
| D. To the best of your knowledge, what was your most recent A1c level as | | |

Guidestar® Insurance Telephone Script

determined by a medical professional? _____%

- 8. Do you need ongoing assistance with activities of daily living (help with eating, bathing, dressing, transferring, use of the toilet or the taking of medications) either provided by a family member or third party? YES NO
- 9. In the last 24 months have you been diagnosed by or received treatment from a medical professional for any of the following:
 - A. Heart disease (excluding hypertension) or any procedure to improve circulation to the heart including coronary artery bypass or stents? YES NO
 - B. Stroke or Transient Ischemic Attack (TIA) or a procedure to improve circulation to the brain? YES NO
 - C. Peripheral arterial disease (PAD, poor circulation) or any procedure to improve circulation to the extremities? YES NO
 - D. Counseling or treatment for alcohol or substance abuse? YES NO
 - E. Kidney or liver disease? YES NO
 - F. Any chronic lung disorder excluding intermittent asthma attacks? YES NO
- 10. In the last 36 months have you been diagnosed by or received treatment from a medical professional for internal cancer, melanoma or disorder of the blood (this excludes squamous cell and basal cell skin cancers)? YES NO
- 11. Have you smoked cigarettes in the last 12 months? YES NO

If a policy will be issued, read the following statement:

For all states except Kansas and Minnesota:

Any policy issued upon receipt of your application shall not go into force until the application is complete, the first premium is paid in full and the application is approved by the company while the proposed insured's condition of health is unchanged from the date of the application.

For the states of Kansas and Minnesota:

Any policy issued upon receipt of your application shall not go into force until the application is complete and the first premium is paid in full.

___ Application will be referred to underwriting for additional information.

___ Application is declined.

Interviewer: _____ Date and Time of Call: _____

Comments: _____

Telesales Phone Interview

AGENT:

Control # _____

State your client's name.

Client's state of residence?

Did you read the Declarations and Authorizations related to the GuideStar product to the proposed insured?

Does your client accept the Automatic Premium Loan benefit?

PLEASE PROVIDE ALL INFORMATION ON THE APPLICANT INCLUDING HEALTH QUESTIONS, WHETHER THERE IS EXISTING LIFE INSURANCE AND WHETHER REPLACEMENT IS INVOLVED.

PROVIDE PRESCRIPTION MEDICATION AND PHYSICIAN INFORMATION.

May I speak with _____?

CLIENT:

Hello, my name is _____ and I am with The American Home Life Insurance Company.

To complete your Application over the phone, we need to record this call and accept your signature electronically through voice recording.

Also, please be sure to answer all questions accurately. Inaccurate or incomplete answers could affect the payment of policy benefits. Are these terms agreeable to you?

Our agent _____ has provided us with information that you have applied for life insurance on your life.

Is the personal information correct?

Are there existing life insurance or annuity policies on your life?

Will this policy replace or change any life insurance policy or annuity policy you now have?

Is the prescription medication and physician information complete and correct?

Have you been read the Declarations and Authorizations allowing the MIB or any other person or organization to release records regarding your medical and prescription drug history?

By stating yes to these questions, you are signing the notice and authorizations electronically and are authorizing American Home Life to immediately obtain this information regarding your medical and prescription drug history. Is that ok?

RUN MIB AND SCRIPT CHECK

Now, we're going to go over the medical questions a second time to make sure everything is accurate and complete.

1. Are you hospitalized, bedridden or confined to a nursing home, hospice or long-term care facility?
2. Have you been diagnosed by or received treatment from a medical professional for any of the following:
 - A. A terminal illness, ALS, Alzheimer's or dementia?
 - B. Diabetes accompanied by heart disease (excluding hypertension), kidney disease, peripheral arterial disease (PAD, poor circulation), Transient Ischemic Attack (TIA) or stroke?
 - C. Cirrhosis or liver failure?
 - D. Kidney failure requiring dialysis?
 - E. Used or been advised to use oxygen to assist breathing?
 - F. Leukemia or organ transplant?
 - G. Coronary artery disease (CAD) with (1) congestive heart failure or (2) cardiomyopathy?
 - H. Implantation of a defibrillator?
3. To the best of your knowledge, have you been diagnosed or treated by a medical professional, for an immune deficiency disorder, HIV, AIDS, or AIDS related complex (ARC), or tested positive on an AIDS related blood test?
4. Have you, within the past 12 months, been advised to have a diagnostic test, surgery, dialysis, home health care, nursing home, hospice or long-term care facility confinement or hospitalization which has not yet been started, completed or for which results are not known?
5. In the last 36 months, have you been convicted of a felony or of operating a vehicle while intoxicated or impaired or are you presently incarcerated, on probation or parole?
6. Do you have diabetes diagnosed by a medical professional (a) with duration of 10 years or more, or (b) requiring insulin, or (c) diagnosed at any age and that is not controlled?
7. Do you need ongoing assistance with activities of daily living (help with eating, bathing, dressing, transferring, use of the toilet or the taking of medications) either provided by a family member or third party?
8. In the last 24 months have you been diagnosed by or received treatment from a medical professional for any of the following:
 - A. Heart disease (excluding hypertension) or any procedure to improve circulation to the heart including coronary artery bypass or stents?
 - B. Stroke or Transient Ischemic Attack (TIA) or a procedure to improve circulation to the brain?

- C. Peripheral arterial disease (PAD, poor circulation) or any procedure to improve circulation to the extremities?
 - D. Counseling or treatment for alcohol or substance abuse?
 - E. Kidney or liver disease?
 - F. Any chronic lung disorder excluding intermittent asthma attacks?
9. In the last 36 months have you been diagnosed by or received treatment from a medical professional for internal cancer, melanoma or disorder of the blood (this excludes squamous cell and basal cell skin cancers)?
10. Have you smoked cigarettes in the last 12 months?

REPLACEMENT:

For ARKANSAS only-

Will this policy replace or change any existing life insurance or annuity you now carry?

If “No”, send Replacement Notice, Form U-86-AR with the issued policy or contract. (You are DONE)

If “Yes”, we must obtain a completed Replacement Memorandum, Form U-3 REP-AR before we can issue the policy.

If “Yes”, send Replacement Notice, Form U-1 REP (REV01/10)-AR (Appendix “C”) with the issued policy or contract along with a self-addressed postage prepaid envelope and instructions for the return of the signed notice. If we do not receive the Replacement Notice back, you are done unless the names of the existing insurers are listed on the application.

If the existing insurers are listed on the application or we receive the Replacement Notice, Form U-1 REP (REV01/10)-AR (Appendix “C”) back from the insured and it includes the names of existing insurers, we must:

- 1) Within 5 business days of receipt of the application or of Form U-1 REP (REV01/10)-AR, notify the existing insurers of the replacement;**
- 2) If thereafter requested by the existing insurer, within 5 business days of such request, mail a copy of an illustration or policy summary for the new contract to the existing insurer; and,**
- 3) In transactions where AHL is replacing its own policy, allow credit on the new policy for the period of time that has lapsed under the replaced policy’s or contract’s incontestability and suicide period up to the face amount of the existing policy.**

For KANSAS only-

If there is an existing policy, but there is no intent to replace, no replacement forms are required.

If there is a replacement involved:

- 1) Confirm with agent that either no sales material was used in the sale or that only AHL approved and printed sales material was used in the sale; and,**
- 2) Confirm with the applicant the names of the existing insurance companies whose policies are to be replaced; and,**
- 3) Within 3 business days, mail to the companies whose policies are to be replaced a statement that the applicant has indicated an intent to replace their policy; and,**
- 4) Concurrent with the notice to the existing company mail Form U-1 REP-EXT-KS to the applicant.**

For MISSOURI only-

If there is existing coverage, but no replacement is involved, no replacement forms are required. If there is replacement of an existing policy, ask the applicant whether our agent proposed the replacement of the existing policy.

If “No”, send the applicant (with the policy) Replacement Form U-1 REP-MO.

If “Yes”, you must:

- 1) Send the applicant (at time of application) Replacement Form U-1 REP-MO; and,**
- 2) Confirm the names of all existing insurance companies whose policies are to be replaced and the name(s) of the insured(s) on the policy(ies) and policy numbers.**
- 3) Within 5 working days of date application is received, send existing insurer notice of replacement with a policy summary and identifying information obtained in #2 above.**
- 4) Maintain in the file for 3 years copies of the Replacement Notice Form U-1 REP-MO and the policy summary.**

For TENNESSEE only-

If there is existing coverage, but no replacement is involved, no replacement forms are required.

If there is replacement of an existing policy, ask the applicant whether our agent proposed the replacement of the existing policy.

If “No”, send the applicant (with the policy) Replacement Form U-1 REP-TN.

If “Yes”, you must:

- 5) Send the applicant (at time of application) Replacement Form U-1 REP-TN; and,**
- 6) Confirm the names of all existing insurance companies whose policies are to be replaced and the name(s) of the insured(s) on the policy(ies) and policy numbers.**
- 7) Within 5 working days of date application is received, send existing insurer notice of replacement with a policy summary and identifying information obtained in #2 above.**
- 8) Maintain in the file for 5 years copies of the Replacement Notice Form U-1 REP-TN and the policy summary.**

For OKLAHOMA only-

If there is existing coverage, but no replacement is involved, no replacement forms are required.

If there is replacement of an existing policy, before the insured signs the application, we must obtain:

- 1) A completed Replacement Notice, Form U-1 REP-OK; and**
- 2) A copy of Replacement Form U-2 REP-OK signed and dated by agent and applicant. If applicant refuses to sign Form U-2 REP-OK, agent must certify to that fact on Form U-2 REP-OK and return a copy to us.**
- 3) If authorized by the applicant on Form U-2 REP-OK, within 5 days of receipt of the application and Replacement forms, send written notifications of the replacement to the existing insurer. Include information from Form U-1 REP-OK with replacement notice.**
- 4) Maintain for 3 years copies of Form U-1 REP-OK; U-2 REP-OK and notifications to existing insurer.**

For TEXAS only-

Will this policy replace, discontinue or change an existing policy or contract?

If “No” or if the applicant fails to respond to this question, send Replacement Notice, Form U-3 REP (DIRECT)-TX with the issued policy or contract. (You are DONE)

If “Yes”, send Replacement Notice, Form U-2 REP (DIRECT)-TX with the issued policy or contract along with a self-addressed postage prepaid envelope and instructions for the return of the signed

notice. If we do not receive the Replacement Notice back, you are done unless the existing insurers are listed on the application.

If the existing insurers are listed on the application or we receive the Replacement Notice, Form U-2 REP (DIRECT)-TX, back from the insured and it includes the names of existing insurers, we must:

- 1) Within 5 business days of receipt of the application or of Form U-2 REP (DIRECT)-TX, notify the existing insurers of the replacement;
- 2) If thereafter requested by the existing insurer, within 5 business days of such request, mail a copy of an illustration or a policy summary for the new policy to the existing insurer; and,
- 3) In transactions where AHL is replacing its own policy, allow credit on the new policy for the period of time that has lapsed under the replaced policy's or contract's incontestability and suicide period up to the face amount of the existing policy.

AGENT:

PLEASE PROVIDE BANK DRAFT AUTHORIZATION FORM INFORMATION INCLUDING FIRST DRAFT DATE AND SUBSEQUENT DRAFT DATE IF DIFFERENT.

CLIENT:

Is the bank draft authorization information correct?

I have that you are applying for the (a) Level/Limited GuideStar policy (w/Accidental Death if applicable) for \$_____ with a monthly bank draft of \$ _____. Is that correct?

Are the answers you have provided to the questions in the application complete and accurate to the best of your knowledge and belief?

Any policy issued with this application shall not go into force until the application is complete, the first premium is paid in full and the application is approved by the company while the proposed insured's condition of health is unchanged from the date of the application. Do you authorize us to draft your bank account for the payment of premiums?

By stating yes to these questions, you are signing the application and bank draft authorization electronically and a copy will be provided to you with your policy. Answer should ALWAYS be YES.

Ok, Congratulations! You are now approved and finished with the application process, welcome to the American Home Life Family! Please remain on the line while I ask (Agent Name) a few final questions.

To: AGENT

Are you aware of any additional information that may affect the underwriting decisions?

Do you have knowledge or belief that there are replacements of existing life insurance or annuities involved?

AR ONLY. IF ANSWER IS YES FOR REPLACEMENT, VERIFY AGENT QUESTIONS 1 & 2 AT THE BOTTOM OF THE NOTICE. BOTH ANSWERS SHOULD ALWAYS BE YES

Do you hereby certify that you truthfully and accurately provided all information for the application and if applicable the replacement notice as provided by the applicant?

By your answers to these questions you understand that you are signing the application and if applicable the replacement notice electronically, is that correct?

Would you like the policy mailed to the owner?

This policy was approved effective _____ . The policy # will be _____ .

SERFF Tracking Number: AHLL-127627912 State: Arkansas
 Filing Company: The American Home Life Insurance Company State Tracking Number: 49824
 Company Tracking Number:
 TOI: L071 Individual Life - Whole Sub-TOI: L071.101 Fixed/Indeterminate Premium - Single Life
 Product Name: 2011 Final Expense Applications
 Project Name/Number: /

Supporting Document Schedules

	Item Status:	Status Date:
<p>Satisfied - Item: Flesch Certification Comments: The forms submitted herein are not policy forms. The American Home Life Insurance Company certifies that the policies that are used with the forms submitted within this filing comply with Arkansas Rule & Regulation 19 & 49 and the Consumer Information Notice. Attachment: Flesch.pdf</p>		
<p>Bypassed - Item: Application Bypass Reason: Form 2011 FEPA-AR is the application form. Comments:</p>		
<p>Bypassed - Item: Life & Annuity - Acturial Memo Bypass Reason: Policy forms are not included in this filing. Comments:</p>		

CERTIFICATION

This is to certify that the following form(s) has achieved the Flesch readability score required in the state of Arkansas.

<u>Form Number</u>	<u>Description</u>	<u>Flesch Readability Score</u>
Form 2011 FEPA-AR	Application for Final Expense Insurance	49.5
2011 FEITS	Final Expense (Guidestar®) Insurance Telephone Script	63.4
2011 TSFE	Telesales Phone Interview	43.6



Les E. Diehl
Vice President - General Counsel

September 19, 2011

Date